Productivity Commission

GPO Box 1428

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Barton ACT 2600

15 September 2025

Submission to the Productivity Commission Interim Report: Delivering quality care more efficiently

We thank you for this opportunity to further contribute to the work of the Productivity Commission (the Commission) and this inquiry following our initial response in June.

Uniting NSW.ACT is the social services and advocacy arm of the Synod of the Uniting Church in NSW and Australian Capital Territory. We provide innovative and person-centred services that in 2024-25 supported over 156,000 people at all stages of their lives, including children, young people and families, older people, and people with disability.

In this submission, we are drawing on our experience providing and coordinating care. Uniting NSW.ACT delivers supports across NSW and the ACT across multiple service systems. This includes aged care, early learning, NDIS funded disability supports, mental health and wellbeing, children and family services and out of home care.

We strongly support the recommendations within the Interim Report. This is a vital discussion for the broader economy, service providers and workers in the sector, and importantly, those who receive care services. By implementing measures that lift productivity in the care sector there is the potential for better, quality care for care recipients and improved efficiency for providers.

In particular, we commend the recommendations relating to a National Prevention Framework which adopts a broad, whole of person approach to prevention to improve outcomes for people and communities. We encourage the Commission to be ambitious in these recommendations which we believe have significant potential to create systemic change.

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Yours sincerely,

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Delivering quality care more effectively

We welcome the work of the Productivity Commission in considering how quality care can be delivered more effectively. This vital discussion holds the potential to produce better economic returns, reduce administrative burdens on staff and improve the quality of care provided to clients. Within this debate, we must ensure that the intent is to ensure that Australians who need support are able to receive the highest quality of care. The Centre for Policy Development described this as follows:

> *Rather than pursuing productivity growth for its own sake, we must clarify its purpose: to lift living standards, improve wellbeing, and accelerate the transition to net zero.*[1]

Care must be seen as an investment in improving living standards and enabling all Australians to enjoy the highest quality of life. By extension, this facilitates participation in activities such as work and study which contribute to broader productivity.

Investment in the care economy should be centred on evidence-based services, relational care and a balance between early intervention and acute care. This should be supported by more effective regulation which meets the needs of care recipients, providers and regulators.

We broadly support the draft recommendations in the Productivity Commission's Interim Report to lift productivity in the care sector. The following will discuss our response to specific recommendations in more detail.

Reform of quality and safety regulation to support a more cohesive care economy

Uniting welcomes the draft recommendations put forward in the Interim Report to pursue greater alignment in quality and safety regulation of the care economy to improve efficiency and outcomes for care users. Services across the care economy share fundamental principles such as quality, safety, respect and dignity. There is value in developing standardised regulations and mutual recognition structures which enable providers to deliver supports across different sectors, while allowing appropriate diversification of standards for high-risk services.

We note that these proposals have been presented without comment on the ongoing conversation regarding mandatory registration for NDIS providers. In his speech to the National Press Club in August 2025, Minister Butler indicated that there are as many as 250,000 unregistered providers compared to only 16,000 registered providers. While the government has committed to reforms to improve registration, increase market oversight and governance, the specific details of future registration reforms remain unclear.

As such, there is therefore a risk that the recommendations in this interim report will not apply to the vast majority of providers currently operating in the scheme. While not in scope, we would like to take this opportunity to endorse the recommendations of the NDIS Review to implement mandatory registration within the NDIS to improve oversight and uphold the safety of participants. The recommendations provided in this report would contribute to a more cohesive registration approach across the care economy and improve overall efficiency which should include the elimination of unregistered providers within the NDIS.

We support the proposal to implement **a national screening clearance for workers in aged care, NDIS, veterans' care and ECEC sectors**. A national clearance system would reduce duplication and

[1] The Centre for Policy Development (2025). *Productivity with Purpose: Clear pathways to a more equitable future*. Accessed at: Productivity with Purpose: Clear pathways to a more equitable future - Centre for Policy Development

administrative burden, particularly for providers such as Uniting that operate across multiple sectors. More importantly, it would provide consistency and strengthen child safety while also improving workforce mobility. This is particularly valuable in regional and rural areas where staffing shortages are most acute, as it would enable quicker employment pathways and greater flexibility in deploying staff across different services. At a minimum, standardising criminal and Working with Children Checks and a ban across sectors should be implemented. We recognise that some of this work is already underway with the alignment of screening for aged care and NDIS workers.

We would like to confirm that this recommendation would mean a singular point of national screening for workers. We also propose that social workers who are registered with the Australian Association of Social Workers should be included in a **national worker registration**.

We also support the proposal to implement **a common suitability assessment for providers operating across the aged care, NDIS, veterans' care and ECEC sectors**. While this relates more to governance and operational capacity than direct quality of care, a common assessment would streamline compliance obligations, reduce duplication of audits, and allow organisations to focus more resources on service delivery. For not-for-profit providers like Uniting, this alignment increases efficiency and transparency, while also building community and government confidence in the standards and accountability of providers. This should also include outreach and proactive market stewardship to capture smaller providers with a heightened risk of non-compliance.

We would appreciate more information regarding the proposed **mutual recognition of audits against the aged care quality standards and NDIS practice standards**. While there are some similarities in the supports provided across both systems, the NDIS provides significantly more diverse services to a broader cohort of people including children with disability. Any mutual recognition must ensure that services are held to existing or higher standards and avoid allowing providers to be audited against less stringent requirements.

We support the implementation of **a single digital portal for providers to manage their registration and audits across the aged care, NDIS and veterans' care sectors**. This will enable providers to more effectively manage oversight of registration and auditing schedules and provides a central point of information.

We support the introduction of **a single (potentially) modular set of practice and quality standards across aged care and NDIS services**, provided that it has adequate specialised standards for specific services. It is important to ensure that there is appropriate delineation and separation of practice standards between different types of services depending on their level of risk. The NDIS currently has three different types of modules: core (applies to all registered providers delivering higher-risk supports), supplementary (service specific modules) and verification (all registered providers delivering lower-risk supports). We would endorse a similar approach to a modular set of practice and quality standards.

We support the introduction of **a cross sectoral registration system for registered providers across the sectors**. This should be accompanied by mutual recognition of banning and suspension orders which would assist in preventing poor providers from moving between care systems while subject to sanctions. However, we are concerned that this would only capture the 16,000 registered NDIS providers and would fail to account for the 250,000 unregistered providers. There remains an inherent and pervasive risk that providers who are subject to sanctions in one system can establish themselves as unregistered NDIS providers and therefore continue to deliver care services to vulnerable people. We echo our previous call for the implementation of mandatory NDIS registration as recommended by the NDIS Review which would address this loophole and ensure the effectiveness of cross sector registration and screening.

A standardised quality and safety reporting framework and data repository would be an important step in reducing the regulatory burden on providers who are often required to report similar

information to different bodies. We believe that reporting and information sharing is critical to supporting effective oversight and enabling consumers to make informed decisions about their care. This reporting should be relevant and meaningful for regulators and consumers while avoiding an administrative burden on providers.

In creating a standardised reporting framework, it is important to ensure that specific measures of quality and safety (particularly for high-risk services) are maintained. The purpose of reporting must be supporting and enabling high quality care.

We see potential value in implementing **a single regulator across sectors**; however, it would be a highly complex undertaking and requires extensive consultation with providers and care consumers. We recognise that this would facilitate more effective regulation, screening and education for the sector. However, we also believe that there would be a risk of the specialist knowledge and expertise currently held within the separate regulators would not be maintained in a larger regulatory body.

Alternatively, the Commission may also consider recommendations which facilitate improved integration, information sharing and communication between the existing regulators to enable efficiency and reduce duplication of reporting. Such recommendations could also be implemented during the consultation and establishment period for a single regulator if this proposal is adopted by government.

We support **greater alignment in the regulation of behaviour support plans and use of restrictive practices** to ensure more consistent definitions and supports which uphold the rights of people with disability and older people. The current regulatory landscape for restrictive practices is inconsistent across sectors and jurisdictions and was recognised by the Disability Royal Commission as inefficient. This places a particular burden on aged care providers who deliver residential aged care services to younger people in residential aged care (YPIRAC) clients with disability who are funded through the NDIS and are therefore subject to two regulatory frameworks.

While some efforts have been made to align the definition and use of restrictive practices between the NDIS and aged care, more work is required. As an example, the NDIS Quality and Safeguards Commission has a list of prohibited forms of physical restraint which are associated with high risk of injury and death including prone restraint, supine restraint, basket holds and takedown techniques. These are currently not present within the regulations for restrictive practices in aged care.

We note that greater alignment in the regulation of behaviour support plans and use of restrictive practices must be driven by the need to ensure that the rights of people with disability are upheld and with the aim of reducing and eliminating the use of restrictive practices. Improved alignment without investment in improving quality will not improve outcomes for people with disability who are subject to restrictive practices and represent one of the most vulnerable cohorts in our society. Any alignment must result in uplifting requirements for behaviour support plans and management of restrictive practices to the highest standards.

Overall, greater consistency across the care economy would benefit families, children and communities who often engage with multiple services. For Uniting, this would also help create a more joined-up experience across our service areas, while ensuring that workforce and governance expectations are clear, fair and consistent.

Further, streamlining regulations and minimising administrative burdens on providers will lift productivity by allowing providers to redirect resourcing and capacity to improve outcomes for care recipients. This includes reducing the administrative burden on frontline staff and enabling more contact hours, investing in innovative ways of delivering care and facilitating more relational ways of working.

Embed collaborative commissioning to increase the integration of care services

Uniting welcomes the draft recommendations put forward in the Interim Report to embed collaborative commissioning, with an initial focus on reducing fragmentation in health care to foster innovation, improve care outcomes and generate savings. In our response we have focused specifically on our experience as a mental health provider in engaging with collaborative commissioning strategic planning and delivery.

We caution that collaborative commissioning approaches must be implemented alongside more effective integration of existing services. There is an inherent risk that collaborative commissioning efforts add an additional layer to an already complex system and contribute to further siloing whereby commissioned projects introduced simply introduce additional (and overlapping) services. Before collaborative commissioning commences within individual regions, there must be a review of the existing services, needs and gaps within a community.

As an example, the current delivery of youth mental health services is fragmented, inefficient and results in duplication of services and poor care pathways for young people. The youth mental health initiative which was funded through the Bilateral Agreement on Mental Health was funded jointly by the federal and NSW Governments and was administered by NSW Health and Local Health Districts (LHDs). This investment represented an opportunity to extend existing programs with demonstrated success (such as headspace Early Psychosis and Youth Enhance Support Services) however, instead it has resulted in new programs which do not address the gap in service delivery, rather duplicated existing services. The care pathway and step-up, step-down progression for young people is poorly defined with conflicting responsibilities which prevent continuity of care.

Introducing further initiatives and supports funded through collaborative commissioning would not address the underlying lack of integration across services. This includes the need for both improved navigation supports and better understanding and agreement on the role of services, the progression of care and responsibilities of Australian, state and territory governments.

We also note that collaborative commissioning requires investment of time, resourcing and administrative capacity from service providers, above the current requirements for commissioning processes. The expectation that providers will engage in relationship building, joint planning and shared governance agreements is not matched by funding. This must therefore be supported by sector capacity building, ongoing assistance for providers engaging in collaborative commissioning processes and recognition of the additional work outside of direct service provision that collaborative commissioning requires.

We agree that it is critical to establish a **joint governance framework** however we believe that this must be accompanied by **mapping to understand the roles and responsibilities of stakeholders including Australian, state and territory, and local government**. In our experience as a provider, there is a lack of clarity regarding the service delivery and funding responsibilities of different levels of government and the purpose of specific services within the mental health ecosystem. Any efforts to implement a joint governance framework must also ensure that each party has a clear understanding of their role and responsibility within that framework.

The joint governance framework should be accompanied by clear guidance to reduce replication and duplication of funding streams. In our experience, funding is released by different levels of government within the same location and targeting the same cohort. This is a barrier for effective collaborative commissioning.

We agree that an **outcome framework** should be designed to support **joint monitoring and reporting**. The outcomes framework should support the reduction of fragmentation, having clear outcomes that assess and monitor integration work. There should be a range of measurements

within the outcomes framework which allow funders and providers to select which are most relevant to a specific collaborative commissioning outcome. For example, in the mental health space it may not be appropriate to measure preventable hospitalisation.

We urge the Productivity Commission to consider how the proposed outcome framework for collaborative commissioning could be linked to existing outcomes frameworks.

More generally, we believe that collaborative commissioning should be delivered through a single model with appropriate flexibility to be implemented according to the needs of individual regions and type of services commissioned. As a provider of services across a large range of local government areas and health districts, we are concerned that there is the potential for differing and conflicting collaborative commissioning models to be implemented across the service system. This would lead to more complexity for providers and fail to address the underlying problems. The collaborative commissioning model should be developed in partnership between Australian, state and territory governments and the community services sector.

We believe it is vital to listen to what ACCHOs express is necessary to support their effective functioning and where possible incorporate co-design approaches to ensure their lived experience and expertise informs design. From our understanding resulting from interactions with ACCOS, joint governance may not be an appropriate or wanted measure, particularly for smaller ACCHOs. Rather, they require support, such as resources and training, to undertake their operations and maintain their independence. We encourage ongoing co-design with the ACCO sector to inform this approach.

Collaborative commissioning approaches have the potential to facilitate more effective partnerships which meet the needs of communities and enable place-based service delivery. However, they must be underpinned by a single model with flexibility to be adapted to individual communities and a clear purpose. Without this, there is an inherent risk that additional (rather than more effective) services are introduced within systems which fails to address barriers to care and places a further administrative burden on providers.

A national framework to support government investment in prevention

Uniting welcomes the draft recommendations put forward in the Interim Report to establish a National Prevention Investment Framework. This proposal represents an exciting opportunity to redefine our collective understanding of prevention and adopt a more holistic approach which views investment in people and communities as an effective mechanism for improving long-term outcomes. We endorse the more expansive definition of prevention as outlined in the Interim Report.

We are pleased to see that the Productivity Commission has adopted a broader perspective on prevention which extends beyond early intervention and embraces the role of preventative programs in supporting adults. The model of primary, secondary and tertiary prevention strongly resonates with our experience as a provider of services across the care sector.

Investment in prevention is too often overlooked in favour of focusing on responding to immediate needs and priorities, due to prevention programs being long-term and potentially more difficult to quantify in both benefits and reduced cost to government. This is compounded by savings flowing to different agencies and levels of government. The care sector is facing a crisis of acute need across service systems including disability, aged care and mental health which requires an intensive and urgent response. While critical, a focus on acute care can result in a missed opportunity to consider how these acute needs can be prevented in the future.

We support the analysis provided by the Productivity Commission which demonstrates the cost-effectiveness of prevention in reducing long-term government expenditure, addressing the current

burden on acute services and benefiting the broader community. We echo the work of SEED who noted that:

> *The most effective and equitable returns come when investment is made early and in the systems that wrap around families, not just in individual interventions. Embedding prevention at the system level is essential to unlocking the full social and economic potential of early childhood investment, especially for families facing intersecting forms of disadvantage.*[2]

We refer to the Commission to recent work completed by the Front Project who estimated that Australia spends $15.2bn every year because children and young people experience serious issues that require crisis services. Additionally, they have found that Australia could have redirected $22.3 billion through more effective early intervention strategies to address need early and reduce the reliance on acute care services.[3]

We welcome the recommendation for a **Prevention Framework Advisory Board** which would adopt a leadership role in providing advice and establishing frameworks for analysis. We encourage the Commission to recommend that resourcing for evaluation is included as standard within funding for preventative programs. Without this, the responsibility for funding evaluation projects is placed on service providers which risks the effectiveness of the prevention activities by requiring redirection of resourcing.

We also support the proposed **funding mechanism** which would provide long term certainty and demonstrate a commitment from government to prevention activities. Too often prevention programs are subject to short term funding structures which inhibit the community relationship building required to succeed.

We would like to highlight that there will always be a need for acute services which support people with high care needs across sectors such as disability, mental health, aged care, and children and family services. While prevention activities can reduce the number of people requiring high intensity services, ongoing funding will still be required to ensure that people are able to access supports which are appropriate for their needs.

The Interim Report does not refer to **age related prevention activities** including reablement programs as a form of prevention. Reablement and wellness programs assist in supporting older people to maintain independence for longer and prevent otherwise avoidable deterioration in care needs. This can include wellness and reablement programs for physical health, mental health and social engagement.

In particular, wellness and reablement programs allow older people to remain at home longer and age in place within their community. Ageing in place prevents avoidable early entry into residential aged care which represents a significant saving to government. In 2023-24, the average cost per recipient of a home care package programme was $22,585 compared to $109,566 for the average annualised cost per occupied bed day.[4] This also has benefits for the health care system through avoidable entry into hospital systems and reduced overall care needs.

We encourage the Commission to recognise the importance of aged care related prevention which has considerable benefits for older people and all levels of government. As Australia's population

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[2] SEED Futures (Unpublished). *Establishing a National Primary Preventative Framework: Conditions and enablers for this 2025 imperative*.

[3] The Front Project (2025). *The Cost of Late Intervention in 2024*. Accessed at: C - COLI The Cost of Late Intervention in 2024-report-V4 2.pdf

[4] Productivity Commission (2025). *Report on Government Services 2025: Aged Care services*. Accessed at https://www.pc.gov.au/ongoing/report-on-government-services/2025/community-services/aged-care-services

continues to age, the cost benefits of wellness and reablement will continue to multiply. Prevention approaches should be adopted with a whole lifespan lens.

We would also like to emphasise the need to embed **mental health and wellbeing** into understanding of prevention. Recognising and responding to indicators of poor mental wellbeing at an early stage is critical for improving outcomes at an individual and systems level.

Models such as **social prescribing** demonstrate the potential for integrating mental health prevention activities within primary healthcare systems. Social prescribing is a tool which offers a systematic and holistic approach towards improving individual health and wellbeing, and unmet social needs that contribute to poor health. By connecting patients with community resources and support, social prescribing aims to improve overall health outcomes, reduce healthcare costs, and enhance quality of life for individuals. Despite having been identified as a priority within Australia's National Preventive Health Strategy, there has been a disappointing lack of progress in resourcing and support for social prescribing as a form of prevention.

Integrated psychosocial teams in primary care models also show demonstrate the significant benefits of primary prevention models embedded in existing service systems. These evidence-based models have been adapted from integrated approaches that have been successfully implemented internationally including New Zealand and the United Kingdom. The model includes a Behavioural Health Consultant, Health Coach/Social Prescribing Link Worker and Community Collaborative Practice approach.

Uniting has supported the implementation of integrated psychosocial teams in primary care through Australia's first pilot of Primary Care Behavioural Health (PCBH) in Hornsby GP Unit (HGPU). An evaluation of the pilot found that it was successful in increasing access to mental health supports, particularly among groups experiencing vulnerability including First Nations people, facilitating collaborative work within the service and improving outcomes among patients.

Finally, we encourage the Commission to view **place-based approaches** as a form of prevention which uplifts the capacity of communities and improves outcomes at both an individual and social level. These approaches adopt a strengths-base lens and is adaptive to the needs of specific communities, addressing their unique circumstances and gaps within services. This creates sustainable change beyond the individual level and reduces need for more intensive forms of services.

We refer the Commission to the Strengthening Communities Alliance Position Paper which provides recommendations for reducing barriers and effectively embedding place-based approaches.[5]

Preventative Frameworks

There are at least 11 preventative frameworks that currently exist Federally and in NSW. Appropriately, these are focused on specific areas such as health, domestic violence and family support.

One primary preventative framework we believe should be considered by governments is the SEED Future's National Primary Preventative Framework (NPPF).[6] The NPPF offers a compelling model for improving the efficiency and quality of care by investing in early, integrated support for children and families. Centred on the first 1000 days of a child's life and parent's journey, the NPPF argues that acting at the preventative end – before challenges compound – is not only more effective but also

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[5] Strengthening Communities Alliance (2023). *Strengthening Communities Position Paper*. Accessed at https://www.uniting.org/blog-newsroom/newsroom/news-releases/organisations-call-for-greater-focus-on-place-based-work-to-strengthen-communities

[6] SEED Futures (Unpublished). *Establishing a National Primary Preventative Framework: Conditions and enablers for this 2025 imperative*.

more economically sound. It outlines four key factors to achieving this vision: a holistic and integrated approach to early support; long-term funding and incentives to unlock cross-jurisdictional and cross-sector collaboration; delivery that allows funding to evolve with community need and emerging evidence of effectiveness; and leadership that aligns the vision of primary prevention with current national reforms, such as in ECEC.

To implement this vision, the NPPF identifies essential conditions including: a long-term societal vision that inspires hope; implementing place-based approaches; the restoration of trust for families with prior negative system experiences; Closing the Gap; and implementing incremental reform. It emphasises the importance of recognising lived experience and collaborative commissioning processes alongside long-term, outcomes-based funding for enabling an effective preventative framework.

We also endorse the Victorian Early Intervention Investment Framework, as referenced by the Commission within the Interim Report. This framework provides a cohesive and agreed strategy for prevention and recognises the importance of a long-term approach.

We encourage the Productivity Commission to consider integrating the key components of the NPPF into the proposed National Prevention Framework. A nationally adopted NPPF would position Australia as a global leader in social investment and wellbeing policy, while delivering more efficient, targeted care that meets the needs of communities before crisis occurs.

Conclusion

We commend the work of the Commission in considering innovative ways to reform and enhance the care economy to better improve outcomes for all Australians. We believe that productivity is a key mechanism for unlocking the potential of providers and the care workforce through more effective regulation, commissioning processes and investment in prevention.

The potential for prevention programs to create sustainable, systemic change at an individual and community level is significant and we strongly encourage the Commission to reflect this positioning within the final report.

We would welcome the opportunity to contribute further to this work. Our experience delivering services across the lifespan from early learning to aged care provides us with unique insights into the barriers, opportunities and benefits of the proposed reforms. Please do not hesitate to contact us for further information.