Name: Fixing the NDIS research team, Centre for Disability Research and Policy, The University of Sydney

Submission date: 5/06/2025

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.

   Disability

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?

   To a great extent

2. What are the reasons for your answer?

   Our research focusing on the reform of the NDIS and national responses to improving support for people with severe mental illness has interviewed over 80 NDIS participants, carers and other stakeholders. Our findings show that uncoordinated quality and safety regulation systems sitting around major policies such as the NDIS impact implementation for this group and reduces the effectiveness and quality of services. Examples of problematic regulatory frameworks include the NDIS Quality and Safeguards Commission. Participants have discussed the ineffective regulatory mechanisms which result in them making complaints to the NDIS commission but receiving no follow up. In some cases they have then had to make police complaints and pursue actions through other mechanisms such as legal routes in order to ensure good practice.

   There have also been concerns about both individuals and services becoming subject to multiple regulatory mechanisms and having to pay the costs of registration and other compliance activities for multiple systems. This means that some are unwilling to go through the important step of registration for the NDIS. Registration for the NDIS is currently optional which can put people with psychosocial disability at heightened risk of poor practices and there is a concern among advocates and providers that unregistered providers with no skills are entering the system and providing supports with no skills to do so. Registration is needed to ensure the quality and safety of care provided.

   In the 2021–22 Budget, the Australian Government committed to aligning regulation across the NDIS and disability services, aged care, and veterans' care. To deliver on this

reform agenda, a cross-agency taskforce, hosted by the Department of Health, was established, bringing together the NDIS Quality and Safeguards Commission, the Aged Care Quality and Safety Commission, the Department of Social Services, and the Department of Veterans' Affairs.

Consultation on this issue was already carried out in 2021. For example, the National Aboriginal Community Controlled Health Organisation (NACCHO) highlighted that using a single auditing system across aged and disability care would avoid running two sets of paperwork for the same client. Currently, this duplication is confusing, time-consuming, and results in more time spent on compliance and less on client support.

Despite clear evidence of inefficiency and tangible recommendations, here we are again - being consulted on something that is, by now, self-evident. I am trying to remain optimistic. Perhaps the Productivity Commission's seemingly redundant consultation can serve a purpose: reassessing stakeholder appetite, building a more defensible economic and service case, and creating public pressure and accountability to finally move this reform forward.

Concrete recommendations have already been put forward, including:

Developing a unified Code of Conduct for care workers;
Implementing a standardized Care and Support Worker Screening Check;
Aligning compliance and enforcement powers among regulators;
Conducting combined audits for aged care and NDIS providers.

We understand that even initiatives that appear straightforward require substantial coordination: legal amendments, harmonised data systems, and workforce retraining. Cross-agency reforms also face cultural and institutional resistance. They challenge bureaucratic turf and power structures - no agency wants to cede control or have its processes overridden. Political cycles and leadership changes can further erode reform momentum. Even well-intentioned commitments like those made in the 2021–22 Budget can stall without strong and sustained political leadership.

However, the current landscape presents a rare and powerful opportunity. Health, aged care, and disability services now all sit within the Department of Health and Aged Care, under the leadership of Minister Mark Butler. This consolidation removes one of the key barriers to reform: fragmented accountability. It provides the structural foundation for building integrated policy and operational frameworks, such as joint regulatory standards, shared audit systems, and unified infrastructure for data, training, and compliance.

These reforms are not only administratively sound but economically rational. Integrated systems reduce duplication (e.g., audits, workforce checks, reporting), lower costs for government and providers, and improve workforce mobility - particularly for workers who operate across multiple sectors, such as those providing both aged and disability care.

Yes, governments are often risk-averse, especially in sectors as sensitive as care quality and safety. But now, with the Albanese Government enjoying a strong majority and Minister Butler in a senior, stable position, the conditions are ripe for meaningful reform.

The time for more consultation has passed. What we need now is implementation - even if it starts with a single, well-executed step.

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 significant duplication in the systems that apply to the quality and safeguarding of individuals receiving support under the NDIS. Those providing supports can simultaneously have their support regulated by both AHPRA and the NDIS Quality and Safeguards Commission.

   What regulatory body individuals complain to is also split according to the service system that they receive support from and this may not be readily understood by participants. They have to follow different processes across systems, which adds an added burden to complaining and may get in the way of making complaints which are needed to ensure the quality and safety of supports. For example, individuals with mental illness receiving supports in NSW can complain to the Health Care Complaints Commission for health care related complaints, and to the NDIS Quality and Safeguards Commission for the NDIS. These two systems have very different ways of operating including the tone of communication which can impact on their ongoing care (e.g. NDIS operates in an adversarial way focused on individual providers, whereas the HCCC is more conciliatory and focused more on improving services and systems). The HCCC approach is far more effective in its role and it (and the other health complaints commissions nationally) should be a model for reform of other systems. They have operated over an extended period and have structures in place that promote a positive culture of complaining aimed at system reform.

2. Embed collaborative commissioning to increase the integration of care services

1. What is your experience with collaborative commissioning

   Partners in Recovery (PIR) is an example of a consortium model that included some collaborative commissioning between PHNs (then Medicare Locals) and local health districts to fill localised gaps in services for people with severe mental illness. PIR itself was based on consortia of government and non-government providers engaged in each PHN region to provide recovery-oriented supports for people with severe mental illness. It is the most evaluated model of community-based collaborative support for this group in Australia. An example of the processes associated with co-commissioning in a particular PIR region has been written up in a paper by Chevertan and Jamamian (2016): https://onlinelibrary.wiley.com/doi/full/10.5694/mja16.00124

   A non-Australian example that is useful is the Getting it Right for Everyone program on collaborative commissioning from the Scottish Government. This has examples of areas that are currently trialling local approaches. https://www.gov.scot/publications/getting-it-right-for-everyone-girfe/pages/about-girfe/

   Our team conducted a study (currently under review - please contact for access) examining inequities in access to health and support services for people with disability.

A key finding was the institutional fragmentation across service delivery systems, which contributes significantly to inequitable access. This lack of integration presents a dual challenge: for service providers, it creates systemic inefficiencies and resource leakage; for individuals seeking support, it results in delays and barriers to accessing essential services. Meaningful integration of local services—particularly when coordinated with other critical social determinants such as housing—can play a transformative role in improving equitable access and outcomes.

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

Here we will again use the Partners In Recovery consortia example as it is the most extensively evaluated program relevant to this question (local evaluations were mandated in each consortium as a ring-fenced part of the funding).

The PIR program was established to function nationally through consortia of government and non-government organizations within each Primary Health Network (PHN), formerly known as Medicare Locals. Initially introduced under the federal Gillard Labor government by then Mental Health and Ageing Minister Mark Butler (now NDIS and Health Minister), it was designed for phased implementation across Medicare Local regions (later PHNs). Although intended for nationwide rollout, a change in government led to the program being limited to the first round of funding, leaving some regions without access. The PIR consortia and networks played a crucial role in shaping an effective support coordination model. As a nationally defined program, PIR was implemented by various consortiums, primarily Medicare Locals, across Australia. Within these consortiums, individual organizations, often NGOs, established the operational framework.

We conducted a systematic review of all peer reviewed papers focusing on PIR (n = 31) and found that the collaborative approach that it took was very helpful for breaking down barriers to collaboration around a participant's needs. While this review of PIR is currently under review we are able to provide it if needed.

The consortia were essential to facilitating support through key roles, as they provided the structural foundation that supported staff to carry out their work for the benefit of participants. The benefits included – a broad network that they could call on to try to work out how to address needs participants might present with where it was not immediately clear to the individual support worker how these needs may be met. It also provided a network around the support workers so that they could develop skills and learn from others in the roles. The consortia also meant that there was less buck-passing and competition because they 1) had to rely on each other to fulfil the contract and 2) could come together to solve implementation problems collectively 3) they were not competing for an individual's funding, but sharing collectively in that funding.

One significant benefit of collaborative commissioning is its potential to reduce unhealthy competition among service providers. Under current funding mechanisms, such as the NDIS, providers are often incentivised to compete for client numbers or market share. This can result in "cherry-picking" behaviour, where providers avoid serving clients with complex needs or those living in rural or remote areas due to higher service costs or delivery challenges.

Collaborative commissioning offers a pathway to shift from competition to cooperation,

enabling providers to work together to design and deliver services that better meet shared population needs. By fostering partnerships and shared accountability, collaborative commissioning encourages more equitable service coverage, reduces duplication, and improves system-level efficiency and outcomes.

The integration of local services—particularly when it includes other critical social supports such as housing—can significantly improve service delivery and equity. Integrated systems reduce bureaucratic red tape, which has long been a barrier to timely and effective support. This approach enhances efficiency in government resource allocation and streamlines service provision for those delivering care. Most importantly, it improves the experience for individuals seeking support by enabling more direct, timely, and coordinated access to the services they need.

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?

Drawing from both our research and the experience of one of our research team in managing and coordinating the After Hours Primary Health Care Program, several key barriers to effective collaborative commissioning stand out:

1. Variation in commissioning capability

A major challenge is the inconsistent capability of lead commissioning organisations, such as PHNs. In both the After Hours PHC and PIR programs, we observed that the success of collaborative commissioning varied greatly depending on the capacity and leadership of the PHN. Some PHNs demonstrated strong strategic planning, stakeholder engagement, governance, and contract management skills, leading to more impactful outcomes. Others lacked the capability to lead collaborative processes fairly, efficiently, or effectively - undermining trust and discouraging local partners from engaging in joint commissioning efforts.

Suggested solutions:

- Provide national or state-level support for capacity building, including dedicated training, mentoring, and communities of practice for commissioning staff.

- Establish clear standards and expectations for collaborative commissioning processes and governance.

- Implement performance monitoring mechanisms to ensure consistency and accountability.

2. Incompatible data systems and limited data sharing

A persistent barrier is the lack of interoperable IT systems. In programs like PIR and After Hours PHC, each organisation operated separate CRM or data platforms, which did not communicate with one another. This severely hampered care coordination, outcome monitoring, and shared learning. Furthermore, it placed administrative burden on service delivery partners, who were often required to duplicate data entry or manually compile reports - diverting resources from client-facing work.

Suggested solutions:

- Invest in data integration infrastructure, including systems that support interoperability across organisations.

- Develop and implement common data standards and privacy-compliant data-sharing agreements.

- Support the creation of trusted data custodians or platforms to facilitate secure, efficient cross-organisational data use and reduce reporting burdens.

3. Short funding periods and policy uncertainty

Short-term funding cycles and frequent shifts in policy direction, often tied to changes in government, undermine the stability needed for effective collaborative commissioning. Two-year funding cycles are common, limiting the ability of lead organisations and service partners to plan long-term, build trust, invest in workforce development, and evaluate impact. This creates service disruption, staff turnover, and a loss of institutional knowledge.

Suggested solutions:

- Introduce longer funding cycles (e.g., five years) for collaborative commissioning initiatives.

- Include built-in review points and outcome-based milestones rather than arbitrary end dates.

- Stabilise the policy environment through bipartisan support for integrated care reforms.

- Embed collaborative commissioning within core program architecture rather than short-term pilots or grant-funded projects.

4. Limited financial discipline among fund-holding organisations

An important tension in collaborative commissioning models is that fund-holding or coordinating organisations (such as PHNs or LHNs) are not themselves subject to the same market pressures as service providers. Without those incentives, there is a risk that public funds are not managed with sufficient cost-consciousness or operational discipline. This can lead to inefficiencies, inadequate oversight of service delivery, and delays in addressing underperformance.

Suggested solutions:

- Introduce independent performance monitoring and benchmarking for fund-holding organisations, including administrative overheads, commissioning outcomes, and stakeholder satisfaction.

- Require fund-holders to publish transparent reports on fund allocation and the return

on investment achieved.

- Tie a portion of administrative funding to the achievement of commissioning outcomes (e.g., reducing duplication, improving client outcomes).

- Establish shared governance arrangements that include service providers and community representatives to enhance transparency and accountability.

Promote a stewardship mindset that emphasises careful, responsible management of public funds.
5. Data Integration - it is essential that data are able to be integrated across systems for more effective working.

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?

Siloed government structures discourage cross-sectoral investment

As noted in Section 2, government departments are typically structured around specific service areas, such as health, housing, education, or justice, each with its own policy objectives, budgets, accountability mechanisms, and performance indicators. However, prevention programs often generate diffuse, long-term benefits across multiple domains. For example, an early childhood intervention may improve mental health outcomes, reduce future justice system involvement, and enhance workforce productivity decades later.

Because no single department reaps the full return on investment, no department is incentivised to fund the upfront costs. This creates a classic “tragedy of the commons” situation: shared benefits result in underinvestment when decisions are made in silos with short-term priorities.

Academic research is also fragmented and bound by disciplinary silos

This structural fragmentation also exists in the academic sector, which plays a key role in generating the evidence base for prevention. Researchers are typically organised by discipline, and their work is shaped by narrowly defined grant objectives, peer review expectations, and disciplinary norms.

Funding calls often focus on specific populations or disease groups and require researchers to demonstrate domain-specific expertise. As a result, most evidence is focused on single issues, with narrow outcomes, and rarely accounts for spillover benefits across sectors or population groups. This is not a reflection of poor research quality but of systemic incentives that determine what gets funded and published.

Without strong, cross-sectoral evidence, policymakers lack the tools to make integrated, whole-of-government investment decisions in prevention. If the evidence itself is siloed, how can it meaningfully inform cross-sectoral policies?

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

Partners in Recovery, explored in detail above, provides an apt example of an effective tertiary prevention program for people with severe and persistent mental illness who have complex support needs. By providing coordinated care, it served to prevent symptom relapse and hospitalisation while improving long-term improvements to quality of life. Furthermore, by focusing on community participation and wrap-around supports the program promoted functional recovery for people with complex, chronic conditions.

PIR was a Commonwealth funded program, administered through the Department of Health utilising existing infrastructure (Medicare Locals and NGOs). Summarising an economic evaluation of one local PIR program, Isaacs et al. found "the total cost of providing the service for a consumer per year (set-up and ongoing) was estimated to be AUD$15,755 and the ongoing cost per year was estimated to be AUD$13,434.... The potential cost of not adequately supporting such persons is likely to far outweigh that of doing so."

Built into the funding model of PIR was an evaluation requirement. Given this, there is a significant number of evaluations of local PIR programs from which we can draw findings and measure outcomes. Of note, participants in the program experienced increased engagement in social and community activities, improved mental health, reduced isolation, and decreases in a range of unmet needs.

The program was folded with the introduction of the NDIS in 2019. Along with many other community based programs, the service was subsumed into the Scheme to avoid duplication. In practice, this resulted in significant gaps as many people who experience severe mental illness were not (and are not) eligible for the NDIS.

The introduction of the NDIS coincided with a policy shift toward individualised funding and consumer choice for mental health. While this model of funding has dramatically improved the lives of many people with disability, results have been underwhelming for people with psychosocial disability. The NDIS market model has not succeeded in addressing the deep system fragmentation that continues to plague Australia's mental health landscape.

It is our firm belief that a tertiary prevention program such as PIR working from a collaborative framework is essential. We commend the Commission on emphasising collaboration and prevention within its consideration. As Federal and State and Territory Governments collaboratively develop Foundational Supports, Australia has a unique opportunity to make lasting change to the systemic cracks that have characterised our systems for decades. We recommend the role of "Navigators" as outlined in the 2023 Independent Review of the NDIS be fervently co-designed in line with Partners in Recovery Principles.

For sample evaluations of PIR, see:

Isaacs A, Beauchamp A, Sutton K, Kocaali N. Care Coordination Can Reduce Unmet Needs of Persons With Severe and Persistent Mental Illness. Front Psychiatry. 2019;10:563.

Hancock N, Smith-Merry J, Gillespie JA, Yen I. Is the Partners in Recovery program connecting with the intended population of people living with severe and persistent mental illness? What are their prioritised needs? Aust Health Rev. 2017;41(5):566-72.

Hancock N, Scanlan JN, Gillespie JA, Smith-Merry J, Yen I. Partners in Recovery program evaluation: changes in unmet needs and recovery. Aust Health Rev. 2018;42(4):445-52.

Wands MMH, A Byrne, L Carklins, . West Moreton-Oxley PIR Evaluation Third Year Evaluation Report. Moffat Beach: Connetica Consulting; 2016.

Integrated service models that address social determinants of health are essential for improving outcomes. Among the various strategies to reduce health inequities—particularly in mental health—addressing social determinants is the most impactful and modifiable factor. Proactively targeting these determinants not only helps prevent the onset of mental health conditions but also reduces the risk of progression to psychosocial disability.

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

1. Shift to outcome-based, pooled funding models

Traditional funding mechanisms are siloed, short-term, and often tied to inputs or outputs (e.g., number of clients served). To incentivise investment in prevention, governments can establish joint prevention funds that pool resources across departments (e.g., health, housing, education, justice) to support initiatives with multi-sectoral benefits. This promotes shared accountability and aligns incentives across portfolios. An example is the UK's Better Care Fund (BCF), which pools resources from the NHS and local government (social care and housing) to reduce avoidable hospital admissions and improve population outcomes.

In addition to pooled funding, governments should incorporate outcomes-based models, where funding is tied to long-term indicators such as reduced emergency department use, sustained employment, or improved wellbeing. These models encourage a longer investment horizon and allow for greater innovation in service delivery.

As suggested in the section heading, a national framework is needed to normalise investment in cross-sectoral, long-term outcomes.

2. Fund long-term independent, collaborative, longitudinal research and evaluation

To ensure the evidence base supports cross-sectoral investment, governments should establish a long-term, independent fund for applied prevention research that:

Spans multiple sectors (e.g., health, social care, education, housing, climate),

Involves interdisciplinary research teams, including health economists, policy analysts, domain experts, and people with lived experience,

Models long-term, system-level outcomes, not just short-term, siloed metrics.

This fund should sit outside traditional competitive research council models, which tend to favour discipline-specific projects. Its primary aim should be to generate policy-relevant, cross-sectoral, actionable evidence to support prevention decision-making at the national level.