



Name: The George Institute

Submission date: 6/06/2025

Participant background

1. For the purposes of this consultation, which of the following best describes you:
I represent an independent health and medical research institute
2. Which of the following care sectors will your feedback relate to? Please select all that apply.
Health
3. What kind of care supports, services and programs do you have experience with, and in what jurisdictions?
The participant did not respond to this question.

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

1. To what extent do differences in quality and safety regulation make it costly or complex to provide or access care services?
The participant did not respond to this question.
2. What are the reasons for your answer?
The participant did not respond to this question.
3. To what extent should quality and safety regulations be more aligned across the different care service sectors and jurisdictions?
The participant did not respond to this question.
4. What are the reasons for your answer?
The participant did not respond to this question.

2. Embed collaborative commissioning to increase the integration of care services

1. What is your experience with collaborative commissioning
The participant did not respond to this question.
2. What are the benefits of pursuing greater collaborative commissioning?
The participant did not respond to this question.
3. What are the barriers to collaborative commissioning, and do you have any suggestions for solutions that would lead to better collaboration in the commissioning of care services?
The participant did not respond to this question.

3. A national framework to support government investment in prevention

1. What are the main barriers to governments investing in evidence-based prevention programs across the care economy?

There are four main barriers to investment in evidence-based prevention programs:

- 1) Financing
- 2) Governance
- 3) Evidence to support action
- 4) Leadership and political will

Financing

The National Preventive Health Strategy published in 2021 identifies a comprehensive set of evidence-based targets and actions to improve the prevention of disease.

However, the Strategy has never had an associated implementation plan, or received dedicated funding in the federal budget. Instead the government has funded specific programs through its annual budget. Federal government expenditure on prevention programs continues to be around 2% of total spending, with the majority of health expenditure allocated to Medicare, the Pharmaceutical Benefits Scheme, hospitals and referred medical services,

While the cost-effectiveness of prevention programs has been consistently demonstrated, obtaining dedicated, long-term and sustainable funding for programs remains challenging. While prevention programs often deliver improved health outcomes and lower health expenditure over the long term, benefits take time to accrue. This means that expenditure on prevention programs today may not deliver the expected benefits for several years, and this has driven a reluctance to invest in prevention because the benefits accrue in the future, but expenditure must be made now. To address this, a modified funding model is needed for prevention that overcomes these barriers. In other parts of the health system (for example the Pharmaceutical Benefits Advisory Committee and Medical Services Advisory Committee), policy decisions are informed by independent expert committees who utilise evidence-supported methods such as health technology assessments. This ensures a clear focus on delivering the most cost-effective interventions, supported by expert advice. This has served us well, and should also be applied in the prevention space.

The Centre for Policy Development and Deakin University have also highlighted in their submissions that capacity within Treasury departments could be strengthened to enable adoption of evidence-based economic analysis methods that are suitable for calculating the costs and benefits of prevention. Standard methods of cost benefit analysis used within Treasuries and offices of impact analysis do not adequately account for avoided costs attributable to prevention programs, and apply highly conservative discount rates that discount away the benefits of prevention programs and preference interventions that can be delivered over shorter timeframes. Recent frameworks such as the Victorian Early Intervention Investment Framework provide an approach to addressing these issues that could be adapted for broader use.

Governance

The governance of healthcare in Australia, shared between the Commonwealth and States and Territories, also presents challenges. Despite recognition that prevention should be included in an expanded National Health Reform Agreement, the NHRA lacks specific funding for prevention, or agreement on who will deliver it. Prevention programs

are mostly confined to small, ad-hoc programs cobbled together at the local health district level because there is a lack of national governance and financing arrangements to enable comprehensive regional, state and national scale programs. The National Preventive Health Strategy is likely to end in 2030 as a well written, but partially implemented plan with limited effectiveness without a rethink of the governance and financing of prevention through our federated decision-making architecture.

The Huxtable Mid-Term Review of the National Health Reform Agreement noted that progress on the identified six long-term reform priorities has been slow, in part because of a lack of dedicated resources (both workforce and funding), measurable outcomes and clear accountabilities. The review recommended that a National Innovation and Reform Agency is established with its focus including embedding a program of action on prevention and wellbeing aligned with the work of the Australian Centre for Disease Control. We broadly support this recommendation. In our view, there needs to be clear allocation of responsibility for prevention programs and agreement across jurisdictions on roles and responsibilities. This needs to extend beyond the scope of the existing National Preventive Health Agreement, and outline a detailed plan for the implementation of the National Preventive Health Strategy.

Evidence to support action

While the evidence base on preventive health programs has grown, there are still many gaps, especially when testing whether prevention programs are effective and cost-effective in achieving more specific objectives. Our flagship health and medical research funding programs still preference treatment over prevention. The diagram below shows the proportion of funding allocated to prevention research from the National Health and Medical Research Council and Medical Research Future Fund, compared with the U.S. National Institutes of Health Research and Canadian Institutes of Health Research:

Less than one third of research funding allocated to clinical trials goes to prevention. A greater focus on prevention in research will strengthen the evidence base, and in turn, provide the information needed to support increased investment.

Leadership and political will

Over the last decade, much of the scientific and technical work on prevention has focused on the economic costs and benefits of prevention programs as health policy interventions. This work has demonstrated that investing in prevention can be 3-4 times more cost-effective than investing in treatment. However governments remain reluctant to invest in prevention. One way of overcoming this is to invest in modelling studies that can project the long-term impacts, as well as evaluations that examine the broader impact of prevention in changing norms and behaviours.

We can learn much from the decades-long push to reduce tobacco smoking. While the landmark plain packaging reforms in 2011 were influential around the world, they were preceded by numerous policy interventions, including:

- 1973: first health warnings mandated on cigarette packs
- 1976: tobacco advertising banned on TV and radio
- 1983-87: smoking on public transport and in government buildings banned in most states and territories
- 1987: tobacco advertising banned in print media
- 1990: phase-out of tobacco sponsorship of sporting events begins
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- 2000s: major increases in tobacco excise taxes and new health warnings
- 2006-08: States begin enforcing comprehensive smoke-free laws
- 2009: ban on tobacco product display at retail outlets
- 2012: plain packaging becomes mandatory.

What this demonstrates is that change occurs in a long series of incremental actions that have broad community support. Prevention needs to be reframed as a long-term health priority that needs to be enabled, resourced and fostered, rather than a single policy initiative to manage both expectations and risks to political leaders and policy makers.

2. What are some examples of successful prevention programs (this could include discontinued programs)?

There are numerous examples of successful prevention programs. The World Health Organization published 'best buys' for noncommunicable diseases in 2021 (updated 2024) identifying the most cost-effective interventions to address the 4 key risk factors (tobacco, alcohol, unhealthy diets and physical inactivity). The WHO Best Buys provides a menu of 90 policy interventions, of which two thirds have been assessed as cost-effective, with no assessments available yet for the remaining third. The WHO best buys form the basis of the country investment cases prepared by the UN Interagency Taskforce on NCDs. 24 country-level investment cases have been developed to date. The investment case for Malaysia for example found that implementing the recommended interventions would save 180,000 lives and recover RM30 billion (approximately AUD\$10.9 billion) in economic output over 15 years. The National Preventive Health Strategy incorporates many of the WHO Best Buys, and prioritises initiatives. This should be the blueprint for action.

Measures that should be immediately implemented are outlined in The George Institute's pre-election and pre-budget statements, and include:

- Making the Health Star Rating mandatory on all eligible packaged foods
- Regulating to reformulate food to achieve lower salt, sugar, saturated fat and banning trans-fats
- Introducing a sugar-sweetened beverages levy to support increased funding for the prevention of diet-related disease and to discourage consumption of sugary drinks
- Restricting unhealthy food marketing to children.
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There is extensive scientific literature on the effectiveness and cost-effectiveness of prevention initiatives. Some examples from The George Institute's researchers are provided in the table at the end of this section.

Two case studies are provided below that demonstrate the benefits of prevention programs in health.

Case study – Hypertension

Raised blood pressure or hypertension is by far the leading risk factor for preventable deaths in Australia, contributing to over 25 000 deaths annually mainly due to stroke, heart disease, kidney disease, heart failure, atrial fibrillation and dementia. Therefore preventing hypertension should be a national priority.

The Roadmap of the National Hypertension Taskforce of Australia highlights prevention of hypertension as one of three key priorities. The roadmap spotlights the need to develop targeted prevention strategies, including reducing sodium and increasing

potassium intake (such as through greater population uptake of potassium-enriched salt substitutes), improving nutrition in the food supply, increasing physical activity and reducing alcohol intake.

Switching Australia's salt supply to potassium-enriched salt presents a rare opportunity to deliver substantial health and economic gains through a population-wide intervention. This initiative is projected to prevent around 3,000 deaths and 9,000 cardiovascular events annually, while reducing health inequities and easing the burden on the healthcare system. Embedding this switch across homes, healthcare settings, and the food industry, would reach all people living in Australia regardless of age, background, and whether or not they've been diagnosed with hypertension . There is a significant and growing body of evidence supporting potassium-enriched salt as an effective prevention measure; however as yet there has been no government funding for implementation of this as a public health measure.

Case study – Sepsis

Sepsis is the body's life-threatening inflammatory response to an infection that can damage its own tissues and organs. Sepsis is not blood poisoning or septicaemia (these are infections in the blood) but is instead the body's reaction to the infection that is not controlled and needs urgent treatment (antibiotics) to stop the reaction .

Sepsis is a serious, life-threatening illness. Up to 50% of sepsis survivors have long term, and in some cases life-long consequences, including permanent disability such as amputations and organ damage.

There is no ongoing dedicated government investment at Commonwealth or State/Territory level for sepsis prevention. Sepsis Australia has advocated for, and secured, small one-off funding allocations for sepsis prevention, but the limited scope of activities has been insufficient to achieving sustained, systemic improvement. Three national sepsis awareness surveys over 6 years conducted by Sepsis Australia suggest poor awareness of sepsis persists despite deaths being four times higher than deaths from road accidents , and two to three times higher than for common cancers (breast or prostate)¹⁰.

Per case cost has increased by 50% over the past 10 years, and while the mortality rate remains relatively stable due to acute care improvements, the number of survivors with long-term and often life-long consequences is growing significantly. A study published in 2021 put the cost to Australian society at \$4.8billion per year. Thus preventing sepsis could result in significantly reduced demand for hospital beds and services.

Sepsis is preventable through increased public awareness, earlier clinician recognition and relatively simple clinical intervention if caught early. We estimate that 30-50% of sepsis cases may be preventable.

The Sepsis Australia - Stopping Sepsis National Action Plan prioritises prevention interventions, however the plan is not funded so funding must be sought on a project-by-project basis.

Table: A selection of scientific papers examining the cost-effectiveness of prevention measures.

Citation

Marklund, M., Trieu, K., Aminde, L. N., Cobiac, L., Coyle, D. H., Huang, L., Neal, B., Veerman, L., & Wu, J. H. Y. (2024). Estimated health effect, cost, and cost-effectiveness of mandating sodium benchmarks in Australia's packaged foods: a modelling study. *The Lancet Public Health*, 9(11), e861–e870. [https://doi.org/10.1016/s2468-2667\(24\)00219-6](https://doi.org/10.1016/s2468-2667(24)00219-6)

Killedar, A., Lung, T., Taylor, R. W., & Hayes, A. (2023). Modelled Distributional Cost-Effectiveness Analysis of Childhood Obesity Interventions: A Demonstration. *Applied Health Economics and Health Policy*, 21(4), 615–625. <https://doi.org/10.1007/s40258-023-00813-9>

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Marklund, M., Lee, Y., Liu, J., Sy, S., Abrahams-Gessel, S., Wilde, P., ... Micha, R. (2020). Health Impact and Cost-Effectiveness of Financing Fruit and Vegetable Subsidies with a Sugar-Sweetened Beverage Tax in the US: A Micro-Simulation Study. *Current Developments in Nutrition*, 4(Supplement_2), 1721–1721. doi:10.1093/cdn/nzaa064_011

Burn, E., Nghiem, S., Jan, S., Redfern, J., Rodgers, A., Thiagalingam, A., ... Chow, C. K. (2017). Cost-effectiveness of a text message programme for the prevention of recurrent cardiovascular events. *Heart*, 103(12), 893.1–894. doi:10.1136/heartjnl-2016-310195

Ojji, D. B., & Huffman, M. D. (2023). The place of polypill in secondary prevention of stroke. *The Lancet Global Health*, 11(10), e1488–e1489. [https://doi.org/10.1016/s2214-109x\(23\)00407-2](https://doi.org/10.1016/s2214-109x(23)00407-2)

Peters, R., Xu, Y., Fitzgerald, O., Aung, H. L., Beckett, N., Bulpitt, C., Chalmers, J., Forette, F., Gong, J., Harris, K., Humburg, P., Matthews, F. E., Staessen, J. A., Thijs, L., Tzourio, C., Warwick, J., Woodward, M., & Anderson, C. S. (2022). Blood pressure lowering and prevention of dementia: an individual patient data meta-analysis. *European Heart Journal*. <https://doi.org/10.1093/eurheartj/ehac584>

Heenan, M., Hart, A. C., Cullerton, K., Jan, S., & Shanthosh, J. (2024). Legal and regulatory instruments for NCD prevention: a scoping review and descriptive analysis of evaluations in OECD countries. *BMC Public Health*, 24(1). <https://doi.org/10.1186/s12889-024-18053-4>

Heenan, M., Jan, S., Ralph, M., Sacks, G., Swinburn, B., & Shanthosh, J. (2023). Priority setting for non-communicable disease prevention – Co-producing a regulatory agenda informing novel codes of practice in Australia. *Social Science & Medicine*, 116149. <https://doi.org/10.1016/j.socscimed.2023.116149>
Wyber, R., Lizama, C., Wade, V., Pearson, G., Carapetis, J., Ralph, A. P., Bowen, A. C., & Peiris, D. (2022).

Improving primary prevention of acute rheumatic fever in Australia: consensus primary care priorities identified through an eDelphi process. *BMJ Open*, 12(3), e056239.

<https://doi.org/10.1136/bmjopen-2021-056239>

Peiris, D., Wright, L., News, M., & Corcoran, K. (2019). Community-Based Chronic Disease Prevention and Management for Aboriginal People in New South Wales, Australia: Mixed Methods Evaluation of the 1 Deadly Step Program. *JMIR mHealth and uHealth*, 7(10), e14259. doi:10.2196/14259

Nugent, R., Bertram, M. Y., Jan, S., Niessen, L. W., Sassi, F., Jamison, D. T., ... Beaglehole, R. (2018). Investing in non-communicable disease prevention and management to advance the Sustainable Development Goals. *The Lancet*, 391(10134), 2029–2035. doi:10.1016/s0140-6736(18)30667-6

3. How can governments better support investment in prevention activities that have broad and long-term benefits for the Australian community?

Recommendations:

1) Establish a task force reporting to the Ministerial Council on Health (a subcommittee of National Cabinet) and charge it with responsibility for prevention and treatment of chronic disease, with its immediate tasks outlined in points 2-6 below.

Rationale: The Australian Health Protection Committee, reporting to the Health Chief Executives Forum, has responsibility for managing emerging health threats posed by infectious diseases, environmental issues, and disasters. However, it does not currently play any role in managing noncommunicable (chronic) disease, which is responsible for more than 90% of deaths in Australia. A task force needs to be established to determine the forward work program, governance and funding for preventive health, with ongoing delivery managed by AHPC.

2) Commit to making prevention a key long-term, whole-of-government priority for all jurisdictions, and to considering impacts on health of all government decisions and vice versa.

Rationale: Prevention is influenced by many factors outside the health portfolio, including social determinants of health such as access to employment, education, housing and healthy environments. To break down siloes and implement a health in all policies approach, prevention needs to be a long-term whole-of-government priority that is considered across portfolios.

3) Reform the governance of prevention to establish clear, agreed roles and responsibilities between jurisdictions, supported by a funding agreement.

4) Develop and fund an implementation plan for the National Preventive Health Strategy, and empower the Australian Centre for Disease Control to lead its implementation.

Rationale: The Centre for Disease Control brings together expertise from across jurisdictions and institutions to better coordinate disease prevention and response. At present, the Centre only addresses communicable disease. To effectively address chronic disease, it needs to build capacity in prevention and chronic disease, and needs authority and funding from government to achieve that.

5) Identify key evidence gaps and prioritise their funding, including modelling studies to

project the long-term impacts and evaluations to examine the impact of prevention on broader norms and behaviours.

6) Establish a knowledge sharing network or community of practice to support learning across jurisdictions, and engagement with people and communities with lived experience.

7) Develop a prevention investment framework informed by the Victorian Early Intervention Investment Framework to guide investment decisions.

8) That the Commonwealth establish an expert advisory committee similar to the Pharmaceutical Benefits Advisory Committee and Medical Services Advisory Committee to evaluate prevention initiatives.

Note: The George Institute for Global Health also supports the submissions of the Public Health Association of Australia, Deakin University, Cancer Council Australia and the Centre for Policy Development.

Cover sheet: Supporting document #1



Delivering Quality Care More Efficiently:

Submission to the Productivity Commission

6 June 2025



Acknowledgement of Country

The George Institute for Global Health acknowledges the traditional owners of the lands on which we work, the Gadigal people of the Eora Nation on which our Sydney office is situated. We pay our respects to Elders past, present and future. We value and respect the ongoing connection of Aboriginal and Torres Strait Islander peoples to Country and are committed to working in partnership with communities to deliver better health outcomes.

Section 4. A national framework to support government investment in prevention

In this section, we are seeking feedback on how to support government investment in evidence-based prevention programs that improve long-term outcomes for the community and reduce demand for future care services.

Care services can play an important role in reducing or eliminating the effects of preventable problems. Prevention activities can reduce risk factors before problems arise, help detect issues early or slow their progression during initial stages.

Despite this, governments can be reluctant to invest in prevention because it requires up-front spending and the benefits often take a long time to materialise, can be hard to measure and can be spread across different areas and levels of government.

1. What are the main barriers to governments investing in evidence-based prevention programs across the care economy?

There are four main barriers to investment in evidence-based prevention programs:

1. Financing
2. Governance
3. Evidence to support action
4. Leadership and political will

Financing

The National Preventive Health Strategy published in 2021 identifies a comprehensive set of evidence-based targets and actions to improve the prevention of disease. However, the Strategy has never had an associated implementation plan, or received dedicated funding in the federal budget. Instead the government has funded specific programs through its annual budget. Federal government expenditure on prevention programs continues to be around 2% of total spendingⁱ, with the majority of health expenditure allocated to Medicare, the Pharmaceutical Benefits Scheme, hospitals and referred medical services^{ii, iii}.

While the cost-effectiveness of prevention programs has been consistently demonstrated, obtaining dedicated, long-term and sustainable funding for programs remains challenging. While prevention programs often deliver improved health outcomes and lower health expenditure over the long term, benefits take time to accrue. This means that expenditure on prevention programs today may not deliver the expected benefits for several years, and this has driven a reluctance to invest in prevention because the benefits accrue in the future, but expenditure must be made now. To address this, a modified funding model is needed for prevention that overcomes these barriers. In other parts of the health system (for example the Pharmaceutical Benefits Advisory Committee and Medical Services Advisory Committee), policy decisions are informed by independent expert committees who utilise evidence-supported methods such as health technology assessments. This ensures a clear focus on delivering the most cost-effective interventions, supported by expert advice. **This has served us well, and should also be applied in the prevention space.**

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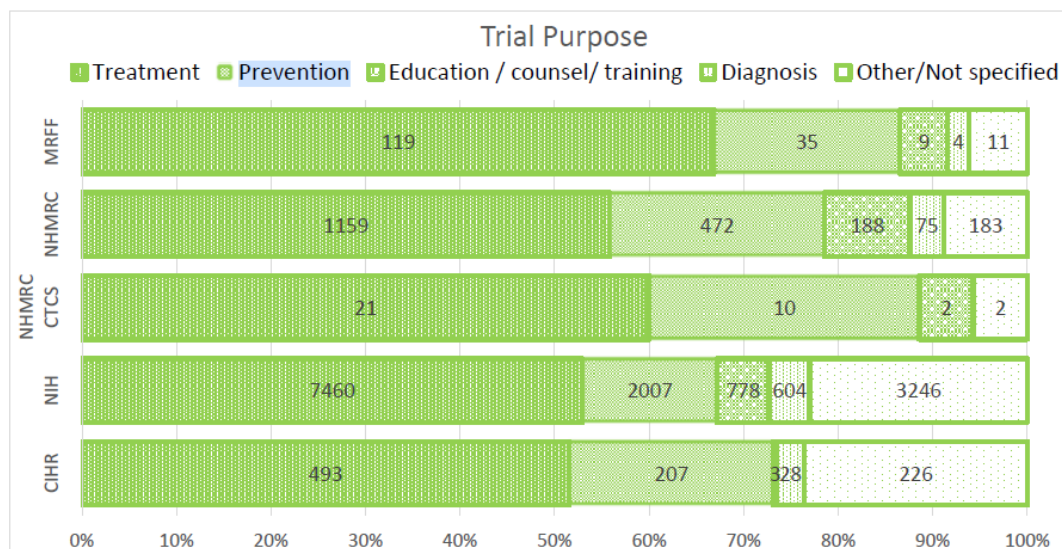


Figure 8 Trial purpose

The proportions of trials in preventative medicine found by the Desktop Review (29% MRFF, 22% NHMRC CTCS), and in treatment areas (61% vs 70%) were generally comparable.

Less than one third of research funding allocated to clinical trials goes to prevention. **A greater focus on prevention in research will strengthen the evidence base, and in turn, provide the information needed to support increased investment.**

Leadership and political will

Over the last decade, much of the scientific and technical work on prevention has focused on the economic costs and benefits of prevention programs as health policy interventions. This work has demonstrated that investing in prevention can be 3-4 times more cost-effective than investing in treatment^v. However governments remain reluctant to invest in prevention. One way of overcoming this is to **invest in modelling studies that can project the long-term impacts, as well as evaluations that examine the broader impact of prevention in changing norms and behaviours.**

We can learn much from the decades-long push to reduce tobacco smoking. While the landmark plain packaging reforms in 2011 were influential around the world, they were preceded by numerous policy interventions, including:

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What this demonstrates is that change occurs in a long series of incremental actions that have broad community support. **Prevention needs to be reframed as a long-term health priority that needs to be enabled, resourced and fostered**, rather than a single policy initiative to manage both expectations and risks to political leaders and policy makers.

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Case study – Hypertension

Raised blood pressure or hypertension is by far the leading risk factor for preventable deaths in Australia, contributing to over 25 000 deaths annually mainly due to stroke, heart disease, kidney disease, heart failure, atrial fibrillation and dementia^{viii}. Therefore preventing hypertension should be a national priority.

The Roadmap of the National Hypertension Taskforce of Australia highlights prevention of hypertension as one of three key priorities. The roadmap spotlights the need to develop targeted prevention strategies, including reducing sodium and increasing potassium intake (such as through greater population uptake of potassium-enriched salt substitutes), improving nutrition in the food supply, increasing physical activity and reducing alcohol intake.

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regardless of age, background, and whether or not they've been diagnosed with hypertension^{ix}, ^x. There is a significant and growing body of evidence^{xi} supporting potassium-enriched salt as an effective prevention measure; however as yet there has been no government funding for implementation of this as a public health measure.

Case study – Sepsis

Sepsis is the body's life-threatening inflammatory response to an infection that can damage its own tissues and organs. Sepsis is not blood poisoning or septicaemia (these are infections in the blood) but is instead the body's reaction to the infection that is not controlled and needs urgent treatment (antibiotics) to stop the reaction^{xii}.

Sepsis is a serious, life-threatening illness. Up to 50% of sepsis survivors have long term, and in some cases life-long consequences, including permanent disability such as amputations and organ damage.

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Per case cost has increased by 50%^{xv} over the past 10 years, and while the mortality rate remains relatively stable due to acute care improvements, the number of survivors with long-term and often life-long consequences is growing significantly. A study published in 2021 put the cost to Australian society at \$4.8billion per year. Thus preventing sepsis could result in significantly reduced demand for hospital beds and services.

Sepsis is preventable through increased public awareness, earlier clinician recognition and relatively simple clinical intervention if caught early. We estimate that 30-50% of sepsis cases may be preventable.

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Table: A selection of scientific papers examining the cost-effectiveness of prevention measures.

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3. How can governments better support investment in prevention activities that have broad and long-term benefits for the Australian community?

Recommendations:

1. **Establish a task force reporting to the Ministerial Council on Health (a subcommittee of National Cabinet) and charge it with responsibility for prevention and treatment of chronic disease, with its immediate tasks outlined in points 2-6 below.**

Rationale: The Australian Health Protection Committee, reporting to the Health Chief Executives Forum, has responsibility for managing emerging health threats posed by infectious diseases, environmental issues, and disasters. However, it does not currently play any role in managing noncommunicable (chronic) disease, which is responsible for more than 90% of deaths in Australia^{xvi}. A task force needs to be established to determine the forward work program, governance and funding for preventive health, with ongoing delivery managed by AHPC.

2. **Commit to making prevention a key long-term, whole-of-government priority for all jurisdictions, and to considering impacts on health of all government decisions and vice versa.**

Rationale: Prevention is influenced by many factors outside the health portfolio, including social determinants of health such as access to employment, education, housing and healthy environments. To break down siloes and implement a health in all policies approach, prevention needs to be a long-term whole-of-government priority that is considered across portfolios.



3. **Reform the governance of prevention to establish clear, agreed roles and responsibilities between jurisdictions, supported by a funding agreement.**
4. **Develop and fund an implementation plan for the National Preventive Health Strategy, and empower the Australian Centre for Disease Control to lead its implementation.**

Rationale: The Centre for Disease Control brings together expertise from across jurisdictions and institutions to better coordinate disease prevention and response. At present, the Centre only addresses communicable disease. To effectively address chronic disease, it needs to build capacity in prevention and chronic disease, and needs authority and funding from government to achieve that.

5. **Identify key evidence gaps and prioritise their funding, including modelling studies to project the long-term impacts and evaluations to examine the impact of prevention on broader norms and behaviours.**
6. **Establish a knowledge sharing network or community of practice to support learning across jurisdictions, and engagement with people and communities with lived experience.**
7. **Develop a prevention investment framework informed by the Victorian Early Intervention Investment Framework to guide investment decisions.**
8. **That the Commonwealth establish an expert advisory committee similar to the Pharmaceutical Benefits Advisory Committee and Medical Services Advisory Committee to evaluate prevention initiatives.**

Note: The George Institute for Global Health also supports the submissions of the Public Health Association of Australia, Deakin University, Cancer Council Australia and the Centre for Policy Development.

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