

Robust evidence is needed to improve care economy productivity

A response to the Productivity Commission interim report

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Executive summary

This paper presents a collective response from senior Australian health economists to the Productivity Commission's interim report on 'Delivering care more efficiently'. We recognise the potential benefits of the draft recommendations but emphasise that large-scale reforms as proposed by the Productivity Commission are complex, challenging and costly, and currently lack sufficient supporting evidence.

On reforming quality and safety regulation, we caution the Government against immediately aligning standards across aged care and disability care without first quantifying the economic benefits and costs. We recommend prioritising the routine measurement of outcomes and wellbeing using preference-based tools, and strengthening systems to monitor, enforce and incentivise quality.

On collaborative commissioning, we highlight evidence from England showing its failure to integrate services and improve quality at scale. We suggest that if collaborative commissioning were pursued by the Government, it should not be implemented system-wide initially but instead trialled in limited settings with embedded evaluation frameworks and a learning ecosystem. Success will depend on overcoming cultural barriers between primary and acute care, building leadership and trust, strengthening local data and analytical capability, and potentially merging PHNs and LHNs into single regional commissioning organisations with pooled funding and strong governance.

We recommend that the Government instead continue to focus on shifting payment models from fee for service models to developing and trialling value based payment models, where providers are rewarded for improved care quality and health outcomes. We suggest bundled payments, which hold groups of providers collectively accountable for outcomes and costs, are more likely to drive care integration and productivity, and that Australia's single-payer system provides a unique advantage for testing such models.

We support a National Prevention Investment Framework but stress that prevention interventions are not always cheaper than the cure. They should be subject to the same rigorous economic evaluation as other health interventions. We recommend that a National Prevention Investment Framework incorporate some mechanism to avoid prevention becoming siloed across sectors, states and territories, and we challenge the Productivity Commission to further consider how a national framework would ensure investments align with unique state and territory public health programs. We highlight the potential inequities associated with prevention interventions and recommend that a National Prevention Investment Framework explicitly incorporate ways to measure health equity to ensure culturally and linguistically diverse people are not left behind.

Australian health economists are internationally renowned for undertaking impactful applied research. We have an established research base and the methodological expertise required to help design and evaluate care economy initiatives aimed at improving productivity. We recommend that the Government substantially invest more in university based health economics training and research to enable health economists to generate targeted research in collaboration with government departments and agencies. This will generate the rigorous evidence needed to guide care economy reform design, implementation, and evaluation, ensuring that changes deliver genuine productivity gains alongside improved wellbeing, equity and sustainability.

Introduction

A more productive care economy is necessary for a more productive Australia. The care economy employs the most workers in Australia and is a leading contributor to Australia's gross domestic product. However, growth in care economy expenditure is outpacing national income, putting relentless pressure on government budgets (1).

In August 2025, the Productivity Commission released an interim report on 'Delivering care more efficiently', calling for submissions to comment on several recommendations made within the report, across three themes. These themes include:

1. Reform of quality and safety regulation to support a more cohesive care economy.
2. Embed collaborative commissioning to increase the integrated of care services.
3. A national framework to support government investment in prevention.

This paper presents the collective views from directors and senior health economists within Australia's leading health economics research centres. We have come together to respond to the Productivity Commission's recommendations and to provide a broader view of potential productivity gains in the care economy.

Against a backdrop of significant ongoing reforms within the health, aged and disability care sectors, the Productivity Commission recommends additional reform for the care economy. While we recognise the potential benefits from those recommendations, there will also be substantial costs that have not been identified or quantified by the Productivity Commission.

We therefore believe that further robust evidence is required to support the adoption and implementation of the Productivity Commission's recommendations. Large scale reform is complex and challenging.

Generating evidence on the potential net benefits of recommendation and the best way to implement recommendations, should be considered early to ensure productivity gains, and other desirable outcomes such as improved wellbeing, equity and sustainability, are realised.

We therefore recommend that the Australian Government substantially invest more in developing rigorous health economic research capability and capacity through universities to deliver evidence that supports a transition towards Productivity Commission recommendations, to identify new ideas for further productivity gains within the care economy, and to evaluate policy outcomes to better align settings with the productivity agenda.

Response to Productivity Commission recommendations

Reform of quality and safety regulation

The Productivity Commission have identified several potential benefits in aligning quality and safety regulation across care markets. However, there is some uncertainty on the scale of productivity gains available relative to the cost of aligning regulation, and therefore whether recommendations made by the Productivity Commission are economically justified.

While misaligned regulation creates additional costs for government and providers, and makes it more difficult for workers to shift between sectors, the monetary quantum of this burden is unclear.

Understanding this quantum is foundational for reform because alignment will impose substantial administration costs on government and providers throughout the transition. Aged care and disability care providers are already burdened with substantial reform change associated with Royal Commission findings, so requiring providers to further reform may be challenging. We therefore recommend that further research is undertaken to compare potential benefits with costs before the Government pursues additional quality and safety regulation reform.

The Productivity Commission recommends the Government create a single set of practice and quality standards across aged care and NDIS services. We believe that standardisation should proceed with caution. Care quality encompasses more than clinical outcomes within aged care and disability care, it should also align with care recipient's needs and preferences. While most people want to live independently and receive consumer directed care, there are likely substantial differences in consumer needs and preferences within and across aged care and disability care sectors. For example, many in the NDIS seek stable employment whereas most receiving aged care are retired.

Australian health economists are well placed to help the Government navigate standardisation across aged care and disability care, along with developing new measures of value in other healthcare sectors. We are world leaders in developing preference weighted measures of outcomes attuned to unique consumer cohorts, from older people living in residential aged care (2) to children receiving healthcare (3).

Quality and safety regulation rightly focuses on minimum standards. However, creating a single set of practice and quality standards as recommended by the Productivity Commission ignores measuring and valuing health and wellbeing outcomes for those receiving aged care and disability care services. There are well known problems in the national measurement of productivity across these sectors, which is not being addressed. While aged care has adopted the Quality of Life Aged Care Consumers (QoL-ACC) tool (2) and the Disability Wellbeing Index (DWI) was recently launched for measuring outcomes in the disability care

sector (4), there are no nationally applicable healthcare preference measures that capture changes in health outcomes in a standardised way.

The routine measurement of wellbeing outcomes across the care economy is an essential prerequisite to raising productivity. Decades of research in measuring health outcomes impacted by healthcare systems have been produced by Australian university based health economics researchers, with extensive evidence about the performance of these measures in different populations and settings. Regardless, there are still substantial barriers to implementation of routine use of patient reported outcomes across health systems in any systematic and standardised way. There are pockets of activity, such as within NSW where the Ministry of Health is collecting Patient Reported Outcome Measures (PROMs). This demonstrates system wide collection of patient outcomes is possible. However, these PROMs were not designed with the evaluation of healthcare interventions in mind, requiring 'work arounds' to map PROMs into an alternative outcome measure that can be used to measure productivity improvements (5).

The benefits of proper outcome measurement are substantial. More productivity gains could be made from investing in better care quality indicators and preference based outcome measures that can be directly used to evaluate value before regulation is aligned. This would help identify perverse outcomes from complex regulatory change associated with standardisation. Consumers would be better equipped to make informed decisions about providers, and providers would have evidence about how to improve the care they provide. Better quality metrics could help consumers choose between alternative GPs, non-GP specialists, disability service providers or home care package providers. Better preference based outcome measures could help governments invest in interventions delivering value, and disinvest in interventions delivering low value or no value care. This could transform the healthcare system considering 30 per cent of care is of low or no value, and 10 per cent of care results in harm (6).

Experience in Australia on harmonising workplace health and safety legislation suggests a reduction in workplace injury and disease comes not from harmonisation itself, but from the associated enforcement activity by state governments and increased managerial focus on improving workplace health and safety due to higher penalties (7). Similarly in the care economy, most productivity benefits are unlikely to come from aligning safety and quality regulation, but from ensuring safety and quality are appropriately measured, monitored and enforced by the Government, and the extent to which government and market structures can create incentives to the production of quality beyond a minimum threshold.

A substantial increase in care economy productivity could come from better understanding how to organise care markets and better understanding what role financial and non-financial incentives play in promoting care quality. Interdependent but operating within siloed quasi-markets, aged care and disability care share

common undesirable market characteristics, such as partially unexplained service demand, inconsistent and often unobservable quality, and limited informed choice. Without better functioning and more sustainable care markets, the Government will struggle further to fund future consumer needs and preferences, potentially leading to suboptimal wellbeing outcomes and no improvements in productivity.

The urgency to ensure an evidence-based approach to improving care market productivity by aligning incentives, promoting innovation and reducing waste cannot be underestimated. In addition to better understanding how to align market incentives to improve quality in care markets, more research is required to better understand how incentives are transmitted through an organisation. Incentives at the organisation level (e.g., a hospital) are different than incentives at the worker level, as demonstrated through the evaluation of health care homes (8). In some instances, financial incentives may undermine intrinsic worker motivation by running counter to their psychological needs of autonomy, competence and relatedness (9). Identifying how to best change workplace behaviour is fundamental for whole of sector safety and quality improvement.

Embed collaborative commissioning

While we welcome the recommendation on healthcare funding reform, it is unclear whether collaborative commissioning involving PHNs, LHNs and ACCHOs will produce large productivity gains given the complexity in developing, managing and evaluating commissioning processes at a local level. Experience with PHN commissioning suggests employees need substantial upskilling to better deliver commissioning services, such as management of data, budgets and risk (10). While the Productivity Commission suggests a ‘modest’ reduction of 10% in potentially preventable hospitalisation could result, it is unclear (and untested) whether this reduction could be achieved at scale using collaborative commissioning.

The England National Health Service provides an excellent case study on the complexity and challenges associated with healthcare commissioning. Introduced in 1991 by creating Health Authorities and GP Fundholding, the UK government has since pursued several periods of major commissioning reform (11), including establishing Primary Care Trusts in 2000 to commission healthcare and community care, and Care Trusts and Children’s Trusts in 2002 to plan and purchase health and social care services (12).

The UK government replaced primary care trusts with Clinical Commissioning Groups (CCGs) in 2012 to give clinicians more planning and purchasing power. However, evidence that CCGs integrated care is limited, and there is no evidence to suggest they improved care quality at scale (13). Evidence suggests patients became more disconnected from primary care services and from managing their own care after CCGs were established, despite CCG’s focus on establishing integrated care (12).

The UK government abolished CCGs for Integrated Care Boards (ICBs) in 2022. These boards comprise system level stakeholders with an explicit mandate to integrate NHS services, public health and social care. Recent evidence suggests they too face challenges, including low access to data, poor quality data and board inability to use all available data, the complexity of procurement services due to limited skilled staff, difficulty in recruiting health and social care workers to deliver care, tension between local needs and national level policies, competing financial priorities, and ongoing financial constraints (14).

In Australia, successful collaborative commissioning between PHNs, LHNs and ACCHOs will require more than joint governance arrangements and removing barriers to pooled funding. Cultural barriers between primary and acute care settings must be addressed, along with investment in strong leadership to enable effective engagement with clinicians, government and the public. Developing trust across organisations will require resources, potentially drawing commissioning clinicians away from delivering care. Contractual mechanisms must ensure neither PHNs, LHNs or ACCHOs can shirk on their responsibility and accountability to clinicians and their public.

The Productivity Commission suggests collaborative commissioning should be governed by joint committees that include members from PHNs, LHNs and ACCHOs. We believe joint committees will not be strong enough to hold organisations to account and could add administrative complexity without delivering results. We recommend that if collaborative commissioning were pursued, the Government considers merging LHNs and PHNs into one organisation with appropriate geographic boundaries, so there is one regional commissioner of healthcare and other services. This would more effectively enable the pooling and holding of funds to support service integration. The governance of these organisations would need to be carefully designed so their missions and values are consistent with broader healthcare system goals.

Commissioning must be informed by good quality data collection and analysis. PHNs, LHNs and ACCHOs will require new data assets to better identify population need and to monitor and measure quality of services and health outcomes. Ongoing opportunities for managers and clinicians to upskill their data collection, cleaning and analysis skills would be needed. Any national funding model reform should be data driven (15).

Importantly, PHNs, LHNs and ACCHOs will require substantial support in developing new funding models that align with government policy towards value based payments (16), given they must address different workforce cultures, patient populations, and a provider's capacity to invest in organisational and infrastructure change (17). Whether to use rewards or penalties, absolute or relative performance targets, how to risk adjust, the incentive size and how to engage providers will have a material impact on

effectiveness, yet there are no templates organisations can employ to circumvent the need for funding model expertise (18).

Any transition towards collaborative commissioning should be accompanied by an established learning ecosystem, where government and collaborators are supported with ongoing evidence based research that highlights areas for improvement. Complex funding reform such as collaborative commissioning cannot happen overnight, nor should it be rolled out all at once. It is unlikely to work the first time. If pursued by the Government, collaborative commissioning should be trialled with an appropriate evaluation framework embedded into trials from the start. Government should refrain from extending investment in collaborative commissioning until trials are completed. It will take more than one trial to identify an initial set of attributes and ongoing research to monitor effectiveness as healthcare needs and systems change.

Alternative funding model reform to improve productivity

We must fundamentally rethink care payment models to improve care integration and increase productivity. Rather than focusing on collaborative commissioning, we recommend that the Government continue to focus on moving the healthcare system away from fee for service payment models towards value based payment models, where providers are financially rewarded for improving health outcomes. The Government's intent is already outlined within the Addendum to the National Health Reform Agreement (16), the MBS Review Taskforce (19) and the Australia's Primary Health Care 10 Year Plan (20).

Experience in the United States suggests that while geographic variations in healthcare spending exist, the primary driver is the substantial variation in individual healthcare provider behaviour within areas. Tying payments to a location, like within collaborative commissioning, could unfairly penalise effective providers in high-cost areas and reward ineffective ones in low-cost areas. The US National Academy of Medicine (NAM) concluded that payment incentives should be tied directly to providers and patient outcomes, not regions (21).

Insights from the US are relevant for Australia. A provider-based bundled payment model, where a group of providers, from GPs to specialists and hospitals, is held collectively accountable and paid based on the overall health outcomes of their patients, is potentially a far more effective approach than collaborative commissioning. A roadmap for introducing scalable value based payments in Australia has already been developed (15), recommending the government substantially invest in developing and testing these model types within a comprehensive learning ecosystem.

We recognise that implementing bundled payment models in the US has been challenging. Their success in achieving better outcomes has been mixed (22), although they are adolescent in their maturity. However,

the US contains many private payers, whereas Australia's single-payer system through Medicare provides a unique advantage to implement these kinds of innovative payment models. LHNs and PHNs could also be jointly funded and paid (in part) if they demonstrate improved patient quality of care and cost savings through genuine collaboration. This approach could be supported by mandating PHNs and LHNs to jointly undertake data collection, needs assessment, service planning and reporting to which they are held accountable.

A national prevention investment framework

We agree that governments must invest more in prevention and that a systematic approach to investment could help encourage that investment. However, the case for prevention is often built on the assumption that prevention is cheaper than the cure. This is not always the case, so prevention programs should be subject to the same rigorous assessments that are used for other health interventions, such as pharmaceutical and medical devices (23).

The Productivity Commission has taken a position that a National Prevention Investment Framework can help government invest in prevention programs that reduce the demand for future acute care services. While this is true, we caution against holding prevention programs to such standards. Prevention is not always a path towards reduced costs. There is often a substantial cost associated with implementing large scale prevention activities, not only because of the sheer number of people to reach, but also the difficulty in changing people's behaviour. A prevention program that increases costs but generates commensurate improvements in health outcomes also has an economic case to proceed (23).

Despite evidence to suggest prevention can significantly improve productivity (24), changing people's behaviours is challenging. Take obesity for example. Reducing unhealthy diets and sedentary lifestyles, a major risk factor for obesity and subsequent chronic disease, is challenging given the complex interplay between personal, economic, cultural, environment and lifestyle factors that cause these risky behaviours. The OECD estimates that food labelling, menu labelling and mass media leads to substantial net benefits, mostly through reduced cardiovascular disease and diabetes (24). However, it also suggests that combining these public health programs into a coherent multiprogram strategy would deliver greater benefits than implementing them independently.

We therefore recommend that a National Prevention Investment Framework have a mechanism to encourage integrated and aligned investment in prevention programs across sectors, states and territories. However, the interim report is unclear on how an independent Prevention Framework Advisory Board or supporting agreements could achieve this coordination given states and territories will have their own public health agenda, dictated by the preferences expressed by their constituents. A mechanism to ensure

coordination must be carefully considered. Qualitative analysis on interviews with state and territory governments for a national mental health investment framework in Australia suggested investment and disinvestment recommendations should strategically align with government policy (25).

The interim report suggests that disadvantaged groups and priority populations benefit more from prevention. We believe this assumption should be tested rather than assumed. The effectiveness of prevention programs will vary considerably, based on its attributes and the characteristics of the target population. While the OECD did not explicitly measure distributional impacts, we could expect that food labelling, menu labelling and mass media in Australia would be less effective for people from culturally and linguistically diverse populations (CALD) without proficient English language skills.

We therefore recommend that a National Prevention Investment Framework explicitly seek to measure the potential distributional impacts on health outcomes (a.k.a. health equity). Substantial research has already been conducted by Australian and international health economists on how to better incorporate equity into economic evaluations. Distributional Cost-Effectiveness Analysis (DCEA) methods are being used to measure lifetime health, wellbeing and inequality impacts (26), and are being adopted by health technology assessment agencies, such as the National Institute for Health and Care Excellence (NICE) in the UK (27). This methodological research area is extremely active and continues to evolve (28). More recently, a novel method known as Aggregate Distributional Cost-Effectiveness Analysis (A-DCEA) has been developed, which requires less resources and data than a conventional DCEA to measure equity implications of a health intervention (29). This tool could potentially be incorporated within a National Prevention Investment Framework.

There are many ways Australian university based health economists can add substantial value to developing a National Prevention Investment Framework and performing rigorous analysis to inform investment decisions. We have extensive experience in evaluating medicines and medical devices for the Pharmaceutical Benefits Advisory Committee and Medical Services Advisory Committee, sitting on these committees to make recommendations to the Minister for Health. Our training and experience can help Government better identify, consider and monitor potential unintended effects from prevention interventions, and help identify novel prevention interventions that sit outside the usual set, such as government programs that improve food, job and housing security. Our capacity to generate insights on how people respond to financial and non-financial incentives using behavioural economic methods would help the Government identify prevention programs with the greatest value.

Conclusion

The major challenge inherent in identifying opportunities for increasing care economy productivity is accommodating complexity and trade-offs. Care sectors set out to achieve both economic and social goals within strained government budgets. These often conflict, requiring trade-offs that make care market design and evaluation challenging. Heterogeneous service types and multidimensional provider characteristics and consumer needs make standardising outcome measurement challenging, while unobservable quality and unobservable consumer preferences weaken traditional demand-side market mechanisms. This complexity has created market failures, inferior health outcomes and an unpaid informal care burden on productive workers, particularly females who are usually the primary informal carer (30). Ongoing reforms within the care economy will continue to evolve, which means productivity will be a moving target.

The Australian university based health economics community is well placed to help the Government identify further care market productivity gains. Health economists working in universities have a rich history of major healthcare policy impact for Australia's benefit. Health economists Richard Scotton and John Deeble (Melbourne Institute of Applied Economic & Social Research) were the architects of Medicare. Australia was the first country to legislate the need to evaluate effectiveness and costs of medicines, leading to government relying on economic evidence to make decisions on subsidising new medicines and medical devices through the Pharmaceutical Benefits Scheme and Medicare. This saves the Australian Government billions of dollars each year, allowing cheap access to medicines and medical services for all Australians.

Australia's university based health economics community has already undertaken substantial research on measuring outcomes, how to improve care economy regulation and markets, and how to improve funding model reform in Australia and internationally. New large government administration data assets curated by the Australian Institute of Health and Welfare and the Australian Bureau of Statistics means our opportunity to explore care market productivity using big data and new data analytic techniques has grown in magnitude, shifting from a nascent possibility to an expansive and almost limitless domain. These data assets can be used to develop new care economy funding models, offering opportunities for better risk adjustment and fairer funding.

While we welcome the substantial body of research the Productivity Commission has produced on the care economy and productivity through its various inquiries and research papers, we believe that Australia's university based health economics community can add significant value by being further funded to conduct comprehensive, targeted research and to transfer skills to the Australian Public Service. The Australian Public Service Commission identified a need to improve policy analysis and data analytic skills within the Australian government (31). Government analytical capacity has been victim to public sector downsizing,

resulting in a large-scale relocation of expertise to non-government organisations (32). Generating innovative care economy policy ideas and design requires a broad church that includes university based health economists drawing from their multitude of embedded collaborative relationships with multidisciplinary teams and international academic experts.

We therefore recommend the Australian Government substantially invest more in developing health economic training and research capability within universities, to deliver evidence that supports a transition towards Productivity Commission recommendations, to identify new ideas for further productivity gains within the care economy, and to evaluate productivity related policy to help government better align settings with an ever-changing productivity landscape. Additional support to Australian university based health economists would help government fill their critical policy analysis gap through better coordinated research with government. It would allow Australian health economists to develop a learning ecosystem that transfers analytical capability across government and industry.

References

1. The Treasury. Intergenerational Report 2023. Australia's future to 2063. Canberra: Australian Government; 2023.
2. Ratcliffe J, Bourke S, Li J, Mulhern B, Hutchinson C, Khadka J, et al. Valuing the Quality-of-Life Aged Care Consumers (QOL-ACC) instrument for quality assessment and economic evaluation. *Pharmacoeconomics*. 2022;40(11):1069-79.
3. Huang L, Devlin N, Chen G, Dalziel K. A happiness approach to valuing health states for children. *Soc Sci Med*. 2024;348:116802.
4. Chen G, Petrie D, Harris A, Olsen JA BS, Woode ME, Aydin G, et al. Disability Wellbeing Index 2025 [Available from: <https://www.dwi.org.au/>].
5. Aghdaee M, Gu Y, Sinha K, Parkinson B, Sharma R, Cutler H. Mapping the Patient-Reported Outcomes Measurement Information System (PROMIS-29) to EQ-5D-5L. *Pharmacoeconomics*. 2023;41(2):187-98.
6. Braithwaite J, Glasziou P, Westbrook J. The three numbers you need to know about healthcare: the 60-30-10 Challenge. *BMC Medicine*. 2020;18(1):102.
7. Bilgrami A, Cutler H, Sinha K. Higher penalties, broader definitions and national standards: did harmonised Australian workplace health and safety laws reduce workers' compensation receipt? *Industrial Relations*. 2025;64:77-102.
8. Pearse J, Mazevska D, McElduff P, Stone C, Tuccia J, Cho O, et al. Health Care Homes trial final evaluation report, Volume 2: Main report. Canberra: Health Policy Analysis; 2022.
9. Kao AC. Driven to Care: Aligning External Motivators with Intrinsic Motivation. *Health Services Research*,. 2015;50 Suppl 2:2216-22.
10. Liang Z, Martin A, Turner CL. Developing Primary Health Network Employee's Capability in Health and Social Care Commissioning. *Journal of Healthcare Leadership*. 2025;17:241-58.
11. Exworthy M, Mannion R, Powell M. The NHS at 75: an unfolding story. In: Exworthy M, Mannion R, Powell M, editors. *The NHS at 75 The state of UK health policy*. Bristol: Policy Press; 2023.
12. Miller R, Glasby J, Dickinson H. Integrated health and social care in England: ten years on. *International Journal of Integrated Care*. 2021;21(4):6.
13. Checkland K, Coleman A, McDermott I, Peckham S. Clinically led commissioning: past, present and future? In: Exworthy M, Mannion R, M P, editors. *Dismantling the NHS? Evaluating the impact of health reforms*. Bristol: Policy Press; 2016.
14. Gongora-Salazar P, Glogowska M, Fitzpatrick R, Perera R, Tsiachristas A. Commissioning [integrated] care in England: an analysis of the current decision context. *International Journal of Integrated Care*. 2022;22(4):3.
15. Cutler H. A roadmap towards scalable value-based payments in Australian healthcare. Canberra: Deeble Institute for Health Policy Research; 2022.
16. Australian Government. Addendum to the National Health Reform Agreement 2020-25. Canberra: Commonwealth of Australia; 2020.
17. Ryan AM, Damberg CL. What can the past of pay-for-performance tell us about the future of Value-Based Purchasing in Medicare? *Healthcare*. 2013;1(1-2):42-9.

18. Cutler H, Olin E, Epp J, Gu Y. The use and usefulness of outcomes based funding for hospitals. Sydney: Sax Institute; 2019.
19. MBS Review Taskforce. An MBS for the 21st Century. Recommendations, learnings and ideas for the future. Canberra: Department of Health; 2020.
20. Department of Health. Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2032. Canberra: Australian Government; 2022.
21. Zhang Y, Baik SH, Fendrick AM, Baicker K. Comparing local and regional variation in health care spending. *New England Journal of Medicine*. 2012;367(18):1724-31.
22. Yee CA, Pizer SD, Frakt A. Medicare's bundled payment initiatives for hospital-initiated episodes: evidence and evolution. *The Milbank quarterly*. 2020;98(3):908-74.
23. Hall J. Disease prevention, health care, and economics. In: Glied S, P S, editors. *The Oxford Handbook of Health Economics*. Oxford, UK: Oxford Academic Press; 2011.
24. OECD. The heavy burden of obesity. The economics of prevention. Paris: OECD Health Policy Studies; 2019.
25. Fookien J, Bilgrami A, Norman A, Aghdaee M, Rapport F, Cutler H. Evaluating and getting value from mental healthcare investment: Qualitative results. Sydney: Macquarie University; 2024.
26. Skarda I, Asaria M, Cookson R. Evaluating childhood policy impacts on lifetime health, wellbeing and inequality: Lifecourse distributional economic evaluation. *Soc Sci Med*. 2022;302:114960.
27. NICE. Support document: Health inequalities. London: National Institute for Health and Care Excellence; 2025.
28. Cookson R, Griffin S, Norheim OF, Culyer AJ, Chalkidou K. Distributional Cost-Effectiveness Analysis Comes of Age. *Value Health*. 2021;24(1):118-20.
29. Jiang S, Li B, Parkinson B, Li S, Gu Y. Aggregate distributional cost-effectiveness analysis: a novel tool for health economic evaluation to inform resource allocation. *Global Health Research and Policy*. 2025;10(1):17.
30. Department of the Prime Minister and Cabinet. Draft national care and support economy strategy 2023. Canberra: Australian Government; 2023.
31. Australian Public Service Commission. Capability Review. Department of Health and Aged Care. Canberra: Australian Government; 2023.
32. Head B. Policy analysis and public sector capacity. In: Head B, Crowley K, editors. *Policy analysis in Australia*. Bristol: Policy Press; 2015.