Purple Orange

Submission to the Productivity Commission about Delivering Quality Care More Efficiently Interim Report

15 September 2025

About the Submitter

JFA Purple Orange is an independent, social-profit organisation that undertakes systemic policy analysis and advocacy across a range of issues affecting people with disability and their families.

Our work is characterised by co-design and co-production and includes hosting a number of user-led initiatives.

Much of our work involves connecting people living with disability to good information and to each other. We also work extensively in multi-stakeholder consultation and collaboration, especially around policy and practice that helps ensure people with disability are welcomed as valued members of the mainstream community.

Our work is informed by a model called *Citizenhood*.

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Recommendation 8: **The Productivity Commission should amend the interim report to ensure that the new system for quality and safety in healthcare is person-directed, rights-based, and culturally safe and responsive, particularly for First Nations and culturally diverse people with disability.**

Recommendation 9: **The Productivity Commission should amend the interim report to explicitly address the needs of people with disability through improved data collection and monitoring.**

2. Introduction

We welcome the opportunity to comment on the Productivity Commission's (the Commission') interim report *Delivering Quality Care More Efficiently* which the Commission published in August 2025. As a South Australian disability advocacy organisation dedicated to advancing choice and inclusion for people with disability, we strongly support efforts to improve the efficiency and effectiveness of healthcare regulation and preventative care. We are encouraged by the interim report's focus on streamlined quality and safety regulation, collaborative care, and preventative health investment. Governments must implement these reforms in a way that upholds the social model of disability, preserves disability-specific safeguards, and advances inclusive, person-directed, and culturally safe support models.

In summary, our submission:

- recommends the Productivity Commission consider our Model of Citizenhood and co-design as integral principles to integrate in any reform.
- supports greater efficiency through a unified quality and safety regulator, provided it retains a social model of disability focus and does not erode disability-specific protections;
- endorses the emphasis on preventative care and urge specific measures to address the severe health disparities experienced by people with disability, particularly people with intellectual disability, who face higher risks of adverse health outcomes and low screening and detection rates;
- highlights examples of health conditions with higher prevalence or poorer outcomes among people with disability such as cancer, cardiovascular disease, oral health, and mental health which warrant targeted attention in any new framework; and
- reinforces the recommendations of the Disability Royal Commission and past JFA Purple Orange advocacy that reforms be co-designed with people with disability and should embed inclusive, person-centred approaches including culturally safe models for First Nations and diverse communities.

3. Model of Citizenhood

Our organisations Model of Citizenhood is a useful lens for the Commission to consider in the design of a new system of care regulation. The Model of Citizenhood Support[1] sets out a framework for how people can be supported to build their chances of a good life and maximise their *Citizenhood*. A good life largely depends on the availability of life chances – the assets and opportunities available to a person. Based on this Model, the purpose of care should be to build the life chances of people with disability, so they are enabled to take up, or remain in, valued roles in mainstream community life that are contributory, meaningful, and fulfilling. The Model asserts our life chances comprise four different, interrelated, types of assets we can call upon, termed the Four Capitals. We believe these provide a sound framework to underpin the unified regulatory system, as well as outcome measures to ensure accountability for impact and a genuine return on investment. Below, we give a brief summary of each of the Four Capitals.

3.1. Personal Capital

The first of the Four Capitals refers to the person's belief in their own value, their gifts, their capacity to grow, to take up valued roles, to see hope in their future, to have jurisdiction over their own decisions, and take purposeful actions. It is Personal Capital that gives you the belief to apply for a job, to ask someone out on a date, to create a sense of home, to take care of your health, and to take a chance on the things that are important to you.

We argue this should be a central outcome for the unified regulatory model. Given the tyranny of low expectations that have dogged the disability community for generations, disability care should enable people with disability to reclaim their right to a fair go at what life has to offer, imagine their valued place in mainstream community life, and see themselves for their strengths and gifts and not for their deficits. This can be measured easily using a few variables that capture how people see themselves and how it changes over time.

[1] The Model Of Citizenhood Support :: Purple Orange.

3.2. Knowledge Capital

The second of the Four Capitals refers to a person's knowledge and skills. It contemplates how a person is supported to make the best use of the skills and knowledge they have, and how they are supported to grow new skills and knowledge. Governments usually intend for disability care to include a 'capacity-building' element. Often capacity-building has a therapeutic character (to be clear, we are not referring to genuine therapy supports here, but other types of supports that can take on a therapeutic character). These can be very important investments, but only if we contemplate how the benefit might be understood. Therefore, we argue investment in such endeavours can best be measured by the extent to which it grows authentic Knowledge Capital that moves people closer to the take up of valued roles. Otherwise, capacity-building supports are at risk of becoming too focused on trying to fix a person's disability instead of trying to address the consequences of disability. Outcome measures based on Knowledge Capital in support of Citizenhood can provide clarity on this.

Meanwhile, it is not unusual for people with disability receiving service provision to lose skills and knowledge. For all of us, the retention of our skills and knowledge is supported by us *using* our skills and knowledge. Unfortunately, it is not unusual in disability services for the service staff to do things *for* the person rather than *with* the person. This is often because it is quicker and more convenient. So, again hopefully with the best of intentions, the service provider inadvertently erodes what the person knows and can do by not giving the time and attention to supporting the person to be centrally involved in those things.

Translating this into outcome measures, Governments might contemplate how to measure the extent the unified regulatory model is facilitating the growth in, and defence of, participant knowledge and skills that can maintain and enhance their knowledge and skills and support them in the take up of valued roles.

3.3. Material Capital

The third of the Four Capitals refers to the tangible things in a person's life. It includes the things a person has, owns, or is in control of, and also the public things the person can access, like public transport, shopping malls, beaches, community clubs, employment, education, and so on.

There are two important things Governments might measure to assess success in building Material Capital. The first is the extent to which the unified regulatory model can defend and advance people with disability's *personal* Material Capital. For example, does a support provider assist the person to move away from poverty (the relative absence of *personal* Material Capital) into waged employment where the person has disposable income on the same basis as most non-disabled Australians?

The second is the extent to which the care system assists a person to use mainstream community resources – *public* Material Capital – on the same basis as most non-disabled Australians. This should not be as a 'community tourist' and not in aloneness. Often service providers take people into the community but do not support genuine participation or interaction. A person might be taken to a café and sit in the corner while a support worker transacts the order and is the only one to speak to staff or other customers present. As such, the person can be said to be *in* the community but is not a genuine *part* of community life. These are all elements that can be measured as care system outcomes, with the goal of increasing social and economic participation.

3.4. Social Capital

The fourth of the Four Capitals refers to the people in our lives. As humans we are interdependent, we give and we take, we live in community where we take up roles that bring value to others, and in turn we gain value from the roles others take up. But Social Capital is not just a marketplace of mutual utility. Social Capital is about the relationships that have importance in our lives. In the many workshops JFA Purple Orange has run over the years exploring the nature of a good life, themes like *family* and *friends* always feature prominently. This taps into the importance of what it means to *belong*, and this sense of belonging is at the heart of social participation.

Governments should design a unified regulatory model that both assists people with disability to retain connection with the people in their lives who are important to them, and to enable them to make new social connections, particularly if the person with disability has low Social Capital. This is important because many people with disability will likely have levels of Social Capital where the only people in their lives, other than core family, might be other people

with disability. It is a cliché of otherness to assume that the only friends a disabled person can have are other disabled people.

Outside of the family each of us was born into or raised in, the most meaningful relationships in our lives – partners, best friends, close friends, sincere acquaintanceships – begin with meeting each of these people for the first time. If that first encounter does not happen, nothing else can follow. This can be a key outcome measure for the unified regulatory model; the extent to which they assist people with disability into new connections and relationships, thereby growing their Social Capital.

To explore the Four Capitals in greater detail, please access the full Model of Citizenhood Support paper here.

3.5. Embedding Citizenhood in the care system

We strongly believe governments can initiate a fresh approach in designing the unified regulatory model underpinned by the Citizenhood framework with outcomes measurement based on quantifying the extent to which they are advancing the Four Capitals and lifting people with disability into valued roles in community and economic life. A set of example measures are set out in Section 10 of the 2013 edition of the Model of Citizenhood Support available here.

There are standardised outcome measurement tools that governments could use to evaluate the success of the unified regulatory model, but these are generally not focused on the goal of building life chances. We believe the design of the unified regulatory model should involve the development of bespoke and reliable outcome measures directly linked to the achievement of the purpose of the unified regulatory model, and that such measures should be anchored on the take up, and defence of, valued roles in mainstream community life.

Recommendation 1: The Productivity Commission should recommend the Australian Government use the Model of Citizenhood Support to inform the design of a coherent and comprehensive unified regulatory model and measure its impact based on assessing how supports build the Four Capitals to enhance the life chances of people receiving care.

4. Co-Design

The broad parameters to support the design of a unified regulatory model needs to be developed through a genuine co-design process. Co-design aligns with Australia's obligations under Article 4 (3) of the United Nations Convention of Rights of Persons with Disabilities (UNCRPD). The drafting of legislation and legislative instruments should then follow. We continue to be concerned many of the processes that governments are currently referring to as co-design fall well short of best practice and do not include active involvement of people with disability in decision making. Governments may find our Guide to Co-Design with People Living with Disability, which was itself co-designed, helpful in considering the essential steps required in undertaking genuine co-design processes. It is available via our website.

The process of designing a unified regulatory model must itself be inclusive and co-designed with the disability community. We note the Commission will be receiving diverse input on this recommendation. Building consensus will require genuine collaboration with stakeholders. In our advice to the NDIS Review taskforce, we highlighted the critical importance of implementing genuine co-design processes and recommended publicly testing options with participants, providers, and other stakeholders before finalising any new model. We urge a similar approach here. The voices of people with disability, those most affected by quality and safety failures, should be central when shaping the future regulator. This will ensure the new system earns the trust of the community it serves.

Recommendation 2: The Productivity Commission should recommend the Federal Government adopt genuine co-design processes including diverse representation from across Australia's disability communities to develop the unified regulatory model. All co-design processes should be supported by a thorough process design methodology to ensure successful implementation. People with disability should be central to these processes and hold leadership and decision-making roles throughout the development and implementation of a unified regulatory model.

5. Toward a Single Care Regulator: Efficiency and Disability Safeguards

The interim report identifies that the current fragmentation of regulators across aged care, disability (NDIS), veterans' care, and other sectors leads to duplication, gaps, and inefficiencies. A more cohesive regulatory system could improve efficiency and consistency. As the report notes, many providers operate across multiple care sectors and must navigate separate accreditation standards, audits, and worker clearances. We have heard these challenges directly from providers in other contexts, such as where there are overlapping state and federal restrictive practices regulations. We agree that a single regulator or a harmonised regulatory framework could reduce this red tape, freeing providers to focus more on frontline care rather than compliance bureaucracy.

JFA Purple Orange supports in principle the Commission's draft proposal for the Australian Government to create unified practice standards, a single provider registration/audit system, and to explore the suitability of a single quality and safety regulator across aged care, disability and veterans' care. We note the goal of these reforms is to *"reduce unnecessary complexity in regulation across sectors while upholding or improving outcomes"* for care users[2]. Under no circumstances should "efficiency" measures dilute the quality, safeguards or person-centred focus of disability services. Any integrated regulator model must retain the specialist expertise, standards and protections needed for disability support. This includes preserving critical disability-specific safeguards such as robust oversight of behaviour support plans and restrictive practices, mandated person-centred practice standards, and enforcement of rights-based principles like choice and control as enshrined in the NDIS Act and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

The Social Model of Disability and human rights-based approach must remain central. Disability supports differ from other care sectors in that there is a greater acknowledgement of the social model, addressing social barriers and enabling full participation, rather than a medical model. We caution that a generic regulator must not revert to a clinical or deficit-

[2] Ibid.

based lens. As we have emphasised previously, effective safeguarding should ensure not only that “bad things do not happen” to people with disability but also that “good things do”; that people live good, active and meaningful lives in community with dignity. It is possible for well-intentioned regulators to become overzealous about preventing harm to the point that they impose paternalistic restrictions, undermining personal autonomy and life quality. The quality and nature of a person’s life must be at the forefront of effective safeguarding and when we worry too much about what could go wrong, we risk removing what is most valuable from people’s lives**.** We urge for any single regulator to be firmly grounded in disability rights, independent living principles, and that it is co-design with people with disability.

In practice, retaining a social model focus could mean ensuring the unified regulator has:

- Strong representation of people with disability in its governance and decision-making processes, such as disability advisory councils or lived experience co-design panels.

- Units trained in disability inclusion, with specialised expertise and understanding of the disability community, can be embedded within the regulator to advise on disability-specific issues, similar to how the NDIS Quality and Safeguards Commission currently focuses on disability service contexts.

- No reduction in existing safeguards unique to disability services. For example, maintaining requirements around positive behaviour support and consent for restrictive practices, even as government explores alignment with aged care. Alignment should raise standards across the entire care sector, not level them down to the lowest common denominator. If anything, aged care, and other sectors should move closer to the more developed safeguarding regime of the NDIS, as recommended by the Royal Commission into Aged Care Quality and Safety, rather than disability services losing protections.

- Commitment to person-centred, outcomes-focused regulation. The regulator’s mandate should explicitly include promoting service quality that leads to social and economic participation outcomes for people with disability, consistent with the NDIS

goals of choice and inclusion. Compliance monitoring should look beyond paperwork to whether services are improving people's lives.

- Community and "natural" safeguards alongside formal regulation**.** Regulators should demand that service providers play their part in assisting the emergence of natural safeguards, such as by helping people with disability build personal relationships and community connections that keep them safe. A new system should not rely solely on top-down rules but also encourage innovation in peer support, family involvement, and community education to prevent abuse and neglect.

Even if all this is implemented, the integration of regulators would not be a panacea; it needs to be accompanied by broader systemic reform. Fragmented oversight is one issue, but many causes of failure in disability safety lie in deeper systemic causes, such as societal discrimination, segregation, and inadequate resourcing of services. Strengthening the regulator alone is not enough; a whole-of-government response is needed to tackle violence, abuse and neglect of people with disability at its roots.

Recommendation 3: The Productivity Commission should amend the interim report to recommend that any unified quality and safety regulators should retain a social model of disability focus and does not erode disability-specific protections.

Recommendation 4: The Productivity Commission should amend the interim report to ensure that any integrated regulator model retains the specialist expertise, standards, and protections needed for disability support, including preserving critical disability-specific safeguards.

6. Preventative Care and Early Intervention for People with Disability

We welcome the Interim Report's focus on bolstering preventative health care and its call to establish a National Prevention Investment Framework to drive coordinated, long-term action. We support this push to "invest now to save later" in health care. Prevention and early intervention are particularly critical for Australians with disability, who experience

significantly poorer health outcomes on average than the general population. It is well documented that people with disability face higher rates of chronic illness, lower rates of health screening, and more risk factors such as physical inactivity yet they often receive less preventative care and health promotion attention[3]. For preventative health initiatives to succeed, government must deliberately include and tailor these towards people with disability, especially those at greatest risk.

The experiences of people with intellectual disability illustrate the urgent need for inclusive prevention. This group experiences some of the starkest health inequalities in Australia due to a combination of biological, social and healthcare system factors. Research presented to the Disability Royal Commission revealed that:

> "Adults with intellectual disability in NSW have an average life expectancy 27 years shorter than the general population. In the 20–45 age bracket, the death rate for people with intellectual disability was found to be four times higher than for their non-disabled peers[4]."

Around 38% of deaths of people with intellectual disability were from potentially avoidable causes, more than double the proportion of avoidable deaths in the general population[5]. Approximately 400 adults with intellectual disability die every year from causes that timely and effective healthcare might have prevented.[6] People with intellectual disability are also eight times more likely to die from a condition such as cancer over a ten-year period compared to the general population[7]. Research has linked this shocking disparity in part to lower rates of early detection and treatment. Health care providers diagnose cancers in

[3] VicHealth, *Disability and health inequalities in Australia* (Research Summary, 2012).
[4] Amanda Lyons, 'Why do people with intellectual disability have lower life expectancy?' (RACGP *newsGP*, online, 2 December 2019).
[5] Matt Woodley, 'Disability royal commission told of hundreds of preventable deaths' (RACGP *newsGP*, online, 20 February 2020).
[6] Ibid.
[7] Amanda Lyons, 'Why do people with intellectual disability have lower life expectancy?' (RACGP *newsGP*, online, 2 December 2019).

people with cognitive disability later, and at less treatable stages; a consequence of barriers to accessing screenings and routine health checks[8].

One major barrier is that people with intellectual or developmental disabilities often miss standard preventative screenings, such as cancer screening programs, due to communication support needs, lack of accessible information, or assumptions by providers. A Victorian study found that cervical cancer screening participation among women with intellectual disability was unacceptably low: only 17% of women with intellectual disability aged 18–39 had a Pap test in the recommended period, compared to 84% of women without disability[9]. In the 40–59 age group, just 14% of women with intellectual disability were screened versus 76% of the general population[10]. Such gaps are extreme. Similarly, breast cancer screening rates lag: while a survey indicated that 78% of women with intellectual disability aged 50–59 had a mammogram in the past two years, only around 61% had ever had a mammogram in their lifetime[11] suggesting many women with disability are not regularly screened from the start of eligibility. Lower screening uptake contributes directly to higher mortality, as treatable cancers go undetected. This pattern extends to other health checks; bowel cancer test participation is also presumed to be lower in the disability community[12].

If preventative health measures are not tailored through co-design to reach people with disability, inequality will widen. We recommend that the new Prevention Investment Framework explicitly address the needs of people with disability through accessible health promotion and education, targeted outreach and reminders, disability specific health checks, improved training for healthcare providers and greater collection of data.

[8] Ibid.
[9] Cancer Council Victoria, 'Profile and statistics – People with Disabilities' (Cancer Screening Hub, updated 2019).
[10] Ibid.
[11] Ibid.
[12] Ibid.

Recommendation 5: The Productivity Commission should amend the interim report to recommend specific measures addressing the severe health disparities experienced by people with disability, particularly those with intellectual disability.

6.1. Accessible health promotion and education

A preventative health response must ensure all public health campaigns, on topics like cancer screening, immunisation and healthy lifestyles, are delivered in formats which are accessible to people with cognitive or sensory differences. For example, Easy Read materials, pictorial guides, captions and sign language in media, and community outreach through peer networks or Disability Representative and Carer Organisations. Governments must develop targeted recall systems for individuals with disability who are eligible for screenings. Partnerships could be formed with the NDIS and disability service providers to facilitate screening appointments, such as by reminding support staff and participants, offering mobile clinics or in-home testing where appropriate. Health services should not assume that the standard invitation letters reach or persuade people with intellectual disability; more initiative-taking follow-up is needed.

These screenings or comprehensive health assessments should be tailored for people with intellectual or developmental disabilities. For instance, research has shown annual health checks by GPs, as implemented in the UK, to detect unmet health needs and significantly improve health outcomes in this population. The Australian Government's pilot program for annual health assessments for people with intellectual disability is a positive step and governments should expand these and make them permanent. We also support government better resourcing GPs to perform such preventive care. Medicare funding should reflect the longer consultation times needed and incentivise initiative-taking care planning.

Recommendation 6: The Productivity Commission should amend the interim report to explicitly address the needs of people with disability through accessible health promotion and education, targeted outreach and reminders in multiple formats, such as Easy Read.

6.2. Training for healthcare providers

Many health professionals lack training in disability-inclusive care, leading to problems like inadequate communication and "diagnostic overshadowing," where the professionals attribute a patient's symptoms to their disability while they miss the true medical issue. The Disability Royal Commission found systemic neglect in healthcare for people with cognitive disability, exacerbated by "services and professionals not equipped with the right knowledge and attitudes" to treat them appropriately[13]. We recommend governments implement the Intellectual Disability Health Capability Framework: a national curriculum to train medical, nursing, and allied health students in caring for people with intellectual disability. The Disability Royal Commission recommended embedding such competencies, and governments have agreed in principle to embed the *"*right of people with disability to good health care*"* in key policies and laws[14]. That commitment must translate into action: mandating co-designed disability inclusion training in professional accreditation standards, and upskilling the existing health workforce in effective communication, consent, and adjustments for patients with disabilities.

Recommendation 7: The Productivity Commission should amend the interim report to explicitly address the needs of people with disability through improved co-designed Disability Inclusion Training led by people with lived experience for healthcare providers.

7. Person-Directed, Rights-Based Support

Achieving quality and safety in healthcare is not only about structural reform but also about cultural reform, embedding a culture of inclusion, respect, and person-centered practice at all levels of the system. We emphasize two critical dimensions that should guide the new

[13] Amanda Lyons, 'Why do people with intellectual disability have lower life expectancy?' (RACGP *newsGP*, online, 2 December 2019

[14] National Centre of Excellence in Intellectual Disability Health, 'Statement on government responses to the Disability Royal Commission' (Media Release, 1 October 2024).

system for quality and safety in healthcare: person-directed, rights-based support and cultural safety and responsiveness, particularly for First Nations and culturally diverse people with disability.

Reforms must uphold the principle that people with disability are experts in their own lives and have the right to be active participants in their healthcare and support. This means adopting a truly person-directed approach, where services listen to and honour the choices, preferences and goals of individuals. The Disability Royal Commission recommended that governments commit to ensuring people with disability can exercise choice and control in all areas of life, including health, consistent with Article 25 of the CRPD: the right to the enjoyment of the highest attainable standard of health without discrimination.

We are pleased that governments have accepted the recommendation to embed the right to health care for people with disability in key policies and legislation[15]. Making this effective will require tangible changes: for example, informing patients of their rights to accessible communication, requiring health providers to make "reasonable adjustments" for disability (as they would for physical accessibility), and measuring healthcare outcomes for people with disability as a performance metric. It also requires independent advocacy and supported decision-making to be available. Many people with cognitive disability rely on supporters or advocates to help navigate complex health systems and to convey their will and preferences. A quality health system should fund disability advocacy services and recognise supported decision-making in healthcare consent processes, so that having a disability never means losing one's voice in one's own medical treatment.

We also stress the role of co-design in shaping person-directed services. Policies made about people with disability should be made with people with disability. We have consistently argued for genuine co-design in reforms, and, as noted earlier, we consider co-design essential to ensure the success of any new model in the disability context. The same applies to health quality initiatives. We recommend that the Commission's final report champion co-

[15] National Centre of Excellence in Intellectual Disability Health, 'Statement on government responses to the Disability Royal Commission' (Media Release, 1 October 2024).

design with people with disability (and their representative organisations) when developing improved health programs, training curricula and complaint mechanisms. One of the consistent themes from the Disability Royal Commission testimonies was that people with disability felt ignored or disrespected by mainstream services; their pain was not believed, their input not sought. A new system for safety and quality must actively counter this by elevating the voice of lived experience at every step.

A person-directed support must also be holistic and values-driven. Healthcare quality should not be defined narrowly based only on clinical outcomes; it should encompass quality of life outcomes that matter to the person. For example, a mental health intervention for a person with an intellectual disability should be judged successful not only if symptoms improve, but also whether it helps the person engage more in the community or to build relationships. We encourage regulators to include quality of life indicators and feedback from people with disability when assessing services. In practical terms, this might entail revising quality standards to require demonstrated person-centred planning, goal attainment, and client satisfaction for people with disability. It also involves ensuring complaint mechanisms are accessible and empowering; people with disability must know they can raise concerns about quality and be taken seriously by regulators.

7.1. Culturally Safe and Responsive Models

Australia's care and health systems must recognise and respond to the diverse cultural backgrounds and identities of people with disability. We consistently hear from the Culturally and Linguistically Diverse (CALD) Community, through our peer networks, about the need for cultural competence training for mainstream disability service and healthcare staff. This is important for understanding cultural views of disability in CALD and Indigenous communities. Quality standards should explicitly mention providing services that are culturally appropriate and trauma-informed, especially for groups like Indigenous Australians who have intergenerational trauma.

Another aspect of inclusion is recognising the needs of intersectionality within the disability community, such as people from non-English speaking backgrounds, LGBTQ+ people with disability, or those in remote areas. Co-design should be broad-based to capture these perspectives. For example, women with disability have specific health safety issues and

improving healthcare quality for people with disability in regional, rural and remote areas might require telehealth innovations or mobile outreach. The guiding principle must be equity: the new system should strive to level up quality of care so that no person with disability is left behind due to where they live or who they are.

Recommendation 8: The Productivity Commission should amend the interim report to ensure that the new system for quality and safety in healthcare is person-directed, rights-based, and culturally safe and responsive, particularly for First Nations and culturally diverse people with disability

7.2. Data and monitoring

We consistently call for improved collection of robust data on healthcare access and outcomes for people with disability. The Commission's prevention strategy should include metrics and reporting on how people with disability are experiencing the system, such as through measuring of screening rates, vaccination rates, and avoidable hospitalisations. As recommended by the Disability Royal Commission in Recommendation 6.19, establishing a Disability Health Unit within the Australian Institute of Health and Welfare could help drive consistent data collection and identify gaps. We also support the Disability Royal Commission's Recommendation 11.14 for a national disability death review function to investigate deaths of people with disability (similar to existing processes examining deaths in care) and make system-wide recommendations to prevent future tragedies.

We urge the Commission to ensure its final recommendations explicitly mention people with disability as a priority population for prevention efforts. The payoff will be substantial: improved preventive care for people with disability can lead to longer, healthier lives and reduce costly acute care episodes. People with disability, who experience higher rates of potentially preventable hospital admissions due to gaps in primary care, stand to benefit greatly from such reforms. We want to see a future where "excess deaths" and avoidable harms among Australians with disability are no longer an accepted reality, but rather a remnant of a past era of neglect.

Recommendation 9: The Productivity Commission should amend the interim report to explicitly address the needs of people with disability through improved data collection and monitoring.

8. Conclusion

We support the Productivity Commission's reform directions on the condition that the reforms are shaped by the lived realities of people with disability and maintain essential safeguards and values. Implemented correctly, these changes are an opportunity to not only gain efficiency, but to set a new standard for inclusive, high-quality healthcare in which people with disability are safe, healthy, and empowered. We urge the Commission to ensure that its final recommendations truly deliver on that promise.

We are available to discuss the issues raised in this submission or to answer questions if this would assist the Productivity Commission. To arrange this, please contact Selena Maddeford, Manager – Policy and Projects, JFA Purple Orange, [REDACTED]