GRATTAN Institute

Delivering quality care more efficiently

Submission to the Productivity Commission inquiry

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1 Delivering quality care more efficiently

Grattan Institute welcomes the Productivity Commission's interim report and its focus on reforms that can improve the quality and efficiency of care. We support the Commission's emphasis on better integration of services and a stronger role for prevention. Our submission responds on two areas where Grattan has undertaken substantial work: commissioning and prevention.

1.1 Collaborative commissioning

As the Commission notes, improving how care is commissioned – how providers are funded and managed – is an important opportunity.

Collaborative commissioning between hospital networks, Primary Health Networks (PHNs), and Aboriginal Community Controlled Health Organisations (ACCHOs) could improve system integration. But the goals of collaborative commissioning, and measurement of success, shouldn't start with the narrow and volatile measure of potentially preventable hospitalisations.

Collaborative commissioning should also be part of a broader agenda that includes improving commissioning *within* systems. There is ample evidence of room for improvement in both federal and state government commissioning. Compared to coordinated commissioning across levels of government, progress here will probably be much easier to achieve, and could have an even greater impact.

Use a suite of performance measures

The Commission suggests potentially preventable hospitalisations (PPHs) as the initial focus of collaborative commissioning, with funding linked to risk-adjusted PPH rates.

While they are a useful measure, PPHs are not a good fit for this purpose. They were developed to measure primary care access, not system integration – the Commission's policy goal. They capture only a sub-set of potentially avoidable admissions that can be measured using hospital coding, many cannot be avoided in practice, and they are strongly influenced by causes well beyond healthcare.[1]

In addition, the number of PPHs is small, making them a volatile performance measure. For example, the ACT PHN recorded the largest annual fall in the rate of PPHs in 2019, making them the best performing PHN in the country. The next year, they were the worst performer. By 2022, they were the best region once more. Other regions, such as Northern Sydney, have also gone from winning the race one year to getting the wooden spoon the next (see Figure 1.1 on the following page).[2]

We recommend anchoring collaborative commissioning in a broader suite of performance measures. That would be consistent with the National Health Reform Agreement Mid-term Review's call for a national performance framework,[3] and with how PPHs are used in other countries.[4] A subset of those measures could be used, ideally ones that reflect shared areas of responsibility that require collaboration

1. Falster and Jorm (2017).
2. Grattan Institute analysis of Australian Institute of Health and Welfare (2025).
3. Huxtable (2023).
4. For example, in the Better Care Fund in the UK (a pooled commissioning approach to integrate NHS and local government services for health, aged care, and disability), PPHs are one of six supporting metrics, sitting below three key indicators. Unlike in the Commission's proposal, they are used for planning, setting targets, and monitoring performance, not to determine funding. NHS England (2025) .

for progress. PPHs might be relevant for some areas – those with persistently high PPH rates – but not for most.[5]

Use 'primary care deserts' as a proving ground

An early application of collaborative commissioning should be co-commissioning primary care in 'thin markets'. In these areas collaboration is required to fill gaps in the system, building on pooled infrastructure and workforce.

There would be immediate, tangible impact through better access to care. It would also be easier to add services in a thin market than reshape a 'thick' health ecosystem. And the goal and scope of commissioning would be clear and bounded.

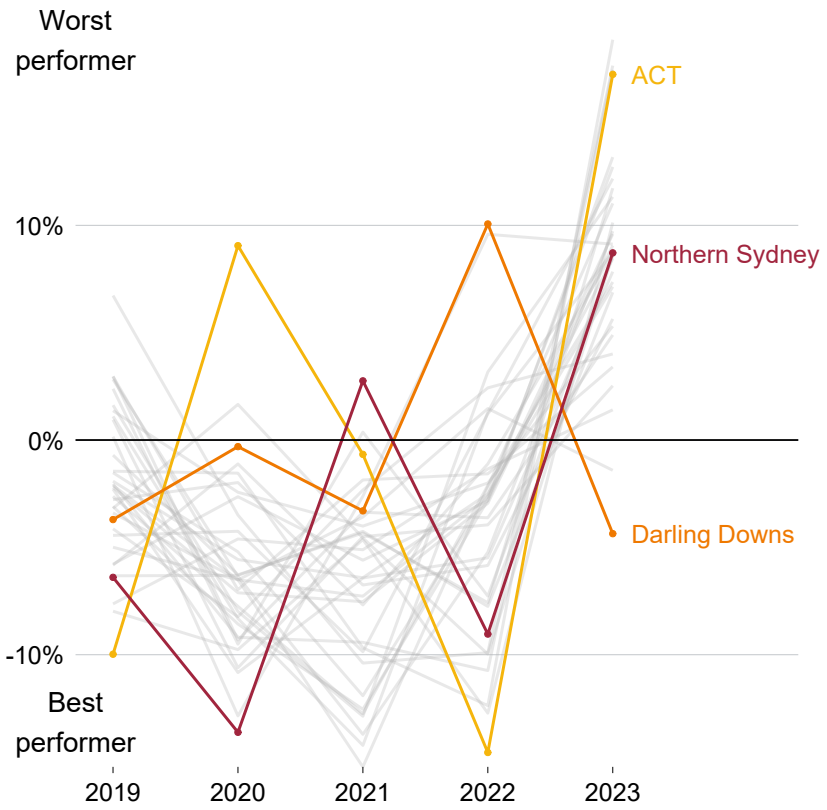
All this makes thin markets an ideal proving ground for collaborative commissioning. Demonstrating success here would build trust and capability for broader reforms. To ensure co-commissioning happens when it's needed, the National Health Reform Agreement should commit to clear triggers for investment in areas with too little care.

Strengthen commissioning capability within systems

The Commission's interim report focuses on collaborative commissioning, but commissioning by individual jurisdictions will be easier to improve, and could make an even bigger difference.

Huge strides can be made to make care more productive and equitable through better system management, as demonstrated by Grattan Institute research on:

Figure 1.1: The performance of Primary Health Networks using rates of potentially preventable hospitalisations (PPHs) is volatile
Percentage change in the annual rate of age-standardised PPHs, 2019-2023



Notes: Data represent aged-standardised total PPHs for all people. Years represent financial years (e.g. 2019 = 2018-19).

Source: Grattan Institute analysis of Australian Institute of Health and Welfare (2025).

5. Grattan Institute has argued for funding to tackle outlier PPH 'hot spots' with persistently high rates for several years, but suggested these interventions be PHN-led since the measure points to problems in primary care. Duckett et al (2016).

- Vaccination – improving equity of uptake through better commissioning of general practice,[6]
- Primary care – improving quality and affordability through better strategic and operational commissioning,[7] and
- Public hospital financial management – increasing system sustainability through better budgeting, pricing, and performance management.[8]

We suggest the Commission recommend a systematic program to build commissioning capability in federal and state departments, and PHNs. This should be informed by assessment of optimum governance and funding settings, performance measurement approaches, current commissioning capabilities, and international best practices.[9]

1.2 Prevention

We strongly support the Commission's proposal for a stronger prevention investment framework. Compared to many other countries, Australia has far less investment, and far less reform, to keep people healthy. Short-termism, vested interests, and coordination challenges stand in the way, and Australia needs strong institutions to overcome these barriers.[10]

Like the Commision, we argue that long-term modelling, cost-benefit analysis, and shared funding responsibilities across governments are critical to shifting resources towards interventions that improve outcomes and reduce future costs. We also endorse the emphasis on prioritising equity, particularly for Aboriginal and Torres Strait Islander people.

Leverage the Centre for Disease Control

Rather than creating a new national prevention board, we recommend embedding its functions in the Australian Centre for Disease Control (CDC). While the idea of a whole-of-government agency is appealing and novel, there is more evidence that the CDC can succeed.

The CDC doesn't require a new government commitment to establish another agency. It will avoid duplication between the proposed cross-government agency and the CDC. And it will be a better fit with government structures, with a lead Minister, rather than being an orphaned cross-portfolio body, or a low priority for the Prime Minister or Treasurer.

The Commission rightly notes that many levers for prevention lie outside the health portfolio. But CDC-type bodies overseas have often advocated for and influenced polices across government (see Box 1).

In our 2023 report, *Highway to Health: The Australian Centre for Disease Control*, we proposed ways to hard-wire cross-portfolio expertise and perspectives through the design of the CDC.[11] They include making cross-portfolio advice a legislated function, establishing a multi-disciplinary board with members from outside the health sector, and requiring engagement with a range of portfolios. The Board that the Commission has proposed could be embedded into the CDC in an advisory role, or as part of the agency's governance structure.

6. Breadon and Stobart (2024).
7. Breadon and Romanes (2022).
8. Duckett et al (2014). We will update and extend this analysis in a new report we plan to publish in November. We would be happy to brief the Commission on this work.
9. UK initiatives including World Class Commissioning and Commissioning Support Units could be useful reference points: Department of Health (England) (2007), NHS Digital (2024).
10. Breadon et al (2023).
11. Ibid.

Box 1: CDC-type agencies can catalyse cross-portfolio reform and investment

UK – tax

Public Health England's 2015 evidence review on sugar and obesity recommended a tax on sugary drinks.[a] In 2016, the UK Treasury announced the Soft Drinks Industry Levy, explicitly citing PHE's evidence as part of the justification.[b]

US – housing

The US CDC advocated for smoke-free multi-unit housing rules,[c] which were later adopted as a nation-wide policy by the Department of Housing and Urban Development.[d]

Canada – cross-portfolio chronic disease prevention

The Public Health Agency of Canada funds projects to prevent chronic disease by tackling smoking, poor diet, and inactivity. It requires multi-sector partnerships, so many interventions extend beyond health, for example programs in schools and municipal planning projects.[e]

a. Public Health England (2015).
b. UK Government (2016).
c. Centers for Disease Control and Prevention (2011).
d. US Department of Housing and Urban Development (2016).
e. Public Health Agency of Canada (2021).

Bibliography

Australian Institute of Health and Welfare (2025). *Potentially preventable hospitalisations in Australia by small geographic areas: 2017–18 to 2022–23 (Data tables)*. Australian Institute of Health and Welfare. https://www.aihw.gov.au/getmedia/45eee7fa-185c-4d37-9704-8cfad328714b/aihw-hpf-72-potentially-preventable-hospitalisations-by-small-geographic-areas-2017-18-to-2022-23-data-tables.xlsx.

Breadon, P. and Romanes, D. (2022). 'A New Medicare: Strengthening General Practice'. *Grattan Institute Report*. https://grattan.edu.au/wp-content/uploads/2022/12/A-new-Medicare-strengthening-general-practice-Grattan-Report.pdf.

Breadon et al (2023). Breadon, P., Fox, L., Emslie, O., and Richardson, L. *The Australian Centre for Disease Control (ACDC): Highway to health*. Grattan Institute. https://grattan.edu.au/wp-content/uploads/2023/02/The-Australian-Centre-for-Disease-Control-ACDC-Highway-to-Health-Grattan-Report.pdf.

Breadon, P. and Stobart, A. (2024). 'Patchy Protection: How to Boost GPs' Patient Vaccination Rates'. *Grattan Institute Report*. https://grattan.edu.au/wp-content/uploads/2024/07/Patchy-Protection-Grattan-Institute-Report.pdf.

Centers for Disease Control and Prevention (2011). *Healthy Homes Manual: Smoke-free Policies in Multiunit Housing*. https://stacks.cdc.gov/view/cdc/26185.

Department of Health (England) (2007). *World Class Commissioning (WCC) Programme: vision, competencies and reforms*. Department of Health. https://navigator.health.org.uk/theme/world-class-commissioning-wcc-programme.

Duckett et al (2014). Duckett, S., Breadon, P., Weidmann, B., and Nicola, I. *Controlling costly care: a billion-dollar hospital opportunity*. https://grattan.edu.au/report/controlling-costly-care-a-billion-dollar-hospital-opportunity/.

Duckett et al (2016). Duckett, S., Griffiths, K., and Swerissen, H. *Perils of place: identifying hotspots of health inequality*. Report No. 2016-10. Grattan Institute. https://grattan.edu.au/report/perils-of-place-identifying-hotspots-of-health-inequality/.

Falster, M. and Jorm, L. (2017). *A guide to the potentially preventable hospitalisations indicator in Australia*. Centre for Big Data Research in Health, University of New South Wales, in consultation with the Australian Commission on Safety et al. https://www.safetyandquality.gov.au/sites/default/files/migrated/A-guide-to-the-potentially-preventable-hospitalisations-indicator-in-Australia.pdf.

Huxtable, R. (2023). *National Health Reform Agreement Mid-term Review: Final Report, October 2023*. Australian Government Department of Health and Aged Care. https://www.health.gov.au/sites/default/files/2023-12/nhra-mid-term-review-final-report-october-2023.pdf.

NHS Digital (2024). *Commissioning Support Units: business definition*. NHS Digital. https://archive.datadictionary.nhs.uk/DD%20Release%20May%202024/nhs_business_definitions/commissioning_support_unit.html.

NHS England (2025). *Better Care Fund: Planning Requirements 2025–26*. NHS England. https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26.

Public Health Agency of Canada (2021). *Healthy Canadians and Communities Fund: Overview*. Government of Canada. https://www.canada.ca/en/public-health/services/funding-opportunities/grant-contribution-funding-opportunities/healthy-canadians-communities-fund-overview.html.

Public Health England (2015). *Sugar Reduction: The Evidence for Action*. Public Health England. https://assets.publishing.service.gov.uk/media/5a7f928c40f0b623026904b7/Sugar_reduction_The_evidence_for_action.pdf.

UK Government (2016). *Soft Drinks Industry Levy*. UK Government policy paper. https://www.gov.uk/government/publications/soft-drinks-industry-levy/soft-drinks-industry-levy.

US Department of Housing and Urban Development (2016). *Instituting Smoke-Free Public Housing*. Federal Register. https://www.federalregister.gov/documents/2016/12/05/2016-28986/instituting-smoke-free-public-housing.