Delivering quality care more efficiently inquiry

Questionnaire response 35

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Participant background

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

   Researcher at a University Research Cente

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?

   To a great extent

2. What are the reasons for your answer?

   Differences in quality and safety regulation significantly increase the cost and complexity of both providing and accessing care services, especially for those operating or receiving support across multiple sectors such as health, aged care, disability, and mental health.

   Separate accreditation processes and compliance systems across sectors are costly. This duplication increases administrative costs significantly—medium-sized providers have reported spending over $100,000 annually to maintain compliance with both regulatory regimes, including audit fees, policy updates, and staff training. These costs are ultimately passed on to consumers or absorbed by the organisation, reducing investment in frontline care.

   Conversely, some positive alignment is emerging in areas such as digital health records and shared care planning in integrated health and aged care pilots, where improved coordination has enhanced continuity of care and safety for older people with complex needs.

   Greater alignment and streamlining of processes would improve efficiency and deliver better outcomes.

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?

Providers working across multiple sectors must navigate separate standards, audits, reporting requirements, and workforce screening processes, resulting in duplicated effort and administrative burden. This not only diverts resources away from direct care but also limits workforce flexibility and hampers integrated service delivery. For people needing support from multiple systems—such as aged care, disability, and health—these regulatory inconsistencies can lead to confusion, delays, and fragmented care.

For example, providers delivering both NDIS and aged care services are often required to undergo separate accreditation processes and maintain parallel compliance systems, despite offering similar types of care.

Another example is worker screening: separate checks are required for working in aged care, the NDIS, and child-related services, even for roles involving the same individuals or similar duties. This has delayed onboarding, increased HR overheads, and limited workforce flexibility—particularly problematic in rural areas where a single worker may need to deliver services across multiple programs.

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

1. What is your experience with collaborative commissioning

Our main experience is in undertaking a rapid systematic scoping literature review to provide evidence to inform guidance for both PHNs and LHDs on how to jointly plan and govern joint regional activities. The research question was What is known about the effectiveness and efficiency of governance and management of jointly commissioned or planned services and health programs at the region or district level?

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

From our scoping review we found that the following factors that were reported to contribute to successful governance of joint activities. These included active engagement of multiple sectors and community organisations, prior collaborative experience, alignment of vision, shared outcomes, culture and systems and recognition of resource dependency. Issues of power or resource imbalance were commented on the literature on collaboration between the health and social services sector. Working relationships needed to be built on trust and effective communication rather than competition or siloed accountability to organisation of origin. The partnerships needed to make decisions collaboratively, have clear roles and responsibility and be willing to learn and take time to get it right.

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?

Our scoping review identified from the literature that rigid contracts or prescriptive business plans and lack of ability to invest time or willingness to be held accountable for the partnership's actions contributed to a lack of success.

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 persistent barriers that limit government investment in evidence-based prevention programs across the care economy. One of the most significant is the time lag between investment and outcomes. Preventive interventions often take years to show measurable results, which can fall outside electoral or budget cycles, making them less politically attractive compared to crisis responses that offer immediate, visible impacts.

Another major barrier is the fragmentation of responsibilities and funding across different sectors and levels of government. Prevention programs often produce benefits that cross health, disability, aged care, housing, and education—yet funding streams and accountability mechanisms remain siloed. This means one agency or jurisdiction may bear the costs while another reaps the savings, discouraging joint investment.

There are also methodological challenges in measuring the full value of prevention. Traditional evaluation and budgeting processes are not well suited to capturing indirect or long-term benefits, such as improved quality of life, increased workforce participation, or reduced carer burden. This leads to prevention being undervalued in cost-benefit analyses and underrepresented in funding decisions.

Finally, systemic preferences for short-term, reactive responses—particularly in health and aged care—can limit investment in upstream, proactive strategies. Prevention is often seen as discretionary rather than essential, and programs may rely on short-term project grants that limit their sustainability and scale. Overcoming these barriers requires coordinated governance, long-term funding commitments, and stronger tools for evaluating and communicating the broader impact of prevention.

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

One notable program is the Healthy Kids Check, introduced by the Australian Government in 2008 and delivered through general practices via Medicare. It aimed to assess the health and development of children aged 4–5 years before school entry. While the program showed potential in identifying developmental and behavioural issues early and increasing referrals to support services, it was discontinued in 2015. Reasons for discontinuation included inconsistent implementation, concerns about GPs' capacity to conduct comprehensive assessments, and a lack of robust evidence linking the checks to long-term outcomes. Evaluations pointed to weak integration with early childhood services and insufficient follow-up mechanisms.

In contrast, Deadly Choices is an example of a successful, ongoing prevention program. Funded by various state and federal government bodies and delivered through the Institute for Urban Indigenous Health (IUIH) and Aboriginal Community Controlled Health Organisations (ACCHOs), Deadly Choices promotes healthy lifestyles among Aboriginal and Torres Strait Islander peoples. The program uses culturally appropriate health messaging and community role models to encourage preventive health checks, physical activity, and smoking cessation. Evaluations have shown strong engagement, increased access to primary care, and improvements in health literacy. The program's success is

largely attributed to its community-led design and long-term, stable funding.

Another valuable example is the Nurse-Family Partnership (NFP) program, originally developed in the U.S. and adapted for use in Australia, including in Aboriginal and Torres Strait Islander communities. This home-visiting program supports first-time mothers from pregnancy through early childhood. International evidence shows it improves maternal and child health, reduces child abuse, and supports long-term development. While the Australian trials reported positive engagement and early outcomes, the program has faced challenges in scaling and sustaining funding. Evaluations also pointed to the need for stronger cultural tailoring and integration with local health systems to maximise its impact.

These examples underline that even well-designed prevention programs can struggle with implementation and longevity without sustained investment, strong local delivery models, and integration across services. Programs that are community-led and supported by long-term funding and evaluation tend to show greater success and resilience.

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

Governments could better support investment in prevention by embedding it as a core priority within national and state policy frameworks, rather than treating it as a discretionary or short-term intervention. A prevention framework, developed in partnership between the Commonwealth, states and territories, could help align goals, funding, and responsibilities across portfolios such as health, aged care, disability, mental health, and social services. This framework would need to clearly articulate shared objectives, measurable outcomes, and priority areas (e.g. chronic disease, healthy ageing, early childhood), while enabling flexibility for place-based adaptation.

A major barrier to sustained prevention investment is the reliance on short-term, fragmented funding. Governments could address this by establishing pooled or blended funding models that allow for long-term planning and cross-sector collaboration. Funding agreements that extend over five to ten years for programs with a strong evidence base, incorporating outcome-based funding would help facilitate this. Joint commissioning arrangements between levels of government and sectors (e.g. health and social care) could also improve efficiency and reduce duplication.

Strengthening the economic case for prevention is another priority. Prevention programs often fail to attract investment due to challenges in quantifying their long-term return on investment. Governments could invest in tools and methodologies that capture the full economic and social benefits of prevention—including productivity gains, reductions in acute service use, and improved equity. These tools could be embedded into budget processes and used to inform funding decisions across portfolios.

Supporting locally-led prevention initiatives is also essential. Community-controlled organisations are often best placed to deliver prevention in a culturally safe and responsive way. Governments could fund and enable local partnerships to design and deliver prevention activities tailored to their populations, while also investing in workforce and organisational capacity to support participation in commissioning, data collection and evaluation.

Finally, a stronger national focus on data, monitoring and accountability is needed. Governments could invest in prevention-specific indicators, improve data sharing and linkage across sectors, and embed prevention outcomes in the performance frameworks of health, aged care and social services. Regular reporting and public transparency on prevention investment and outcomes would help build momentum and maintain focus on long-term, system-wide benefits for the Australian community.