Delivering quality care more efficiently inquiry

Questionnaire response 34

Name: Deafness Forum Australia

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Participant background

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

   I am an industry or advocacy organisation, professional association or peak body

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

   Disability; 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?

Governments face a range of systemic, structural, and cultural barriers that limit long-term investment in prevention, despite the proven cost-effectiveness of such approaches.
The following is not listed in any particular order of priority,.
1. Short political cycles and pressure for quick wins

Governments are often required to demonstrate measurable outcomes within short election cycles. Prevention programs, particularly those focused on public awareness, early intervention, and behaviour change, may take years—or even decades—to deliver visible savings or improvements in community wellbeing.

2. Fragmented responsibilities across government portfolios

Prevention benefits are not confined to a single department or agency. Instead, they cut across health, education, disability, aged care, employment, and housing portfolios. Without mechanisms for coordinated investment and governance, prevention programs often fall between the cracks. Jurisdictional divisions between federal and state governments can further complicate responsibility.

3. Limited data and evaluation of long-term outcomes

Prevention outcomes, particularly those in non-clinical or community-based settings, are harder to measure than direct treatment outcomes. Longitudinal tracking and social return-on-investment modelling are underutilised due to a lack of funding and infrastructure. This makes it difficult to make the case for sustained investment.

4. Competing priorities within the public health and care sectors

Multiple health advocacy groups compete for finite government resources, each advancing their own condition-specific agendas. While all are valid and often backed by evidence, this competitive environment can lead to fragmented attention, duplication of effort, and siloed responses. It becomes difficult for policymakers to assess what to prioritise, especially when initiatives are not framed within a broader public health strategy or collective vision. The result is a patchwork of prevention efforts, rather than cohesive, system-wide investment in shared goals like healthy ageing, equity, or workforce participation.

5. Lack of coalition-building and smart coordination around shared priorities

In many cases, prevention efforts lack a central coordinating body or framework to align stakeholders around common goals. While numerous issues demand attention, there is a pressing need for cross-sector coalitions—spanning health, disability, education, aged care, and community sectors—to work together on “whole-of-population” and “whole-of-life” prevention priorities.

Government investment is more likely to be sustained when it targets shared risk factors

(e.g. social isolation, noise exposure, low health literacy) or high-impact entry points (e.g. early childhood, school, mid-life workplace health checks). Building coalitions around this kind of shared prevention infrastructure—and seeking what might be considered “low-hanging fruit” or scalable success stories—helps avoid fragmentation and creates a clearer case for government action.

Without this kind of prioritisation and coordination, efforts can become diluted or reactive. We need structured leadership—potentially via a national prevention council or taskforce—to help set strategic priorities, allocate resources accordingly, and track collective impact.

6. Lack of alignment around whole-person health and care

The absence of a common framework for integrated care means that prevention is often treated in isolation rather than as part of a person’s whole-of-life and whole-of-system experience. For example, hearing loss prevention should be part of healthy ageing, falls prevention, workplace safety, and chronic disease management strategies—not treated as a standalone issue.

7. Complexity of issues and difficulty translating into actionable policy

Some public health and social issues—like intergenerational hearing loss in First Nations communities, or age-related sensory decline—can feel too complex or overwhelming to tackle. This results in inaction or partial responses. Policymakers often need support to break complex challenges down into clear, fundable actions, with realistic timeframes and cross-portfolio benefits.

8. Difficulty translating research into accessible and actionable change

Much of the evidence underpinning prevention programs is generated in clinical, academic, or research settings. However, this evidence is often not communicated in ways that policymakers can easily act on—or in formats that resonate with the public. As a result, prevention messages may not be effectively adopted by the people they are meant to support. There is a crucial gap between the production of high-quality research and its translation into public policy, community awareness, and individual behaviour change. Bridging this gap requires better partnerships between researchers, policy-makers, and community leaders to ensure that evidence-based approaches are also user-friendly, culturally appropriate, and community-driven.

9. Difficulty reaching underserved communities and marginalised groups

Prevention efforts often fail to adequately reach rural and remote populations, culturally and linguistically diverse (CALD) communities, people with disabilities, and other marginalised groups. These communities may face systemic barriers such as language, transport, discrimination, or service unavailability. As a result, they are at greater risk of preventable conditions but less likely to benefit from mainstream prevention campaigns or services.

10. Low investment in community capacity-building and health literacy

Prevention relies on individuals and communities having the confidence, knowledge and resources to act. However, there is often insufficient focus on building health literacy and local capacity—especially in disadvantaged communities. Many people are unsure how to access support, what steps they can take to reduce risk, or how to advocate for their own needs. Without ongoing investment in education, peer networks, and community leadership, prevention efforts may not be sustained or equitable.

11. Lack of an explicit, system-wide commitment to health equity

A national prevention framework cannot succeed without a clear and sustained commitment to health equity. Without it, prevention efforts risk reinforcing existing inequalities—reaching only the most informed, resourced or connected populations. A health equity lens ensures that prevention investment is targeted where it will have the greatest impact: in communities with the highest preventable burden and the least access to support.

Equity must guide both policy prioritisation and resource allocation. This includes:
• Funding community-driven models of care that reflect local needs
• Embedding cultural safety and accessibility in program design
• Ensuring rural, remote, First Nations, CALD and disability communities are co-designers and leaders of prevention strategies.

Equity is not an add-on; it is a foundational principle that improves effectiveness, maximises return on investment, and reduces long-term care demand. Building the case for government action requires a unifying narrative, and health equity offers a clear and measurable framework for doing so.

12. Under-recognition of certain conditions as preventable

Hearing health and balance disorders, despite affecting over 4 million Australians, are often excluded from preventive health agendas. These conditions are sometimes perceived as age-related, 'inevitable' parts of ageing, rather than preventable or manageable chronic conditions. This perception limits policy attention and investment.

For example, hearing loss, which effects 3.6 million (14% population) and expected to rise to 7.8 million by 2060, has well-documented impacts on employment, cognitive decline, mental health, and aged care costs. Yet public investment in hearing health promotion and hearing loss prevention remains limited.

Additionally, the cost of untreated hearing loss to the economy has been estimated between 15.9 to 33.3 billion which suggests there are significant returns on preventive investment that are not currently being realised.

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?

Deafness Forum Australia supports a national approach to prevention that recognises and addresses the full range of social determinants of health. These determinants—

including income, education, housing, employment, social inclusion, and access to communication—shape people's ability to live healthy lives and avoid preventable conditions.

We acknowledge that prevention must take a whole-person, whole-of-life approach, addressing not just individual behaviours or clinical risks, but also the broader systems and conditions in which people live and age. In this context, hearing and communication health are both outcomes of the social determinants—and enablers of broader health and wellbeing.

Good hearing supports early childhood development, school readiness, employment and workforce safety, healthy ageing, social participation and mental wellbeing. Yet hearing and balance health are often under-recognised in prevention policy, despite being preventable or manageable for millions of Australians.

Our recommendations reflect this dual perspective: we advocate for system-wide, coordinated, equity-driven investment in prevention, while also highlighting the specific—and often overlooked—role of hearing health in achieving long-term care and wellbeing goals.

1. Embed prevention within a national framework that prioritises health equity

A sustainable and effective approach to prevention must be guided by a national framework that is coordinated, long-term and equity-focused. This framework should:

• Align with Australia's Disability Strategy, Closing the Gap targets, and National Preventive Health Strategy

• Prioritise conditions and communities currently under-served, including those with hearing and balance issues

• Be co-designed with people with lived experience and the organisations that represent them

This ensures prevention efforts are not only evidence-based, but also inclusive, relevant, and targeted where they will have the greatest impact.

2 Recognise hearing and communication health as a public health priority

Hearing health should be fully integrated into the national prevention agenda—not treated as a niche, age-related or specialist concern. Governments should:

• Include hearing screening and awareness in mainstream preventive health activities (e.g. early childhood health checks, school health programs, workplace safety protocols, aged care assessments)

• Tackle noise-induced hearing loss in occupational and community settings

• Prioritise chronic and preventable ear disease in First Nations communities as a public health emergency

By positioning hearing health as part of broader goals such as healthy ageing, mental health, and workforce participation, governments can deliver greater impact.

2. Establish long-term, stable funding for prevention initiatives

Prevention cannot succeed under short-term, ad hoc funding models. Governments should:

• Commit to multi-year investment in community and population-level prevention strategies

• Support community-led, culturally safe models of prevention, particularly in rural, remote, and marginalised communities

• Invest in the early detection and timely access to hearing and communication services, especially in high-need populations

Stable funding creates the certainty needed to build evidence, innovate, and scale what works.

3. Strengthen community capacity and health literacy
Prevention relies on informed individuals and empowered communities. Governments must:
• Fund campaigns that improve health literacy and promote protective behaviours (e.g. safe listening, early testing, assistive technology uptake)
• Support the development of peer-led and localised prevention models, especially in First Nations, CALD and disability communities
• Partner with trusted national organisations like Deafness Forum Australia to ensure prevention messaging is inclusive, accessible and relevant
4. Improve integration across sectors and portfolios
Many conditions—including hearing loss and balance disorders—span multiple portfolios such as health, education, aged care, disability, justice, and employment. Governments can:
• Establish a National Prevention Council or cross-portfolio taskforce to align investment, planning and evaluation
• Identify shared risk factors and fund integrated approaches (e.g. falls prevention, cognitive health, social isolation, communication access)
• Embed prevention across primary care, aged care, early childhood and community services as a standard of practice
5. Invest in research translation and long-term evaluation
There is often a gap between research and real-world implementation. Governments can bridge this by:
• Funding the translation of clinical and academic evidence into actionable tools for policy-makers, communities and consumers
• Embedding longitudinal tracking and evaluation into funded programs to measure return on investment and health outcomes
• Supporting co-design between researchers, community leaders and policy-makers to ensure evidence is relevant and applicable

Deafness Forum Australia is committed to working with governments and stakeholders to ensure prevention becomes a core function of Australia's care and health systems. We understand that governments must prioritise, coordinate and deliver prevention in a way that serves all Australians—and believe hearing and communication health must be part of this agenda.
By embedding prevention in a coordinated, equity-focused framework, and recognising the foundational role of hearing in lifelong wellbeing, governments can reduce demand for downstream care, improve population health outcomes, and build stronger, more inclusive communities.