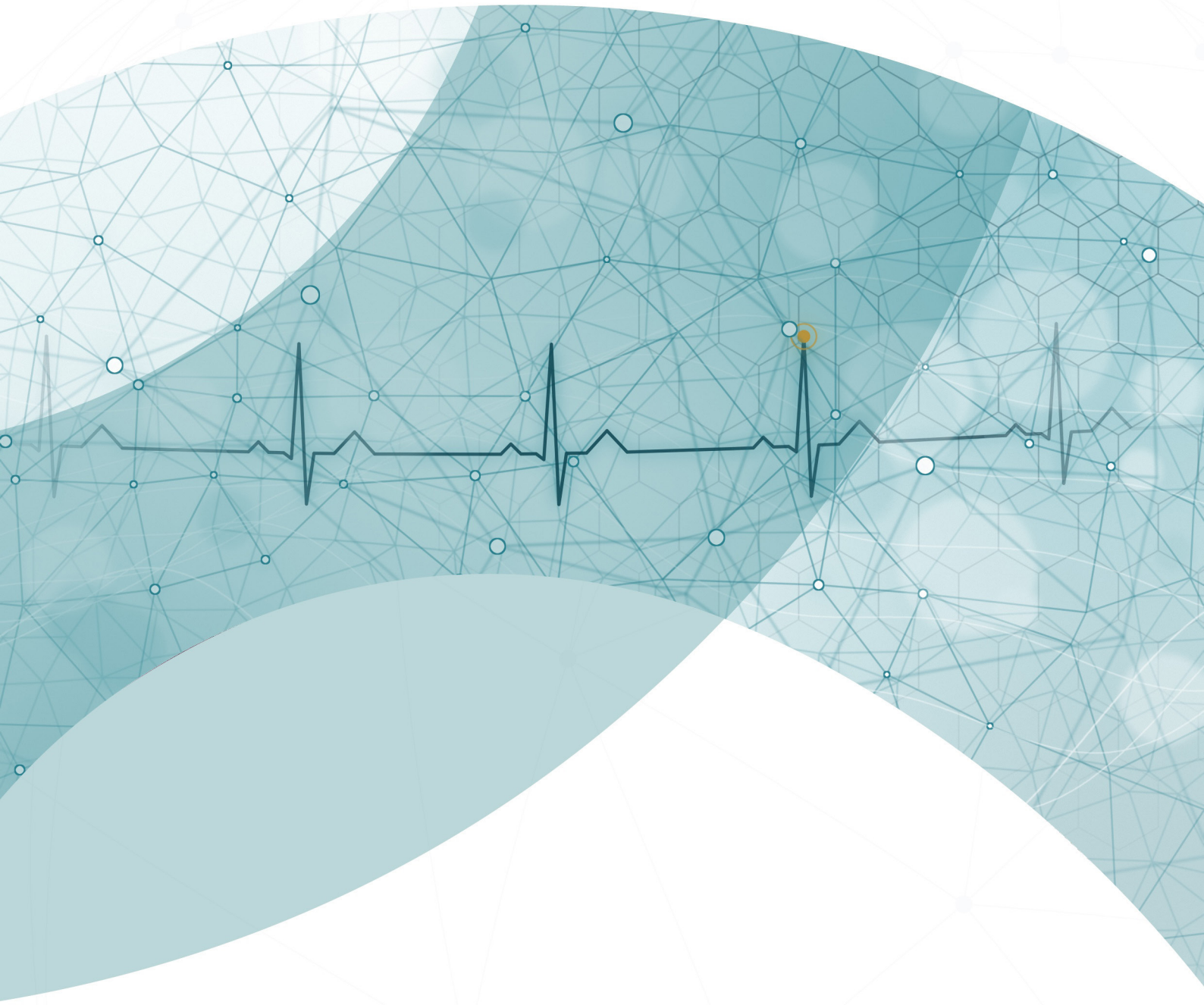

Make Capacity Count

Advancing Australia's Health System Reform Through Capacity Enhancing Innovation

Edwards

Crowell Global Advisors

MTAA Medical Technology Association of Australia

hearts4heart

Executive Summary

Australia's health-system reforms aim to improve access, equity, quality, sustainability and productivity while delivering better health outcomes for all Australians. Through the *National Health Reform Agreement (NHRA)* and its associated Addendum, the Commonwealth, state and territory governments have committed to advancing these objectives. These commitments include addressing persistent inequities in health outcomes and access to care, particularly for Aboriginal and Torres Strait Islander peoples, and advancing the objectives of the *National Agreement on Closing the Gap*.[2]

Achieving these objectives will require Australia to make better use of existing health-system resources while responding to growing demand. Population ageing, the rising prevalence of chronic disease and increasing demand for complex care are placing pressure on the health workforce, infrastructure and service delivery. Workforce shortages, infrastructure constraints and service bottlenecks are particularly consequential in rural, regional and remote communities, where limited access to healthcare professionals and specialist services can contribute to longer waiting times and poorer health outcomes.[7]

These capacity constraints have significant implications for Aboriginal and Torres Strait Islander peoples, who continue to experience a disproportionate burden of cardiovascular disease, diabetes, chronic kidney disease and other chronic conditions, alongside persistent barriers to timely diagnosis, treatment and ongoing care. Communities with the greatest healthcare needs can therefore be disproportionately affected when health services lack the capacity to respond. Improving health-system capacity is not only a question of productivity or sustainability; it is also important for advancing equitable access to timely, high-quality care.

Expanding workforce and infrastructure remains important, but will not, on its own, be sufficient to meet future healthcare needs equitably.

How, then, can Australia create additional healthcare capacity without relying solely on continuously expanding its resource base?

Capacity enhancing innovation (CEI) offer an opportunity to increase the health system's ability to meet this demand. By improving patient flow, reducing avoidable utilisation, increasing workforce productivity and enabling new models of care while maintaining or improving patient outcomes, CEI can release capacity and support more timely, high-quality care. They may also expand service availability, enable specialist care closer to home and reduce some of the practical barriers associated with distance and limited service availability. Where appropriately designed and implemented in partnership with affected communities, CEI could contribute to more equitable access to care.

Despite their potential, CEI are not routinely adopted, implemented and scaled across the Australian health system. Capacity creation is not consistently recognised as an explicit health-system objective, captured in assessments of value, rewarded through financing and procurement, supported through implementation, or measured through ongoing learning. As a result, innovations that could improve productivity and expand access may struggle to translate their potential into sustained health-system benefits.

Australia does not lack innovation; it lacks a sufficiently coordinated system for recognising and acting on the capacity value that innovation can create.

This paper builds on the Healthcare Leaders Series (HLS) 2025 white paper, *Accelerating Access to Innovative Medical Technologies in Australia, which examined how Australia could accelerate patient access to innovative medical technologies. While the Healthcare Leaders Series (HLS) 2025 white paper* focused on accelerating patients' access to innovation, this paper examines how the Australian health system can realise its value through adoption, implementation and scale. Together, the two papers address complementary challenges in the innovation pathway: enabling promising innovations to reach patients and ensuring they deliver sustained benefits through routine healthcare delivery.

Drawing on evidence, policy analysis and stakeholder interviews with clinicians, policymakers, health-system leaders, industry and patient representatives *(see Appendix A for the full methodology), this paper identifies five strategic levers for advancing the adoption of CEI across Australia:*



Policy and governance: Make capacity creation an explicit health-system reform objective, with clear responsibilities for supporting innovation adoption.



Evidence and value: Assess capacity gains, workforce productivity, throughput and avoided infrastructure requirements alongside clinical outcomes.



Financing and procurement: Align funding and purchasing arrangements with whole-system value, including mechanisms to sustain and reinvest verified capacity gains.



Implementation and scale: Strengthen workforce and organisational capability to embed effective innovations in routine care, while addressing barriers to adoption and de-implementing low-value practices.



Learning, equity and stewardship: Strengthen the use of real-world evidence, patient and caregiver perspectives, and data on equity and appropriate use to inform decisions across all other levers.

These levers are interconnected. Policy and governance can establish capacity creation as a priority; evidence and assessment can make its benefits visible; financing and procurement can create incentives to realise those benefits; implementation can translate potential into operational change; and ongoing learning can inform future decisions and support the effective and sustainable use of high-value CEI

The objective is not to create another parallel innovation system, but to connect existing policy, assessment, financing, implementation and learning functions so that high-value CEI can translate into sustained health-system capacity gains.

By making capacity creation a recognised objective of health-system reform, Australia can accelerate progress toward the very objectives that governments have already identified as central to the future of the healthcare system: improved access, greater equity, enhanced sustainability, and better health outcomes for all Australians.

Make capacity count.

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Acronyms and Abbreviations

ABF	Activity Based Funding
ACCHOs	Aboriginal Community Controlled Health Organisations
ACSQHC	Australian Commission on Safety and Quality in Health Care
AIHW	Australian Institute of Health and Welfare
ALOS	Average Length of Stay
APM	Alternative Payment Model
AS	Aortic stenosis
CEI/CEI	Capacity Enhancing Innovation/ Capacity enhancing innovations
CKD	Chronic kidney disease
CVD	Cardiovascular Disease
COPD	Chronic obstructive pulmonary disease
DoHDA	Department of Health, Disability and Ageing
EVA	Early Value Assessment
FTE	Full-time equivalent
HLS	Healthcare Leaders Series
HTA	Health Technology Assessment
HVD	Heart Valve Disease
ICU	Intensive care unit
ICS / ICSs	Integrated Care System / Integrated Care Systems
IHACPA	Independent Health and Aged Care Pricing Authority

LHD / LHDs	Local Health District / Local Health Districts
LOS	Length of stay
MBS	Medicare Benefits Schedule
MDSAP	Medical Device Single Audit Program
MDHTAC	Medical Devices and Human Tissue Advisory Committee
MRA / MRAs	Mutual Recognition Agreement / Mutual Recognition Agreements
MSAC	Medical Services Advisory Committee
NACCHO	National Aboriginal Community Controlled Health Organisation
NHMRC	National Health and Medical Research Council
NHS	National Health Service, UK
NICE	National Institute for Health and Care Excellence
NSW	New South Wales
PBAC	Pharmaceutical Benefits Advisory Committee
PAAE / PAAEs	Potentially avoidable adverse event / events
PREMs	Patient-Reported Experience Measures
PROMs	Patient-Reported Outcome Measures
QuART	Quick Access Response Team
RAID-ED	Rapid Assessment, Intervention and Discharge–Emergency Department
SAVR	Surgical aortic valve replacement
SMRF	Service Model and Funding Reform
TAVI	Transcatheter aortic valve implantation
TEVWs	Technology-enabled virtual wards
UK	United Kingdom

Key Definitions

Capacity enhancing innovation	Technologies, service models, or care pathway innovations that improve health system performance by releasing, preserving, or better utilizing constrained workforce and infrastructure resources, while also maintaining or improving patient outcomes.
Capacity creation	The enabling of a health system to provide additional services, manage more patients or perform work that it previously could not accommodate with its existing configuration of resources.
Capacity release	The reduction of the amount of existing capacity required to deliver care, releasing resources such as staff time, beds, theatre hours or appointments for other uses.
Capacity dividend	The measurable value generated by capacity created or released, assessed against baseline capacity and considered alongside outcomes, equity and implementation costs.

SECTION 1.

Why Australia Needs Capacity enhancing innovation (CEI) Now

Australia's healthcare system delivers high-quality care and strong health outcomes by international standards. Yet demand for healthcare is increasingly outstripping the capacity available to deliver it. Population ageing, rising chronic disease and multimorbidity, workforce constraints and persistent post-pandemic demand are increasing both the volume and complexity of care required. The challenge is therefore not simply whether Australia has enough healthcare resources, but how much care the system can generate from the workforce, infrastructure and resources it already has.

Demand is Growing Faster Than Capacity

Australia's population is ageing and more people are living longer with chronic and complex conditions.

In 2022, nearly 38% of Australians were living with two or more chronic conditions. Cardio-renal-metabolic diseases illustrate the resulting burden: around one million Australians live with at least two of diabetes, cardiovascular disease and chronic kidney disease,[8] while CVD alone accounts for approximately 1,500 hospitalisations each day and 11% of hospital admission expenditure.

This growing multimorbidity is shifting demand from episodic treatment towards ongoing monitoring, specialist review, long-term management and coordination across settings. As complexity rises, so does the intensity of workforce, diagnostic, specialist and hospital resources, required for each episode of care.

At the same time, workforce shortages are limiting the system's ability to expand supply, particularly in nursing, allied health, specialist, rural and regional workforces.[12]



Australia faces a **projected undersupply of 70,707 full-time equivalent (FTE) nurses by 2035,** which translates to an **estimated 79,473 individual nurses** needed to fill the gap[12]

Approximately **82% of Health Occupations** experienced critical labour shortages in 2023[5]

Demand is increasing in both *volume and complexity,* while the workforce and infrastructure needed to meet it cannot expand at the same pace. Workforce growth remains essential, but education, training, recruitment and retention take years. Physical infrastructure faces similarly long capital and construction timelines.

Traditional Solutions Alone Are Insufficient



Australia will continue to need investment in workforce, infrastructure and healthcare funding. These are fundamental to maintaining and expanding capacity. But they cannot provide an immediate or unlimited response to rising demand.

This creates an important distinction between adding resources and increasing the productive capacity of those resources.

Additional beds, clinicians or funding do not necessarily translate into proportional increases in care delivered if capacity is absorbed by growing demand, inefficient pathways or avoidable utilisation. Conversely, changing how care is organised and delivered can allow existing resources to serve more patients without proportional increases in inputs.

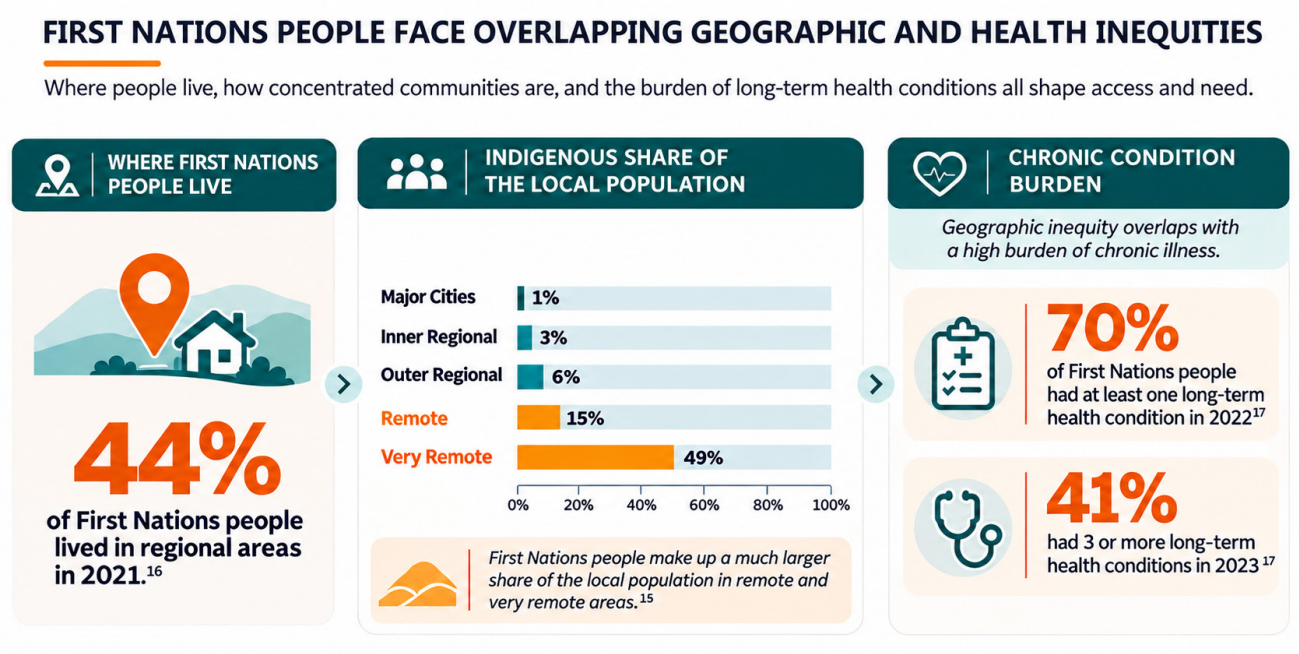
The policy challenge is therefore not to replace conventional capacity expansion, but to complement it by making existing capacity go further.

Capacity Has Become an Equity Challenge

The consequences of constrained capacity are already visible in delays to specialist consultations, diagnostics, procedures and follow-up care. These delays can create a reinforcing cycle: delayed care can lead to deterioration and more resource-intensive treatment; patients unable to access timely planned care may present through emergency departments; and longer hospital stays further constrain already limited bed and workforce capacity.

Capacity constraints also have an equity dimension. Rural and regional communities face reduced access to specialist services, while socioeconomic disadvantage can compound barriers to timely diagnosis and treatment.[13] The majority of people from rural and remote regions are Aboriginal and Torres Strait Islander people who continue to experience a disproportionate burden of chronic disease and poorer health outcomes across a range of conditions.

First Nations are affected disproportionally by disease burden and geographic health service disparities



Capacity is therefore not simply *how much care the system can provide. It is also where, when and for whom that care is available. An intervention that increases overall throughput but leaves geographic, socioeconomic or cultural access gaps unresolved may improve efficiency without improving equity.*

Resilience depends on adaptive capacity

Capacity also matters for resilience. COVID-19 demonstrated the vulnerability created when health systems operate with limited reserve capacity: workforce fatigue, disruption to routine care and deferred treatment generated additional demand while making rapid expansion difficult. Resilient systems not only need sufficient resources, but the ability to adapt capacity when demand changes suddenly.

This raises a critical policy question: **How can Australia create additional healthcare capacity without relying solely on continuously expanding its resource base?**

The Opportunity for Australia

Australia therefore faces a capacity challenge that cannot be addressed solely by adding more inputs to the health system. Continued investment in workforce, infrastructure and funding will remain essential, but Australia also needs to increase the amount of care those resources can generate. This means considering innovation not only as a means of improving clinical outcomes or reducing costs, but as a source of additional health-system capacity.

Greater capacity can enable people to access care earlier, reduce avoidable deterioration and support better health and participation in work and society. The benefits therefore extend beyond healthcare to the wider economy.

> Getting people treated faster and better improves workforce participation and social productivity. People return to work sooner and contribute to the economy for longer, generating returns that extend well beyond the healthcare system.

Martin Bowles
Former Secretary, Commonwealth Department of Health
Former CEO, Calvary Healthcare



SECTION 2.

How CEI can Enable Australia's Reform Priorities

Capacity enhancing innovation offer a practical mechanism for advancing many of Australia's healthcare reform priorities, including improving access, reducing system pressures, supporting care closer to home, and increasing productivity. While often assessed through a clinical lens, their broader value lies in their ability to create capacity across the health system and enable new models of care.

What is considered as a CEI?

Capacity enhancing innovation as we define it in this paper, refer to technologies, service models, or care pathway innovations that improve health system performance by releasing, preserving, or better utilizing constrained workforce and infrastructure resources, while also maintaining or improving patient outcomes.

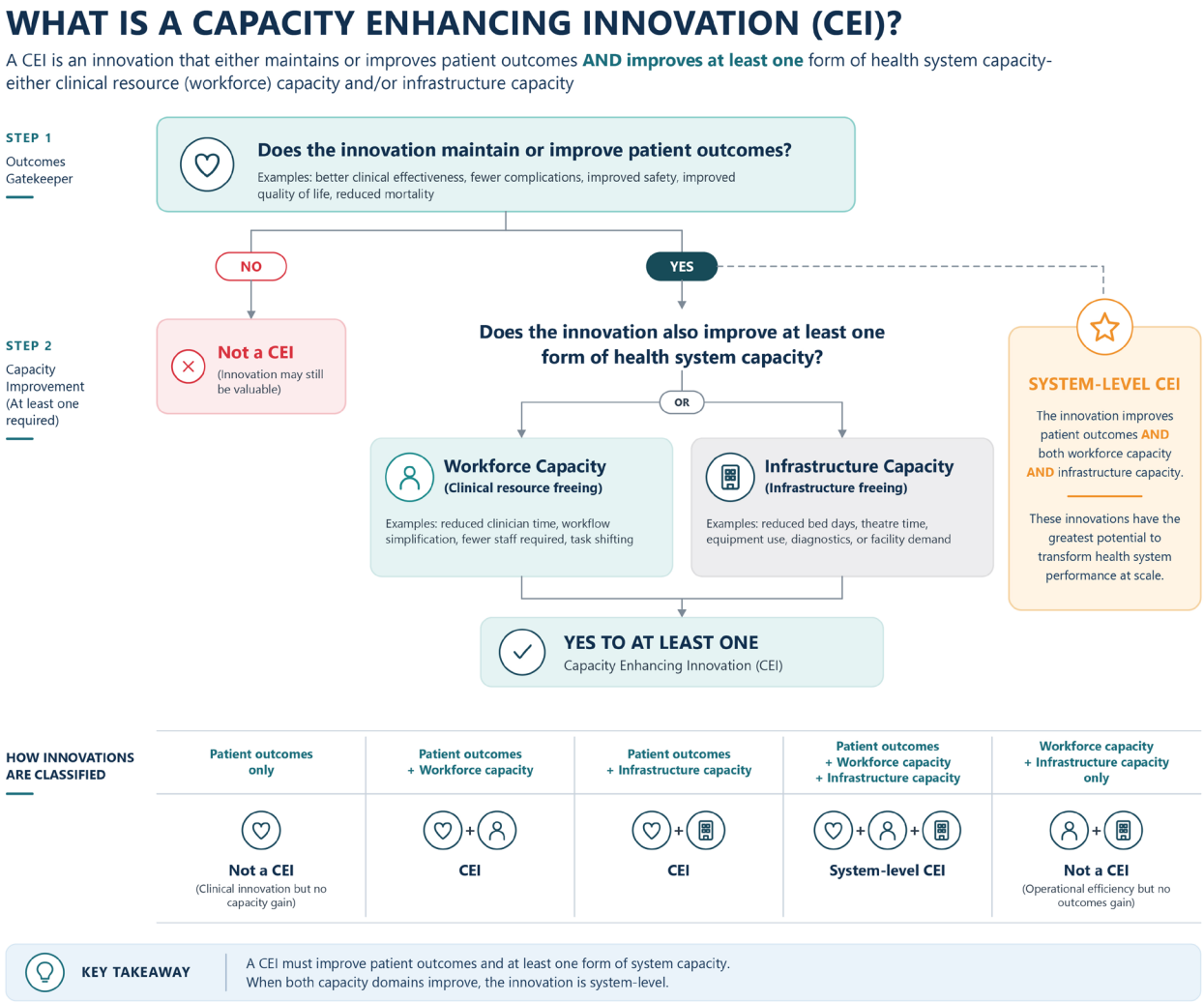


Figure 1 What is Capacity Enhancing Innovation

At a foundational level, CEI deliver at least one form of system efficiency, either by reducing clinical resource utilisation (such as admissions, clinician time, or procedural demand) or by freeing infrastructure capacity (such as beds, theatres, or diagnostic services). A subset of CEI can be considered system-level when they generate multiple reinforcing efficiencies across the care continuum, creating compounding effects rather than isolated gains.

How CEI can create value

CEI generates value not solely by clinical effectiveness, but by their ability to relieve structural constraints within the health system and improve flow across interconnected service domains. This dual emphasis on patient outcomes and system capacity distinguishes CEI from conventional clinical innovations, positioning them as deliberate levers for health system redesign.

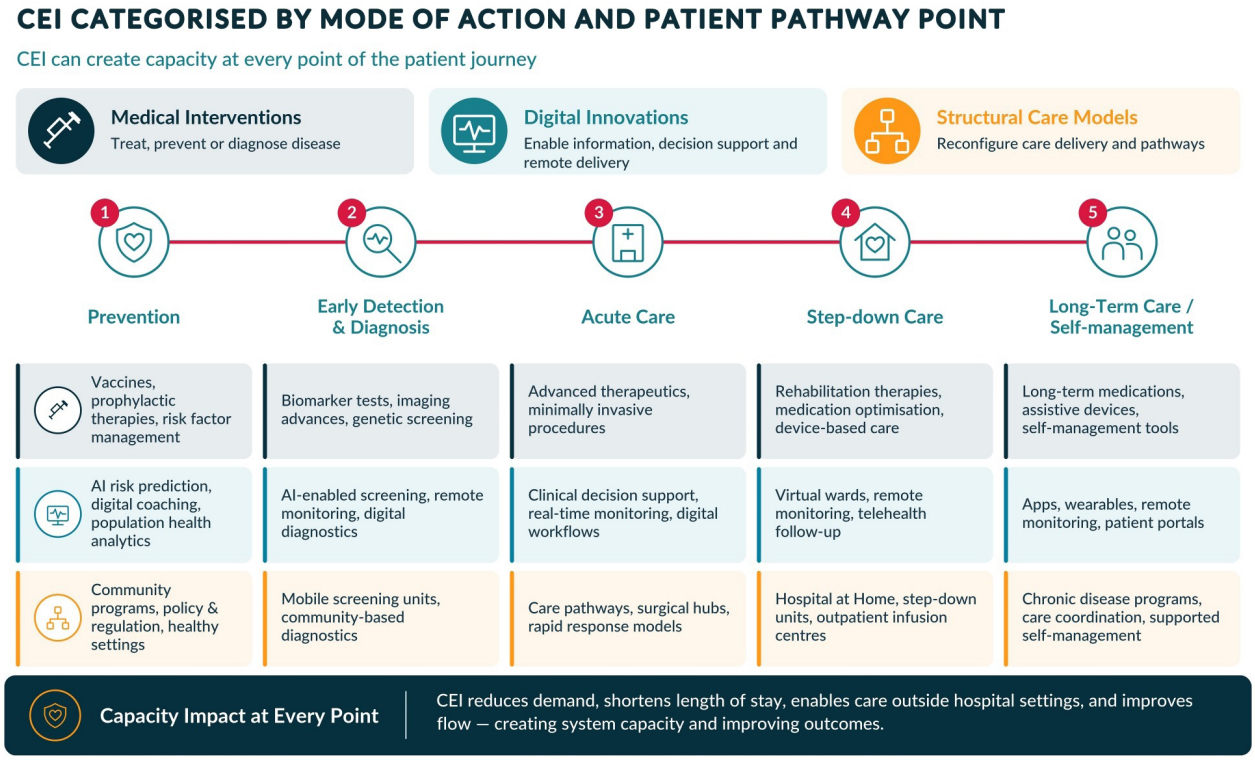


Figure 2 Categorizing Capacity Enhancing Innovation

CEI can be categorized according to both their primary mode of action and the stage of the patient journey at which they generate value. These innovations enhance health system capacity through three broad mechanisms: **medical interventions**, which improve clinical outcomes through new therapies, procedures, and diagnostics; **digital innovations**, which leverage technology to strengthen decision-making, coordination, monitoring, and patient engagement; and **structural or care model innovations**, which redesign how, where, and by whom care is delivered to improve efficiency, access, and continuity of care. Mapping these innovations across the continuum from prevention and early detection through treatment, recovery, and long-term management demonstrates that capacity can be strengthened at multiple points in the care pathway.

Importantly, these categories are not mutually exclusive. Some innovations create value through multiple mechanisms, for example, peritoneal dialysis is a medical innovation that also enables home-based care, enhancing patient autonomy while expanding health system capacity by reducing demand for facility-based dialysis services.

Australian Real-World Evidence	Economic Evaluation Estimate
Virtual Hospital in the Home – Queensland[20]	Occupied bed-days estimated to be freed in 2023[21]
16,651 **Inpatient bed-days saved over 11 months** This virtual Hospital in the Home service managed 3,192 patients with COVID-19 across adult, paediatric and maternity cohorts, delivering hospital-level care at home with zero reported deaths and only 0.4% escalation to a physical bed.	**1,094** **Across three rpavirtual models** An economic evaluation of Sydney Local Health District's rpavirtual estimated that three virtual care models freed up 1,094 occupied hospital bed-days in 2023. These included Virtual Trauma, Virtual Rehabilitation and Virtual Emergency Department.

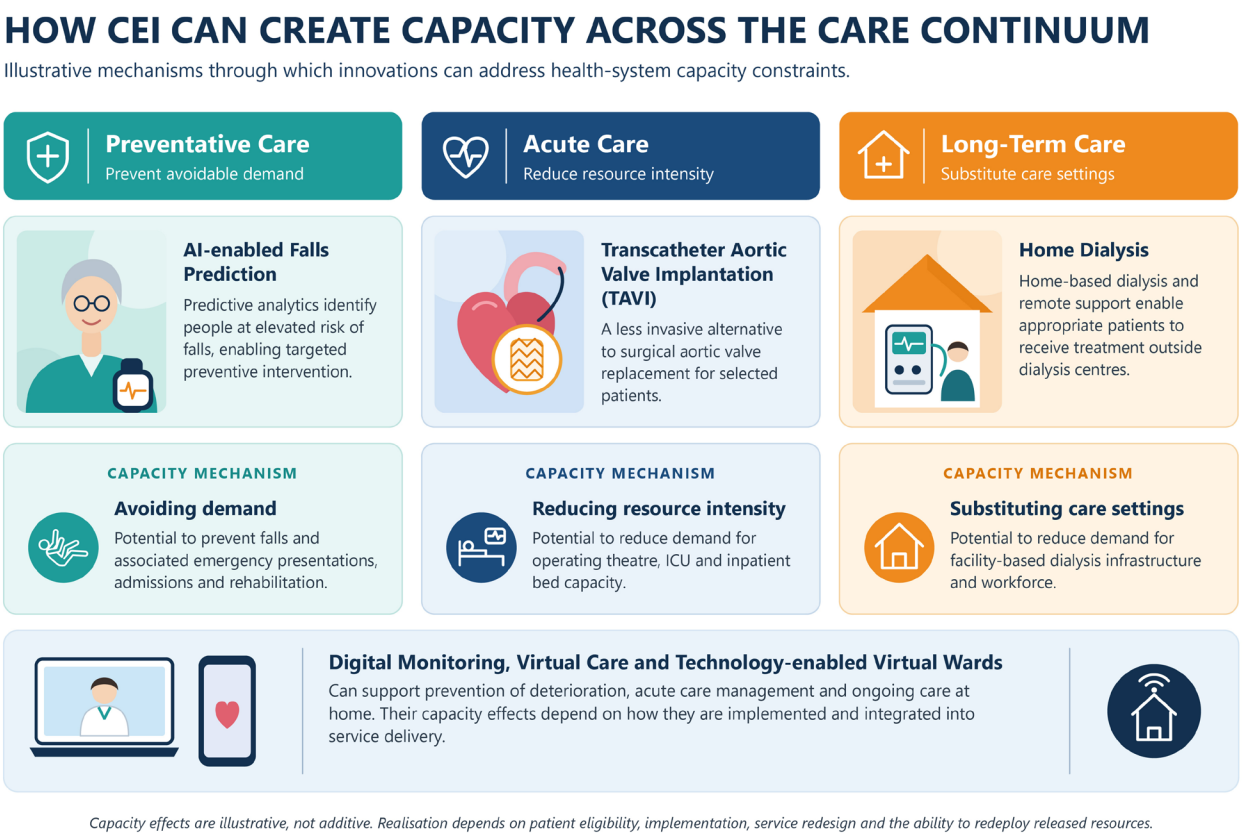
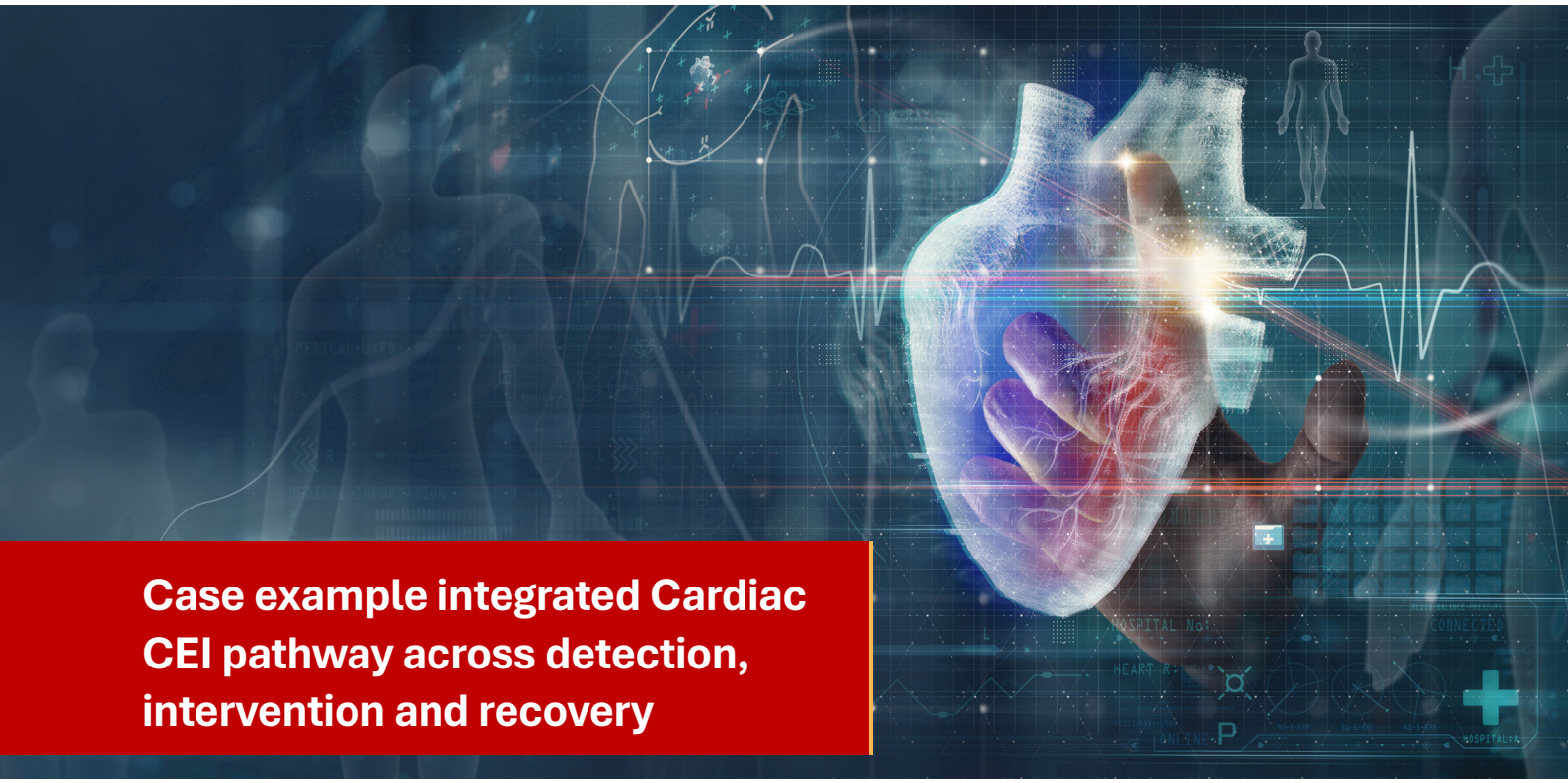


Figure 3 How CEI can create Capacity across the Care Continuum

Capacity enhancing innovation across different categories and patient journey points can be stacked up for a specific condition to yield compounding benefits to both patients and the health system.



Case example integrated Cardiac CEI pathway across detection, intervention and recovery

Heart failure (HF) represents a substantial clinical burden in Australia, with important implications for health-system capacity. In 2022–24, an estimated 146,000 adults aged 18 and over were living with HF, based on self-reported data. Almost two-thirds were aged 65 and over. However, these estimates likely understate the true prevalence, as early-stage heart failure may cause few symptoms and many cases remain undiagnosed. In 2024, these conditions were the underlying cause of 5,200 deaths and an associated cause of a further 22,400 deaths.[22]

In 2023–24, approximately 188,000 hospitalisations recorded heart failure or cardiomyopathy as a principal or additional diagnosis.[22] HF also contributes to high readmission rates: two-thirds (64%) of people hospitalised with heart failure were readmitted within one year, including 23% within 30 days. These challenges were more pronounced for First Nations people, who had higher emergency readmission rates than other Australians (64% compared with 57%), older people and people living in remote and very remote areas.[23]

A key contributor to this burden is heart valve disease (HVD), increasingly described as the “next cardiac epidemic”. More than 500,000 Australians are living with diagnosed HVD, with a further approximately 250,000 people likely to be living with undiagnosed disease. HVD occurs when one or more heart valves do not open or close properly, disrupting normal blood flow. If left untreated, it can progress to heart failure, stroke and death.

Together, these conditions contribute to a substantial and growing cardiovascular disease burden, driving recurrent acute admissions, prolonged hospital stays and demand for specialist and inpatient services.

The example below illustrates how three CEI could work together across the cardiovascular care pathway for a potential heart failure patient.

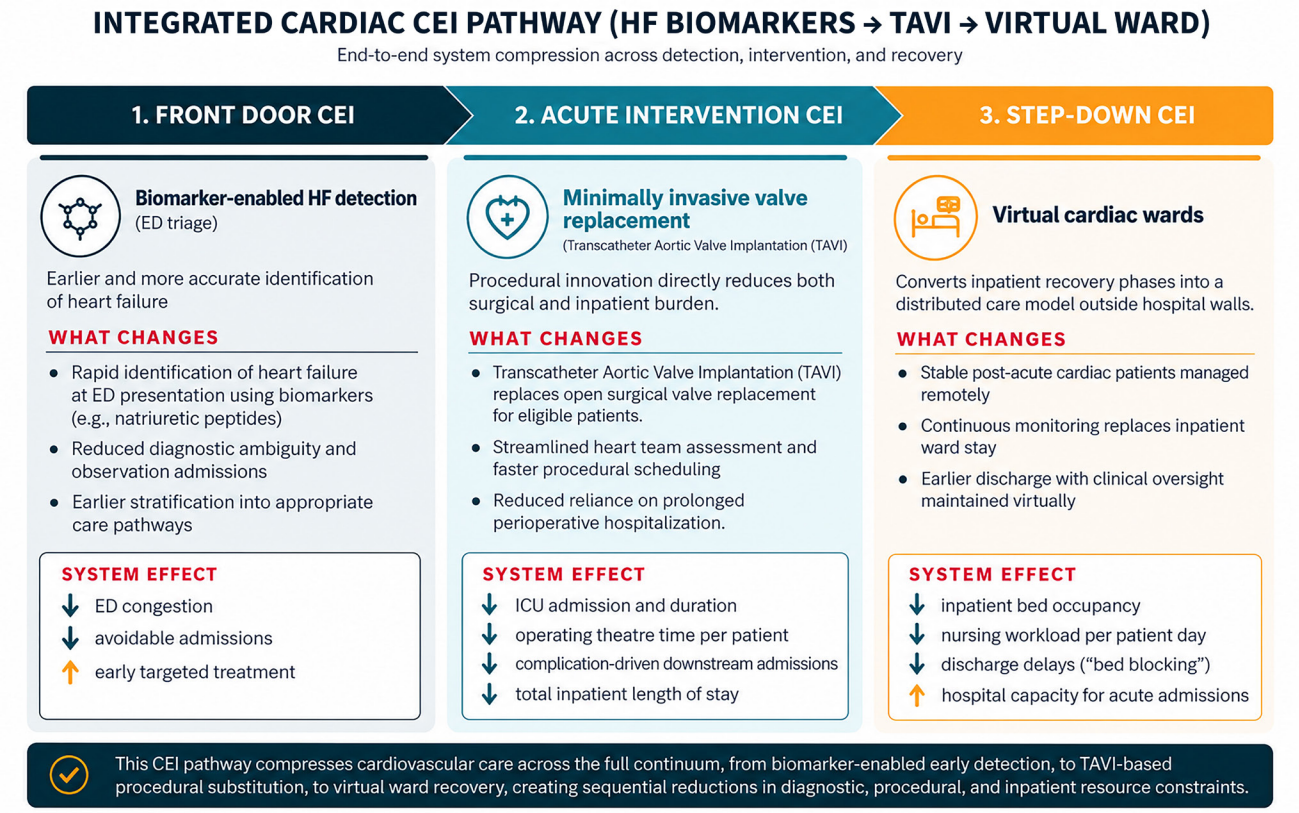
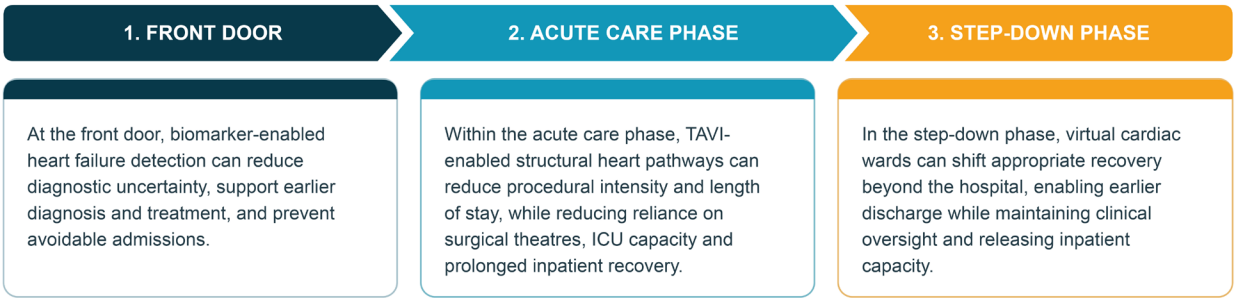


Figure 4 Integrated Cardiac CEI Pathway

The integrated deployment of CEI across the acute cardiac care pathway illustrates how capacity gains along with clinical benefits can be generated by addressing multiple constraints across the patient journey, rather than optimising individual interventions in isolation.



Together, these interventions can generate cumulative system-level capacity gains by reducing avoidable demand, lowering the intensity of care required, and shortening inpatient stays. Rather than addressing hospital congestion at a single point in the pathway, CEI can therefore release capacity at multiple points across the patient journey, allowing services to manage more patients with existing infrastructure and workforce capacity.

SECTION 3.

Unlocking CEI

What Is Holding Adoption Back

The impact of Capacity enhancing innovation depends not solely on their clinical efficacy or technological readiness, but also on the health-system architecture through which they are assessed, financed, implemented and sustained.

In Australia, CEI adoption is constrained by interconnected barriers across five system levers: policy and governance, assessment, financing, implementation, and ongoing system learning (Figure 5). These barriers are not independent or confined to individual levers; they can arise at multiple points along the pathway from innovation to adoption and scale and may reinforce one another. A CEI may have strong evidence but lack a viable funding pathway or the implementation capacity needed for adoption. Alternatively, it may be implemented successfully but fail to scale because its system-level benefits are not adequately captured, measured or rewarded.

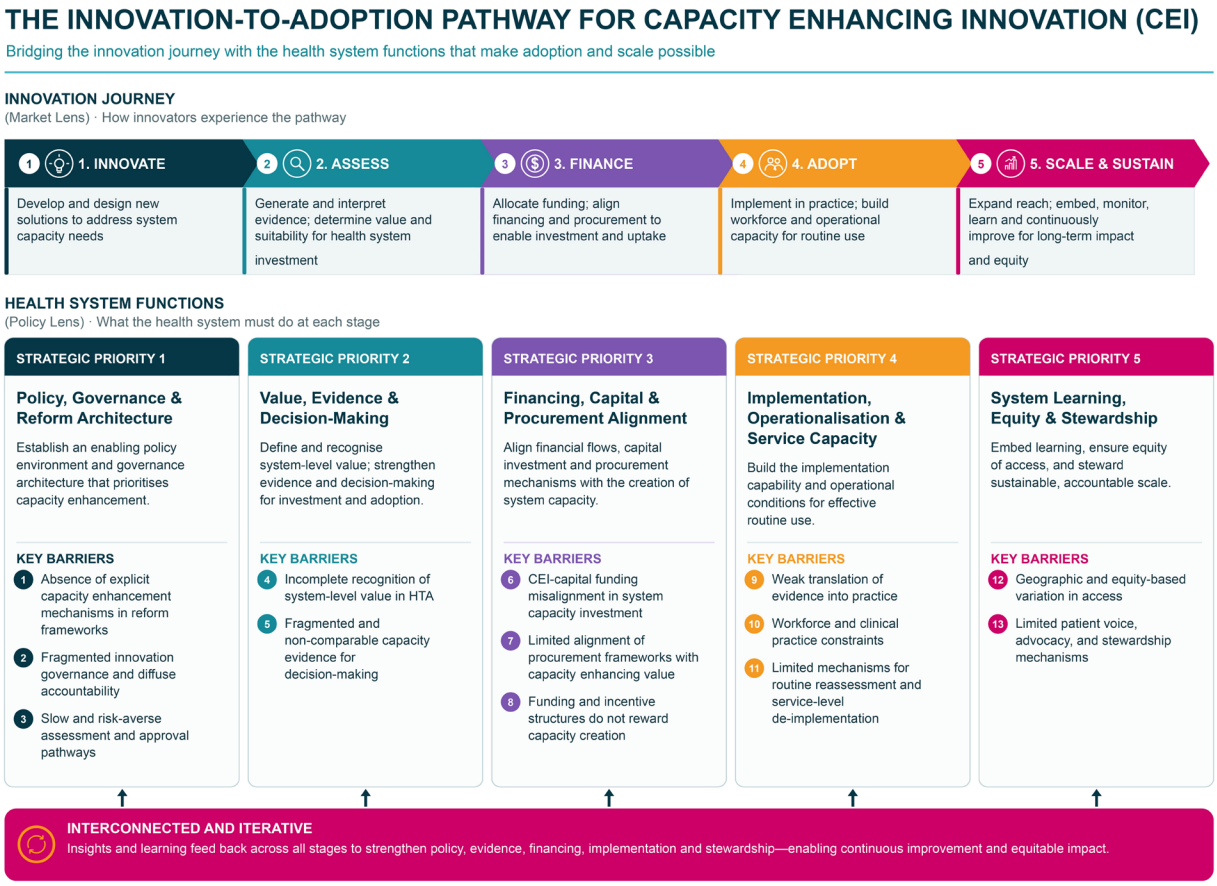


Figure 5 Innovation to adoption pathway

Realising the capacity-releasing benefits of CEI in the Australian health system requires action across the following five strategic priorities, with coordinated efforts from relevant stakeholders over the short, medium and long term.

Strategic Priority 1: Establish Policy Direction and Governance

Key Constraints

1. Capacity is not recognised as a system-level policy objective

Australian health reform increasingly emphasizes sustainability, efficiency, workforce optimisation and new models of care, but capacity enhancement is not yet consistently recognised as an explicit dimension of health-system value.[25] Existing reform and workforce frameworks do not routinely measure outcomes such as clinician time released, reduced administrative burden, task substitution, increased throughput or additional patients served.

2. Fragmented innovation governance.

Responsibility for moving an innovation from regulatory approval to funded access and implementation is distributed across multiple organizations and levels of government. Regulatory approval, reimbursement, procurement, state-level decisions, hospital business cases and clinical credentialling can each create separate decision points.

> New technologies may face multiple federal, state and local decision points spanning regulatory approval, HTA, funding, procurement, service establishment and clinical credentialling. The applicable pathway differs by technology and care setting. [36]

3. Slow and risk-averse pathways.

Innovations can face lengthy and sequential assessment and approval processes, even where evidence of safety and effectiveness already exists from comparable healthcare settings.

> The current system demands human-level outcome data over an extended timeframe, eight to ten years of data for innovations such as a heart valve, meaning any new technology has to go through another eight to ten years before clinical data can justify the investment, making it practically unachievable to advance innovation to the next level.

Prof. Jayme Bennetts
Former ANZSCTS President
Cardiovascular Expert Clinical Advisory Group
Medical Devices and Human Tissue
Advisory Committee (MDHTAC)

Together, these constraints reflect a health system in which capacity is not yet consistently recognised as an explicit objective of health-system performance and reform. Without this policy-level recognition, the capacity value of innovation may not be considered in assessment and decision-making, meaning CEI can be undervalued before they reach funding and adoption decisions. Fragmented and protracted pathways can further delay those that do progress through the system.

Recommendation:
Create a policy and governance environment that recognises and enables Capacity enhancing innovation.

Australia should explicitly recognise the creation and release of health system capacity as a core objective of health reform, alongside quality, safety, access, equity and cost-effectiveness. This should be embedded across national reform architecture, including the NHRA and its Service Model and Funding Reform agendas.

Formal, visible and coordinated linkages across existing assessment, evidence, funding, procurement, implementation and evidence-generation processes are needed to ensure that capacity release is consistently recognised and valued throughout the innovation-to-adoption pathway. Rather than creating a new pathway, these linkages would strengthen continuity across existing regulatory, funding and delivery systems, reducing fragmentation between stages and enabling innovations with demonstrable capacity, productivity and access benefits to progress more coherently from validation to adoption and scale.

CASE EXAMPLE:

Singapore's National Innovation Translation Ecosystem

Singapore has developed a coordinated national innovation ecosystem that connects **evaluation, regulation, funding, procurement and implementation,** supporting promising health technologies and models of care from development through to routine adoption. Rather than relying primarily on individual hospitals or local champions to navigate these functions independently, national institutions and integrated health clusters provide infrastructure for coordinated testing, evaluation and scale-up.

Key features include regulatory and implementation sandboxes that enable technologies and models of care to be tested in controlled settings; dedicated innovation funding that supports development and implementation; integrated health clusters that provide testbeds for evaluation and scale-up; central digital infrastructure that enables interoperability and system-wide deployment; and close alignment between government, regulators, funders and providers.

Strategic Priority 2: Recognise Capacity Value in Assessments

Key Constraints

1. **Incomplete recognition of system-level value.**

   Current HTA approaches appropriately emphasise clinical effectiveness, safety and cost-effectiveness, but system-level benefits such as workforce productivity, patient throughput, reduced hospital utilisation, improved access and capacity release are not captured.[28]

2. **Evidence requirements can delay adoption.**

   Assessment processes can favour mature evidence generated before implementation, even though the evidence base for many technologies develops iteratively through clinical use.[28] Greater use of lifecycle assessment and real-world evidence could allow uncertainty to be managed without unnecessarily delaying access to promising innovations.

3. **Fragmented capacity evidence.**

   Capacity indicators are not consistently defined or measured across health services. This makes it difficult to compare the impact of CEI across regions or settings or incorporate capacity benefits into broader funding and adoption decisions.

> In Australia, all public hospitals collect and contribute data to state and national data sets, and this performance data is routinely reported on sites such as the Australian Institute of Health and Welfare, NSW Bureau of Health Information and My Hospitals. However, these assessments do not include infrastructure and workforce capacity indicators and thus there is no consistent approach for standardizing or aggregating capacity creation, although workforce and resource indicators exist. As a result, evidence on the value of CEI is often not directly comparable across settings.

Without consistent recognition and measurement of system-level value, CEI may be undervalued in assessment and investment decisions, while evidence requirements and fragmented capacity data can delay adoption. This limits the ability to demonstrate the capacity gains achieved by CEI and build the case for wider adoption and scale.

Recommendation:

Ensure CEI is assessed on its economic and system-capacity value, in addition to its clinical benefits.

Australia should strengthen how innovations are assessed so that system-capacity and economic value are considered alongside clinical benefits. Conventional assessment processes tend to focus on clinical effectiveness, safety and direct costs, which can undervalue CEI whose principal contribution is to release constrained resources, improve workforce productivity, expand access or avoid future infrastructure requirements. A broader and more consistent definition of value is therefore needed to make the capacity dividend of CEI visible, measurable and comparable across jurisdictions.

This requires a common evidence framework and national CEI sentinel indicator framework that establish consistent measures of bed-days and clinical hours released, workforce productivity, additional patients treated, waiting-list reduction, theatre and outpatient capacity, avoided infrastructure requirements, care substitution and system resilience. These indicators should be embedded within existing national and jurisdictional data collections rather than creating parallel reporting systems, enabling the capacity effects of CEI to be measured consistently and compared across health systems and over time.

Relevant HTA and assessment processes should incorporate these system-level effects and draw appropriately on international evidence, regulatory reliance and accelerated or conditional assessment where evidence is already available.

Evidence generation should also continue during adoption through controlled real-world implementation and evaluation to address residual uncertainty.

Together, these changes would enable Australia to identify, measure and compare the capacity dividend generated by CEI and, over time, make capacity value a routine component of HTA, funding and health system investment decisions.

CASE EXAMPLE:

United Kingdom's Early-use HealthTech Guidance Assessments [37] [38]

In 2022, the UK's National Institute for Health and Care Excellence (NICE) introduced the **Early-use HealthTech guidance** assessments to accelerate access to promising medical technologies that address unmet needs but lack sufficient evidence for a full health technology assessment. Rather than delaying adoption, this assessment provides conditional access in NHS settings while additional evidence is generated.

As of August 2024, 120 innovative medical technologies had been assessed through **Early-use HealthTech guidance** assessments (formerly called early value assessment or EVA) with 57 conditionally recommended for use while further evidence is collected. NICE develops evidence-generation plans for these technologies and typically allows 2–4 years of real-world evaluation before reassessment for routine adoption.

Described by NICE as a "bridge" to full appraisal, this assessment enables earlier patient access while systematically reducing evidence uncertainty and supporting implementation planning.

A similar CEI pathway in Australia could enable promising devices, diagnostics, digital health solutions, and new care models to be deployed in controlled real-world settings while generating evidence on clinical outcomes, healthcare utilisation, equity, workforce impacts, and system capacity benefits, reducing delays between innovation and adoption.

Strategic Priority 3: Align Financing, Investment and Procurement

Key Constraints

1. **Capital and funding responsibilities are misaligned.**

   CEI can require upfront investment in infrastructure, equipment and service redesign, while their benefits may accrue over time or across different parts of the health system.

2. **Procurement does not consistently capture capacity value.**

   Procurement frameworks generally emphasise value for money and lifecycle costs, but do not assess benefits such as workforce release, increased throughput, reduced waiting lists or avoided downstream utilisation.

3. **Funding incentives can penalise efficiency.**

   Episode-based funding arrangements can create situations where a hospital that successfully reduces length of stay or shifts care to a more efficient model receives less funding, even though the change releases scarce capacity and benefits the wider system.

> At Royal Hobart Hospital, pressure from bed shortages prompted clinicians to implement a pathway for safely discharging TAVI patients on the day of their procedure. Under the activity-based funding model, this attracted base reimbursement for the patient episode. However, additional reimbursement, weighted to account for patient complexity and the average length of stay for that type of episode, historically required patients to remain in hospital for at least one to two days post-procedure. By discharging patients earlier, the hospital forfeited this additional reimbursement. Consequently, despite improving patient flow and releasing capacity through faster clinical discharge protocols, Royal Hobart faced a net financial disincentive to adopting the new model of care.[41]

Funding and procurement arrangements can make it difficult to invest in CEI and realise its full system value. Where upfront costs are borne by one part of the system while benefits accrue elsewhere, or where funding rewards activity rather than capacity release, organisations may have limited incentive to adopt innovations that improve efficiency and expand capacity.

Recommendation:

Align funding, capital and procurement incentives with whole-system value and capacity creation

Australia should align financing, investment and procurement with the whole-system value generated by CEI, so that innovations that improve capacity, productivity and access are not disadvantaged by funding arrangements designed around conventional models of care. The pathway should move from positioning CEI within funding reform, to testing appropriate reimbursement models, to purchasing on whole-system value, and ultimately to removing financial penalties for efficiency.

CEI should be positioned within the Service Model and Funding Reform (SMRF) agenda as high-value models of care.

The NHRA Reform Addendum provides a formal pathway for jurisdictions to trial innovative funding arrangements, bundled payments, capitation models, and novel service delivery approaches. These mechanisms provide an important opportunity to build the evidence base required for future funding reform and national scale-up of CEI-enabled models of care.

Focus on generating evidence that can be transferred across jurisdictions, reducing duplication and strengthening the national evidence base for capacity-enhancing care models.

Rather than presenting CEI solely as individual technologies seeking reimbursement, stakeholders should demonstrate how they enable pathway redesign, reduce avoidable utilisation, release workforce and infrastructure capacity, improve access and support sustainable models of care. This creates a route for CEI to be considered within existing funding reform processes and for their contribution to high-value care to be assessed at the pathway level.

NHRA Alternative Payment Model trials2 should be used to test how CEI-enabled models of care can be reimbursed more appropriately to generate real-world evidence demonstrating the impact of Capacity enhancing innovation. These trials provide an opportunity to test bundled, pathway-based, capitation, value-based and other alternative payment approaches in real-world settings. Trials should incorporate standardised measures of patient outcomes, workforce sustainability, utilisation, capacity and equity, generating transferable evidence about which funding models best support CEI adoption and system performance.

Procurement should reflect whole-system value rather than primarily acquisition cost or local budget impact. Procurement processes should incorporate HTA-derived evidence and consider capacity release, workforce impacts, access, throughput, downstream utilisation and whole-of-life value. Greater integration between national assessment, procurement, clinical, finance and service-planning functions would reduce duplication and enable purchasing decisions to reflect the broader system benefits demonstrated by CEI.

CASE EXAMPLE:

NHS England's Value-Based Procurement Programme[43]

The NHS Value-Based Procurement programme moved purchasing away from lowest-price decisions toward whole-life value.

Procurement teams use standardized value frameworks that consider five domains that recognise value more broadly, including efficiency which explicitly states capacity release. And requires quantifying the impact the deliverable will have on resources for the pathway.

Importantly, procurement decisions are informed by national evidence from NICE rather than requiring hospitals to recreate economic evaluations locally.

Finally, funding arrangements should remove penalties for improved efficiency and enable the capacity gains generated by CEI to be retained and reinvested. Activity-based funding can create a perverse incentive where, reducing length of stay, avoiding admissions, or increasing productivity reduces provider revenue even when it improves system performance. Funding reform should therefore explore mechanisms such as shared savings and pathway-based payments that allow verified efficiency gains and released resources to be retained and reinvested in service improvement and higher-value care.

CASE EXAMPLE:

Sweden's OrthoChoice bundled payment model for hip and knee replacements [44]

Since January 2009, all non-complex hip and knee replacements in the county of 2 million people have been reimbursed with a bundled payment, covering over 4,000 procedures per year. After the reform, accessibility increased and waiting times for primary hip/knee replacements decreased. The risk of complications significantly reduced and providers were also generally satisfied with the bundled payment model.

Payment design: Healthcare providers received a fixed package price of SEK 56,300 covering the full continuum of care, including diagnostics, surgery, prosthetic costs, and necessary pre- and post-surgical visits. Patients could choose among authorised providers meeting specified criteria.

The model was designed to encourage appropriate care at the primary-care level by reducing compensation for the initial visit by 50%, while making primary-care units responsible for the cost of the initial medical work-up. A penalty also applied to providers when more than 35% of initial visits did not lead to surgery, creating a financial incentive to ensure that patients were appropriately assessed and referred for surgical treatment. In addition, radiological examinations were not reimbursed separately, discouraging unnecessary diagnostic testing.

Providers assumed financial responsibility for potentially avoidable adverse events (PAAEs) related to the primary surgery for up to two years, extended to five years where an infection treated with antibiotics occurred during the first two years. A further 3.2% of the bundled payment was withheld and paid as performance compensation when providers met predetermined targets, primarily process measures.

The basic principle of bundled payments is that the provider receives a package price for an entire chain of care instead of being reimbursed for each individual activity. The package price may also include compensation for expected costs related to potentially avoidable complication and thus include a warranty reimbursement, which results in the provider bearing financial responsibility for these predefined complications. By compensating providers with a package price, parts of the financial risk shifts from the payer to the provider, which means that the provider is given both more freedom and more responsibility to ensure effective and high-quality patient flows.

To remain profitable under this fee model, clinics streamlined their care pathways and significantly shortened the average patient length of stay (LOS) and patient outcomes were improved in terms of the risk of complications decreasing, following the adoption of the new model.

Impact: this operational efficiency created new capacity within the same physical infrastructure. The number of physician visits per surgery decreased by 7 percent and the number of inpatient days of care decreased by 16 percent after the adoption of the new model. In total, 1,444 doctor visits and 4,640 bed days per year were freed-up for additional patients annually, based on 2010 surgical volumes.

Strategic Priority 4: Support Implementation, Adoption and Scaling

Key Constraints

1. **Weak translation of evidence into practice.**

   Implementation remains fragmented across jurisdictions and health services, with adoption often dependent on local clinical champions or industry support. This contributes to uneven uptake and slow diffusion of proven innovations [41]

> "Adoption is almost entirely clinician-driven and industry-supported. There is no independent service facilitating technology transfer into clinical settings. A dedicated, independent translational support infrastructure, one not reliant on industry and not captured by professional societies, would meaningfully accelerate CEI adoption in the structural heart space."
>
> ***Dr Heath Adams***
> *Director, Structural Intervention and Clinical Lead for TAVI*
> *Royal Hobart Hospital*

2. **Workforce and clinical practice constraints.**

   Workforce shortages, [5] workload pressures, established clinical practices and rising labour costs reduce organisational capacity to implement change. Scope-of-practice restrictions and professional norms [26] can also limit the ability to redesign work around new technologies and models of care.

3. **Limited mechanisms to de-implement low-value care.**

   New innovations must often be introduced into systems where existing services, procedures and practices continue to consume scarce workforce, funding and infrastructure. Without systematic reassessment and de-implementation of low-value care, there is limited capacity to absorb new models of care.

Even when evidence, assessment and funding barriers have been addressed, CEI may still fail to reach routine practice if health services lack the workforce, infrastructure and implementation capability required to change how care is delivered. At the same time, without de-implementing low-value care, services may lack the capacity to absorb new models of care. These operational constraints can therefore become the limiting factor in adoption and scale.

Recommendation:

Build the organisational, workforce and implementation capability required to translate evidence into routine practice, strengthen system resilience and scale validated CEI.

Australia should strengthen the workforce and organisational capability required to adopt and sustain CEI in routine practice. CEI should be recognised not only as innovations that require workforce adaptation, but as potential mechanisms for improving workforce sustainability, enabling staff to work at the top of scope, reducing administrative burden and strengthening system resilience. Implementation support should therefore accompany adoption decisions, including workflow redesign, change management, targeted education and micro-credentialling. Workforce impact measures should capture changes in staffing requirements, workforce utilisation, administrative burden and service capacity, and CEI should be considered within broader workforce planning and resilience initiatives.

CASE EXAMPLE:

NSW Health's Scalable Workforce Solutions[49]

NSW Health's Workforce Planning and Development Branch works with Local Health Districts and other agencies to assess workforce implications and support scalable solutions.

Implementation toolkits for Rapid Assessment, Intervention and **Discharge–Emergency Department (RAID-ED)** and **Quick Access Response Team (QuART)** provide practical resources—including models of care, scope-of-practice guidance and position descriptions—to support consistent implementation across services. These allied health-led models aim to improve patient flow, reduce avoidable admissions and make better use of workforce capability.

Australia could build on this approach as the **translation and scale layer of the national CEI pathway.** Rather than creating a separate implementation system, existing jurisdictional workforce functions could be connected through a common CEI framework, providing tools and expertise for workforce planning, workflow redesign, training, capacity measurement and implementation.

Australia should also establish a national CEI translation and implementation capability to support validated innovations from pilot through implementation and scale. This capability should provide structured implementation support, connect research translation centres and health services, and facilitate coordination across jurisdictions. It should also support standardized collection of patient, workforce, utilisation and capacity measures during real-world implementation, enabling successful CEI to generate transferable evidence that can inform NHRA funding reform, procurement and broader national adoption. This would reduce reliance on individual hospitals or local champions and create a repeatable pathway for moving validated innovations into routine practice.

Continuous reassessment and de-implementation should form part of the adoption cycle. Health systems should routinely identify and reassess established practices that no longer represent high-value care, using consistent standards and evidence frameworks across jurisdictions. Where low-value practices are discontinued, the resulting workforce, financial and service capacity should be measured and linked to explicit reinvestment pathways that support higher-value CEI. This ensures that innovation does not simply add new activity to an already constrained system but actively creates room for higher-value care.

Strategic Priority 5: Embed Learning, Equity and Stewardship

Key Constraints

1. **Geographic and equity-based variation.**

   Access to innovation varies according to geography, workforce availability, infrastructure, funding priorities and whether care is delivered in public or private settings. Rural and regional populations can face additional barriers to accessing specialised services and technologies. Certain patient groups such as First Nations may also experience lower visibility within policy and funding discussions despite carrying significant burden of disease and unmet need. [8 17]

> "There is limited structured integration of lived experience into decision-making. Patient input is often invited but not embedded in a way that meaningfully influences outcomes. As a result, decisions can miss the broader value of innovations, particularly those that reduce caregiver burden, enable faster recovery, or prevent long-term complications."
>
> ***Tanya Hall***
> *Chief Executive Officer*
> *Hearts4Heart*

2. **Limited patient voice and advocacy.**

   Patient perspectives are not consistently embedded in decision-making, despite their importance in understanding outcomes such as independence, treatment burden, recovery and caregiver impact.

3. **Inconsistent stewardship and feedback.**

   Appropriate use of CEI requires ongoing clinical stewardship, monitoring and evaluation. Without effective data and governance mechanisms, technologies may be used inconsistently, fail to deliver anticipated benefits or continue to consume resources despite limited value. Weak feedback mechanisms also limit the ability to use real-world evidence to refine policy, assessment, funding and implementation decisions.

CEI adoption should not end once an innovation is funded or implemented. Real-world evidence of the capacity, clinical and equity gains achieved through implementation should be captured and used to support wider adoption and scale. Without effective feedback loops, successful innovations may not generate the evidence needed to build confidence and enable their benefits to spread across the system.

Recommendation:

Create feedback loops that support equitable access, appropriate use and continuous evaluation.

Australia needs a learning system that continuously assesses whether CEI deliver their expected clinical, capacity and economic benefits in real-world settings, and uses this evidence to improve future decisions. This requires consistent monitoring of patient outcomes, patient experience, safety, workforce impacts, utilisation, capacity released, cost and equity across jurisdictions. Common indicators and national benchmarking should allow CEI access, adoption and outcomes to be compared across jurisdictions and service settings, while remaining sensitive to differences in local context.

Equity should be embedded throughout the CEI lifecycle rather than assessed only after implementation. Monitoring should identify geographic and population-level variation in access, adoption and outcomes, with particular attention to rural, remote and underserved communities where workforce and infrastructure constraints may limit the ability to implement CEI. CEI that address major sources of inequitable access and avoidable healthcare utilisation should be prioritised, and real-world evidence should capture whether benefits are being realized across different populations and service contexts. Cross-jurisdictional data sharing and learning should support identification of inequities and enable successful approaches to be adapted and scaled.

Patient and caregiver partnership should form part of CEI decision-making throughout the lifecycle. Patients and caregivers should have meaningful opportunities to inform assessment, procurement, implementation, evaluation and reassessment, including consideration of outcomes that may not be captured through conventional clinical or economic measures. Consumer participation should be sufficiently diverse to reflect populations experiencing geographic and other barriers to access.

CASE EXAMPLE:

National Institute for Health and Care Excellence (NICE) Patient and Public Involvement Programme + MedTech Stewardship

In the UK, NICE embeds patient organizations and public representatives throughout health technology assessment committees, ensuring lived experience informs evidence appraisal and recommendations and also has formal processes for patient involvement throughout guidance development. Following adoption, technologies are supported by clinical guidance, audit standards, and real-world evidence collection to monitor appropriate use and outcomes. This combination of patient partnership and ongoing stewardship helps ensure innovations deliver value in practice while informing future updates to guidance.

Stewardship should extend beyond whether a CEI benefits individual patients to whether it represents appropriate use of health system resources. Clinical stewardship mechanisms including appropriate-use frameworks, clinical audit, registries, PROMs, PREMs and post-implementation review can identify unwarranted variation, overuse, unintended consequences or diminishing value, supporting appropriate and sustainable use of CEI.

This creates a continuous learning cycle in which evidence from one generation of CEI adoption improves selection, evaluation, implementation and scaling of the next generation of innovations.

Risks, Limitations and Implementation Considerations

While CEI offers significant potential to release, create and enhance health-system capacity, these benefits are neither automatic nor uniformly distributed. Realising a capacity dividend requires attention to demand absorption, downstream constraints and equitable access. This section examines these risks and the implementation conditions needed to translate capacity gains into measurable, system-wide value.

1. Demand absorption: released capacity is not necessarily a dividend

If an innovation frees up capacity, will that capacity simply be absorbed by unmet demand, increasing activity without reducing waiting times, expenditure or workforce pressure?

Capacity creation is not synonymous with cash-releasing savings. In demand-constrained health systems, released capacity may be absorbed by existing waiting lists, previously unmet need, more appropriate care or additional activity. This may be desirable, but it does not automatically produce a reduction in expenditure or a measurable improvement in access. Conversely, if demand shifts towards the newly available service, downstream bottlenecks may worsen.

For example, a procedure that reduces inpatient length of stay may free beds while leaving theatre availability, specialist staffing, rehabilitation or community care as the binding constraint. If released capacity is not actively managed, the system may experience higher throughput without a commensurate improvement in waiting times or productivity.

Implications for CEI assessment and implementation:

- Distinguish technical capacity released from capacity redeployed, additional patients treated, waiting-time reductions and cash-releasing savings.
- Establish a baseline and specify the intended use of released capacity before implementation.
- Assess the entire care pathway, including downstream services, workforce requirements and potential induced demand.
- Track whether additional activity addresses unmet clinical need and improves outcomes, rather than assuming increased utilisation is inherently beneficial.

2. Capacity displacement and spillovers: gains in one area may create constraints elsewhere

Does releasing capacity in one service genuinely improve system-wide capacity, or does it simply transfer the bottleneck to another service?

CEI can alter the distribution of resource use across a care pathway rather than reduce total resource requirements. A CEI may reduce hospital bed-days but increase demand for specialist assessment, diagnostic imaging, follow-up, rehabilitation, community nursing or long-term monitoring. It may also require scarce staff, infrastructure or training that displaces other activities.

The relevant unit of analysis should therefore extend beyond the individual technology or procedure to the care pathway and the wider health system. Capacity effects should be assessed across relevant settings and time horizons, accounting for both resources released and resources newly required.

Implications for CEI assessment and implementation:

- Map resource flows across the pathway before and after adoption.
- Identify complementary inputs and downstream constraints that determine whether released capacity can be used.
- Measure net capacity effects across settings, not just gross reductions in one department.
- Examine whether implementation transfers costs, workload or waiting times to another service, provider or level of care.

3. Uneven access: Capacity enhancing innovation may widen geographical inequities

Will CEI disproportionately benefit well-resourced metropolitan hospitals, while regional, rural and remote services lack the funding, infrastructure, workforce or patient volumes needed to adopt them?

Adoption may depend on specialist availability, capital investment, procurement arrangements, minimum procedural volumes, referral networks and the capacity to deliver follow-up care. These conditions can favour metropolitan centres and leave under-resourced services unable to realise equivalent gains.

CEI evaluation should therefore consider not only system efficiency but also where capacity is released, who receives the benefit, and which populations remain underserved.

Implications for CEI assessment and implementation:

- Report uptake, eligibility, referral, waiting times and outcomes by geography and population group where data permit.
- Assess implementation requirements for regional and rural services, including workforce, infrastructure, transport and follow-up.
- Consider hub-and-spoke models, regional referral networks, shared specialist services and targeted implementation funding where appropriate.
- Evaluate whether efficiency gains improve equitable access or concentrate resources and benefits in already well-served settings.

SECTION 4.

Charting a CEI Action Agenda

A coordinated CEI approach can align interests around a common objective—improving health outcomes while increasing the capacity, productivity and sustainability of the health system.

Why CEI Matters Across the Health System

CEI adoption will require collaboration and coordination across policy, funding, assessment, service delivery, clinical practice, research organisations and patients. Each stakeholder group has a different role to play, but also a distinct interest in accelerating the adoption of innovations that release health-system capacity. Please see Appendix C for details of stakeholders and their respective roles.

Commonwealth and state health agencies can use CEI to improve system productivity, address rising demand and workforce constraints, and strengthen the sustainability of publicly funded services.

Funders have an interest in ensuring that health investment generates greater value, including through avoided costs, released capacity and more efficient use of infrastructure and workforce.

Health technology assessment and evidence bodies can strengthen decision-making by recognizing not only clinical and economic value, but also the capacity and system-level benefits of innovation.

Health services and hospital leaders can use CEI to address operational constraints, improve patient flow, increase throughput and make better use of existing workforce and infrastructure.

Clinicians and professional bodies can benefit from reduced avoidable workload, more efficient models of care and the ability to direct scarce clinical expertise towards patients with the greatest need.

Patients can benefit from improved access, reduced waiting and avoidable hospital use, and more timely access to appropriate care closer to home.

The opportunity is therefore shared across the system: governments and funders need sustainable ways to meet growing demand; health services need to release constrained capacity; clinicians and patients need better access and care; and innovators need clearer pathways to adoption.

Action Agenda

Various stakeholders will need to collaborate across different stages and timeframes to advance each priority and support its implementation. The five strategic priorities should move forward together, with the focus changing as the system matures. In the first two years, the priority is to put the foundations in place and test new approaches. Over the following years, successful approaches can be embedded and scaled across the system. Longer term, capacity optimisation should become a routine part of how the health system plans, funds and delivers care.

Immediate Term 0-2 Years

Strategic Priority 1: Establish Policy Direction and Governance

Recommendation: Create a policy and governance environment that recognises and enables Capacity enhancing innovation.

ACTION: Embed Capacity Enhancement as a Core Objective of Health Reform

- Define capacity outcomes (throughput, workforce efficiency, access, waiting times) as reform objectives.
- Integrate CEI explicitly into national reform and service planning frameworks
- Ensure CEI representation in reform governance and consultation processes

Stakeholders: DoHDA | Commonwealth Treasury | State and Territory Health Departments| NHRA governance bodies | Clinical Colleges and Professional Associations| Patient Groups | NACCHO

ACTION: Build on Existing Processes to Establish a National Rapid Assessment and Adoption Pathway

- Incorporate 1–3-year real-world implementation pilots with embedded evaluation. Findings from these should inform development of a CEI evaluation framework.
- Leverage international harmonization initiatives such as Medical Device Single Audit Program (MDSAP) that satisfy regulatory requirements across multiple jurisdictions including Australia, Brazil, Canada, Japan, and the United States.
- Explore mutual recognition agreements (MRAs) and collaborative assessment arrangements to reduce redundant evaluations and accelerate market access.

Stakeholders: PBAC | MSAC | MDHTAC | IHACPA

Strategic Priority 2: Recognise Capacity Value in Assessments

Recommendation: Ensure CEI is assessed on its economic and system-capacity value, in addition to its clinical benefits.

ACTION: Develop a National Capacity Sentinel Indicator Framework to Enable Comparable Capacity Evidence Across Jurisdictions

- Research and develop standardized capacity dividend metrics (Table 1, Appendix B) for system throughput, workforce productivity, bed-day avoidance, waiting list reduction, care substitution (hospital to community/home), and caregiver burden reduction.

Key sentinel capacity dividend metrics could include:

- Net bed-days released per 100 patients treated
- Patients managed per clinical FTE
- Additional outpatient appointments created
- Surge capacity dividend

Stakeholders: AIHW | Clinical and Academic Research Centres | Local Health Departments | ACCHOs

Strategic Priority 3: Align Financing, Investment and Procurement

Recommendation: Align funding, capital and procurement incentives with whole-system value and capacity creation

ACTION: Position CEI for Service Model and Funding Reform (SMRF) Pathway Eligibility

- Align CEI capacity dividend metrics with SMRF criteria across access, equity, quality, outcomes, workforce sustainability, utilisation, and cost.
- Develop pathway-level business cases demonstrating CEI contributions to high-value care and service reform.
- Engage with ACSQHC on priority cohorts and best-practice care models.
- Inform funding reform discussions on bundled payments, capitation, and value-based funding.

Stakeholders: DoHDA | IHACPA | ACSQHC | Local Health Departments | Commonwealth and State Treasuries | Clinical Registries | Professional Societies | Health Services | Industry Partners

ACTION: Align Funding Models with Capacity Release and System Efficiency

- Reduce distortions in activity-based funding that penalize efficiency

Stakeholders: Commonwealth Treasury | State Treasuries | DoHDA | IHACPA | NHRA Governance Bodies

Strategic Priority 4: Support Implementation, Adoption and Scaling

Recommendation: Build the organisational, workforce and implementation capability required to translate evidence into routine practice, strengthen system resilience and scale validated CEI.

ACTION: Strengthen Workforce Readiness and System Resilience Through Capacity enhancing innovation

- Support clinicians and health services to adopt CEI through targeted implementation support, education, and change-management programs.
- Expand micro-credentialling and workforce development programs focused on CEI-enabled models of care.
- Advocate for inclusion of CEI-related workforce metrics within NHRA workforce monitoring and reform activities.

Stakeholders: DoHDA | Local Health Departments | NACCHO | ACCHOs | Industry Partners | Apex Clinical Organisations | Clinical and Academic Research Centres

ACTION: Embed Continuous Reassessment and Low-Value Care Disinvestment

- Develop national standards for consistent identification and classification of low-value care across jurisdictions

Stakeholders: DoHDA | IHACPA (MSAC) | NHMRC | Clinical Societies | State Health Departments | Local Health Services

Medium Term 2-5 Years

Immediate Term 0–2 Years | **Medium Term 2–5 Years** | Long Term >5 Years

Strategic Priority 1: Establish Policy Direction and Governance

Recommendation: Create a policy and governance environment that recognises and enables Capacity enhancing innovation.

ACTION: Coordinating a National Rapid Assessment and Adoption Pathway

- Identify and remove duplication between federal assessment processes and state or local reassessments.
- Introduce defined timeframes from assessment to funding and adoption decisions.
- Integrate implementation planning alongside funding approval.

Stakeholders: DoHDA | PBAC / MSAC / MDHTAC | IHACPA | State Procurement Authorities | Local Health Departments

Strategic Priority 2: Recognise Capacity Value in Assessments

Recommendation: Ensure CEI is assessed on its economic and system-capacity value, in addition to its clinical benefits.

ACTION: Establish a National Capacity Sentinel Indicator Framework to Enable Comparable Capacity Evidence Across Jurisdictions

- Embed tested capacity-dividend metrics as a sentinel indicator set within routine data collection.

Stakeholders: DoHDA | Local Health Departments | NACCHO

Strategic Priority 3: Align Financing, Investment and Procurement

Recommendation: Align funding, capital and procurement incentives with whole-system value and capacity creation

ACTION: Leverage NHRA's Alternative Payment Model (APM) Trials for CEI funding model evidence generation

- Partner with State and Territory governments to develop CEI-enabled pathway reform proposals suitable for APM trials.
- Prioritise pathways where significant capacity constraints, access challenges, workforce pressures, or preventable hospitalizations exist.
- Embed capacity dividend metrics and associated sentinel indicators within trial design.
- Use trial data to evaluate the suitability of bundled payments, capitation funding, value-based pricing, and other alternative payment approaches.

Stakeholders: DoHDA | Local Health Departments | IHACPA | Clinical colleges and professional associations | NACCHO | Health economists and academic institutions

ACTION: Align Procurement Systems with System-Level Value Realization

- Standardize interpretation of HTA-derived system value in procurement processes
- Build procurement capability through training in system value assessment and CEI metrics
- Embed capacity metrics (access, throughput, workforce impact) in procurement templates
- Strengthen integration between procurement, clinical, finance, and service planning functions

Stakeholders: IHACPA | DoHDA | ACSQHC | Local Health Departments | Industry Partners

ACTION: Align Funding Models with Capacity Creation and System Efficiency

- Transition toward pathway-based or bundled payment models
- Test shared savings mechanisms across Commonwealth and States

Stakeholders: Commonwealth Treasury | State Treasuries | DoHDA | IHACPA | NHRA Governance Bodies

Strategic Priority 4: Support Implementation, Adoption and Scaling

Recommendation: Build the organisational, workforce and implementation capability required to translate evidence into routine practice, strengthen system resilience and scale validated CEI.

ACTION: Strengthen Workforce Readiness and System Resilience Through Capacity enhancing innovation

- Support nurses, allied health professionals, and other healthcare workers to practice at the top of their scope through CEI-enabled service redesign.
- Develop workforce impact measures that capture reductions in administrative burden, workforce utilisation, staffing requirements, and clinician burnout.



Stakeholders: DoHDA | State and Territory Health Departments | Health Workforce Taskforces | Professional Colleges and Societies | Universities and Research Translation Centres | Local Health Districts and Health Services | Clinical Leaders | Industry Partners

ACTION: Coordinate CEI Translation and Implementation

- Provide structured implementation support (workflow redesign, service adaptation)
- Integrate research translation centres into implementation pathways
- Standardized real-world evidence capture during scale-up



Stakeholders: NHMRC | Research Translation Centres | State Health Departments | Clinical Innovation Agencies | Hospital Networks | NACCHO | ACCHOs

ACTION: Embed Continuous Reassessment and Low-Value Care Disinvestment

- Establish routine reassessment cycles for legacy interventions aligned with clinical guideline update processes
- State health departments to determine disinvestment decisions based on reassessment outputs, informed by national standards and evidence frameworks



Stakeholders: DoHDA | IHACPA | MSAC | NHMRC | Clinical Societies | State Health Departments | Local Health Services

Strategic Priority 5: Embed Learning, Equity and Stewardship

Recommendation: Create feedback loops that support equitable access, appropriate use and continuous evaluation.

ACTION: Embed Equity and Patient Voice in CEI Implementation

- Establish equity indicators to monitor whether CEI improve access, outcomes and service availability across population groups and geographic settings.
- Incorporate patient, caregiver and community perspectives into CEI implementation and evaluation, including through culturally appropriate engagement with First Nations communities.

Stakeholders: DoHDA | State and Territory Health Departments | AIHW | NACCHO and relevant ACCHOs | Patient and Consumer Organisations | Multicultural, Rural and Remote Health Organisations | Primary Health Networks (PHNs).

ACTION: Strengthen Monitoring of Appropriate CEI Use

- Develop mechanisms for monitoring clinical appropriateness, patient outcomes and unintended consequences following CEI adoption.
- Support health services to use real-world evidence and clinical feedback to identify variations in use and opportunities for improvement.

Stakeholders: DoHDA | State and Territory Health Departments | ACSQHC | Clinical Colleges and Professional Associations | Hospital Networks and Health Services | AIHW.

Long Term >5 Years

Immediate Term 0–2 Years | Medium Term 2–5 Years | **Long Term >5 Years**

Strategic Priority 1: Establish Policy Direction and Governance

Recommendation: Create a policy and governance environment that recognises and enables Capacity enhancing innovation.

ACTION: Coordinating a National Rapid Assessment and Adoption Pathway

- Progressively integrate assessment processes that were streamlined in years 0-5, building on early removal of duplicative assessments and excessive evidence requirements, insights from real-world pilots, and the development of implementation support, to establish a clearer, more coordinated and user-friendly route to assessment and adoption.

Stakeholders: DoHDA | PBAC / MSAC / MDHTAC | IHACPA | State Procurement Authorities | LHDs | NACCHO

Strategic Priority 2: Recognise Capacity Value in Assessments

Recommendation: Ensure CEI is assessed on its economic and system-capacity value, in addition to its clinical benefits.

ACTION: Modernize HTA to Explicitly Include System Capacity Value

- Embed societal and health-system value in HTA reference cases, using capacity dividends as a measure.
- Reduce over-reliance on short-term budget impact as the primary decision driver.

Stakeholders: PBAC | MSAC | MDHTAC | IHACPA | Health Economics Units | Clinical and Academic Research Centres| DoHDA| NACCHO| ACCHOs

Strategic Priority 3: Align Financing, Investment and Procurement

Recommendation: Align funding, capital and procurement incentives with whole-system value and capacity creation

ACTION: Leverage NHRA's Alternative Payment Model (APM) Trials for CEI funding model evidence generation

- Use trial data to evaluate the suitability of bundled payments, capitation funding, value-based pricing, and other alternative payment approaches.
- Establish mechanisms to aggregate and share trial outcomes nationally, creating transferable evidence for future adoption and funding decisions.
- Ensure trial outcomes inform future NHRA funding reforms, pricing reforms, and pathway redesign initiatives.

Stakeholders: IHACPA | DoHDA | ACSQHC | Local Health Departments | Industry Partners

ACTION: Establish Shared Savings and Reinvestment Mechanisms Across Jurisdictions

- Implement robust shared savings mechanisms that work across Commonwealth and territories.
- Enable reinvestment of CEI-generated savings into service improvement

Stakeholders: Commonwealth Treasury | State Treasuries | DoHDA | IHACPA | NHRA governance bodies

Strategic Priority 4: Support Implementation, Adoption and Scaling

Recommendation: Build the organisational, workforce and implementation capability required to translate evidence into routine practice, strengthen system resilience and scale validated CEI.

ACTION: Embed Continuous Reassessment and Low-Value Care Disinvestment

- Local health services to implement approved disinvestment decisions and reallocate operational capacity within service delivery settings
- Link disinvestment processes to reinvestment pathways supporting CEI adoption and scale-up

Stakeholders: DoHDA | IHACPA (MSAC) | NHMRC | Clinical societies | State health departments | Local health services| ACCHOs

Strategic Priority 5: Embed Learning, Equity and Stewardship

Recommendation: Create feedback loops that support equitable access, appropriate use and continuous evaluation.

ACTION: Establish Continuous Learning and Clinical Stewardship Mechanisms

- Embed routine review of CEI performance, equity impacts and clinical appropriateness into health-system governance and clinical guideline processes.
- Use real-world evidence, patient experience and emerging clinical evidence to inform ongoing reassessment, adaptation and disinvestment decisions.

Stakeholders: DoHDA | State and Territory Health Departments | ACSQHC | Clinical Colleges and Professional Associations | IHACPA | Local Health Services | NACCHO | ACCHOs

ACTION: Embed Equity and Accountability in Long-term CEI Investment and Scale-up

- Use evidence on access, outcomes and capacity impacts across population groups and geographic settings to guide the equitable allocation of resources and scale-up of CEI.
- Establish accountability for ensuring that CEI-generated capacity gains translate into sustained improvements in access and outcomes for underserved populations, including Aboriginal and Torres Strait Islander communities.

Stakeholders: DoHDA | State and Territory Health Departments | AIHW | NACCHO and relevant ACCHOs | Patient Organisations | Rural and Remote Health Organisations

SECTION 5.

Make Capacity Count

Australia does not lack innovation and CEI are often well-supported at the level of clinical innovation, but their system-level value is not consistently carried through the full chain of policy, funding, implementation, and learning. This is a set of structural misalignments in how innovation is processed through the system.

Every health service knows where capacity is being lost—through avoidable admissions, long stays, repeated appointments, workforce time tied up in low-value tasks, or infrastructure that cannot keep pace with demand. The opportunity is to systematically identify and scale innovations that release that capacity.

There are a strong set of enabling conditions already present across the system, including ongoing reform activity, increasing focus on productivity and sustainability, expanding data capability, and growing recognition of workforce and access pressures. These provide a foundation on which more coherent approaches can be built.

CEI do not require a parallel system, rather, their value is best realized when existing system components are better aligned around capacity as an outcome. Strengthening this alignment would improve how innovations are assessed, funded, implemented, and learned from regardless of technology type. In this sense, CEI do not sit outside current reform efforts; rather, they help clarify where greater coherence is needed for those efforts to achieve their intended impact.

The broad system-level recommendations and action agenda provide stakeholders with an opportunity to build a health system capable of stronger performance and sustained capacity.

Now is the time to act.

In the near term, the priority is to make capacity visible. The next step is to make action easier by removing the barriers that prevent high-value innovations from progressing through assessment, financing, procurement and implementation.

Over time, these changes should make capacity optimisation part of routine health system decision-making, with evidence from implementation informing what is funded, adopted, scaled and, where appropriate, de-implemented and reinvested.

The result should be a health system that can respond to rising demand not simply by adding more resources, but by continually finding better ways to use its resources, workforce and infrastructure to meet more patient need.

Australia should move beyond asking whether an innovation is effective and cost-effective to also asking whether it can improve or maintain quality of care, release or enhance health-system capacity, and enable the system to meet more patient need.

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APPENDIX A

Methodology

This whitepaper draws on a combination of desk-based research, policy and literature review, and qualitative insights from stakeholder interviews. The research examined the policy, funding, assessment and implementation arrangements shaping the adoption and scale-up of Capacity enhancing innovation (CEI) across the Australian health system.

Several semi-structured stakeholder interviews were conducted with representatives from across the health system, including clinical practitioners, healthcare leaders and patient group representatives. These interviews explored practical experiences of innovation adoption, institutional and system-level barriers, funding and procurement arrangements, and opportunities to improve the translation of innovations into routine care.

Interview findings were synthesised thematically and used to inform the analysis, identify implementation challenges, and ground the policy recommendations in real-world health-system experience. Where interview insights are referenced in the whitepaper, anonymised identifiers (e.g. E01, E02) are used to distinguish individual sources while maintaining confidentiality. Interviews are cited as expert interview insights in the reference list.

The analysis also draws on published literature, government policy documents, health technology assessment frameworks, and national and international case examples. These sources were used to examine existing approaches to assessing, funding and implementing innovations, and to identify opportunities to better recognise and realise their potential to create and sustain health-system capacity.

APPENDIX B

This example illustrates how a capacity dividend metric can be operationalised through an appropriate baseline indicator. It identifies what the indicator measures, potential data sources within existing databases, and what it reveals about capacity release.

For further examples of capacity dividend metrics that could be used together to develop a more comprehensive capacity monitoring framework, see Table 2 (Appendix B).

Table 1. Illustrative Example of Developing a Capacity Sentinel Indicator Framework

Capacity dividend metric	**Net bed-days released per 100 patients treated**
Baseline indicator required	**Average length of stay (ALOS)** **Bed occupancy rate (%)** **Inpatient bed-days per admission** **Admissions/episodes of care**
What it measures	**Reduction in inpatient bed utilisation compared with usual care**
Data source	**AIHW Admitted Patient Care Database; hospital administrative datasets; CEI evaluation data**
What it indicates about capacity	**Quantifies physical hospital capacity released and ability to accommodate additional demand without new beds**

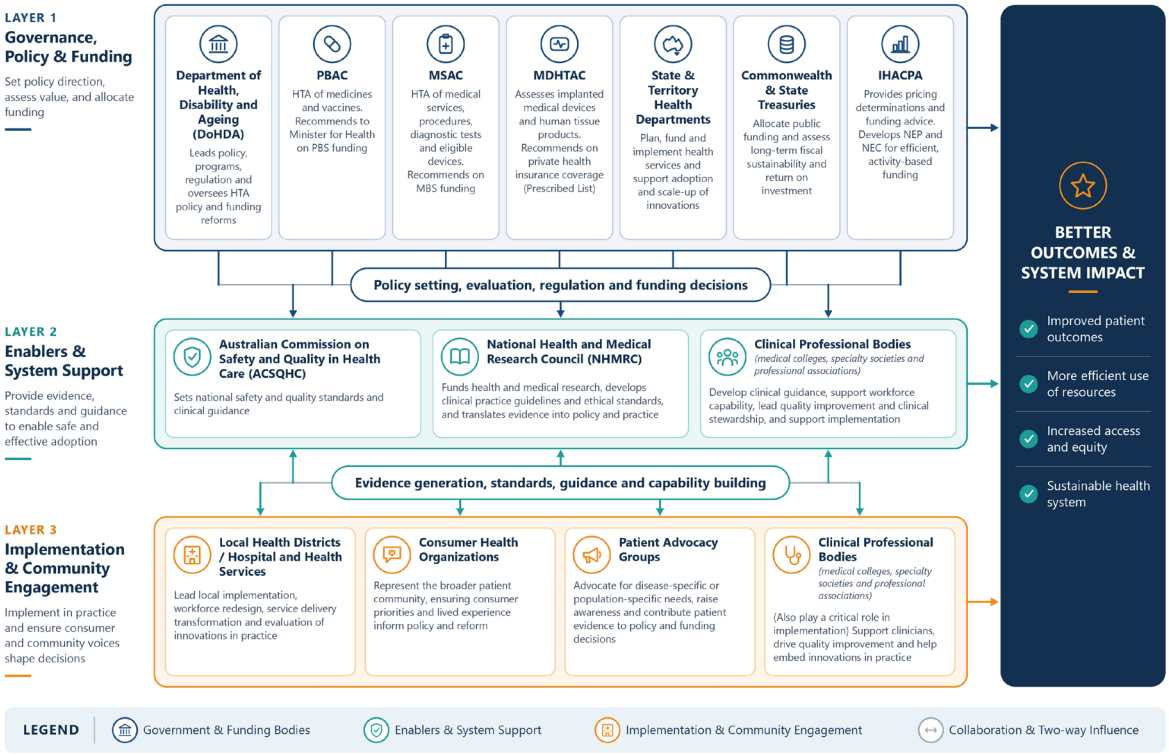
Table 2: Suggested List of Capacity Dividend Metrics

Capacity dividend metric	What it indicates about capacity
Net bed-days liberated per 100 patients treated	Quantifies physical hospital capacity released and ability to accommodate additional demand without new beds
Clinical hours released per 100 patients treated	Converts efficiency gains into available workforce capacity
Patients managed per clinical FTE	Indicates whether CEI expand effective workforce capacity and reduce workforce pressure
Theatre sessions released	Measures additional procedural capacity without increasing infrastructure
Outpatient appointments created	Measures improved access and ability to meet demand without proportional workforce expansion
Estimated avoided capital expenditure	Quantifies financial value of CEI by demonstrating avoided expansion costs
Surge capacity dividend	Measures resilience and ability to absorb pandemics, disasters, seasonal surges, or demand spikes

APPENDIX C

STAKEHOLDERS ACROSS THE CEI ADOPTION PATHWAY

Multiple stakeholders work across interconnected layers to enable, fund, regulate, implement and embed capacity-enhancing innovations in the health system.



- **Commonwealth Department of Health, Disability and Ageing (DoHDA)** (formerly DoHAC): Supports Australian Government in shaping health, disability and ageing system. It does this through evidence-based policy, well-targeted programs and best-practice regulation including overseeing HTA policy and funding reforms.

- **Pharmaceutical Benefits Advisory Committee (PBAC):** An independent statutory expert committee appointed by the Australian Government DoHDA. PBAC evaluates the comparative clinical effectiveness, safety, cost-effectiveness, and broader value of medicines and vaccines through health technology assessment (HTA) and makes recommendations to the Minister for Health on whether they should be publicly funded through the Pharmaceutical Benefits Scheme (PBS).

- **Medical Services Advisory Committee (MSAC):** Medical Services Advisory Committee (MSAC): An independent statutory expert committee supported by the Australian Government Department of Health, Disability and Ageing (DoHDA). MSAC undertakes health technology assessment (HTA) of new medical services, procedures, diagnostic tests, and eligible medical devices, evaluating their comparative

safety, clinical effectiveness, cost-effectiveness, and broader value. It provides recommendations to the Australian Government on whether these technologies should receive public funding through the Medicare Benefits Schedule (MBS).

- **MDHTAC (Medical Devices and Human Tissue Advisory Committee):** An expert advisory committee that assesses surgically implanted medical devices and human tissue products seeking reimbursement through Australia's private health insurance system. MDHTAC provides recommendations regarding inclusion on the Prescribed List (formerly Prostheses List), enabling eligible implanted devices to receive private health insurance reimbursement.

- **State and Territory Health Departments:** Plan, fund, and implement health services, supporting the adoption and scale-up of innovations within public hospitals and community care.

- **Commonwealth and State Treasuries:** Allocate public funding and assess the long-term fiscal sustainability and return on investment of health reforms.

- **Independent Health and Aged Care Pricing Authority (IHACPA):** An independent statutory agency that provides evidence-based pricing determinations and funding advice to the Australian Government. IHACPA develops the National Efficient Price (NEP) and National Efficient Cost (NEC) to support activity-based funding of public hospitals and provides pricing and costing advice to improve the efficiency, transparency, and sustainability of Australia's hospital and aged care systems.

- **Australian Commission on Safety and Quality in Health Care (ACSQHC):** Sets national safety and quality standards and clinical guidance to support the safe, effective, and appropriate adoption of healthcare innovations.

- **Local Health Districts / Hospital and Health Services:** Lead local implementation, workforce redesign, service delivery transformation, and evaluation of innovations in practice.

- **Consumer health organizations:** Represent the broader patient community, ensuring consumer priorities and lived experience inform health policy and system reform.

- **Patient advocacy groups:** Advocate for disease-specific or population-specific needs, raising awareness and contributing patient evidence to policy and funding decisions.

- **Clinical Professional Bodies (e.g., medical colleges, specialty societies and professional associations):** Develop evidence-based clinical guidance, support workforce capability, lead quality improvement and clinical stewardship, and contribute to the implementation and evaluation of innovative models of care and technologies.

- **National Health and Medical Research Council (NHMRC):** Australia's primary national health and medical research funding agency and a key source of evidence-based health guidance. NHMRC supports research that improves health outcomes, develops clinical practice guidelines and ethical standards, and translates evidence into policy and practice. Through its funding priorities and evidence standards, NHMRC influences the generation, adoption, and implementation of healthcare innovations.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