



Productivity Commission - Delivering quality care more efficiently Interim report

Submission

September 2025

About

The Australian Multicultural Health Collaborative (the Collaborative) is the national multicultural health peak body.

***Vision Statement:** In a truly multicultural Australia, our health and social care system is committed to health equity, and works proactively towards sustained improvement in the physical, mental and spiritual health and wellbeing of our multicultural communities.*

The Collaborative is an initiative of the Federation of Ethnic Communities' Councils of Australia (FECCA). We provide a national voice, leadership and advice on policy, research, data, and practice to improve access and equity, address systemic racism, and achieve better health and wellbeing outcomes for Australians from multicultural backgrounds.

The Collaborative is representative, and membership based. Members include consumers and carers; health services and wellbeing/social care services; practitioners; and researchers. The Collaborative also welcomes as affiliates other national health peak organisations.

Background: Multicultural Australians in the Health and Care Workforce

Multicultural Australians are significantly over-represented in several parts of the care economy.

Around 40% of the care and support workforce were born overseas, compared with about 32% of the total workforce nationally (Jobs and Skills Australia, 2023). Research in 2016 found that 37% of frontline care workers (aged care, disability support, personal carers) were overseas-born, with a growing proportion from non-English-speaking backgrounds (Charlesworth & Howe, 2018).

In residential aged care, the proportion is even higher: in 2021, more than half of direct care workers were born overseas, many from Southern and Central Asian backgrounds (AIHW, 2021). Migrant women are also strongly represented in home care and community support, where work is often casual or insecure (Charlesworth & Howe, 2018).

Internationally qualified health professionals are essential to the broader health system, with internationally qualified nurses and midwives making up about one in five nurses nationally (AHPRA, 2022). Recruitment has also accelerated with more than 16,600 overseas-trained nurses registered in 2022–23, nearly triple the pre-COVID intake (Department of Health and Aged Care, 2023). Similarly, overseas-trained doctors provide a critical share of medical services in rural and regional areas (NCEPH, 2024).

Despite this workforce reliance, migrant aged-care workers often occupy lower-quality jobs. Multicultural Australian workers are more likely than locally born workers to be in casual roles, under-employed in hours, or employed on less secure contracts (Isherwood et al., 2020). At the same time, overseas-born Australians are under-represented in leadership, governance, and policy roles in the care economy, meaning their lived experience and cultural knowledge are not adequately shaping reforms (UNSW, 2018).



Workforce and Economic Costs

Barriers preventing skilled migrants from working at their full capacity cost the Australian economy billions of dollars annually (Monash University, 2021). In the health and care workforce this underutilisation is particularly stark: many overseas-trained professionals are concentrated in low-paid, insecure roles despite possessing qualifications and experience that could address workforce shortages. Nowhere is this clearer than in aged care, where more than half the direct care workforce is overseas born (AIHW, 2021). Migrant women are heavily over-represented in home care and community support, where insecure hours and low pay are the norm (Charlesworth & Howe, 2018). Regulatory duplication and inconsistent recognition of skills not only undermine efficiency but represent a direct economic loss, limiting the potential of this workforce to meet growing demand.

Australia relies heavily on internationally trained health professionals, with one in three medical practitioners trained overseas and more than 40% in some critical specialities such as intensive care and emergency medicine (AIHW, 2023). Yet while overseas-trained clinicians fill essential roles across the system, many migrant workers in the aged care, disability and home care sectors remain concentrated in casualised, low-wage jobs. The Grattan Institute (2023) has documented how these workers are more likely to experience systematic underpayment and exploitation, including unpaid overtime, wages below award, and pressure to accept poor conditions due to visa insecurity. This not only harms individual workers and their families but suppresses fair wages across the sector, effectively shifting costs onto the migrant workforce that props up the system. In practice, the aged care sector - like much of the care economy - is subsidised by under-utilised skills and underpaid labour. Addressing these inequities through fairer pay, stronger safeguards, and streamlined regulation is essential if reforms are to deliver sustainable quality care.

Introduction

The Australian Multicultural Health Collaborative (the Collaborative) welcomes the opportunity to provide input to the Productivity Commission's interim report on Delivering Quality Care More Efficiently.

The Collaborative is the national peak body for multicultural health, established to ensure that the voices, needs and experiences of Australians from multicultural backgrounds are embedded in health and care reform. Australia is one of the most culturally diverse nations in the world: more than half of the population were either born overseas or have at least one parent born overseas, and over 5.6 million people speak a language other than English at home.

Despite this diversity, multicultural communities often face significant barriers to quality care - including language and literacy challenges, low cultural competence among providers, fragmented system navigation, affordability issues, and gaps in data collection. These barriers contribute to poorer health outcomes and inefficiencies across the care economy.

Australia's care economy - spanning health, aged care, disability and community services - is undergoing significant reform. The Commission's interim report recognises persistent inefficiencies caused by fragmented regulation, siloed commissioning, and under-investment in prevention. For multicultural Australians, these system weaknesses are magnified. Barriers such as language, health literacy, cultural competence, and affordability intersect with structural fragmentation, leaving many people without timely or appropriate care.

Multicultural Australians are over-represented in the care workforce, especially in aged care and home care, where more than half of direct care staff are overseas born (AIHW, 2021). Many are migrant women working casually or across multiple insecure jobs (Charlesworth & Howe, 2018; Isherwood et al., 2020). For these workers, overlapping regulations - such as separate checks and registrations for aged care, NDIS and home care - create unnecessary duplication, lost income and barriers to workforce entry. Weak safeguards compound the risk of underpayment and exploitation. Streamlining regulation, as the Commission proposes, is therefore not only about efficiency but about fairness and protection for a workforce that is disproportionately multicultural.

The outcomes of this inquiry are not only a matter of equity in service access, but also of fairness and sustainability in the workforce. Put simply, the effectiveness of the proposed reforms will be judged by whether they work for multicultural Australians - both as consumers and as providers of care.

The Commission's interim report is timely and important. The three areas identified for reform:

- Alignment of quality and safety regulation
- Collaborative commissioning, and
- Investment in prevention are directly relevant for multicultural Australians.

For these reforms to succeed, cultural responsiveness must be treated as a core component of quality, safety and efficiency. With this in mind, our Submission:



- Highlights the implications of the interim report's reform directions for multicultural communities.
- Shares illustrative community stories that reflect the kinds of challenges and positive solutions multicultural Australians encounter.
- Recommends practical steps to ensure reforms deliver equitable and culturally responsive outcomes.

The Collaborative thanks the Commission for the opportunity to provide this submission. Our overarching positions on each draft recommendation, along with a detailed table of sub-points supported by community stories for context, are outlined below.

1. Reform of Quality and Safety Regulation

We support Draft Recommendation 1.1 to align quality and safety regulation across care sectors. The current system is especially difficult for multicultural communities, who often interact with multiple parts of the care economy - aged care, disability, health and community services - while also navigating cultural and language barriers.

Community story – challenges

A newly arrived carer from Afghanistan supporting her elderly father must complete separate background checks for aged care respite and National Disability Insurance Scheme (NDIS) transport services. The overlapping paperwork is confusing, not available in Dari, and delays her ability to earn an income.

Community story – positive potential

With a unified worker clearance and single provider portal, this same carer could enter the workforce faster, receive clearer information in her preferred language, and focus on delivering culturally safe care. The family benefits, and the system gains a much-needed bilingual worker.

Key recommendations

1. Embedding multilingual and culturally accessible communication into the proposed national worker registration portal.
2. Ensuring consumer rights statements (e.g. in the new Aged Care Act) are translated and co-designed with multicultural users, so rights are meaningful across languages and cultures.

Draft Recommendation	Sub-point	Collaborative Position
1.1	National screening clearance for workers across aged care, NDIS, veterans' care, and ECEC	Support – must be multilingual, accessible, low-cost for migrant/refugee workers
1.1	Unified worker registration approach with mutual recognition	Support – simplify mobility, include recognition of overseas qualifications, translated guidance
1.1	Common suitability assessment for providers	Support – include cultural safety criteria
1.1	Mutual recognition of audits against quality standards	Support – ensure audits check interpreter access, cultural safety training, multicultural engagement
1.1	Single digital portal for providers to manage registration and audits	Support in principle – portal must be multilingual, mobile-friendly, with digital literacy support
1.1	Single modular set of practice and quality standards across aged care and NDIS	Support – cultural responsiveness must be core module
1.1	Cross-sectoral registration system for providers across aged care, NDIS, and veterans' care	Support – provide guidance/support for small multicultural-run services
1.1	Consistent regulation of AI across care sectors	Support – ensure accuracy, avoid bias against non-English users



1.1	Standardised quality and safety reporting framework and data repository	Strong support – must capture data by ethnicity, language, cultural background
1.1	Explore a single regulator across aged care, NDIS and veterans' care	Support in principle – regulator must include multicultural expertise, equity safeguards
1.1	Explore alignment of behaviour support and restrictive practices regulation	Support – safeguards must reflect cultural context and family roles

2. Collaborative Commissioning

We support Draft Recommendation 2.1 to embed collaborative commissioning, especially where Local Hospital Networks (LHNs), Primary Health Networks (PHNs), and Aboriginal Community Controlled Health Organisations (ACCHOs) are central. We urge the Commission to also explicitly include multicultural health services and community organisations as partners in this model.

Community story – challenges

A 62-year-old Vietnamese-speaking man with diabetes is discharged from hospital but receives follow-up information only in English. He misses community care appointments, ends up back in emergency, and loses confidence in the system.

Community story – positive potential

In a collaborative commissioning model, the LHN and PHN partner with a local multicultural health service. The man receives translated materials and support from a bilingual health navigator. He manages his condition at home, avoids hospital readmission, and reports feeling respected and safe.

Key recommendations

We recommend governance frameworks for collaborative commissioning:

1. Require formal inclusion of multicultural health organisations in joint planning committees.
2. Resource culturally responsive service design, including interpreters, bilingual staff, and health literacy initiatives.

Draft Recommendation	Sub-point	Collaborative Position
2.1	LHNs and PHNs should plan together (needs assessments, agreed plans, joint monitoring)	Support – assessments must include multicultural data and community input
2.1	LHNs and PHNs must work in partnership with ACCHOs and other organisations	Support – add multicultural health organisations explicitly
2.1	Formal joint collaborative commissioning committees and data-sharing arrangements	Support – guarantee multicultural consumer and organisation representation
2.1	Remove barriers to pooling/joint commissioning of funding	Support – allow multicultural-specific programs (e.g. navigators, translated materials)
2.1	Provide flexible funding for PHNs and LHNs	Support – must include ability to fund smaller multicultural organisations
2.1	Sufficiently resource LHNs, PHNs, and ACCHOs for governance	Support – extend resources to multicultural organisations to enable genuine participation



3. National Prevention Investment Framework

We support Draft Recommendation 3.1 to establish a National Prevention Investment Framework. Prevention has particular benefits for multicultural communities, who face higher risks of some chronic diseases, lower screening participation, and additional barriers to care.

Community story – challenges

A young Sudanese-Australian mother misses out on antenatal classes because they are not culturally adapted. She enters the hospital system late, increasing risks for herself and her baby.

Community story – positive potential

A prevention program co-designed with Sudanese community leaders provides culturally tailored antenatal support. The mother engages early, feels culturally safe, and delivers a healthy baby. The program reduces long-term hospital and neonatal costs.

Key Recommendations

We recommend:

- The proposed Prevention Framework Advisory Board includes representation from multicultural health experts and consumer voices.
- The actuarial model used to assess prevention programs incorporate equity and cultural responsiveness as part of its cost-benefit analysis.
- Prevention investments prioritise communities where culturally adapted programs can significantly increase participation and outcomes.

Draft Recommendation	Sub-point	Collaborative Position
3.1	Independent Prevention Framework Advisory Board	Support – must include multicultural expertise and consumer voices
3.1	Standardised actuarial model for prevention programs	Support with conditions – model must include equity and cultural responsiveness
3.1	Evaluate prevention programs and recommend continuation/termination	Support – evaluations must use culturally competent methods
3.1	Funding mechanism for prevention initiatives	Support – must be accessible to smaller multicultural organisations
3.1	Intergovernmental agreement outlining prevention funding arrangements	Support – agreement should commit to multicultural equity and mandate reporting by ethnicity/language

Conclusion

The Productivity Commission's interim report offers a critical opportunity to reshape the care economy so that it works for everyone who relies on it and everyone who delivers it. For multicultural Australians, the test of these reforms will be whether they remove duplication, embed cultural safety, and ensure equitable access to prevention and care.

We urge the Commission to move beyond seeing cultural responsiveness as an optional add-on and instead to treat it as central to efficiency, quality, and fairness. Embedding multicultural perspectives into regulation, governance, and prevention frameworks will not only improve outcomes for diverse communities but will also strengthen the resilience of the workforce on which the care economy depends.

The Collaborative stands ready to contribute our expertise, networks and lived experience to support the Commission's final recommendations and their implementation. Together, we can build a system where high-quality care is not just universal in principle, but universal in practice.



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