Name: Working with Women Alliance, Australian Multicultural Women's Alliance

Submission date: 6/06/2025

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.

   CALD; Early childhood education and care; Health; Women

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?

   Somewhat

2. What are the reasons for your answer?

   In the early childhood education and care (ECEC) sector, there is a notable disconnect between existing regulations and the enforcement and oversight mechanisms designed to uphold them. This regulatory gap contributes to safety failures and creates unsafe working conditions for care providers, undermining the quality of care delivered.

   The provision of abortion services is subject to different legislation and regulatory requirements across states and territories, leading to inconsistent access and service delivery. This fragmentation results in limited transparency around where service gaps exist and why cost discrepancies occur, making it more difficult for individuals to access timely and affordable care.

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?

   There is a strong need for better cohesion of quality and safety regulations across care service sectors and jurisdictions. A more cohesive approach to regulatory frameworks would reduce fragmentation and improve the consistency of care delivery nationwide. Better transparency and data sharing between regulatory bodies is essential, but this must be designed in consultation with affected communities to ensure that reforms do not produce unintended consequences or further entrench inequities.

   The introduction of national standards for gender-affirming care is a positive step

towards consistent, safe, and inclusive service delivery. Similarly, there is an urgent need for national standards governing abortion care, particularly in relation to cost, access, and quality. Establishing aligned regulations across states and territories would not only improve outcomes for care recipients but also support providers in navigating clearer, more efficient regulatory environments.

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?

Pursuing greater collaborative commissioning enables services to be more effectively targeted to community needs, ensuring they are culturally appropriate and accessible to those who need them most. This approach is particularly important for improving service delivery in rural, remote, and regional areas, where access can be limited and needs vary widely.

Collaborative commissioning also opens up opportunities for partnerships between larger systems and smaller, community-based organisations. These collaborations can enhance the capacity of smaller providers to deliver tailored support to specific cohorts, leading to more responsive and equitable care outcomes.

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?

A major challenge is the significant gap in evidence relating to service costing and identifying community needs. Without this data, it is difficult to design services that are truly responsive or to allocate resources efficiently. Additionally, smaller providers often lack the funding and capacity to evaluate their programs, which limits their ability to compete in commissioning processes, even when they are best placed to meet the needs of specific communities.

Larger providers, while typically better equipped to navigate commissioning processes, often lack the deep community or cohort-specific knowledge required to deliver culturally appropriate or targeted care. Moreover, larger and for-profit organisations are frequently able to undercut smaller providers by absorbing overhead and incidental costs, undermining the sustainability of grassroots and community-based care models.

Grass roots, migrant community organisations are conduits between the government and their communities and have intimate understandings of barriers of access and information in their community. However, there can be challenges in identifying organic community leaders with local expertise. There is also lack of due recognition of community expertise, which widens distrust between grassroots organisations and service providers as well as government institutions.

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?

One of the primary challenges is the lack of comprehensive data and evidence, particularly in areas affecting women, especially women from CALD backgrounds, as well as non-binary and intersex people. Research into the experiences of LGBTIQA+ people, particularly in relation to domestic and family violence, is also limited, creating significant gaps in understanding and service design.

Prevention often requires upfront investment, and its outcomes can be difficult to measure. For example, it is challenging to quantify how many instances of domestic violence or deaths have been averted through early intervention or behaviour change programs. This can make it difficult to demonstrate the immediate value of prevention to policymakers and funders.

Additionally, there is a lack of funding for rigorous evaluation of programs, especially those delivered by not-for-profit organisations. Without evidence of impact, these programs struggle to secure ongoing support. The community care sector also faces systemic issues such as low wages, high staff turnover, and insecure funding models. These conditions make it difficult to sustain prevention programs long enough to realise their full impact, leading to a cycle of underinvestment and unmet potential.

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

Baby Makes 3, funded by VicHealth, is a group-based program designed to support first-time parents in building knowledge and skills for equal and respectful relationships. The program consists of three weekly, two-hour sessions and includes broader capacity-building initiatives to train staff working in health services, local government areas, and public hospitals. The program aims to reshape social norms in homes, workplaces, and communities by promoting gender equality and equitable parenting practices. An evaluation conducted in 2011 found that participation increased awareness among new parents about how traditional gender and parenting norms influence family dynamics and relationships. Participants reported greater understanding and support for shared parenting roles and relationship equality. A more recent evaluation involving participant interviews confirmed that the program positively influenced engagement with gender-equitable parenting, attributing this to the practical tools and resources provided.

The Readiness Program is a national training initiative funded by the Department of Health and delivered by Safer Families. This program provides training to primary care providers to help them effectively recognise, respond to, refer, and record domestic and family violence (DFV) using a trauma- and violence-informed approach. Evaluations of the Readiness Program found it to be successful in building the capacity of the primary care workforce, improving their knowledge, skills, and confidence in responding to DFV. The program reached a wide and diverse range of healthcare workers across Australia, contributing to more effective and sensitive responses to domestic and family violence within primary care settings.

The Tresillian program for families with children under five (ACT & NSW) offers a range of services; day Services provide in-person or home visits for practical advice and

support with newborns and toddlers while residential services offer intensive support through a 4-night/5-day program for families experiencing significant parenting challenges. The program is primarily by the NSW Ministry for Health, with additional support from the corporate sector and individual donors for special projects. The program aims to increase parents' confidence and provide guidance on managing challenges such as sleep, feeding, and 'just for dads' support. Feedback indicates that a high percentage of parents would recommend Tresillian services to others.

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

Governments must take a more inclusive and evidence-driven approach to funding and policy design. This begins with prioritising investment in building the evidence base around gender and its intersection with other key factors such as ethnicity, economic status, religion, disability, and age. This includes funding not only research but also the monitoring and evaluation of community-based programs to ensure they are effective and scalable.

Governments should also implement targeted measures to improve access to care for vulnerable groups. For example, migrant women, particularly those on transitional or temporary visas, face compounded financial and social vulnerabilities that prevent timely access to healthcare for themselves and their children. Incentivising access through subsidised support and expanded bulk billing options, where appropriate, can act as a powerful preventive measure, reducing the risk of more severe health and social outcomes.

The broader issue of healthcare access also requires renewed investment in bulk billing for general practitioners. Many communities are delaying or avoiding medical care due to cost, resulting in the escalation of preventable conditions into serious or critical health crises. Addressing poverty is itself a vital prevention strategy. Raising income support rates would reduce the incidence of DFV, poor physical and mental health, involvement with child protection services, housing insecurity, and homelessness. Embedding gender-responsive budgeting across all levels of government would ensure that preventive investments are not only effective, but equitable and inclusive of those most at risk.

There is a critical gap in current frameworks such as the National Preventive Health Strategy, which does not identify women as a priority population. Recognising the unique preventive health needs of women, particularly in relation to reproductive healthcare, access to long-acting reversible contraceptives (LARCs), and domestic and family violence (DFV), must be central to prevention policy. Importantly, intervention should be recognised as a form of prevention, especially in cases of DFV, where timely support can disrupt cycles of harm before they escalate.