Delivering quality care more efficiently inquiry

Questionnaire response 9

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Participant background

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

   I am an interested community member

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

   Aged care; Disability; Health; Veterans

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?

   To a great extent

2. What are the reasons for your answer?

   Safety regulation by its very design is applied to a business environment where income is derived.
   This leads to businesses taking advantage of safety regulation in order to improve returns.
   Safety legislation promotes management of risk to as low as reasonably practical.
   Care services use innovative ways to develop services that purportedly improve patient outcomes, however these are often highly bureaucratic and not material in the patient outcome.
   Administration and PPE, while having their place in managing risk, are disproportionately more costly and much less effective than controls higher up the hierarchy of control.
   Ultimately, the bureaucratical approach results in a disproportionate amount of financial resources going to business profits with minimal, if any benefit, to the patient outcome.
   In fact the safety legislation, or the way it is interpreted, encourages the bureaucratic approach as it seeks to document and record events that may be used in the ultimate day in court where a business/ service provider may be held accountable.
   The problem here is far more fundamental and simple. A large proportion of care in Australian society is one that belongs in the family unit. The family unit is not a business, nor is it subject to Safety regulations.
   The problem here is that, as in the care industry, the greater proportion of care in the family unit is provided by women, however women are strongly encouraged to be in the workforce, hence do not have the time and space to take care of those in their family that need care services that in other cultures are provided by the family unit. In effect and in very simple terms what is happening; women are going to work for a business, and caring for someone else's patient, rather than, not working and, caring for a person

in need in their own family unit.
This became very clear during the time of the COVID pandemic where the Australian health and safety laws where used to implement controls to protect people through business. These health and safety laws however did not apply to the home environment. Other cultures where care is provided in the home/ family environment did not have this level of risk management, as socially/ culturally care is provided in the family unit. Of note is that in these cultures the average life expectancy is higher than that in Australia. The problem here is social and in the design.

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

   Not at all

4. What are the reasons for your answer?

   I believe that this is the wrong question to ask, as it is not recognising that the problem is social, and related to the family unit. This is a policy issue no an issue of safety regulation miss alignment. If nothing changes, nothing changes.

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

1. What is your experience with collaborative commissioning

   The concept of collaborative commissioning is not new. This concept is well known in nature where species that communicate and collaborate across the lifespan of the species survive longer. This too is true for humanity. Experience tells me that if i manage my care needs and get the different service providers to interact, communicate, and consult i get a better outcome.

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

   Improved patient outcomes. Collaborative commissioning is also part of safety regulation under the umbrella of "Consultation and Communication". In my experience, this is generally one of the least understood and implemented ways of managing risk in a business. Pursuing greater collaborative commissioning across and amongst different service providers/ businesses will likely result in increased cost and little if any improvement to patient outcomes. Activity is not progress.
   If however focus is put strengthening the family unit, and care predominantly returns to the family unit, collaborative commissioning will by its very nature occur between independent family units, bringing along improved care and lower cost. As family units collaborate one by one, this then becomes a social/ cultural approach to care.

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?

   The barrier to collaborative commissioning is the policy itself. Improved problem definition and review of policy would to address the root causes would see far more achievable and sustainable outcomes from both cost and care perspectives.

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?

Government is focussed on and maintaining GDP based growth, which often drives social side effects. These side effects occur as people are focussed on employment and earing an income to support their consumption, which arguably in Australia is excessive. Further government barriers are business driven, rather than socially driven.

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

Successful prevention programs in the early 2000's, funded by the Australian government, sought to increase the birth rate in Australia, which has far reaching social and care benefits, As those children grow in the very society risks that are being discussed here, they are the ones who go through our education system and contextualise and solve the problems and risks discussed here through the family unit.

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

Design and implement multi generational policy that is community, society, and family unit based, rather than financial/ GDP based. The saying that comes to mind "If you look after your people, your people will look after you". This applies at all levels, the family unit, local community, and national level.