Delivering quality care more efficiently inquiry

Questionnaire response 54

Name: National Eating Disorders Collaboration

Submission date: 10/06/2025

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.

   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

   NEDC has indirect experience in collaborative commissioning, due to our range of relationships and joint projects with Primary Health Networks around the country. Of particular note, this includes the 'Right Care Right Place' project, a collaboration between NEDC, Adelaide PHN, Northern Territory PHN, Northwest Melbourne PHN, and Western Queensland PHN, funded by the Australian Government Department of Health and Aged Care. This project involves piloting place-based approaches to eating disorder care navigation and workforce development. We have observed the high degree of local responsiveness required to ensure that wider systems and structures support local communities, with each project partner devising a tailored .

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

Collaborative commissioning offers significant benefits for addressing complex health issues such as eating disorders - these are complex mental health conditions affecting 1.1m Australians at any time, for which only 30% of people receive treatment.

In the context of the National Eating Disorders Strategy 2023–2033, collaborative commissioning could enable:
- Whole-of-system alignment and joined-up services across the stepped system of care. Eating disorders require coordinated step-up/step-down responses across physical and mental health, psychosocial and recovery support services, and occupation/education. Collaborative commissioning breaks down silos, allowing services to work together toward shared outcomes and consistent standards.
- Place-based approaches to meeting national standards. The National Eating Disorders Strategy sets out key standards and priority actions for the whole system of care. Our experience through the Right Care Right Place project is that these standards and actions can be met and operationalised in widely different contexts, and that this requires robust collaboration with national and local stakeholders, including community and workforce stakeholders.
- Workforce development at scale. Coordinated planning and commissioning enable workforce planning, ensuring training, supervision, and service design are aligned, targeted and sufficiently comprehensive. This is particularly critical to increasing workforce capability and coverage in under-resourced areas. In the eating disorder context, this involves understanding which levels of competence (i.e. prevent, identify, respond, treat, support) are required by which workers within a particular service, community and region to ensure safe and effective responses to EDs as well as avoidance of iatrogenic harm (e.g. by failing to account for ED risk when treating other conditions).

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?

We have observed the following barriers to effective collaborative commissioning when addressing complex issues such as eating disorders which require a cross-sectoral response:
- Fragmentation and siloing. Variability in funding models and policy priorities between federal, state/territory, and local bodies can lead to duplication and/or misalignment. Siloing of services can compound this, creating gaps in care when local services impose exclusion criteria which may either reflect funding priorities, contractual constraints or local workforce capability.
- Capacity and capability constraints (actual or assumed). In our experience, advancing a position that 'eating disorders are core business' may be met with opposition, particularly where services are concerned that they lack sufficient "specialist" expertise, even though the vast majority of eating disorders are treatable in community-based settings. This can create a barrier to effective collaboration at the service level.
- Structural issues. Time-limited funding cycles inhibit long-term planning and relationship-building, which are essential for effective collaboration and sustainable systems change. Short-term contracts directly inhibit engagement with some communities and erode trust in the service system, as well as contributing to workforce turnover and associated losses. In addition, the absence of unified data systems and shared success metrics makes it difficult to evaluate and coordinate approaches to care

across sectors and regions.

To address these barriers and strengthen collaborative commissioning, NEDC suggests the following strategies:
- Nationally endorsed shared priorities and outcomes frameworks. Tools like the National Eating Disorders Strategy 2023–2033 and the Eating Disorder Safe Principles can offer a common foundation for cross-sectoral collaboration, planning, and accountability. Their key features include being grounded in wide consultation and lived experience, informed by implementation science, and specifically designed to support place-based and context-specific approaches which maintain fidelity to the wider framework.
- Long-term, flexible funding models. Multi-year agreements with built-in flexibility enables planning, responsiveness, innovation, and effective collaboration between multiple stakeholders. This has been key to the success of the Right Care Right Place project.

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 of eating disorders receives comparatively little research or program funding from governments when compared to intervention, treatment and recovery support, which in turn receive less funding than other similarly complex and prevalent conditions. This is despite the proven cost effectiveness of a range of eating disorder prevention programs (see Long et al, 2022, https://doi.org/10.1016/j.amepre.2022.07.005), and Australia's position as a global leader in national policy for eating disorder prevention. There are several likely drivers of this:
- Stigma, myth and misconception. In the case of eating disorders, an enduring (and erroneous) view that these conditions are matters of choice or vanity, under personal control, low-incidence and of limited public health significance undermines the seriousness of these conditions and the need for investment and action. This low eating disorder literacy is prominent across the community, including among health professionals, policymakers and funding decision-makers.
- Limited framing of prevention. Where eating disorder prevention investment does occur, this is typically confined to areas where research has been able to be conducted. At this time, this is largely concentrated on programmatic approaches to prevention for young 'mainstream' populations, often within or attached to educational settings. While this research and the delivery of associated evidence-based programs is important, it does not reflect or meet the breadth of need. The National Eating Disorders Strategy calls for wide-scale dissemination of existing evidence-based programs as well as further research investment to fill gaps in prevention programs for other age groups, as well as underserved and higher risk populations.
- Perceived lack of urgency. In the main, prevention initiatives can take longer and be more complex to measure, as well as yielding less compelling case studies relative to models of intervention and support. This makes it easier to make a case for funds to be directed towards treatment programs, even though the cost effectiveness of prevention programs is established. This becomes a self-perpetuating cycle: it is harder to build a case for investment in prevention when there is insufficient data on which to build that case.
- Competing priorities. In the context of eating disorders, a false dichotomy exists where investment in eating disorder prevention may be perceived as "less important" than

prevention of other health conditions or related factors, such as obesity*. These perceptions are built on the stigmas and myths outlined above, and serve to place different areas of preventive healthcare in competition for investment (where those areas which have already had some investment are better able to make a case for more).
- Policy and practice silos. Effective prevention for eating disorders necessarily includes action across a wide range of portfolio areas, including but not limited to health, education, sport, media and food systems, This breadth of necessary coordinated action creates a diffusion of responsibility - if no one portfolio can solve this issue alone then it becomes easier to assume the problem persists because other parts of the system have not contributed to the solution.

In addition to the above points regarding prevention programs, the framing of prevention as a programmatic response misses the opportunity to take a wider view of prevention and health promotion. In formulating the National Eating Disorders Strategy, the standards and actions for prevention were heavily informed by lived experience, where people told us that much wider shifts were needed than would be reasonably achievable within a programmatic approach. We used frameworks such as the Ottawa Charter for Health Promotion (1986) to ensure a broad view of prevention was taken, encompassing policy, environments, communities and health system redesign alongside programmatic approaches to building individual skills and resilience.

*NOTE: we are using this term in this context given the prevalence of policy geared towards obesity prevention in the public health sphere and wider public discourse, however we note that this is not the preferred term among people with lived experience of eating disorders and higher weight.

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

Several eating disorder prevention programs have been developed, implemented and/or evaluated in Australia, with varying levels of uptake, adaptation, and success. These include:

Butterfly Body Bright
Target group: Primary schools
Model: Whole-of-school approach, including curriculum-aligned lesson plans, classroom resources, teacher training, and family engagement.
Reach: Over 200 schools across Australia
Outcomes: Positive evaluation results for teacher confidence, student engagement, and protective body image attitudes. Ongoing improvements recommended to increase accessibility and inclusivity.

Media Smart
Target group: Secondary Schools and young people aged 13-25
Model: Two formats have been evaluated. These are in-school programs within the PDHPE curriculum, and an online delivery format.
Reach: Over 3500 students (in-school), 555 young people (online)
Outcomes: A 58% reduction in the onset of clinical concerns about body shape and weight. Improvements in factors such as dieting behaviors, appearance-related pressures, screen time, depression, and anxiety. High approval ratings, with over 98% of participants finding the program valuable and enjoyable.

Embrace Kids Classroom Program
Target group: Late primary and early secondary school students
Model: A modular, evidence-based resource aligned with the Australian Curriculum, featuring five lesson plans.
Reach: Piloted in 20 schools across South Australia and Queensland and now rolling out more widely.
Outcomes: Increased self-compassion and positive social media intentions among participants.

Additionally, several other key evidence-informed prevention programs are currently rolling out, with evaluation data not yet publicly available. These include Body Blocks by Embrace Kids (targeting Early Childhood Education and Care settings), Activate by Embrace (targeting community sports clubs and young athletes), Butterfly BodyKind (targeting secondary schools, sports clubs and families).

While substantial government investments have been made in Body Bright and Embrace Kids, the level of investment in both cases has been insufficient to ensure wide-scale or sustainable implementation. In both cases, funding from other sources was required to develop and pilot the programs.

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

Australia leads the world in national policy for eating disorder prevention, though investment support for implementation is still required. Upstream, downstream and place-based approaches should all be prioritised, owing to the multifactorial nature of eating disorders, the substantial socio-cultural risk factors, and the potential lifelong complications and other impacts of these complex illnesses.

Upstream eating disorder prevention initiatives have a strong focus on reducing the impact of weight stigma - an established contributor to eating disorder risk and intervention-generated harm, as well as a contributor to other areas of ill health such as cardiovascular disease, and a driver of delayed, missed and misdiagnosis of health complaints among people with higher weight. This shows how investment in wide-scale, multi-pronged approaches to eating disorder prevention can also make substantial contributions to wider population health.

The Eating Disorder Safe principles are a key policy translation framework which ought to guide investment in prevention activities to ensure a harm minimisation approach is adopted in any initiatives focused on health, physical activity, food, nutrition, mental health, weight as a proxy for health or related conditions.

At present, much of what we see in health policy and practice (particularly in reference to nutrition and obesity) contains scope for unintended consequences and structural harm in relation to eating disorders, disordered eating and body image distress. This again speaks to the under-valuing of eating disorders as serious public health concerns. Despite this, or perhaps due to it, we have seen substantial appetite for Eating Disorder Safe implementation support in the 11 months since the principles were published. This includes from health service providers, PHNs, peak bodies, health promotion organisations, national sports organisations, state education departments and more.

This is heartening, however greater structural support for the widespread implementation of these approaches is required.

Government investments in prevention ought to give adequate attention to eating disorders - whether as the key focus of the prevention initiative or as an avoidable harmful externality of another preventive action. When combined with other key success factors such as muti-year flexible funding agreements, widespread application of ED Safe approaches across preventive healthcare and policy can help to drive eating disorder rates down, as well as reducing the impact of weight stigma on people experiencing a wider gamut of health complaints. Further, promotion of body esteem can support wider uptake of health promoting behaviours, such that at a population level more people take proactive care of their physical and mental health.