Inquiry into the use of technology to assist in improving productivity

House of Representatives Standing Committee on Economics

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Executive summary

Healthcare is a major and growing part of the Australian economy, and people's health affects workforce participation and productivity across every sector. Improving healthcare productivity is therefore important both to the sustainability of the health system and to Australia's broader economic performance. Digital and medical technologies can help by freeing clinical capacity, avoiding preventable care, extending access and supporting participation in work and community life. This includes artificial intelligence, which can support diagnosis, help prioritise clinical work and automate selected administrative tasks. However, these gains do not come from purchasing technology alone. They depend on evidence, investment in people and workflow, systems that can exchange information, sustainable funding, appropriate human oversight and clear measurement.

Core proposition

Australia should treat the capabilities required for safe and scalable digital health as national productivity infrastructure. These capabilities include trusted data exchange, proportionate assessment, sustainable funding, implementation capacity and consistent measurement. Public support for individual technologies should remain evidence-based, technology-neutral and conditional on clinical value, a credible productivity pathway and appropriate safeguards.

Digital health is also an industry-development opportunity. Australia can capture more value when local research, clinical expertise and product development are connected to credible domestic adoption pathways, Australian reference sites, investment, manufacturing and export growth. Without an adoption pathway, Australian companies may generate evidence locally while pursuing revenue and scale overseas.

Australia does not have a shortage of digital-health innovation. It has a persistent adoption problem: funding remains tied to established care settings, successful pilots often lack a clear route into standard care, and no sufficiently resourced policy function is responsible for bringing together funding and adoption across digital therapeutics, remote monitoring and digitally enabled models of care.

MTAA recommends five reforms: clear routes from evidence to funded adoption; payment and procurement that consider the full cost and benefit across a patient's care; Commonwealth-state arrangements that support implementation at scale; consistent measurement of productivity; and a dedicated Commonwealth team to plan and accelerate digital-health funding and adoption. Together, these reforms would help move safe and effective technologies from pilots into routine use while maintaining accountability for outcomes, costs and technologies that do not deliver the expected benefits.

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Recommendations

Headline reform	What government should do
1. Create a predictable route from evidence to funded adoption	The Australian Government should coordinate existing regulatory, assessment, reimbursement and procurement functions so digital medical technologies have transparent evidence requirements, proportionate assessment, managed entry where uncertainty is resolvable, and scheduled reassessment or exit.
2. Pay and procure for the complete technology-enabled care model	Payment and procurement should recognise the technology, patient onboarding, clinical review, monitoring, escalation, integration, training and support required to deliver outcomes. Decisions should consider whole-of-pathway value rather than acquisition price or the clinical encounter alone.
3. Use Commonwealth-state health reform arrangements to implement at scale	Governments should pair national evidence and interoperability principles with Commonwealth reimbursement where applicable, state and territory commissioning, local workflow design, common real-world evidence and nationally reusable implementation assets.
4. Measure, share and scale what works	Australia should adopt a digital-health productivity framework that reports clinical outcomes, released capacity, avoided utilisation, workforce and patient burden, budget incidence, economic participation, implementation costs and uncertainty. Successful models should transition to routine funding; unsuccessful models should be modified or exited.
5. Create a small Commonwealth team to turn evidence into funding and adoption decisions	The Australian Government should establish a small team within the Department of Health, Disability and Ageing to identify promising technologies, clarify how they can be assessed and funded, coordinate evidence requirements and prepare proposals for government decisions. It should focus initially on digital therapeutics, remote patient monitoring, software as a medical device and digitally enabled care.

1. Why digital health is a productivity issue

Healthcare productivity is about the relationship between the resources used and the capacity, access, quality and health outcomes delivered. Lower spending is not the only measure of success. A technology may improve productivity by enabling more care with existing resources, slowing future growth in demand, reducing preventable care, improving outcomes or helping patients and carers participate in work and community life.

- Capacity: releasing clinical time, diagnostic capacity, beds or procedure capacity for additional care.
- Avoidance: reducing preventable deterioration, complications, admissions, readmissions or unnecessary travel.
- Coordination: reducing duplication, delay and information gaps across settings.
- Access: extending monitoring, rehabilitation and specialist capability into homes and regional communities.

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- Participation: supporting patients and carers to maintain employment and daily activities.
- Industry development: strengthening Australian evidence generation, commercialisation, investment and export capability.

2. Priority technology fields and Australian capability

Medical technology is a practical convergence point for artificial intelligence, advanced information and communication technologies, advanced sensing and imaging, robotics, biotechnology and advanced manufacturing. Applications include AI-enabled diagnostics, remote monitoring, connected implants, surgical robotics, digital therapeutics, digitally enabled rehabilitation and interoperable care platforms.

Australia's economic opportunity is not limited to inventing these technologies. Domestic adoption can provide reference sites, implementation capability, real-world evidence and commercial credibility. These assets can support investment and export, while local manufacturing and supply capability can strengthen resilience. Policy should therefore connect research translation, regulation, evidence generation, reimbursement and procurement rather than treating them as separate stages.

Requirements should be risk-based, proportionate and nationally harmonised. Duplicative assurance, integration and procurement requirements impose costs on all suppliers and can be especially difficult for Australian start-ups and SMEs.

3. From pilots to funded adoption

Australia frequently tests digital technologies through pilots, grants and local innovation budgets. The productivity problem is that successful demonstrations do not necessarily transition into routine commissioning. Costs and benefits may fall in different budgets; conventional payment may fund an encounter but not the enabling technology; and implementation costs may be excluded from procurement.

Australia does not have a technology problem. It has an adoption problem. Promising digital models are often tested successfully but do not secure ongoing funding. Technology can support care outside a hospital, consulting room or other traditionally funded setting, but the funding system often does not recognise the full technology-enabled service that replaces, prevents or improves that care. We continue to pay for the traditional appointment or treatment while leaving the monitoring platform, digital therapeutic, patient support, review conducted outside an appointment, system integration and escalation pathway unfunded. This mismatch prevents productivity gains even when the clinical model and technology are ready for wider use.

The same problem occurs after successful pilots. Australia is good at funding trials but less successful at turning demonstrated value into ongoing funding and standard care. There is no consistently clear and accountable route from a successful evaluation to a funding decision, no common approach to implementation and review, and not enough dedicated policy capacity within the Australian Government Department of Health, Disability and Ageing to resolve these barriers. Unless government establishes clear adoption pathways and the departmental capability to maintain them, Australia will continue funding pilots without securing the productivity benefits of wider use.

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A federated operating model

- National evidence principles proportionate to clinical risk, maturity and the decision being made.
- Regulatory approval for supply kept distinct from comparative value, reimbursement and workflow readiness.
- Commonwealth reimbursement decisions where the benefit and funding mechanism are national.
- State and territory commissioning and procurement for public services, supported by nationally reusable specifications.
- Local clinical governance and workflow design, including escalation responsibilities.
- A common minimum real-world evidence dataset and scheduled reassessment.
- Clear continuation, modification and exit criteria.

This model does not require every technology to follow one identical route. A regulated software device, remote-monitoring service, connected implant and hospital workflow platform may require different decision pathways. The common requirement is transparency about evidence, decision rights, implementation and reassessment.

3.1 Establish dedicated departmental capability

The adoption problem is also a Commonwealth coordination problem. Digital therapeutics, remote patient monitoring, software as a medical device and digitally enabled models of care cut across technology assessment, Medicare, Commonwealth programs, public hospital funding, private health, regulation, information exchange and Commonwealth-state reform. Many bodies have important roles, but no adequately resourced team is responsible for bringing together information about available technologies, the supporting evidence, funding options and adoption planning.

MTAA recommends that the Australian Government establish a small Digital Health Funding, Adoption and Market Intelligence team within the Department of Health, Disability and Ageing, initially with 3–5 policy and technical staff. It would not be a new regulator or a lower-standard assessment body. It would work with existing departments, agencies, states and territories to clarify funding routes, identify gaps, track available and emerging technologies, prepare proposals for government decisions, coordinate conditional funding while further evidence is collected, and help successful models move from pilots into routine care.

Priority deliverables should include a national digital-health funding and adoption roadmap; a usable classification and market-intelligence framework for regulated software, digital therapeutics and remote monitoring; clear routing through existing assessment and payment mechanisms; advice on provisional and recurrent funding options; coordination with National Health Reform Agreement implementation; and an annual pipeline of evidence-based adoption priorities. The capability would not commit government to funding every technology. It would give government the capacity to make disciplined decisions about which technologies and service models should be assessed, reimbursed, adopted, reassessed or exited.

4. Illustrative composite case studies

Status of the following examples
These are hypothetical composite scenarios created for policy illustration. They synthesise recurring features of real-world member examples and MTAA policy work. They are not named implementations, verified evaluations or approved member case studies. No numerical outcome is asserted as observed fact.

Illustrative composite 1: Remote monitoring after cardiothoracic surgery

A public hospital introduces a regulated post-discharge monitoring platform for selected cardiothoracic patients. Patients report symptoms and physiological measures from home. A clinical team reviews risk flags and follows defined escalation protocols.

Element	Illustrative analysis
Productivity pathway	Earlier identification of deterioration may prevent some high-cost readmissions or reduce their severity. Follow-up can be targeted according to risk rather than delivered uniformly.
Complementary investment	Patient onboarding, devices or connectivity, integration, clinical review time, escalation pathways, technical support and governance.
Barrier to scale	The hospital may bear the software and implementation cost while avoided activity appears elsewhere in its budget or funding flows. A pilot budget does not establish recurrent payment.
Evidence required	Comparator readmission and emergency activity; alert volume; clinician review time; patient adherence; false-positive burden; implementation cost; equity of access; and distribution of costs and benefits.
Policy lesson	Fund and evaluate the complete service configuration, with managed entry and a defined route to routine commissioning if outcomes are demonstrated.

Illustrative composite 2: AI-supported diagnostic imaging workflow

A regional imaging network deploys a regulated AI-enabled tool to support prioritisation and review of a defined class of studies. Clinicians retain responsibility for interpretation and clinical decisions.

Element	Illustrative analysis
Productivity pathway	Workflow prioritisation may shorten time to review for urgent studies and help scarce specialist capability focus on higher-value tasks.
Complementary investment	Technical validation, integration, clinician training, monitoring of subgroup performance and drift, incident management, cybersecurity and human oversight.

Element	Illustrative analysis
Barrier to scale	Procurement may focus on licence price without valuing workflow effects. Local integration and assurance may be repeated across services, increasing cost and delaying diffusion.
Evidence required	Baseline and post-implementation turnaround time; sensitivity and specificity within intended use; workload distribution; override rates; subgroup performance; implementation cost; and impact on downstream care.
Policy lesson	Use nationally reusable assurance and interoperability requirements, while requiring local validation, clinical governance and ongoing performance monitoring.

Illustrative composite 3: Digitally enabled cardiac rehabilitation

A service offers eligible patients a digitally enabled rehabilitation pathway combining remote education, activity monitoring, clinician review and escalation, with in-person care retained when clinically appropriate.

Element	Illustrative analysis
Productivity pathway	A hybrid pathway may increase reach and completion, reduce travel and use face-to-face capacity for patients who need it most. Earlier recovery may also support return to work and normal activity.
Complementary investment	Patient assessment, onboarding, clinical supervision, behaviour-change support, accessibility, connectivity and integration with referral and primary-care workflows.
Barrier to scale	Funding may reimburse face-to-face activity but not the digital platform or asynchronous clinical work. Benefits may accrue to hospitals, primary care, patients and employers while no single purchaser captures the full return.
Evidence required	Participation and completion; clinical and patient-reported outcomes; clinician time; travel and patient time; equity of uptake; recurrent cost; hospital utilisation; and return-to-activity outcomes.
Policy lesson	Payment should recognise the complete hybrid care model and measure health-system, patient and selected societal effects without double counting.

5. A worked productivity logic model

The following framework shows how a technology claim should be tested. It is illustrative and contains no assumed numerical benefit.

Question	Required analysis
Baseline and comparator	Define current care, eligible population, activity, outcomes, workforce inputs and unmet need.

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Question	Required analysis
How the model operates	Specify technology, version, integration, onboarding, training, review, escalation, support and governance.
Resources required	Measure acquisition and recurrent cost, clinician time, administrative work, infrastructure and patient or carer burden.
Clinical and service outcome	Measure outcomes relevant to intended use, such as deterioration, turnaround, completion, utilisation or access.
Effect on capacity	State whether capacity is released for additional care, changes skill mix, reduces overtime or avoids future expansion.
Where costs and savings occur	Identify which organisation incurs each cost and receives each saving or offset.
Wider economic benefits	Where justified, report patient or carer time and participation separately from health-budget impacts.
Uncertainty	Report data limitations, sensitivity, adoption assumptions, implementation risk and subgroup effects.
Decision and exit	Specify routine, restricted or conditional funding; evidence-generation obligations; review date; and exit or modification criteria.

6. Payment and procurement for whole-of-pathway value

Digital health often changes how care is delivered rather than replacing one funded service. Payment should therefore cover both the technology and the clinical and operational work needed to achieve the intended outcome. Procurement should consider the total cost and benefit across the patient's care, including implementation support, information exchange, switching suppliers and retiring a system, rather than focusing only on the licence or device price.

- Define the population, comparator, intended outcome and implementation configuration.
- Attribute costs and benefits across Commonwealth, state, provider, patient and private-payer budgets.
- Use managed entry where uncertainty is material but can be resolved through use.
- Require a data collection plan, review point and continuation, modification or exit criteria.
- Avoid preferential funding based only on technology category or regulatory status.
- Apply proportionate, harmonised cybersecurity, privacy, accessibility and interoperability obligations.

7. Workforce, patients and implementation

Technology should augment the workforce and support higher-value care. It may also shift or create work. Implementation plans should identify changes to clinical tasks, escalation load, cognitive burden, technical support and accountability. Capability is needed in clinical informatics, workflow redesign, implementation science, cybersecurity, data governance, health economics, procurement and change management.

Universities, vocational education providers, professional colleges, health services and industry each have roles, but training must be connected to real implementation needs. Active workforce engagement should occur before workflow and accountability settings are fixed.

Equity and burden principle

A claimed productivity gain should not be counted where cost, complexity, work or clinical risk is merely transferred to patients, carers or an unfunded part of the workforce. Implementation should consider accessibility, language, digital literacy, connectivity, culturally safe design, non-digital alternatives and reliable escalation pathways.

8. Commercialisation, investment and sovereign capability

Australian medtech and digital-health companies face long development pathways involving product design, clinical validation, regulation, integration, procurement and funding. A domestic adoption environment that is slow or unpredictable weakens the value of local evidence and can push commercial focus offshore.

Government can improve investment conditions by connecting existing programs and decisions: predictable evidence expectations; early advice; proportionate regulation; nationally reusable technical requirements; public procurement that recognises innovation and implementation; access to Australian reference sites; and a credible route from evaluation to routine adoption. This is particularly important for SMEs that cannot repeatedly fund bespoke state-by-state integration and assurance.

Sovereign capability should not be treated as a reason to lower evidence or accountability standards. It is strengthened when Australian firms can generate trusted evidence, compete through transparent procurement, scale domestically and participate in international markets.

9. International lessons

Model	Potential lesson	Caution for Australia
Germany: DiGA	A defined route for eligible digital applications can make evidence expectations and reimbursement more visible.	Australia should not copy a single-product pathway without adapting it to federal responsibilities, clinical settings and existing HTA and funding routes.
United States: remote monitoring payment	Payment can recognise monitoring activities and associated clinical work rather than only in-person encounters.	Fee design, eligibility, billing integrity, workload and incentives require careful local design.

The common lesson from these international approaches is that assessment, payment, implementation and review must be connected if technology is to move beyond pilots. Australia should adapt these lessons carefully, considering evidence standards, risk allocation, outcomes review, interoperability, clinical workflow and the potential for unintended incentives.

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10. Response to the terms of reference

Term	MTAA response	Productivity channel
Priority technologies	Connect medtech research and capability to domestic evidence, adoption, commercialisation and export.	Innovation, investment and retained economic value.
Adoption and diffusion	Create transparent routes from evidence to funded implementation and reassessment.	Faster diffusion and fewer stranded pilots.
Uptake and investment	Fund complete care models and procure for whole-of-pathway value.	Capacity, avoidance and investment certainty.
Barriers	Address fragmented incentives, bespoke integration, evidence mismatch and unfunded implementation.	Lower adoption cost and reduced delay.
Workforce and skills	Fund workflow redesign and build multidisciplinary implementation capability.	Higher-value use of scarce workforce.
International experience	Adapt defined reimbursement and managed-adoption lessons to Australian institutions.	Predictability with accountability.

Conclusion

Australia will not improve health-sector productivity simply by purchasing more technology. Gains depend on widespread adoption, investment in the workforce and redesigned ways of working, systems that exchange information, aligned funding and credible measurement. The central policy task is to create clear and accountable routes from evidence to routine adoption and to stop funding models that leave effective technologies stranded at the pilot stage.

MTAA recommends five linked reforms: predictable routes to funded adoption; payment and procurement for the complete care model; Commonwealth-state arrangements that support implementation at scale; a common way to measure productivity; and a dedicated Commonwealth team to plan and accelerate digital-health funding and adoption. Together, these reforms would support better outcomes and greater capacity while strengthening Australian commercialisation and investment.

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