Delivering quality care more efficiently inquiry

Questionnaire response 39

Name: Dr Vicki Brown

Submission date: 6/06/2025

Participant background

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

   University, academic researcher

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.

Survey responses from the Productivity Commission's Delivering quality care more efficiently inquiry are publicly available on the PC's website: **pc.gov.au**. Copyright and the views expressed belong to the submitter(s), not the PC.

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?

Prevention initiatives often require upfront investment but deliver long-term returns, which is misaligned with political and budget cycles. The benefits of prevention are largely experienced into the future, particularly for early prevention of childhood obesity where chronic diseases associated with overweight/obesity generally present later in life. Our researchers have produced evidence on the cost-effectiveness of early prevention initiatives over a short (i.e. 5-10 year) and longer term (i.e. lifetime) timeframe (for example, [1-4]), This research consistently demonstrates the value of prevention. Our work, and that of many others, shows that even small changes in health behaviours in early childhood can be cost effective and could potentially deliver substantial health benefits and cost savings over a lifetime if their effects were sustained. Although long-term investment is vital for the success of prevention initiatives, the need for sustained funding often conflicts with short-term political agendas, limiting government willingness to invest.

Lack of visibility of the value of prevention – when prevention works, nothing happens. Successful prevention initiatives mean that the diseases, hospitalisations or costs it averts do not materialise, making the benefits less tangible to policymakers and the public. This lack of visibility undermines political and institutional support despite the significant benefits.

Siloed government structures and poor intersectoral governance. Prevention initiatives require cross-sectoral collaboration, which is a significant barrier given disjointed governance across sectors and levels of government. Our research has shown that Australia has limited policy infrastructure to connect policies across government for early childhood obesity prevention at the federal level, compared with similar countries (including Canada, England and New Zealand). There is also significant overlap of responsibility for early childhood health and wellbeing between levels of government, and across care sectors.[5] Prevention should be a shared responsibility between all levels of government and sectors but poor intersectoral governance provides opportunities for cost-shifting, where those incurring the costs do not necessarily receive the associated benefits.

Commercial interests pose substantial political and institutional barriers to many primary prevention initiatives. Measures like marketing restrictions for unhealthy products and taxes on sugar-sweetened beverages threaten industry profits and market share. Corporate political activity is a powerful influence on policy-making. Common strategies include lobbying, funding research to cast doubt on evidence, and framing policy responses as infringements on personal freedom, a matter of personal responsibility or as harmful to the economy. This corporate influence significantly impedes the development and enactment of effective prevention policies.

A lack of investment in implementation readiness and workforce capacity. Care economy practitioners are not adequately trained in prevention, nor are they adequately resourced to provide preventive services. In many sectors, clinical or custodial models of care remain dominant.

A lack of investment in evaluation of prevention initiatives. Prevention initiatives are often not rigorously evaluated, and this impedes adaptation and scalability to other settings or contexts. In addition, many preventive initiatives are not amenable to gold standard evidence generation study designs (i.e. randomised controlled trials). This perceived lack of causal evidence on effectiveness can hinder investment in prevention initiatives, particularly when this argument is incorporated into industry lobbying tactics designed to undermine political will.

References

1. Brown V, Ananthapavan J, Sonntag D, Tan EJ, Hayes A, Moodie M. The potential for long-term cost-effectiveness of obesity prevention interventions in the early years of life. Pediatr Obes. 2019;14(8):e12517. Available: The potential for long-term cost-effectiveness of obesity prevention interventions in the early years of life - Brown - 2019 - Pediatric Obesity - Wiley Online Library
2. Centre of Research Excellence in the Early Prevention of Obesity in Childhood. Evidence brief- Building the economic case for preventing obesity in early childhood: University of Sydney; 2021. Available: https://earlychildhoodobesity.com/wp-content/uploads/2022/01/Stream-3-brief-2-in-template_final-21-July.pdf.
3. Hayes A, Lung T, Wen LM, Baur L, Rissel C, Howard K. Economic evaluation of "Healthy Beginnings" an early childhood intervention to prevent obesity. Obesity. 2014;22(7):1709-15. Available: Economic evaluation of "healthy beginnings" an early childhood intervention to prevent obesity - Hayes - 2014 - Obesity - Wiley Online Library
4. Killedar A, Lung T, Taylor RW, Taylor BJ, Hayes A. Is the cost-effectiveness of an early-childhood sleep intervention to prevent obesity affected by socioeconomic position? Obesity. 2023;31(1):192-202. Available: Is the cost-effectiveness of an early-childhood sleep intervention to prevent obesity affected by socioeconomic position? - PMC
5. Centre of Excellence in the Early Prevention of Obesity in Childhood. Evidence brief - National Leadership needed to prevent obesity in early childhood Sydney: University of Sydney; 2021. Available: https://earlychildhoodobesity.com/wp-content/uploads/2022/01/Stream-4-policy_in-template_final-21-July.pdf.

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

Example 1: INFANT

The Institute for Physical Activity and Nutrition (IPAN), Deakin University developed INFANT (www.infantprogram.org) an effective, universal intervention that enhances existing Maternal and Child Health services, with evidence based approaches to feeding, nutrition and active play for parents with young children (birth –18 months). The program helps families to establish health behaviours in the early years with related health, social and economic benefits and budget savings for the health system, immediately and long-term.

INFANT – laying the foundation for health and wellbeing in the early years

1. Timely support for parents with four group sessions provided by trained health and early years professionals, together with the INFANT app and evidence-based resources.
2. Builds social and community connection between parents during a time of new challenges and life changes, via group-based parenting support.
3. Early support is available through the INFANT app, including breastfeeding support which has been found to be acceptable and useful, particularly for women with lower

levels of education.
4. INFANT Also improves mothers' dietary intakes, as role models for their child's health behaviours.

The original randomised controlled trial of INFANT was trial was funded by a National Health and Medical Research Council (NHMRC) grant (APP425801). The follow up of outcomes for children in the trial at 3.5 and 5 years of age was also funded by NHMRC grant (APP1008879). From 2021, INFANT has been scaled up across Victoria with implementation support funded by Victorian Government Department of Health, Vic Health and Deakin University, supported by a strong network of partner organisations. The evaluation of the scale up is funded by NHMRC Partnership grant funds the (APP1161223). Local delivery of the program is not funded, rather the program is integrated into existing service delivery such as Maternal and Child Health Services.

INFANT is approved as an evidence-based program in the Australian Institute of Family Studies' Guidebook for Communities for Children Facilitating Partners (since 2020).

The US Centers for Disease Control (CDC) found in a key 2023 review that INFANT is "… the strongest model for translating findings from a Randomised Control Trial to wide-spread implementation of an intervention in the community." (US CDC Complementary Feeding Review). The US National Cancer Institute lists INFANT as a recommended evidence-based program, rating it highly for research integrity and dissemination capability. It is the only program in its database of 207 endorsed healthy lifestyle programs that starts from birth.

INFANT has reached more than 16,000 families with new babies so far.
The research conducted by IPAN, Deakin University shows:
• Young children eat more fruit and vegetables and drink more water, with reduced sugar-sweetened beverage intake and less television watching - these healthy habits are sustained when they're getting ready for school, at 5 years of age.
• Mothers have heathier diets, improved knowledge and more confidence in their parenting, as well as improved social connection with other parents and local health services.
• Families from diverse backgrounds have better access to critical health information - INFANT parent resources are available in six priority languages, supporting more families to raise healthy, happy children at the time they need it most.
• Health economic modelling shows a one-serve reduction in discretionary food per week results in approximately $1.2 billion savings in healthcare costs during a lifetime and could prevent more than 50,000 cases of type 2 diabetes nationally. INFANT trial results show a 1.7 serve reduction in discretionary foods per week at age 5 years (compared to children not receiving the program).
• Reduced health service use by parents engaged with INFANT who were less likely to seek advice on feeding, activity or growth across the first nine months of life from health services, including parent helpline, GPs and paediatricians, with significant health cost savings estimated at $6.9 million annually from fewer GP and paediatrician visits alone.

The implementation of INFANT continues in 2025-26 with the support of Victorian Health Promotion Foundation and the Victorian Government Department of Health.

Extensive evaluation of INFANT has undertaken over the 15 years, including health

outcomes, economic evaluation and qualitative evaluation with users and interested parties.

Visit the INFANT website infantprogram.org or contact infant-study@deakin.edu.au

Example 2: Healthy Beginnings

Healthy Beginnings is a staged early intervention led by early childhood nurses from late pregnancy to child ages 2 years that targets key modifiable risk factors associated with early onset of childhood obesity.

The intervention is designed to coincide with early childhood developmental milestones, with the key intervention messages including “Breast is best”, “No solids for me until 6 months”, “I eat a variety of fruit and vegetables every day”, “Only water in my cup”, and “I am part of an active family”.
Over the past 15 years, a suite of Healthy Beginnings early intervention programs has been developed, tested, and culturally adapted for supporting mothers to establish their child healthy behaviours from the beginning of life. The intervention modes include home-visiting, telephone or text messaging support, smartphone app, an interactive website, and virtual meetings. Healthy Beginnings has been demonstrated its effectiveness and cost-effectiveness through several randomised controlled trials funded by NHMRC in promoting child health growth and preventing risk factors of childhood obesity.
Healthy Beginnings early intervention programs were developed by Sydney Local Health District Health Promotion Service in partnership with School of Public Health.

For more information about Healthy Beginnings, please visit https://www.healthybeginnings.net.au/ or contact Professor Li Ming WEN via Liming.Wen@health.nsw.gov.au.

Example 3: 4-Year-Old Health Check (Medicare Item 709)
The program was funded by the Australian Government through Medicare and provided by general practitioners (GPs) across Australia. The check aimed to identify health, developmental, and behavioural issues in children before they started school. It reportedly increased GP engagement with preventive child health, helped detect issues such as vision, hearing, and developmental delays, and improved referrals to allied health services. Uptake varied across regions, with better reach in areas where services were coordinated with early childhood services.

The MBS item was removed in November 2015. Reasons for discontinuation likely include limited uptake, duplication with other state-based health checks (e.g. through child and family health nurses), administrative burden for GPs, and mixed evidence of effectiveness. Some stakeholders also noted that universal preschool attendance offered an alternative setting for developmental screening.
Evaluations were limited. A 2014 evaluation by the Department of Health noted inconsistent uptake and challenges in implementation. A review by the MBS Review Taskforce in 2015 suggested that while the concept was sound, delivery via Medicare was not the most efficient or equitable approach. Academic studies (e.g. by Goldfeld et

al.) also examined early childhood screening in Australia and highlighted systemic gaps in access and coordination.

MONITORING AND SURVEILLANCE
Our researchers have developed world-leading advances in monitoring and surveillance of early childhood obesity prevention interventions, a critical component in the design, implementation and delivery of effective prevention initiatives.

Core Outcome Set for Early Childhood Obesity Prevention (COS-EPOCH)
EPOCH-Translate has developed the COS-EPOCH to standardise outcome measures in early childhood obesity prevention trials. This initiative involved stakeholders, including parents, policymakers, and health professionals, to identify the most critical outcomes to measure. The adoption of COS-EPOCH facilitates consistent evaluation and comparison across studies, enhancing the evidence base for effective interventions.
More details: https://earlychildhoodobesity.com/publications/what-outcomes-of-early-childhood-obesity-prevention-interventions-are-valued-by-stakeholders/

TOPCHILD Collaboration and TOPCHILD Policy
The TOPCHILD (Transforming Obesity Prevention for CHILDren) collaboration is an international trials network focused on improving early childhood obesity prevention by enhancing the design, implementation, and scaling of behavioural interventions during the first 2,000 days of life. It is a pooled analysis of >65 trials (N=>52000 participants). This collaborative approach underscores the value of combining data to strengthen evidence for policy and practice.

More details: https://www.topchildcollaboration.org/

These programs exemplify successful prevention strategies that are evidence-based, culturally sensitive, and scalable. Their integration into routine care settings demonstrates the potential for widespread impact on child health outcomes. To aid decision makers to select appropriate programs for their context, budget and resources, or for guidance on how to integrate evidence into existing programs and services, across the Care Economy, we are developing a dashboard. From early 2025, this dashboard will be available for use in health, education and social service organisations and settings to guide strengthening prevention in place, in a way that aligns with the sector or organisational priorities.

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

- Strengthen national leadership and governance for prevention. Treat prevention as a core public investment in human capital, not a discretionary health expense. Adopt a health-in-all-policies approach, with shared accountability across jurisdictions and sectors.

- Establish dedicated, sustained financing that is protected from shorter-term political reallocation. Attain bipartisan agreement to invest in prevention. This could involve:
o An independent agency (similar to the Pharmaceutical Benefits Advisory Committee and Medical Services Advisory Committee) that assesses the 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%)
o Develop and utilise a transparent priority setting exercise to invest in effective and efficient policies/programs
o Develop an implementation plan for the National Preventive Health Strategy
o Improve co-ordination between State and Federal government policy priorities.

- Build capacity for prevention. Invest in prevention-specific workforce development across the care economy, including roles in public health, early childhood education and care and community services.

- Address the commercial determinants of health. Develop robust regulatory frameworks for harmful industries and remove undue influence from policy processes.

- Develop a national early childhood road map to support optimal growth, health and development from pregnancy and across the life course. Investment in early childhood prevention yields long-term benefits in health, education, and social outcomes. The National Framework for Universal Child and Family Health Services, published in 2011 by the Australian Health Ministers' Advisory Council, outlines the core services that all Australian children (from birth to eight years) and families should receive at no financial cost, regardless of their location or how they access healthcare. Since its publication, the framework has not been formally updated. While the Department of Health and Aged Care last updated the publication date to 18 January 2023, there is no indication of substantive revisions to the framework's content. The lack of updates may be attributed to factors such as shifts in policy priorities, resource constraints, or challenges in coordinating across multiple levels of government. Additionally, the complexity of measuring long-term outcomes and the need for robust intergovernmental mechanisms may have contributed to the framework remaining unchanged since its inception. Updating the National Framework for Universal Child and Family Health Services would significantly strengthen Australia's prevention agenda by creating a more integrated, contemporary, and equity-focused platform for supporting the health, growth, and development of children. By aligning the framework with current evidence and cross-sectoral priorities, it could embed a broader understanding of child wellbeing that includes physical and mental health, social determinants, and development from birth through early schooling. This would enable more proactive identification and response to developmental, family, and social risks, reducing the likelihood of children entering crisis or high-cost service systems later in life.

An updated framework could also better leverage touch points across the care economy—such as early childhood education, maternal and child health, general practice, disability supports, and family services—by clearly defining their role in universal prevention. Enhancing prevention efforts to support healthy child growth, health, and development can be achieved through coordinated, cross-sectoral strategies that make the most of existing touchpoints with children and families. Standardising and aligning child health and development checks across sectors—such as health, early childhood education, and family services—using a shared tool and a single-entry point can improve consistency, early identification, and coordinated support. Digitising personal health records like the 'blue book' can strengthen navigation and referral

pathways, improve transparency for families and providers, and ensure smooth handover between services. Embedding a “Making Every Contact Count” approach and equipping professionals to engage in healthy conversations during routine interactions ensures that every touchpoint becomes an opportunity for prevention, support, and early intervention.

- Strengthen general practice capacity to support child health and wellbeing with MBS item. Expand the Medicare Benefits Schedule (MBS) to include comprehensive child health consultations. These would focus on monitoring and promoting healthy behaviours and optimal growth during the first five years of life. They could also support early intervention through referrals to allied health professionals and evidence-based community programs. Since health behaviours are formed early in life and often continue into adulthood, and more than 1.5 million children aged 0 to 4 years visited a GP in 2022 to 2023, this presents a critical opportunity for prevention and chronic disease prevention.

- Embed long-term evaluation frameworks to demonstrate the costs and benefits of prevention initiatives across sectors and levels of government. Enabling comprehensive and consistent measurement and evaluation of costs and outcomes over time, in order to better inform decision-making on the ‘best buys’ for prevention.