Submission

Delivering Quality Care More Efficiently

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Submitted by

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Acknowledgement of Country

We acknowledge the Traditional Owners of the land on which we work and live. We pay our respects to Aboriginal and Torres Strait Islander Elders past, present and future. We value Aboriginal and Torres Strait Islander histories, cultures, and knowledge. We extend our respect to Aboriginal and Torres Strait Islander women who for thousands of years have preserved the culture and practices of their communities on country. This land was never surrendered, and we acknowledge that it always was and always will be Aboriginal land. We acknowledge the strength of Aboriginal and Torres Strait Islander people and communities. We acknowledge that Australian governments have been complicit in the entrenched disadvantage, intergenerational trauma and ongoing institutional racism faced by Aboriginal and Torres Strait Islander people. We recognise that Aboriginal and Torres Strait Islander people must lead the design and delivery of services that affect them for better life outcomes to be achieved.

About AMWA

The Australian Multicultural Women's Alliance (AMWA) is led by the Federation of Ethnic Communities' Councils of Australia (FECCA), the national peak body representing Australians from culturally and linguistically diverse (CALD) backgrounds in partnership with Settlement Services International (SSI) and Media Diversity Australia (MDA). The Australian Multicultural Women's Alliance is the national voice for multicultural women. AMWA advocates for gender equity, representation, and inclusion across all facets of Australian society. Our work is informed by lived experiences, community insights, and evidence-based research to ensure that systemic barriers are addressed, and opportunities for women are unlocked. As an intersectional alliance, we aim to empower women from all multicultural backgrounds to thrive and contribute fully to Australia's prosperity.

About NATSIWA

The National Aboriginal and Torres Strait Islander Women's Alliance (NATSIWA) is the peak body for Aboriginal and Torres Strait Islander women in Australia. The leadership team of Directors are Indigenous women each representing States and Territory across Australia. NATSIWA is funded by the Australian Government to bring together the issues and voices of Aboriginal and Torres Strait Islander women's organisations and individuals across Australia.

About WWDA

Women with Disabilities Australia (WWDA) is the national representative organisation run by and for women, girls and gender-diverse people with disabilities. WWDA works to promote and advance the human rights, safety and wellbeing of women, girls, and gender-diverse people with disabilities in all of their diversity. As a National Women's Alliance, WWDA represents and advocates for the interests of women, girls and gender-diverse people with disabilities to inform government policies and programs in advancing gender equality in Australia. WWDA has a particular focus on decision-making and agency, participation and leadership, health, prevention of all forms of violence, sexual and reproductive health and rights, and economic security and social protection.

About WwWA

The Working with Women Alliance (WwWA) represents two key portfolios: National Women's Safety (NWS) and National Women's Equality (NWE). The WwWA connects the

critical areas of gender-based violence prevention and the advancement of women's economic equality and leadership, bridging these important policy fields for greater impact. We work with members and stakeholders, including the Australian Government, to provide expertise and advice on gender equality and women's safety.

Executive Summary

It is difficult to measure productivity in the care sector. In part, this is because economic models are unable to value outputs in the non-market sector, even though care work is fundamental to the functionality of Australian society. It is also because care work is most often done by women, and Australia continues to struggle with valuing women's work. The care sector is often constrained by worker shortages, chronic underfunding and poor integration across services, and it is primarily women who suffer – as both workers and recipients. Economists tend to assume that better working conditions, including higher pay, are the result of productivity improvements, but fail to recognise how subpar working conditions and gender-driven undervaluation contribute to lagging productivity through high rates of worker-burnout and turnover, community distrust and barriers to access. Though the Productivity Commission proposes efficiency improvements in the care sector, through prevention, regulation reform and collaborative commissioning, it fails to address the fundamental undervaluation of care that limits effective structural reform.

It is vital that formal care sector reform is accompanied by programs and policies to value unpaid care, which is disproportionately done by women, and particularly by women with disabilities, migrant and refugee women, Aboriginal and Torres Strait Islander women and women living in rural, regional and remote areas. When women are not adequately or financially supported to do this work, there is added strain on the formal care sector. Similarly, inefficiencies in the formal sector and worn by the women who must take time away from paid work or study to fill in the gaps for their loved ones and their communities.

Though emerging technologies may provide some opportunities to reduce inefficiencies in the health and care sectors, we are concerned about potential unintended consequences, including the compounding of bias, the protection of privacy and data sovereignty, and the funding of workforce development and re-skilling. The introduction of any such technology must be done carefully, and in close consultation with impacted communities and sector experts.

We believe stronger coordination between care sectors will be more impactful than alignment, and where alignment does occur it must be to the highest standard. This is because care work is often context specific, and what works in one sector may not work in another. Additionally, the care sector is larger than aged care, disability services and early childhood education and care. For example, housing and homelessness services, drug and alcohol services, prisoner support services, and LGBTIQA+SB specific services are all part of the care economy ecosystem and must be factored into regulation reform. If the Productivity Commission wants to understand where sectors overlap, it must engage with

workers in these sectors, and the communities most impacted by any potential changes to regulation or standards of care. While collaborative commissioning is a promising option for better coordinating care across sectors, funding must be secure and long-term and must focus on communities with significant barriers to accessing care.

We strongly advocate for an approach to prevention that recognises and addresses the social determinants of health, such as access to housing, economic security, and climate mitigation and response. Investment in prevention can improve outcomes and care sector efficiency. However, we are wary of the creation of a framework and standardised evaluation methodology that risks overlooking the benefits of grassroots and community driven programs. An advisory body could coordinate across existing strategies and frameworks and consult with community groups to ensure that prevention investment aligns with community expectation and need.

Finally, we recognise that both formal and informal care are overwhelmingly done by women, and specifically by women who experience multiple forms of marginalisation. Reforms and efforts to improve productivity across the care economy must include these women in planning, design and governance.

Summary of Recommendations to Government

Artificial Intelligence in the Care Economy

1. Establish standards that address bias in documentation and decision-making.
2. Introduce AI training into medical training curriculum.
3. Provide equitable access to AI workplace training and resources.
4. Mandate human supervision for all medical decisions made using AI.
5. Embed anti-racism and cultural-safety benchmarks in AI procurement, validation, and audit processes, co-designed with affected communities.
6. Embed Aboriginal and Torres Strait Islander data sovereignty principles into AI regulation.

A More Coordinated Care Economy

1. Respect sectoral specificity while improving coordination.
2. Embed consultation and co-design with lived experience.
3. Take a gender-based violence lens to aged and disability care.
4. Strengthen accountability through coordination, not uniformity.
5. Build reforms on evidence and standards of care quality and safety.

Collaborative Commissioning

1. Ensure that capacity-building for small and grassroot organisations is included in funding arrangements.
2. Expand funded interpreter services across primary, acute, disability, and aged care.
3. Ensure that organisations that are led by the communities they serve are prioritised to lead and deliver commissioned services.
4. Prioritise multi-year funding arrangements to allow for strategic planning and sustainable growth.

Prevention Framework

1. Ensure intersectional representation on any advisory board.
2. Ensure any Prevention Framework that is developed incorporates existing frameworks and findings of inquiries, including the Disability Royal Commission.
3. Embed consultation and co-design with lived experience.
4. Respect sectoral specificity in assessment criteria.
5. Require anti-racism and cultural-safety micro-credentials for frontline and managerial staff in commissioned services within a phased rollout.
6. Explicitly include anti-racism in prevention governance and indicators (e.g., cultural safety, interpreter uptake, discrimination complaints resolved) to track equity and efficiency.

Care as a Gendered Issue

Care is shaped by gender at every level. Women make up almost four in five of the workers in the health care and social assistance sector and are overrepresented in the aged care[1] and disability workforce.[2] Women are also the majority of those providing unpaid care when formal services are unavailable. On average, women perform nine more hours of unpaid care each week than men.[3]

Migrant and refugee women are overrepresented in non-professional care occupations[4], and often manage complex, multigenerational caring responsibilities that place unique pressures on their time and wellbeing. Limited informal networks in Australia mean fewer supports to share this load, leaving women from multicultural backgrounds more isolated in their caring roles. Women with disabilities are also overrepresented as both paid and unpaid care workers, with more than 40% of primary carers having a disability themselves, and women with disabilities constituting a significant portion of the peer support workforce in the health and care sectors.[5] Aboriginal and Torres Strait Islander women are concentrated in female-dominated care sectors and do vast amounts of unpaid work, generally more than other Indigenous or non-Indigenous groups.[6] This unequal distribution of responsibility impacts women's economic security and their ability to participate fully in the workforce.

Despite its centrality in Australia's economy, care work is persistently undervalued. Full-time workers in residential aged care earn $400 less per week compared to an average across all Australian industries.[7] High rates of part-time and insecure work leave women with unpredictable hours and limited career pathways. Migrant women are especially concentrated in broken-shift, low-paid roles with little progression, despite often holding tertiary or postgraduate qualifications. These conditions fuel turnover and burnout, destabilising services and eroding the trust and continuity that underpin quality care. Australian Multicultural Women's Alliance (AMWA) survey participants described these environments as culturally unsafe and lacking career pathways, which discourages retention. When services cannot retain staff, the quality of care and outcomes for people relying on them decline. Growth in care work has been three times faster than total employment, and a workforce gap of more than 211,000 roles is forecast by 2050.[8] Without reform, women will continue to absorb the strain as unpaid carers, cementing inequality.

Women's experiences as service users also highlight how gender and efficiency are interconnected. In Australia, women outspend men on health services overall,[9] largely because they see doctors more frequently due to higher rates of chronic health issues[10] and waiting longer for diagnoses.[11] Racialised bias in services also results in delayed care by driving avoidance.[12] These delays create inefficiencies by compounding illness and

increasing costs, while limiting women's capacity to participate in the workforce and community. Further, certain visa types are not eligible for Medicare, adding more onerous costs for migrant and refugee women. Greater investment in women's health research and diagnostic pathways would improve outcomes and reduce the long-term burden on the system.

Care must be understood as both a driver of women's inequality and a foundation for efficient, person-centred services. Without embedding a gender lens in reform, Australia risks deepening existing gender inequities while failing to secure the workforce and service outcomes needed to deliver quality care.

Recommendations:

1. Support cultural identity and well-being of care workers to avoid burnout and turnover.
2. Expand scholarships, training, and mentoring for Indigenous nurses, midwives, and doctors.
3. Greater investment in women's health research and diagnostic pathways to overcome diagnosis delay and improve women's health outcomes.

Defining Care

How care is defined has direct consequences for the way quality and efficiency are understood and measured. If definitions are narrow then large parts of the care economy remain invisible, with women's work and expertise undervalued and under-resourced as a result.

An effective definition needs to encompass the full spectrum of care. This includes direct, indirect, and community-based activities, as well as the emotional and moral responsibilities that shape care relationships. Transnational care practices demonstrate how women from multicultural and migrant backgrounds continue to provide care across distance through financial, emotional, and social support. Aboriginal and Torres Strait Islander women's caregiving roles often draw on deep intergenerational knowledge, cultural expertise, and complex skills sets that are central to community wellbeing. Definitions that ignore culturally shaped caregiving practices – such as expectations to care for elders, or stigma around aged care services, mean their labour remains undervalued and unsupported.

Due to culturally unsafe settings and institutional racism[13], women report avoiding health services, instead carrying an even greater share of unpaid care.[14] Therefore, definitions

should also recognise racism's role in shaping who gives and who receives care, including 'apprehended discrimination' that leads women to avoid services or under-disclose needs.[15] Without acknowledging these realities, policy settings risk reinforcing outdated assumptions about who provides care and where it takes place.

Adopting a broader, more inclusive definition of care is crucial for productivity. When care is narrowly defined, policy responses fail to capture the true scale of labour, leaving gaps that women are forced to fill at personal, social, and economic cost. By contrast, best practice definitions that are intersectional and culturally respectful provide a stronger basis for improving service delivery and outcomes.

A definition of care that reflects the realities of women's experiences must underpin any reforms aimed at delivering quality care more efficiently. Additionally, true efficiency should not be measured by reducing expenditure alone, but also by enhancing trust, participation, and long-term health outcomes for women.

Recommendations:

1. Include traditional healers within service frameworks.
2. Embed cultural safety in definitions and metrics of care.

Artificial Intelligence in the Care Economy

The integration of artificial intelligence into the care economy needs regulation that is specific and gender responsive. Emerging technologies are increasingly expected to deal with sensitive and complex information, where inaccuracies can have serious consequences for women's health and safety.

Using generative AI to create patient notes has some benefits, like allowing healthcare providers to focus more on direct patient care instead of administrative burden. Nonetheless, differences in how AI tools summarise medical information could unintentionally create inconsistencies that disproportionately impact women's health. Some large language models (LLMs) have shown gender bias in their AI-generated case notes, emphasising men's physical and mental health needs more frequently and directly.[16] If women's health concerns are consistently downplayed in patient records, they may face reduced access to care. These risks extend across the AI development pipeline. Biases in data, design, implementation, and evaluation can compound over time, contributing to substandard clinical decisions and widening existing disparities in health outcomes.

These risks are heightened for migrant and refugee women, Aboriginal and Torres Strait Islander women, and women with disabilities, whose health needs are often

underrepresented in data sets and whose language or visa status can create barriers in digital service use. For trans- and gender-diverse communities, cis-normative data models also risk producing inappropriate or harmful treatment recommendations.[17] Further, racial inequities in health systems are absorbed within AI training data, perpetuating historical injustices and the oppression of racially marginalised communities. Therefore, AI design and evaluation must include anti-racism standards and representation from racially marginalised communities.

Additionally, health care workers need proper training to interact with Gen AI both effectively and ethically. There is a persistent gender gap in confidence and uptake of AI systems, with only 50% of women in the workplace using and trusting Gen AI, compared with 70% of men.[18] The level of disconnect for migrant and refugee women is much higher, leaving them even more excluded.[19] Yet only 24% of Australian healthcare professionals have received formal AI training.[20] This gap leaves workers ill-prepared to integrate new systems and risks further eroding confidence in health services. For women, opportunities to upskill are neither accessible nor available. As a consequence of being overrepresented in an undervalued care sector, many women do not have access to employer-sponsored training.[21] At the same time, the overwhelming amount of unpaid care that women perform each week[22] leaves little time to pursue additional education. These structural barriers place the onus on women to retrain, with no support to do so, and little promise of meaningful or well-paid employment.

In any approach to regulating AI in health sectors, it is important to address the level of access large-language models may have to individuals' sensitive data. Aboriginal and Torres Strait Islander communities have the inherent right to govern how their cultural knowledge and health data are collected, accessed, and used. Respecting Indigenous ownership of health data will ensure that regulation strengthens, rather than undermines, community control.

While AI can assist health care professionals spend more time with patients, it should not be seen as a substitute for human workers. For many women, care interactions are not only about treatment but about much needed company. If automation reduces those important moments of contact, the quality of care will inevitably decline. Hence, any opportunities for AI-driven efficiency in health must be context-specific and adapted to the needs of care receivers.

<u>Recommendations:</u>

1. Establish standards that address bias in documentation and decision-making.
2. Introduce AI training into medical training curriculum.

3. Provide equitable access to AI workplace training and resources.
4. Mandate human supervision for all medical decisions made using AI.
5. Embed anti-racism and cultural-safety benchmarks in AI procurement, validation, and audit processes, co-designed with affected communities.
6. Embed Aboriginal and Torres Strait Islander data sovereignty principles into AI regulation.

A More Coordinated Care Economy

Each part of the care economy delivers distinct forms of care that are shaped by the unique needs of recipients and by the skills of those providing support. Treating these sectors as interchangeable by taking a one-size-fits-all approach risks weakening safety and quality of services. Women With Disabilities Australia (WWDA) has raised concerns about the current push for consistency and alignment across care sectors, warning that this approach overlooks the fundamentally different principles underpinning each type of care and support.

Rather than alignment, what we recommend is stronger coordination across the care economy. Coordination recognises the vital differences between sectors while enabling more effective collaboration. For example, better information sharing between regulators could prevent gaps in oversight, and improved coordination of worker registration schemes could reduce risks of misconduct being hidden across sectors. These measures strengthen accountability without forcing sectors into ill-fitting regulatory frameworks.

Any reform to sector regulation must be co-designed and implemented in consultation with people with lived experience of accessing the care sector. The process must be culturally safe and anti-racist, with mandatory representation of Aboriginal and Torres Strait Islander and other negatively racialised women in governance and complaints pathways. At present, there has been little meaningful or targeted consultation on care sector reform with older people's networks or with disability representative organisations. Multicultural women's networks also report being sidelined in consultation, despite carrying significant unpaid care responsibilities and being heavily represented in the care workforce. Further, there has been little engagement with the significant work already undertaken on reforms to the funding and delivery of disability services and supports that has been completed through a wide range of inquiries and reviews.

These oversights have serious implications for women's safety and wellbeing. For example, WWDA is deeply concerned by proposals to align regulation of restrictive practices – rather than eliminate them. In the disability sector, restrictive practices

including forced contraception, sterilisation, and menstrual suppression persist, despite calls for their elimination. They are often overlooked in broader reform discussions, despite their significant impact on women and girls.[23] In the context of aged care, these forms of restrictive practice may not be visible post-menopause, but they remain urgent gendered concerns that must be addressed.[24] It is important to note that these practices are recognised as forms of gender-based violence under both the Working for Women Strategy and the National Plan to End Violence Against Women and Children 2022-2032.

Taken together, these issues highlight the need to expand the reform process and engage in a codesign process with women's specialist organisations, to ensure that regulation strengthens rather than weakens protections for women across different forms of care.

Recommendations:

1. Respect sectoral specificity while improving coordination.
    i. Avoid one-size-fits-all regulation that erodes safety and quality.
    ii. Strengthen cross-sector coordination through improved information sharing between regulators and harmonisation of worker registration schemes, while preserving the distinct principles underpinning each care sector.
2. Embed consultation and co-design with lived experience.
    i. Genuine engagement with priority populations.
    ii. Ensure consultation includes older people's networks, disability representative organisations, and groups representing women with lived experience of restrictive practices and gender-based violence.
    iii. Prioritise voices of women with disability, older women, women from racialized and marginalised multicultural backgrounds, and carers in shaping reforms.
3. Take a gender-based violence lens to aged and disability care.
    i. Recognise that restrictive practices such as forced contraception, sterilisation, or menstrual suppression disproportionately affect women and girls, and constitute gender-based violence.
    ii. Ensure reforms address risks of gender-based violence, racism, coercion, and medical mistreatment of older women, particularly those living with dementia, including through the elimination of restrictive practices.
4. Strengthen accountability through coordination, not uniformity.
    i. Create mechanisms for regulators to share data on misconduct to prevent perpetrators moving across sectors undetected.
    ii. Align approaches to worker registration to improve oversight.
    iii. Require regulators to record and share race-based misconduct and discrimination data to prevent 'portability' of harm across sectors.
5. Build reforms on evidence and standards of care quality and safety.

i. Draw on expertise in aged care, disability services, child safety, and health regulation to identify where coordination adds value without diluting protections.
ii. Commission independent review of how reforms intersect with existing sector standards, and align with key findings of reviews and inquiries, to ensure high standards across the sector and no reduction in safeguards for women, children, and people with disability.

Collaborative Commissioning

Women face distinct and compounding barriers when it comes to accessing quality health care, shaped by location, culture, socioeconomic status, disability, and gender norms. Services that do not respect cultural identity often fail, leading to misdiagnosis or delayed care that becomes more costly down the line. In rural and remote areas, limited health infrastructure and workforce shortages force women to travel long distances or delay care, often at the expense of their health. For Aboriginal and Torres Strait Islander women, mainstream services are not always culturally safe, while the community-controlled services they trust are chronically underfunded. Migrant and refugee women struggle to navigate services that are not designed with language, visa status, or cultural context in mind. Women with disability experience physical, attitudinal and informational barriers to accessing mainstream services, and are poorly served by both disability and health systems. High costs and long wait times for public or specialist services further impact these groups, making access even harder.

Addressing these challenges involves approaches that reflect local contexts and incorporate the experiences of women. That is why Aboriginal Community Controlled Health Organisations (ACCHOs) are so vital in providing culturally safe environments where people feel welcome and respected. There is a lot of potential in collaborative commissioning, including avoiding duplication and developing services that are more accessible, which would prevent families from having to navigate disconnected systems. For migrant and refugee women, collaborative commissioning could also provide culturally safe, language appropriate services that recognise visa and residency-related barriers to accessing care. Further, collaborative commissioning is important for incorporating traditional healing and connection to Country into care pathways. For effective implementation, it requires long-term, adaptable funding arrangements and genuine co-design processes with the community. Commissioning standards should mandate cultural safety, anti-racism training for providers, and funded interpreter access as core quality requirements.

Short-term or pilot funding cycles often limit the ability of organisations to evaluate outcomes or build sustainable models. Longer funding cycles would allow programs to build on what already works rather than starting from scratch. Flexibility within these cycles is also critical, ensuring that funding can respond to emerging needs rather than locking organisations into rigid program structures.

Any effective collaborative commissioning model needs to recognise the role of grassroots and community-based organisations in providing care. Many grassroots organisations have devised and demonstrated innovative solutions to service gaps in their communities. They also carry deep expertise and trusted relationships with the communities they serve, often through the help of volunteers who work in addition to their full-time jobs. Yet these organisations are too commonly leveraged for insights without adequate compensation or capacity-building support. Embedding requirements within grants to engage and resource grassroots organisations instead of just consulting with them would ensure their contributions are properly valued. Capacity-building investment is equally important so that smaller organisations can fully participate in collaborative commissioning processes alongside larger providers.

While pooling funds across sectors could reduce duplication and support the development of scalable, sustainable programs, it should not be confused with consolidation. Some organisations, particularly ACCHOs, have expressed concern about being pressured to share or lose their funding. Collaborative commissioning must therefore protect the independence and funding security of smaller organisations while enabling stronger coordination.

Best practice in collaborative commissioning needs to be locally driven. Place-based approaches, designed with and by communities, ensure that services meet the diverse needs of women. Embedding knowledge systems, including Indigenous knowledge systems, into health and care frameworks will strengthen accountability and cultural safety. The Birthing on Country programs demonstrate how culturally led, integrated collaborative commissioning approaches improve both quality and efficiency of care. These models provide culturally safe maternity care led by Aboriginal midwives, resulting in lower rates of preterm birth and improved maternal wellbeing. The structure of these programs could be replicated, as appropriate, across chronic illness management, mental healthcare and drug and alcohol support services, for example.

Recommendations:

1. Ensure that capacity-building for small and grassroot organisations is included in funding arrangements.

2. Expand funded interpreter services across primary, acute, disability, and aged care.
3. Ensure that organisations that are led by communities they serve are prioritised to lead and deliver commissioned services.
4. Prioritise multi-year funding arrangements to allow for strategic planning and sustainable growth.

Prevention Framework

Prevention is one of the most effective ways to improve care outcomes and reduce long-term costs. When prevention is underfunded, women are disproportionately affected as workers forced to carry the load of under-resourced services, and as care users facing poorer health. We strongly advocate for an approach to prevention that recognises and addresses the social determinants of health, such as access to housing, economic security, and climate mitigation and response. However, WWDA is concerned about any aim to reduce service demand by preventing disability: this is at odds with a human rights approach to disability, which recognises disability and impairment as a natural part of human diversity.

Underinvestment in prevention creates inefficiencies across the system, increasing the likelihood of crisis and the need for more intensive care later. Delayed NDIS planning and a shortage of accessible housing keep women with disability in hospital far longer than necessary[25], driving up costs while reducing system capacity. In rural and remote areas, patients experience the highest rates of potentially preventable hospitalisations due to a lack of local health services.[26] AMWA survey participants identified language, cultural and financial barriers as major obstacles to receiving timely care, which increases preventable health crises.

While government investment in prevention is welcomed, as is embedding a variety of social determinants of health into care planning, we are wary about a standardised actuarial model for the analysis of prevention programs. For prevention to be effective, it needs to be context-specific and tailored to community needs. Attempting to fit initiatives as different as housing programs, frontline services, and grassroots supports into a single set of criteria risks overlooking their value and undermining the diversity of approaches that prevention requires.

Grassroots and community-led organisations play a central role in prevention but often lack resources to demonstrate their impact, which is why we support funding arrangements that provide support for evaluation and assessment processes.

It is worth noting that prevention frameworks already exist. The National Women's Health Strategy 2020-2030 and the National Plan to End Violence Against Women and Children 2022–2032 are both explicitly preventative in focus. Broader initiatives such as the *ACT Wellbeing Framework*[27] and the *Measuring What Matters* initiative[28] provide broad indicators across housing, health, equality, income, and life satisfaction. The challenge is not a lack of frameworks, but the need for integration, coordination, and adequate investment. An effective example of this is the Australian Multicultural Health Collaborative, which integrates social determinants of health to promote a more holistic approach to prevention within Australia's multicultural communities. Building yet another framework risks duplication and pulling resources away from what is already in place.

An advisory board could lead coordination across existing frameworks and strategies. This advisory board would need to include genuine intersectional representation in governance and decision-making to ensure proper accountability mechanisms and alignment with community needs.

Recommendations:

1. Ensure intersectional representation on any advisory board.
2. Ensure any Prevention Framework that is developed incorporate existing frameworks and findings of inquiries, including the Disability Royal Commission.
3. Embed consultation and co-design with lived experience.
    a. Genuine engagement with priority populations.
    b. Prioritise voices of women with disability, older women, multicultural women and carers in shaping reforms.
4. Respect sectoral specificity in assessment criteria.
5. Require anti-racism and cultural-safety micro-credentials for frontline and managerial staff in commissioned services within a phased rollout.
6. Explicitly include anti-racism in prevention governance and indicators (e.g., cultural safety, interpreter uptake, discrimination complaints resolved) to track equity and efficiency.

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