Delivering quality care more efficiently inquiry

Questionnaire response 33

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Submission date: 5/06/2025

Participant background

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

   Academia/Research

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

   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

   The participant did not respond to this question.

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

   The participant did not respond to this question.

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 participant did not respond to this question.

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?

There are several key barriers that are outlined below:

Short term political cycles versus long term gains for prevention:
• Governments operate according to short political cycles, which incentivise policies with immediate, visible benefits of investment. However, the impacts of prevention initiatives take many years to demonstrate measurable benefits
• Reactive resource allocation to urgent pressures within the health system e.g. hospital capacity/ambulance ramping, mean preventive health is de-prioritised (even though effective investment will mean decreased pressure on the healthcare system in the longer term).

Issues with economic appraisals of prevention initiatives:
• Economic appraisals for government decision-making are required to use short time horizons and high discount rates that diminish benefits attained many years into the future.
• The epidemiological modelling required for preventive health cost-benefit analyses is different to that commonly used in other agencies, and shows that small changes to risk factors at a population level have large impacts on disease incidence. However, government departments who review these analyses (Treasury, Office of Impact Analysis) are not generally familiar with the modelling techniques and our research has shown that there may be scepticism of whether the predicted outcomes are realistic.
• Health behaviours require supportive environments that require the implementation of a suite of interventions – therefore attribution of benefit to single policy/program is difficult.
• Access to linked data across sectors is required to better understand how to drive change across primordial, primary and secondary prevention.

Siloed government budgets and fragmented decision-making:
• Primary prevention initiatives often require investment and action by sectors other than health. Our research has shown siloed government budgets and decision-making are a key barrier to considering health and wellbeing in all policies across government. Currently, siloed budgets mean agencies other than health lack incentives to invest in prevention where the benefits are accrued by health departments.
• All levels of government are responsible for prevention but there is a lack of co-ordination or a common understanding of priorities. This adds further complexity, opportunity for cost-shifting, and means that those bearing the cost don't always bear the benefit.
• Fragmentation also makes it difficult to co-ordinate longer term investments and track longer term return on investment across the system.

Industry lobbying impedes effective government action:
• Many primary prevention initiatives (e.g. marketing restrictions for unhealthy products, sugary drinks tax) impact powerful industries (Big food, gambling) impeding effective policy action.
• Many preventive health interventions are not amenable to gold standard study designs which are intended to test clinical interventions i.e. randomised controlled trials. This

perceived uncertainty in evidence of effect of preventive health policies can undermine political will and provide another argument for industry lobbying against effective policy action.
• There is a current emphasis on the 'personal responsibility' ideology, where it is believed that people should take responsibility for their own health behaviours. This is often pushed by industry lobby groups as a reason for governments not to intervene. However, this view discounts the large impact our environment has on our ability to make healthy choices.
• Preventive health interventions are not adequately evaluated to inform adaption and adoption in other settings. Cultural and institutional investment shifting to prevention requires some institutional change and reform.

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?

• Implement a health in all policies approach to decision-making across all government departments/agencies. This should be embedded in policy and legislation.
• Incentivise cross-sectoral decision-making
• Attain bipartisan agreement to invest in prevention. This could involve:
o An independent agency (similar to PBAC and MSAC) that assesses the effectiveness and economic credentials of preventive health interventions, with authority to recommend governments invest in cost-effective policies and programs. This function could be undertaken by the new Australian CDC.
o Commit to investing a percentage of the health budget on prevention (the Public Health Association of Australia has recommended 5%) on an ongoing basis.
o Develop and utilise a transparent priority setting framework to invest in effective and efficient policies/programs. Features of this framework
 Reflects community values
 A prevention specific framework for fairly assessing the effectiveness of programs. The program logic of how the intervention will work should be assessed.
 Consideration of how to invest in a broad range of interventions that impact different risk factors, age groups, special populations.
o Strengthen the evidence base and data infrastructure - with governments supporting access to data for researchers and practitioners (in a timely manner).
o Develop an implementation plan for the National Preventive Health Strategy with bipartisan support and in collaboration with State and Federal governments.
o Improve agreement and co-ordination between State and Federal governments on policy priorities.
o Build a compelling narrative that can gain political and public support for prevention