15 September

Submission to the to the Productivity Commission Interim Reports: *Delivering Quality Care More Efficiently* and *Building a Skilled and Adptable Workforce*

Executive Summary

Australia's health system performs strongly by international standards yet continues to underperform on **access** and aspects of the **care process**. At the same time, the **$22.3 billion annual cost of late intervention** for children and young people underscores the urgent need to rebalance investment toward prevention and early help. The Productivity Commission's draft recommendations on regulatory alignment, collaborative commissioning and a National Prevention Investment Framework provide the right structural levers, but their success depends on embedding equity, valuing the Aboriginal and Torres Strait Islander workforce, and ensuring culturally safe, multidisciplinary models of care.

1. Introduction

Indigenous Allied Health Australia (IAHA) welcomes the opportunity to contribute to the Productivity Commission's interim report *Delivering Quality Care More Efficiently* and its linkages with *Building a Skilled and Adptable Workforce*. IAHA represents the national voice for the Aboriginal and Torres Strait Islander allied health workforce and is deeply engaged in workforce, policy and service reform that enables culturally safe, holistic and sustainable care for Aboriginal and Torres Strait Islander peoples and communities, and for all Australians.

While Australia was ranked top in the Commonwealth Fund's *Mirror, Mirror 2024* international comparison of health systems, the report identified weaknesses in **access** (affordability and availability of services) and the **care process** (prevention, safety, coordination, patient engagement, and responsiveness to preferences). These domains align closely with the Commission's interim report priorities, reinforcing that efficiency gains depend on improving access, integration, and prevention, rather than cost-cutting alone.[1]

We particularly note the interim report's three draft recommendations:

- greater alignment of safety and quality regulation, with a focus initially in the areas of aged care, the NDIS and veterans' care.
- embed collaborative commissioning arrangements, including governance and funding, between Primary Health Networks, Local Hospital Networks and Aboriginal Community Controlled Health Organisations (ACCHOs).

[1] Blumenthal, D., Gumas, E.D., Shah, A., Gunja, M.Z., Williams II. R.D. 2024. Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System, Comparing Performance in 10 Nations. The Commonwealth Fund. USA .: https://www.commonwealthfund.org/publications/fund-reports/2024/sep/mirror-mirror-2024.

- development of a national framework to support government investment in prevention.

IAHA supports these directions the reforms:

- Recognise and strengthen the Aboriginal and Torres Strait Islander health workforce across all professions and roles.
- Embed the National Agreement on Closing the Gap Priority Reforms[2], especially formal partnerships and strengthening the community-controlled sector.
- Address systemic workforce inequities identified in the HumanAbility Workforce Plan 2025[3].

2. Workforce as the Foundation of Efficient, High-Quality Care rather than a cost burden

The HumanAbility Workforce Plan 2025 underscores that care and support industries employ over 3.2 million Australians – nearly one in five workers – with projected employment growth of 21% by 2034. Despite this, these workforces remain undervalued, feminised, and often precarious[4]. For the Aboriginal and Torres Strait Islander workforce, barriers include limited recognition of cultural knowledge, systemic racism, and inadequate training and career pathways.[5]

Efficiency in the care economy cannot be achieved by cost-cutting alone; it depends on building, sustaining, and valuing a skilled, diverse, and adaptable workforce that responds to the needs and preferences of the community.

The Australian Institute of Health and Welfare recognises that **social determinants**, including educational attainment, income, employment, housing, and working conditions, contribute **30–55%** of health outcomes[6]. Although the Australian Burden of Disease Study (ABDS 2024) focuses on modifiable risk factors, it acknowledges that **social determinants are increasingly being recognised** and, where possible, should be incorporated into estimates of preventable burden.[7] Integrating these determinants into burden estimates would strengthen the economic case for addressing upstream drivers of illness and reducing inequities

Educational attainment matters for employment: according to AIHW, in 2023 about **69% of Australians aged 25–64** held a non-school qualification at **Certificate III level or above**.[8] ABS data shows that **79% of people aged 15–74 with a non-school qualification** were employed compared to just **58% without**.[9] This sharp employment differential highlights the

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[2] Council of Australian Governments. (2020). National Health Reform Agreement 2020–2025 (extended to 2026). Canberra.

[3] HumanAbility. (2025). Workforce Plan 2025. Canberra.

[4] Fair Work Commission. (2022). Aged Care Work Value Case – [2022] FWCFB 200. Melbourne

[5] Department of Health. (2021). National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031. Canberra

[6] Australian Institute of Health and Welfare (AIHW). *Social determinants of health*. Canberra: AIHW, 2023. Retrieved from https://www.aihw.gov.au/reports/australias-health/social-determinants-of-health

7 Australian Institute of Health and Welfare (AIHW). *Burden of disease overview*. Canberra: AIHW, 2024. Retrieved from https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/burden-of-disease/overview

[8] AIHW. 2023. Op cit

[9]Australian Bureau of Statistics (ABS). *Education and Work, Australia*. Canberra: ABS, 2024. Retrieved from https://www.abs.gov.au/statistics/people/education/education-and-work-australia/latest-release

economically transformative impact that AQF-level qualifications (Certificate III and above) can have, especially for those currently under-qualified.[10]

IAHA recommends:

- Explicit prioritisation of allied health and multidisciplinary teams into proposed reforms.
- Recognition of cultural knowledges and capabilities as workforce skill, remunerated and embedded into competency frameworks, alongside continued investment in cultural safety in the non-Indigenous workforce.
- Systematic investment in workforce development, reducing siloes and competition for workforce, particularly in regional and remote Australia where maldistribution of services remains acute. This includes:
    - Expansion of "Earn While You Learn" and apprenticeship-style pathways in health and community services, particularly for Aboriginal and Torres Strait Islander students, and block intensive training models that reduce barriers for remote learners and embed flexible delivery.
    - Localised workforce pathways that enable Aboriginal and Torres Strait Islander people to train and work in their own communities, with supports aligned to social needs and life stages, such as the IAHA National Aboriginal and Torres Strait Islander Health Academy.
    - Clear articulation pathways and upskilling opportunities from vocational to tertiary education, as well as structural reforms to ensure effective utilisation of vocationally trained workforce, recognition of prior learning and lived experience to accelerate entry and progression through health careers.
    - Improved local and jurisdictional workforce data to support workforce planning, programs and evaluation, including better understandings of skills needs and targeting of incentives.
    - Supports for the allied health workforce and businesses, in recognition of both their value add to the productivity of Australia and our communities and the essential role they play in support the social, cultural and economic participation of the broader public.
    - The implementation of the *National Aboriginal and Torres Strait Islander Health. Workforce Strategic Framework and Implementation Plan. 2021–2031* and Aboriginal and Torres Strait Islander workforce specialist organisations – including IAHA – to support its success.

3. Alignment of Quality and Safety Regulation

IAHA supports Draft Recommendation 1.1 to align worker screening, registration, provider audits and reporting across aged care, disability and other care sectors. However, regulation must not exacerbate inequities. The HumanAbility Workforce Plan highlights the risk of unintended consequences for Aboriginal and Torres Strait Islander workers, such as difficulties accessing required identification or disproportionate exposure to punitive systems.

[10] Australian Bureau of Statistics (ABS). *Measuring What Matters – Education Attainment*. Canberra: ABS, 2023. Retrieved from https://www.abs.gov.au/statistics/measuring-what-matters/measuring-what-matters-themes-and-indicators/prosperous/education-attainment

International comparisons highlight that Australia lags on **administrative efficiency**, despite strong overall performance. Streamlining duplicative regulation through mutual recognition of worker screening, provider audits and accreditation will release workforce time for patient-centred care. Equity must also be embedded: regulatory alignment should include **equity indicators** to ensure Aboriginal and Torres Strait Islander workers are not inadvertently excluded or disadvantaged.[11]

IAHA Recommends:

- Co-design of regulatory frameworks with Aboriginal and Torres Strait Islander organisations.
- Provisions that recognise cultural authority and community governance in workforce accreditation.
- Safeguards to prevent regulatory processes reinforcing systemic racism or directly or indirectly excluding Aboriginal and Torres Strait Islander workers.

4. Embedding Collaborative Commissioning

IAHA strongly endorses Draft Recommendation 2.1 to embed collaborative commissioning across the health system. IAHA members consistently demonstrate that collaborative, place-based approaches led by Aboriginal Community Controlled Organisations (ACCOs) who deliver more efficient, culturally safe services. However, it remains essential that Aboriginal and Torres Strait Islander people can access services, including allied health, in the manner and setting they choose.

The *Cost of Late Intervention 2024*[12] report estimates that late intervention for children and young people costs **$22.3 billion annually**, with child protection alone accounting for **$10.2 billion (43%)**. These avoidable costs have grown faster than inflation and population, reflecting capacity constraints that make late responses more expensive. The Commission's proposed **National Prevention Investment Framework** should explicitly include a child and youth prevention stream, with pooled Commonwealth–State funding aligned to where the long-term fiscal benefits accrue.

IAHA **recommends:**

- Making ACCOs equal partners in governance, planning, and evaluation under collaborative commissioning frameworks, in line with Closing the Gap Priority Reforms.
- Cross sectoral investment in workforce leadership, the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031 and organisations such as IAHA. This is required to support development of allied health capability and capacity, including within ACCHOs, ensuring allied health workforce skills and perspectives are embedded.
- Providing dedicated, flexible funding to support allied health business viability, local partnerships and innovations that reduce preventable hospitalisations and address social determinants of health.

[11] Blumenthal et al. 2024. op cit.
[12] Early Intervention Foundation. (2024). The Cost of Late Intervention in Australia 2024. Canberra: Early Intervention Foundation and partners.

5. Investing in Prevention

IAHA supports Draft Recommendation 3.1 for a National Prevention Investment Framework, noting the limited progress to date under the *National Preventive Health Strategy 2021-2030*. The evidence is clear that prevention reduces long-term costs while improving wellbeing, and allied health is a leader in prevention, reablement and enhancing social and cultural participation. The HumanAbility Workforce Plan 2025 reinforces that prevention - oriented services - mental health, community services, sport and recreation – face major workforce shortages and undervaluation. Without parallel investment in these workforces, prevention efforts will not be scalable or sustainable.

Primary health care in its broadest sense must be taken seriously with investment if we are to reduce the ever-increasing costs and thus pressure on health budgets. “The splitting off of community-based care into different diagnostic areas – a centre for urgent conditions, a centre for mental health, a list of conditions that could get a prescription from a pharmacist (whether or not they need one) is by definition not primary care, as it removes the comprehensiveness. This is fragmented care.”[13] Thus IAHA supports the Commissions’ focus on prevention programs that can reduce demand for future acute care services.

IAHA recommends that prevention must be:

- Strengths-based and culturally centred, incorporating the cultural determinants of health for Aboriginal and Torres Strait Islander people, their families and the community.
- Grounded in Aboriginal and Torres Strait Islander-led design, delivery and evaluation, including patient reported measures.
- Linked to workforce reform, ensuring allied health assistants, community health workers, and other roles have clear training and scope of practice, to contribute to the system under appropriate delegation, as well as career pathways into health professions.
- Accompanied by political will and tri-partisan commitment to shifting from a biomedical system of ill-health toward a health promoting system, noting this is often undermined by media reporting on issues such as wait times and political interests.

6. Additional Considerations for Efficiency and Equity

In addition to the draft recommendations highlighted in the interim report, IAHA notes several cross-cutting considerations that will be critical to ensuring reforms deliver both efficiency and equity. These issues build on international benchmarking evidence and the economic case for prevention, and they speak directly to the structural levers that shape access, workforce sustainability, and long-term fiscal responsibility. Addressing these matters will strengthen the Productivity Commission’s final recommendations and ensure they deliver practical benefits for Aboriginal and Torres Strait Islander peoples and for all Australians.

6.1 Equity Metrics and Measurement

IAHA recommends that the Commission’s proposed national safety and quality reporting framework incorporate **equity indicators** across jurisdictions and programs. This would enable consistent tracking of access, affordability, and cultural safety outcomes for

[13] Dr Tim Senior is a GP working in an ACCHO and a member and contributing editor of Croakey 2025. Health Media https://www.croakey.org/taking-a-history-of-primary-healthcare/

Aboriginal and Torres Strait Islander peoples and other priority groups, alongside traditional measures of quality and safety.

6.2 Intergovernmental Fiscal Architecture

IAHA notes that states and territories bear most short-term costs of late intervention while the Commonwealth reaps long-term savings through reduced welfare and health expenditure. The proposed National Prevention Investment Framework should therefore include **co-funding formulas** that rebalance incentives and support sustained state–Commonwealth investment in prevention.

6.3 International Benchmarking Beyond Outcomes

IAHA recommends that Australia's performance benchmarking include equity, access, **and patient experience domains**, not only clinical outcomes. This approach aligns with international best practice and would ensure that system improvements benefit Aboriginal and Torres Strait Islander peoples and other populations facing systemic barriers to care.

6.4 Workforce Financing and Incentives

IAHA recommends that the Commission consider **funding models that reward prevention and multidisciplinary care**, such as bundled payments, flexible funding pools and commissioning arrangements that explicitly include allied health and community services. These models will enable more efficient and holistic care, particularly in regional and remote Australia where maldistribution of services remains acute.

6.5 Workforce Mobility and Migration

Australia relies heavily on migrant workers in health and care, but underemployment and de-skilling of migrant women remain widespread, and IAHA have a regional leadership role not to undermine capability within neighbouring health systems. IAHA urges reforms that balance international recruitment with investment in domestic Aboriginal and Torres Strait Islander workforce development, to avoid perpetuating inequities.

6.6 Housing, Transport and Regional Workforce Barriers

Workforce attraction and retention is directly affected by shortages of affordable housing and transport, particularly in rural and remote areas. IAHA recommends embedding essential worker housing into health and social infrastructure planning and further investing in equitable workforce initiatives; to improve access for the allied health workforce and to ensure local, Aboriginal and Torres Strait Islander people are not overlooked in workforce support.

6.7 Technological Change and AI

Technology can improve efficiency but risks widening the digital divide. For Aboriginal and Torres Strait Islander communities, digital health must be accompanied by investments in infrastructure, digital literacy, and culturally responsive service models. Per earlier comments, localised workforce and support roles, such as allied health assistants, provide significant scope to address these risks and improve quality, continuity and therapeutic outcomes. This also supports the retention of social and economic resources within communities, not the centralising of funding in regional and metro areas (as currently occurs with FIFO/DIDO models).

7. Conclusion

IAHA welcomes the Productivity Commission's interim report and urges the final recommendations to explicitly recognise Aboriginal and Torres Strait Islander workforce development, the importance of allied health, and the need for culturally safe workforce models and models of care as essential to delivering quality care more efficiently.

Efficiency cannot be separated from equity: productivity gains must flow from investing in people, communities, and culturally responsive systems, not from reducing care to a transactional service.

It also requires political will and leadership. IAHA stands ready to work with the Productivity Commission, governments and partners to implement reforms that will truly deliver high-quality, efficient, and culturally safe care for all Australians.

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