Submission to the Productivity Commission Interim Report

Delivering Quality Care More Efficiently

From Community Mental Health Australia (CMHA)

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Executive Summary

Community Mental Health Australia (CMHA) welcomes the opportunity to respond to the Productivity Commission's Interim Report *Delivering Quality Care More Efficiently*.

CMHA represents five State and Territory Community Mental Health peak bodies, and through its member organisations, speaks for more than 700 non-government, community-based mental health organisations across the country, delivering services to tens of thousands of people living with mental illness, their families, and carers. Our sector provides critical, recovery-oriented supports that complement clinical care and extend beyond the scope of the NDIS.

This submission emphasises:

1. The existence and value of the community-managed mental health sector.

2. The need to recognise services outside the NDIS.

3. Alignment with the Interim Report's reform agenda.

4. Economic and social benefits.

By explicitly recognising and resourcing the non-government community mental health sector, governments can reduce preventable hospitalisations, ease pressures on acute systems, and promote recovery, inclusion, and participation in community life.

Introduction

The Productivity Commission's Interim Report rightly identifies the care economy as central to Australia's future productivity, wellbeing, and fiscal sustainability. It highlights three core reforms: alignment of safety and quality regulation across care sectors; embedding collaborative commissioning; and establishing a prevention investment framework.

CMHA strongly supports these directions. However, the Interim Report primarily emphasises aged care, disability (via the NDIS), and veterans' services. The absence of

explicit reference to the broader non-government, community-managed mental health sector risks perpetuating fragmentation and overlooking a critical contributor.

The care economy must be seen as an interconnected system, not a set of silos. Community mental health plays a bridging role between health, housing, disability, employment, and social supports. If this role is not recognised, Australia risks continued inefficiencies, avoidable crises, and poorer outcomes for people with psychosocial disability. This submission therefore seeks to articulate clearly the scope, value, and contribution of the sector, while responding to the Commission's recommendations in detail.

The Community Mental Health Sector: Scope and Role

CMHA represents five State and Territory Community Mental Health peak bodies, and through its member organisations, speaks for more than 700 non-government, community-based mental health organisations nationwide. These organisations are non-government, not-for-profit entities, embedded in their local communities, and delivering services ranging from psychosocial support and peer work to housing assistance, employment programs, and recovery-focused rehabilitation.

These services range in size from small locally-based organisations to large, national organisations with hundreds of employees delivering supports for tens of thousands of Australians.

The Australian Government's national network of Medicare Mental Health Centres depends on the non-government community mental health sector, who were successful in tendering to operate centres across the country.

Key characteristics of the non-government community mental health sector include:

- Non-clinical, recovery-oriented services that complement clinical care but focus on social determinants.
- Accessible both inside and outside the NDIS.
- Peer and lived experience leadership, embedding authentic consumer perspectives.
- Culturally safe, with many organisations led by Aboriginal, CALD, and LGBTIQA+ communities.

The sector supports hundreds of thousands of people each year who would otherwise fall through gaps in health or disability systems. For example, someone experiencing severe depression may not meet NDIS eligibility but still requires support to maintain housing, manage daily activities, and stay connected to their community. Community mental health organisations provide these supports, preventing escalation into crisis care.

The Productivity Commission's report did not account for the role the non-government sector plays in the broader care economy, or the way that regulatory frameworks create specific challenges for the non-government sector. We would welcome further discussion with the Productivity Commission about the role of our sector and how the identified regulatory challenges affect our members.

Size of the care sector in the economy

The Productivity Commission's analysis of the size of the care sector and the number of people accessing formal care services is an underestimate because it does not appear to account for the non-government community mental health sector.

The analysis in the use of "formal care services" does not appear to include supports that are provided in formal, structured ways but not paid for by Medicare or the NDIS, such as those provided by the non-government community mental health sector which are funded through separate funding streams. We appreciate the difficulty in quantifying access to these services given the large and disparate nature of the non-government community mental health sector, but draw the Commission's attention to this sector and the role it plays in complementing other care services.

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

CMHA welcomes the commitment to regulatory cohesion, noting that organisations in the non-government community mental health sector often provide services captured by the NDIS and veterans' care as well as services funded through other models, such as funding from State and Territory Governments for other programs.

The non-government community mental health sector has had an uncomfortable relationship with the NDIS across the life of the program, with spending shifting to individualised care packages rather than funding for an organisation. The shift in funding and regulatory models has meant that services typically provided by the non-government community mental health sector are now underfunded or unfunded, leading to a significant proportion of people with 'unmet needs' as identified by the Commission's inquiry into the Mental Health Agreement.

The regulation therefore of the NDIS has never quite fit within the model of the non-government community mental health sector and we would welcome an analysis of whether the regulatory requirements for the NDIS could be aligned with State and Territory Government regulatory requirements for funded organisations, to reduce regulatory burden for organisations seeking funding through tenders, grants, and similar opportunities.

CMHA agrees that high administrative costs are a barrier to providing services. We would recommend that the alignment of regulation extend to the State- and Territory-funded community services with the NDIS.

Costs, benefits and risks of a single quality and safety regulator

The risks of a single quality and safety regulator across aged care, NDIS, and veterans' care services is that the model and benefits proposed include:

- A focus on the provision of services by private, for-profit, providers with clear funding streams from the NDIS, aged care, and/or veterans' care service, at the expense of community organisations funded through a complex combination of funding sources (Australian Government, State and Territory Government, local government, and private)

- A regulatory system that is not responsive or well-adapted to the needs of participants, with a focus on what is easiest to regulate rather than what is needed for those that use the service

Effective implementation

The effective implementation of a regulatory framework will rely on the regulatory systems integrating with State and Territory regulation, particularly for elements of the care sector that receive funding from multiple sources and must acquit, report on, and account for spending to multiple agencies across multiple States and Territories as well as the Australian Government.

Collaborative commissioning

We welcome the Productivity Commission's decision to cross-reference this inquiry with the *Mental Health and Suicide Prevention Agreement Review*, particularly in relation to commissioning models.

While a shift toward collaborative commissioning is commendable, and would in principle reduce inefficiencies caused by gaps and duplications, we note that the Mental Health and Suicide Prevention Agreement contained commitments to introduce commissioning. The Commission's own review found that these were not effectively implemented.

Despite commitments made over several years to use commissioning as a tool to reduce fragmentation, the mental health sector continues to experience significant gaps and duplication. The mental health sector has also not sufficiently resolved the challenge of timely implementation of commissioning models with meaningful consumer involvement through co-design. Implementing a similar model across the broader care economy risks entrenching these difficulties.

Although commissioning may appear to be the optimal mechanism for ensuring efficient service delivery, reducing overlap, and addressing unmet demand, the experience in

mental health demonstrates that commissioning is poorly understood and often executed ineffectively.

The non-government community mental health sector plays a critical role in the care economy and must be systematically engaged in commissioning. It is also a valuable source of intelligence on unmet needs, which are not always visible within clinical data or broader health system reporting. However, as non-clinical providers, community mental health organisations have historically struggled to find their place in the LHN/PHN framework, given they are not strictly "primary" health providers.

We acknowledge that the Productivity Commission has consistently promoted commissioning as a pathway to efficiency in health service delivery. We urge, however, that the Commission also weigh its own findings regarding the persistent implementation challenges associated with commissioning frameworks.

National framework to support government investment in prevention

The non-government community mental health sector operates across the full continuum of care, from prevention and early intervention to acute support. The sector has long advocated for the need to address the social determinants of health, such as stable housing, secure employment, and access to education in order to protect mental health and reducing downstream demand for higher-cost services.

The transition from block funding to individualised NDIS care packages has fundamentally reshaped service provision. While this shift has benefited some, it has also created substantial gaps. Individuals with psychosocial disability who are not eligible for the NDIS are frequently left without adequate support. CMHA has consistently observed that unmet need has grown markedly since this transition.

The *National Analysis of Unmet Need for Psychosocial Supports outside of the NDIS* prepared by Health Policy Analysis in partnership with The University of Queensland and the Australian Institute of Health and Welfare documents the severe consequences of failing to fund Foundational Supports. The findings underscore that targeted, systemic investment outside the NDIS is essential to avoid worsening cycles of exclusion and ill health.[1]

Access to housing supports including priority social and affordable housing options is a crucial part of any foundational supports ecosystem. Homelessness is both a cause and a consequence of psychosocial disability, and without explicit housing-related investment, broader reform in health, including mental health, will fall short.

[1] https://www.health.gov.au/sites/default/files/2024-08/analysis-of-unmet-need-for-psychosocial-supports-outside-of-the-national-disability-insurance-scheme-final-report.pdf

The Productivity Commission's 2020 *Mental Health Inquiry* provided a comprehensive blueprint. Its core recommendations remain pressing: additional, recurrent funding streams outside the NDIS are required to meet the needs of Australians with psychosocial disability and those experiencing mental ill-health who fall outside scheme eligibility.

The non-government community mental health sector has a unique preventative role. Our workforce, especially our peer workforce, provides trusted, community-based supports that government services cannot always replicate. The legitimacy and engagement achieved through lived experience are critical: people with complex needs often will not seek help from government providers, even when those services are well-designed and well-resourced.

If national funding arrangements are to be effective, they must explicitly recognise and resource the non-government community mental health sector as a core partner in prevention, early intervention, and recovery. Without this, Australia will continue to see escalating unmet demand, inefficiencies in service delivery, and poorer outcomes across the care economy.

Investment in the non-government community mental health sector

One of the greatest barriers to improved efficiency in the non-government community mental health sector is the rigid conditions attached to government funding. Current funding models typically require resources to be directed almost exclusively to frontline service delivery, with little or no capacity to invest in the organisational infrastructure that underpins quality, sustainability, and efficiency.

This constraint prevents providers from allocating resources to essential back-office functions, including workforce development, management systems, and data and digital, all of which are prerequisites for delivering services more effectively at scale. By underfunding these foundations, governments inadvertently perpetuate inefficiency, as providers are left without the tools, systems, and skills to innovate, adapt, and coordinate care.

Strategic investment in skills, training, and technology across the non-government mental health sector would deliver significant returns in efficiency. A workforce equipped with advanced skills, supported by modern digital systems, and enabled by strong organisational governance is far better positioned to provide high-quality, timely, and cost-effective care.

The lesson from other parts of the care economy is clear: efficiency gains are realised not simply through tightening service delivery budgets, but through enabling organisations to build the capability to deliver services well. For the non-government community mental health sector, this means government funding models must shift to

recognise that organisational capacity and infrastructure are not administrative “overheads” to be minimised, but critical enablers of efficient service delivery.

Without this shift, the sector will remain locked into a cycle of short-termism and inefficiency, where providers are expected to deliver more with less, without the necessary investment in capability that would allow them to do so.

Conclusion

Unless the community-managed mental health sector is explicitly recognised, reforms risk entrenching the current challenges faced in the broader care economy. By valuing and resourcing this sector, governments can build inclusive communities, reduce preventable crises, and realise billions in productivity and wellbeing gains.

The Productivity Commission’s Final Report must therefore embed the non-government community mental health sector as a core partner in regulatory, commissioning, and prevention reforms.