Delivering quality care more efficiently inquiry

Questionnaire response 94

Name: Kaarin Jane Anstey

Submission date: 6/06/2025

Participant background

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

   Professor at UNSW working in dementia prevention research.

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

   Aboriginal Community Controlled; Aged care; 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?

- Prevention has to compete with other priorities and immediate and urgent issues are always prioritised so a mechanism is needed to prioritise prevention.
- Leadership or organisations may not be committed to preventive actions, and lack of staff training can lead to organisations being reactive rather than the implementing prevention strategies ahead of time.
- There is often a lack of evidence on the economic benefits of prevention to inform decision-making.
- If preventive activities are not included in guidelines and assessed for accreditation, they are not seen as important or not seen as a priority.

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

There have been successful programs to reduce risk of dementia in the community through vascular risk management and lifestyle change. My team conducted an intervention study (funded by NHMRC) in 7 GP practices in the ACT. It targeted middle-aged adults (average 50 years) who had multiple chronic disease risk factors eg. mean BMI was 30. The program led to a change in a dementia risk score which was maintained for 62 weeks (as long as we followed up participants). The dementia risk score is made up of points for modifiable risk factors like physical activity, diseases, and diet. This study was published, as was a health economics analysis which showed the benefit of dementia risk reduction for reducing future health and care costs for Australia. It was discontinued due to cessation of grant funding.

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

The risk factors for dementia are shared with other chronic diseases such as diabetes, stroke and heart diseases. They include cardiovascular, lifestyle and environmental risks so a holistic approach is needed. Preventive activities could be supported by:
- Awareness campaigns explaining the benefit of risk reduction for health ageing and disease prevention. These have been very successful in mental health and smoking. We need one for dementia and ageing.
- Development of specific strategies to address inequality in access to primary care and preventive health advice for CALD and low-income groups, and people with low literacy.
- Implementation of mid-life dementia risk assessment at the 45-49 health check. This risk assessment covers vascular risk factors so benefits multiple chronic diseases of ageing.
- Implementation of policies that support healthier lifestyles relating to nutrition (e.g. sugar tax, regulation of ultraprocessed food), making healthy food available in lower income areas, have standards for urban design to support physical activity, community funded exercise and social engagement activities, implement policies to reduce air pollution, support active transport, support free health checks for vascular risk factors in middle age such as high cholesterol, hypertension, obesity.
- Incentivise and reward GP private practices, PHNs, community centres and organisations that conduct preventive health activities.