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Individual submission – Delivering quality care more efficiently
23 August 2025

Please find below general comments in relation to each recommendation, as well as feedback on specific information requests. Note that some of the papers I refer to are under embargo or are in preparation. Given the timeline for submissions, please feel free to contact me later in the year to see whether they have been published.

1 Recommendation 1.1 – quality and safety regulation

1.1 General comments

Consolidating and improving regulation of the care sector is critical – including reducing unnecessary complexities and costs. This should benefit people accessing care, their families, the care workforce, and the care system more broadly.

It is not clear to me why Recommendation 1.1 only applies to aged care, NDIS and the veteran care sector, and not to other care workers in institutional settings, including hospitals, prisons, OOHC and other settings where care is provided to potentially vulnerable people. There is sufficient evidence in various Royal Commissions to warrant broader application. Fig 1 of the PC report highlights 22m people accessed medicare, while 1.4m children accessed early childhood education and care, and about 1.5m people accessed either age care or NDIS supports. Carers work in other settings too. It appears that this recommendation is targeted to the smaller care workforce which is concerning.

While quality and safety are critical, the mechanisms suggest must be supported by other interventions that will benefit both carers and those cared for. For example, providing mandatory and free training, providing support (recognising that many care workers work independently or in unsupported contexts), and establishing mechanisms to report any concerns without fear. This should include mandatory training about human rights, decision making, and support for decision making (for NDIS and aged care). Upholding rights, will and preferences is often done best with the support of someone trusted. Look to the research and guidance on things like support for decision making and rights to help understand that relationships matter and relationships occur through regular continual care – care that is not rushed, and care that has oversight. Quality and safety go beyond care worker screening.

See for example:

- Bates S; Kayess R; Laurens EJ; Katz I, 2024, 'The importance of supporting evolving capacity: The need to support young people with cognitive impairment in out-of-home-care', *Children and Youth Services Review*, 156, pp. 107315, http://dx.doi.org/10.1016/j.childyouth.2023.107315

- Bates S; Kayess R; Katz I, 2023, Transitioning to a human rights based formal supported decision-making framework in NSW, UNSW, Sydney, http://dx.doi.org/10.26190/7670-xa21

- Bates S; Laurens EJ; Kayess R; Fisher K, 2021, Good Practice in Supported Decision Making for People with Disability: Principles and Guide, http://dx.doi.org/10.26190/unsworks/28102, https://apo.org.au/sites/default/files/resource-files/2021-06/apo-nid313465.pdf

- Laurens EJ; Bates S; Kayess R; Fisher K, 2021, Good Practice in Supported Decision-making for People with Disability: Final Report, UNSW Social Policy Research Centre, Sydney, http://dx.doi.org/10.26190/0v9z-6223

Many care workers work in the gig economy and work outside of organisations – some may work for free. For example, carers supporting individuals at home are micro-commissioned by care recipients under packages of care. Therefore providing quality and safety of individual workers is critically important (for both the carer and the client) and must be done in a way that allows care recipients to easily check the safety of the staff they individually hire (and vice versa). This system needs to work equally with single providers working for single clients, as well as teams of staff working in organisational and residential settings.

There are possible similarities with working with children checks. The mechanism needs to, as those checks do, allow for people working in paid roles and also unpaid roles. They should also extend to researchers (as WWCCs do).

Last question, will the regulation of quality and safety in these sectors also consider the safety and quality of processes (such as NDIS scheme or Aged care schemes) and organisations, or only the care workforce?

1.2 Information request 1.1

(1) No comment

(2) No Comment

(3) What information should be reported. Great question. What is worth reporting?
    - Number of carers registered? Meaningless unless you know carers not registered.
    - Number of carers registered in your area? Meaningless without knowing whether they are active or available, or the care demands in the area.

Thinking about working with children checks, is there information published about who has them, number revoked, etc.? Is there a need to report if the registration process does its job?

1.3 Information request 1.2

(1) Making comparisons again with WWCCs, there are many benefits to having a single quality and safety regulator across different services – and most importantly, across states and territories. Currently, people working in care sector and in research need multiple WWCCs depending on where they are working. This impacts people more

so in border towns and in research than most carers. But, in setting this scheme up, this then creates another system which impacts say people working as carers in both preschools, schools and at home (even with the same child).

(2) The extent to which a single regulator may produce a more coordinated, consistent and efficient system, depends on how well it is implemented. While great in theory, there is a poor track record of centralising administration (NDIS).

(3) Each of the three sectors operate in different legislative/policy contexts and different states and territories. Any nationalised approach must be agreed with all states and territories and any duplication removed locally. Ideally an office based in each state and territory working with the local government would aid transition and implementation but would not necessarily overcome the differences across the three sectors.

1.4 Information request 1.3

(1) Refer to experts on behavioural support plans to ensure the focus is on the individual needs and not used to manage poor staffing levels or insufficiently trained staff.

(2) Refer to research carried out by the Social Policy Research Centre UNSW on restrictive practices – undertaken for the Disability Royal Commission.

2 Recommendation 2.1 – collaborative commissioning

2.1 General comments

The recommendations on collaborative commissioning are not new by the PC's own admission. Given this, attention should be given to understand why existing efforts are not working and how to overcome those barriers. Implementation requires commitment from all parties to make it happen, and resources to overcome initial hurdles. Issues with collaborative commissioning include – differences in funding cycles, reporting bodies, risk appetite, governance mechanisms, legal contracts, standards, etc. But these costs will reduce over time as partners get to know and understand each other. Collaborative commissioning requires strong and committed leadership, understanding of the issues, and willingness to participate. Collaborative commissioning has been endorsed through PHNs and Health departments for years, but the challenges of delivery have impeded implementation. For more detailed explanation see:

- Co-Commissioning paper: Bates S; Harris-Roxas B; Wright M, 2023, 'Understanding the costs of co-commissioning: Early experiences with co-commissioning in Australia', *Australian Journal of Public Administration*, 82, pp. 462 – 487, http://dx.doi.org/10.1111/1467-8500.12599

- Homelessness NSW paper: Bates S; Cortis N, 2023, Commissioning Homelessness Services: A Review of Possible Approaches, UNSW, Sydney, http://dx.doi.org/10.26190/hrg6-c739

I commend the recommendation to make PHN funding more flexible. PHNs currently have very limited flexible funding to respond to local needs and enable innovation. Increasing flexible funding should enable PHNs to do exactly what they are designed to do – identify needs, identify service gaps, address gaps with local knowledge and expertise. For further explanation, see:

- Bates S; Wright M; Harris-Roxas B, 2022, 'Strengths and risks of the Primary Health Network commissioning model', *Australian Health Review*, 46, pp. 586 – 594, http://dx.doi.org/10.1071/AH21356

The commissioning process itself requires better data. Currently, PHNs commission services based on data they have – often services accessed, rather than unmet need. More research is required to understand what services are needed (particularly around unmet need or people not accessing the health system), what models of care are suited, and how they might be provided and funded. The literature that talks about PHNs provides additional insights. See for example https://doi.org/10.1016/j.healthpol.2021.02.002, https://doi.org/10.1071/PY21209 and https://doi.org/10.1111/hsc.12464.

The co-commissioning recommendations focus on health services including prevention. The responsibility for health prevention work needs to be clearer (see Section 3). Often LHNs/LHDs are not interested in investing in prevention as they think it is the responsibility of primary care/Commonwealth. The funding model for hospitals provides little incentive for preventive work.

Innovation in commissioning, improving care outcomes, is likely to cost more in the short-term. All parties need to be willing to invest to achieve longer term gains. Gains that are unlikely to be seen in the current funding cycle.

In terms of efficiency, the other approach would be to provide more resources to states and territories under the national health reform agreement to consolidate and improve services. This would reduce transaction costs with only one organisation needing to design, implement, and monitor services.

2.2 Information request 2.1

(1) In terms of what factors need to be considered to establish a joint governance framework. Again, it is worth looking at the PHN model and their governance mechanisms that engage the community and other key organisations. It is important to understand the extent to which you mean "joint governance framework". There is a report and guidance about to be published from work commissioned by ANZSOG on the subject of co-governance and what is required to implement co-governance. This highlights the importance of a mandate, the work required to establish joint governance mechanisms, and ensure they are trusted pieces. Please contact me if you would like to receive a copy when published. The scoping review which provides the foundation to the study is available here:

- Smyth C; Bates S, 2023, Would adopting more co-governance arrangements with communities build public trust? A scoping study, ANZSOG, Melbourne, http://dx.doi.org/10.54810/ZLLK8645

(2) An outcomes framework should be produced by the joint governance framework. This should include data from different sources – and not bias data not coming from government. Again, see the work produced for ANZSOG.

(3) Partnership requires willingness and resources. ACCHOs are resource constrained organisations and may be unable to participate without resources. Again, see the work produced for ANZSOG. One early publication is available here – see:

- Bates S; Haigh F, 2024, Co-governance Case Studies: Waterloo Collaborative Group, UNSW, Sydney, http://dx.doi.org/10.26190/unsworks/30312

2.3 Information request 2.2

(1) Resourcing would be contingent on each case (prior experience, starting point, and in particularly differences between parties), the number of parties involved, and the complexity of what is being commissioned. Again see:

a. Co-Commissioning paper: Bates S; Harris-Roxas B; Wright M, 2023, 'Understanding the costs of co-commissioning: Early experiences with co-commissioning in Australia', *Australian Journal of Public Administration*, 82, pp. 462 – 487, http://dx.doi.org/10.1111/1467-8500.12599

b. Homelessness NSW paper: Bates S; Cortis N, 2023, Commissioning Homelessness Services: A Review of Possible Approaches, UNSW, Sydney, http://dx.doi.org/10.26190/hrg6-c739

c. ANZSOG reports on co-governance

- Smyth C; Bates S, 2023, Would adopting more co-governance arrangements with communities build public trust? A scoping study, ANZSOG, Melbourne, http://dx.doi.org/10.54810/ZLLK8645

Bates S; Haigh F, 2024, Co-governance Case Studies: Waterloo Collaborative Group, UNSW, Sydney, http://dx.doi.org/10.26190/unsworks/30312

Final report, guidance, and two other case studies forthcoming.

(2) It is unclear what is meant by types of funding. I'd suggest there is an administrative cost that should be separate to funding for services. Collaborative commissioning should not draw resources away from services. In accounting terms – fixed costs (administration), variable costs (services). Allocation should also be made for process review and improvement.

(3) One unintended consequence of collaborative commissioning is paralysis – it is critical to improve or maintain service delivery while partners in collaborative

commissioning work out the logistics. Another potential unintended consequence is a reduction in funding or prevention activities – either due to the cost of collaborative commissioning, due to national requirements being less than what was being implemented locally, or because parties are seeking to invest equally to manage power (and in a low resource environment, it may be a reduction as parties may be unable to increase funding).

Better health outcomes are not measured in potentially preventable hospitalisations alone. The outcome measures identified should reflect the aim of the program and should include a mix and should also include measures across the program logic. For example, number of GP visits, number of vaccinations, number of health plans, etc.

(4) There has been mixed success of collaborative commissioning by PHNs. Success may come from PHNs who have long established relationships with collaborators. This is reported in the PHN literature as mentioned above.

2.4 Information request 2.3

(1) When the PHNs were established, they were largely aligned with LHN/LHD boundaries, although some PHNs contain more than one LHN/LHD. The change in alignment from the previous Medicare Locals has taken time to settle and relationships to build. PHNs have been operating for 10 years, the cost of changing those borders again would be a setback to the relationships formed and would risk the potential of collaborative commissioning. Similarly, PHNs and LHN/LHDs have existing relationships with ACCHOs and other key stakeholder organisations through the way they operate. Geographical boundaries are not the barrier to collaborative commissioning. Also, PHNs have demonstrated their ability to partner and scale up as required (as do LHNs/LHDs)

(2) Additional supporting actions are needed to support collaborative commissioning. It is not enough to say it should be done. Government should identify and where possible remove barriers to collaborative commissioning. Government should also support the enablers to collaborative commissioning. See references cited above.

(3) There is a substantial literature and guidance on place based initiatives. The guidance coming out of the State of Victoria is quite comprehensive. The International Centre for Future Health Systems is currently undertaking a scoping study with colleagues at the University of Oxford that is looking specifically at place based initiatives focused on integrating health and social services. This is in response to NHS reforms in England that have announced the establishment of Neighbourhoods. The paper is under preparation and we are happy to share a copy of the manuscript with you when published.

There is also substantial overlap with our research on co-governance which can also be place-based (but not always). Again, the ANZSOG funded research reports are

forthcoming.

One consideration is the concept of proportional universalism – ensuring everyone has access to services but additional support may be required in some places to ensure access and overcome barriers to access.

3 Recommendation 3.1 – investment in prevention

3.1 General comments

Additional investment in prevention is critical to support fundamental human rights and increase productivity, yet by the PC's own admission is currently lacking across all governments given the split of responsibilities. Clarifying roles and responsibilities (and establishing accountability) is critical –everything else should follow.
The recommendation is for an independent board, actuarial models and frameworks for the analysis of prevention programs. While evaluation of programs is essential, care should be taken to ensure that the cost of this does not exceed prevention interventions – not just the cost of establishing the board, but also the cost of doing business in prevention through the funding and assessment mechanisms.

The recommendations are specific about governance, analysis and funding. They are not clear on the scope of prevention activities. Given these vary vastly from education to better treatment and better treatment compliance, clarity would be beneficial.

A point is made on p58 that some prevention programs may be more effective than others. This is a fair point, but ignores the fact that people are influenced by different programs in combination. This also makes evaluations difficult in attributing an outcome to a single program. Perhaps more focus should be placed on identifying baselines and tracking trends in health care use and in particular primary health care use, and health outcomes should be considered in the short, medium and longer term.

Figure 3.1 displays the spectrum of care from primary to acute. How are primary care practices going to be involved in primary prevention? Will this be part of the primary care reforms and delivered by multidisciplinary teams? Or by hospital networks? Or centrally (eg screening programs). The obvious choice is doing more through primary care and through those trusted relationships between GPs/practice nurses and patients. A simple approach could be to offer free 5 year health (as seen in France) checks from 18-50, and then more frequently thereafter. See for example Republique Francaise CLEISS. The French health care system (Systeme de sante en France). 2025. Available from: https://www.cleiss.fr/particuliers/venir/soins/ue/systeme-de-sante-en-france_en.html

Prevention needs to start by education: the right to health, priority on prevention, healthy lifestyles, importance of screening and vaccination, etc. This can be done from

preschool throughout education and into workplaces. Our diverse population, with recent migrants coming from different contexts with different experiences of health service provision and use, needs to understand what is available, how to access it, and how to stay well in Australia.

The government should also be prepared to support higher health service use recognising the longer term cost savings (recognised in Fig 3.2). Further, if you bring more people in to the health and social service system, there need to be services available to access. Case in point, a universal screening program in NSW screened young people at school and identified students who needed psychosocial supports – unfortunately supports were limited and long wait lists prevented young people from accessing the services that were identified as needed. See:

- Blunden H; Wong B; Bates S; Cheung S; Hsieh W; Katz I, 2024, Evaluation of the Universal Screening and Support Pilot: Final Report, UNSW, Sydney, http://dx.doi.org/10.26190/936q-fe64).

Earlier intervention and prevention is ideal and offers long term savings – but this needs to be backed up by short term investment in additional services. Is the system as it currently stands capable of this? For mental health – probably not.

Targeting vulnerable populations is critically important. But vulnerable populations are not static; think about proportional universality to ensure everyone has access to care they need, and ensure new vulnerable populations are not created as the result of services targeting only some groups.

In terms of cost-effectiveness of prevention. Prevention has long term outcomes and may incur more cost up front compared to BAU, particularly if more earlier intervention services are required.

The underlying question is how will different governments work together – given mandate for collaboration and co-commissioning etc. is not new.

3.2 Information request 3.1

(1) While it is important to evaluate individual programs, they often work as part of a wider system. For example, any mental health service offering a specific type of service relies on other services being available to implement stepped care – where clients may be stepped down (if there support needs reduce) or up (where they increase) as needed. Likewise, GPs do not function alone, they work with pathology, radiology, specialists, allied health care, pharmacies, etc. Therefore, as well as understanding the individual benefits of a program, it is also critical to evaluate the programs place in a wider network and system. A program may not be achieving great outcomes alone (for example, Community Health Workers who help people navigate systems), but may be making a difference in helping a under-served cohort access the broader health system. The cost effectiveness of such a program would be difficult to quantify.

The commissioning process established in the PHN program helps overcome these issues and helps consider service needs and effectiveness from a systems level. Ease of implementation can be considered from a systems, organisational, professional and patient perspective. PHNs will explain that implementation of a new program takes time – to onboard staff and to establish new clinical/care pathways. This requires support.

(2) No comment – see above.

(3) In terms of assessing early effectiveness – this can be achieved through process evaluations. Most interventions are evidence based; therefore, evaluating other aspects of the program logic should provide confidence that longer outcomes will be achieved and provide confidence for longer-term funding.

(4) See point (1) above. A needs assessment should include a diversification strategy. Diversification is sometimes necessary to engage with different communities. However, care should be taken not to diversify too much as this will incur higher transaction costs.

3.3 Information request 3.2

(1) Clear obligation and responsibility for prevention is required. Private health insurers should also be included in this framework (and have obligations under this framework) as it is in their interest to invest in prevention to avoid future costs. Along with Department of Veterans' Affairs.

(2) No comment.

(3) See work on co-governance (ANZSOG).

(4) Any new framework must place accountability on all parties under the framework and supported by additional resources. Previous directives and enablers to co-governance (NSW Health/PHNs, or Mental Health Strategies) were insufficiently resourced (or not resourced) and it was not surprising they resulted in little change. Any new national framework needs to consolidate all existing initiatives and add to them to remove any inconsistencies between states and territories and ensure that all Australians have equal access to preventive health.