Name: Anonymous

Submission date: 26/05/2025

Participant background

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

   I am a carer of someone who uses care services (carer)

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

   Aged care; Early childhood education and care; 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?

   Very little

2. What are the reasons for your answer?

   An overhead is incurred, both in terms of time and extra costs, when on-boarding a new staff member to a new system, but these costs are relatively small when compared to the labour costs associated with care delivery.

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

   To a great extent

4. What are the reasons for your answer?

   Regulation across the care economy should be singularly focused on ensuring the safety of care recipients and that the care they are receiving is appropriate. Routine administrative checks such as police checks and working with children checks, while coarse and rearward looking, should be transferable across sectors. The use of national registers may achieve this end.

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

1. What is your experience with collaborative commissioning

   I've been involved, in an executive leadership capacity, in collaborative commissioning projects between a PHN and an LHD, as well as between a PHN and NSW Health. In both instances, Commonwealth funds were channeled through the PHN while State funds were channeled through the LHD and NSW Health. Both efforts were directed

towards the provision of mental health services, but only the NSW Health collaboration yielded positive results. Ministerial interest and executive alignment across the organisations seemed critical to ensuring data was shared and reported on. I left the PHN prior to the conclusion of the projects, so cannot comment on their continuation.

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

Collaborative commissioning has great potential to plug service gaps and reduce duplication, but runs counter to the innate desire of bureaucracies to expand their influence and control. Perhaps for this reason, having Ministerial and/or Senior Executive support for the commissioning is critical.

For better or worse, the project I was involved in seemed to duplicate already instantiated services. This seemed to be an accident of history, related to pandemic related work. While extra psychological services were delivered to the community, the marginal benefit of these services to the recipients was not possible to determine.

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 effectiveness of PHNs is significantly handicapped by their near total lack of external accountability. Sloppy Departmental governance, highlighted in recent audit reports, only exacerbates this problem. Increasing PHN transparency and accountability to the communities they serve, through mandatory reporting and audits, combined with improved capacity and capability to evaluation population health impact will help these ends.

Having PHN and LHD CEOs report to relevant ministers with annual, audited and published outcome measures, perhaps governed by an independent third party, will help address some of these concerns.

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?

Lobbying by incumbents, siloed benefits, lack of crisis, impractical or ineffective solutions, diffused benefits, ideological misalignment.

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

Basic sanitation, immunisation, tobacco control, gun control, compulsory seat belts, random breath testing, HIV/AIDS control.

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

By taking an all-of-community, all-of-government, long-term view of such investments; and presenting proposals to novel entities that are able to digest such proposals in an un-conflicted manner e.g. citizen juries convened from the communities that will be affected by the activities.