Delivering quality care more efficiently inquiry

Questionnaire response 8

Name: Minda Incorporated

Submission date: 26/05/2025

Participant background

1. For the purposes of this consultation, which of the following best describes you:

   I am an organisation that provides or coordinates care services

2. Which of the following care sectors will your feedback relate to? Please select all that apply.

   Aged care; Disability; Early childhood education and care; Health

3. What kind of care supports, services and programs do you have experience with, and in what jurisdictions?

   The participant did not respond to this question.

1. Reform of quality and safety regulation to support a more cohesive care economy

1. To what extent do differences in quality and safety regulation make it costly or complex to provide or access care services?

   The participant did not respond to this question.

2. What are the reasons for your answer?

   The participant did not respond to this question.

3. To what extent should quality and safety regulations be more aligned across the different care service sectors and jurisdictions?

   The participant did not respond to this question.

4. What are the reasons for your answer?

   The participant did not respond to this question.

2. Embed collaborative commissioning to increase the integration of care services

1. What is your experience with collaborative commissioning

   In the mid 1990's when working in the NHS in the UK I led one of ten national pilots on developing Primary Care Trusts. These bodies involved GPs taking the lead in commissioning hospital services for their patients on a population basis. The pilot was unique amongst the ten because it's geographic/population which was coterminous with a local authority boundary/population. At the time local government was responsible for social care and therefore the Primary Care Trust worked with the local authority to commission across health and social care for specific population groups, e.g. older people. This led to more efficient service delivery, made better use of public funds and let to better outcomes for the care recipient. Over time this led to the development of Strategic Commission Boards across England.

In the early 2000's as Chief Executive of the City of Brighton & Hove in the UK I oversaw the development of the UK's first Childrens Trust. This brought together the government-funded school system, childrens social care (including Child Protection Services) and child health and hospital services together under one commissioning structure, This led to the benefits identified above of increased efficiency, better use of public funds and better outcomes for children. This activity also, in time, became part of the responsibility of Strategic Commissioning Boards mentioned above.

I was recruited to South Australia in 2004 to implement the State review of the public hospital system which wanted to integrate primary care with the public hospital system. Whilst some progress was made and the State started to develop it's GP Plus Health Care Centres (3 of a planned 10 were established) working with what were then Divisions of General Practice this got undermined by the Federal Government's creation of GP Super Clinics.

I presented evidence to the Aged Care Royal Commission on the benefits of 'strategic commissioning' for older people - for simplicity this proposed that all public funding spent on over 75's across health and aged care in a given population be combined into a single bucket and a 'commissioning entity' be established to spend these funds on commissioning integrated care for those older people within that population. This was commented upon favourably by the Commissioners but they felt it too difficult to implement within an Australian context of the different roles of State and Federal Governments in funding the different components of health and social care.

This remains a problem today. In my view there are huge inefficiencies in care delivery and poorer outcomes for individuals that are meant to be benefitting from the services because of this siloed approach. For examples whilst PHNs commission services they really only focus on 'add-on' or supplementary services which primarily benefit GPs rather than attempt better integration of service delivery. In my own current experience of the NDIS and the 'rules' around what it will or will not fund lead to poorer outcomes and system inefficiencies. For example, NDIS will not support a participant who may be non-verbal and have complex behaviours once they have entered hospital. The NDIS expectation is that the hospital will be able to support such a person. In reality this is not the case as they do no have the skill set and as a consequence the individual often spends much longer in hospital than necessary and leads to the employment of a security guard to deal with their behaviour. I have discussed this with the State health system and proposed that it is cheaper for them in the long run and certainly better for the individual to employ our support worker to support them in hospital rather than a security guard. They agree with this in principle but will not implement because they feel that the NDIS should really pay for this activity and if the State accepted my proposal it would let the NDIS 'off the hook' and lead to other consequences.

2. What are the benefits of pursuing greater collaborative commissioning?

As described above I believe a collaborative commissioning approach would lead to;

- greater efficiency in the system
- better use of public funds
- better outcomes for the individuals in need

Unfortunately people don't come in a way which fits the various silo's the system has created across health, aged care, disability, veterans, children, etc. In my experience people need to be considered holistically otherwise gaps are created which have long term consequences for both the system and the person.

A collaborative commissioning system also has the ability/potential to create new incentives within systems to generate better outcomes for all involved.

First steps would be to look a small number of 'gaps' which currently contribute to current inefficiencies, poor performance and poorer health outcomes for individuals. These would be

- the general practice and the hospital system where there are few incentives for GP's to actively manage patients in line with a preventative agenda and instead rely upon the availability of the hospital system to pick individuals up

- the hospital system and aged care where there are too many older people in hospitals who could be better cared for in a non-hospital environment with greater use of 'hospital at home' models and extending these into residential home care

the hospital system, general practice and disability support where this interface is not currently good, particularly for people with intellectual disability, and it is known that life expectancy of this population is lower than the broader community largely due to access issues

- the disability sector and aged care as currently it is not 'legal' for someone to receive both NDIS funding and Aged Care funding - this becomes problematic when a person with disability has reached 65 years of age and the NDIS system determine their changed needs are to do with their ageing and not their disability so they will not support a change in their funding level - they are told instead to go to aged care - one of the NDIS Review recommendations is to change this situation so an individual can access both systems but the Government's response to this is still not known.

3. What are the barriers to collaborative commissioning, and do you have any suggestions for solutions that would lead to better collaboration in the commissioning of care services?

As outlined above the main barriers to implementing effective collaborative commissioning are the different levels of Government their respective responsibilities. In addition there has to be an openness to legislative change. For example whilst States/Territories remain responsible for public hospital and Federal Government for General Practice operating a 'item of service' payment model it is difficult to see how the current pressure being faced by EDs and hospital beds can improve. The States/Territories solution at every election is to put more hospital beds on the table and the one 'truism' in my career running health services is that the more beds you create the more they get filled. Whilst the Federal Government election response, as we have recently seen, is to 'create' more GP appointments which is futile unless you can determine more effectively what GPs do in those appointments.

3. A national framework to support government investment in prevention

1. What are the main barriers to governments investing in evidence-based prevention programs across the care economy?

The participant did not respond to this question.

2. What are some examples of successful prevention programs (this could include discontinued programs)?

The participant did not respond to this question.

3. How can governments better support investment in prevention activities that have broad and long-term benefits for the Australian community?

The participant did not respond to this question.