Name: Australian Health Promotion Association

Submission date: 6/06/2025

Participant background

1. For the purposes of this consultation, which of the following best describes you:

   I am an industry or advocacy organisation, professional association or peak body

2. Which of the following care sectors will your feedback relate to? Please select all that apply.

   Aboriginal Community Controlled; Aged care; Disability; Early childhood education and care; Effective health promotion strategies contribute to positive outcomes across all care.; Health; Veterans

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?

Institutional barriers are blocking investment in prevention and health promotion
Despite clear evidence of the economic and social returns of prevention (Starfield, 2005; Nichols et al., 2024; Productivity Commission, 2005; Corvo et al., 2022), Australian governments continue to underinvest in evidence-based preventive health and community interventions (Bennett, 2013; Breadon et al., 2022). This reluctance is primarily due to entrenched institutional barriers that impede long-term planning, undermine health equity, and constrain the productivity and sustainability of the broader care economy (Commonwealth Department of Health and Ageing, 2009; Smith et al., 2021). This reflects a health system that continues to prioritise downstream responses while neglecting the structural determinants of health equity, despite their critical role in shaping health outcomes (Crawford & Trebeck, 2025).

Prevention pays - but government still won't commit
Governments remain reluctant to commit to sustained investment in prevention. Prevention programs deliver outcomes that are diffuse, long-term, or intangible - such as improved quality of life, increased social cohesion, or avoided downstream costs (Masters et al., 2017; Smith et al., 2012). These benefits are undervalued by traditional cost-benefit frameworks, particularly when they extend beyond the health sector or accrue over extended time frames (Drummond et al., 2015). There is a systemic bias in public policy that favours easily quantifiable, short-term returns over complex, long-term investments in wellbeing, often sidelining interventions that would benefit those impacted by health inequity (Crawford & Trebeck, 2025). This reluctance reflects a policy environment that favours short-term, easily measurable returns. Without structural reform and a genuine commitment to long-term investment, prevention will remain an underutilised lever - despite its proven capacity to improve population health, promote equity, and boost national productivity (Baum et al., 2013; Breadon et al., 2022). It is important for policy makers to address health inequalities by investing long term in the upstream (Crawford & Trebeck, 2025).

Short-term political cycles undermine long-term investment in prevention
Governments prioritise interventions with immediate, visible outcomes due to electoral pressures, sidelining long-term preventative strategies that may take years to yield returns (Drummond et al., 2001; Productivity Commission., 2009; Breadon et al., 2022). This preference for reactive measures over proactive prevention hampers efforts to address chronic diseases and social determinants effectively (Nichols et al., 2024; Drummond et al., 2001). Its delayed and diffuse outcomes make it less politically attractive (The Australian Prevention Partnership Centre, 2024).

The economic value of prevention is overlooked in policy and investment decisions
There is a strong yet underutilised economic case for prevention (Carvalho et al., 2022; Australian Government, 2023; Nichols et al., 2024). A healthier population participates more fully in education, employment, and civic life. Estimates indicate that every dollar invested in preventive health returns a conservative $14.30 in avoided healthcare and societal costs (Masters et al., 2017; McDaid, 2018). Yet prevention is rarely viewed as a productivity strategy or investment in human capital. It is still commonly treated as a cost, rather than a means of reducing future demand for acute services and boosting

national economic performance (Corvo et al., 2022). This stems from a narrow economic paradigm that treats health as a service outcome rather than a shared social asset (Corvo et al., 2022; Crawford & Trebeck, 2025). A central barrier to effective health promotion is a political paradox: while some policymakers focus narrowly on GDP growth as a solution to social challenges, others recognise but avoid confronting the economic structures driving health inequalities - sidelining upstream reform in favor of limited, downstream interventions (Corvo et al., 2022; Crawford & Trebeck, 2025).

Fragmented responsibilities across government undermine prevention efforts
Prevention benefits multiple sectors (e.g., health, housing, education, justice), yet funding and accountability mechanisms remain siloed (Baum et al, 2013; Breadon et al, 2022; Nichols et al, 2024). This fragmentation creates disincentives for any one department or level of government to bear the initial costs, leading to underfunded and poorly coordinated preventive initiatives (Breadon et al', 2022; Nichols et al., 2024; RACGP, 2022; Duckett and Willcox, 2015). Non-profit organisations (NFPs) often overcome these barriers by delivering agile, community-led interventions that integrate health promotion, early intervention, education, and social support (Baum et al, 2013; Morgan et al, 2023; Nichols et al, 2024; Held et al., 2021). However, their funding is frequently short-term, project-based, and fragmented, limiting their ability to scale or sustain their impact (Nichols et al., 2024). These organisations often shoulder the responsibility of addressing inequities but are unsupported by policy frameworks that undervalue relational, place-based work (Crawford & Trebeck, 2025). Strengthened, long-term partnerships between governments and the NFP sector could dramatically improve the reach and effectiveness of prevention across the care economy (Smith et al, 2021; Baum et al, 2013: Australian Government, 2023; Nichols et al., 2024).

The barrier isn't evidence or workforce - it's a lack of sustained government investment
Australia's health promotion workforce is capable, committed, and essential to delivering prevention - particularly in rural, remote, and disadvantaged communities (Smith & Leavy, 2020; Nichols et al., 2024). Yet, unlike the broader health or clinical prevention workforce, it faces a distinct set of structural challenges that remain largely unaddressed in policy and funding frameworks (Coombe et al., 2022). These challenges include widespread job insecurity, an over-reliance on short-term, project-based roles, and a lack of inclusion in national workforce data and planning. There are no government-supported training pipelines, and the workforce is often missing from major health workforce strategies. For example, while the National Preventive Health Strategy 2021–2030 recognises the importance of prevention, it still does not commit to investing in or sustaining a dedicated health promotion workforce, despite a pledge to do so (Australian Health Promotion Association, 2025). It is the persistent underinvestment, not a lack of evidence or workforce capacity, that is a key barrier to scaling evidence-based prevention (Smith & Leavy, 2020). Without long-term, structural support for this workforce, national strategies will continue to fall short of their potential (Coombe et al., 2022; Smith & Leavy, 2020; Breadon et al., 2022). This workforce remains invisible in economic models that overlook the relational work essential to community wellbeing (Crawford & Trebeck, 2025).

Political resistance and industry influence undermine prevention policy
Structural reforms are hindered by political resistance and vested interests (Freudenberg, 2014). Industry lobbying continues to delay effective regulatory measures, such as levies on sugary drinks, restrictions on alcohol marketing, and

gambling controls - despite robust evidence of their effectiveness (Lal et., 2017; Baum et a.l, 2013; Breadon et al., 2024). These interventions are often framed as politically contentious, further narrowing the space for evidence-based prevention (The Lancet Public Health Commission, 2022).

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

Prevention works. Australia has seen measurable public health gains from programs that are: Australia has seen measurable population health gains through prevention programs that are:
- Evidence-based and community-led
- Sustained through long-term, stable funding
- Backed by robust evaluation and policy alignment
- Integrated across sectors like health, education, transport, and environment
These programs not only change individual behaviours but also tackle the social determinants of health —such as housing, employment, education, and social inclusion—that underpin health inequity. This is where a Health in All Policies (HiAP) approach becomes critical: by embedding health considerations into all areas of policymaking, governments can more effectively and sustainably improve health outcomes across populations (World Health Organization, 2014).

A series of articles in a virtual edition of the Health Promotion Journal of Australia, 'Towards a stronger health promotion and prevention future in Australia' https://onlinelibrary.wiley.com/doi/toc/10.1002/(ISSN)2201-1617.towards-a-stronger-health-promotion-future?page=1 highlight a range of articles covering health promotion and prevention programs, evidence, evaluation, investment and health equity.

The following examples demonstrate some scalable, cross-sector impact of well-designed prevention initiatives.

1. South Australia's Health in All Policies Initiative (2007–ongoing)
a) Funded and delivered by: South Australian Government, through SA Health and the State Cabinet
b) Outcomes:
Formal adoption of a HiAP mandate by the SA Cabinet.
Integration of health across portfolios such as education, transport, employment, mental health, and regional development.
Improved policy coherence, stronger cross-sector relationships, and better alignment between health and non-health sectors.
c) Not discontinued: Still operational and globally recognised.
d) Evaluation:
WHO praised the model as an international benchmark for integrated governance (World Health Organization, 2014).
Peer-reviewed research (Delany-Crowe et al., 2018) demonstrated improved intersectoral collaboration, though population health outcomes take longer to materialise.

2. Aboriginal Community Controlled Health Services (Ongoing)
a) Funded by: Jointly by the Australian Government and state/territory governments.
Delivered by: Aboriginal Community Controlled Health Organisations, overseen by the

National Aboriginal Community Controlled Health Organisation (NACCHO).
b) Outcomes:
Significantly higher immunisation rates compared to national averages (Australian Institute of Health and Welfare, 2023).
Increased uptake of health checks: 57% of eligible First Nations adults received a health assessment in 2020–21 vs 20% in 2009 (Australian Institute of Health and Welfare, 2022).
Improved chronic disease management and culturally safe service delivery.
c) Ongoing, though funding disparities and workforce shortages persist across jurisdictions.
d) Evaluation:
Improved access, cost-effectiveness, and cultural safety (Freeman et al., 2014)
Sustained improvements in prevention and early intervention (AIHW, 2020)

There are many well-evaluated programs in specific health areas that should be considered. It is important to have well-planned, implemented, and evaluated initiatives that have ongoing investment. Investment in prevention should also go beyond programs to have a strong focus on determinants of health.

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

Economic growth alone does not guarantee improvement in the health of a population. Population health outcomes are, to a significant degree, a result of political choices (Dawes, D. E., et al. 2022; Sendall, M. C., et al., eds. 2024). Political decisions impact on the social determinants of health and thus health equity, including through policies made by governments which shape unhealthy living and working environments, or which fail to address the marginalising systems of power that create unequal distribution of power, income and resources and make key groups in our society prone to ill health (World Federation of Public Health Associations 2020).

Adopt a whole of system approach
Governments must lead with an integrated national prevention agenda that transcends fragmented, disease-specific efforts. A whole-of-system strategy is essential to addressing the root causes of poor health, including social, cultural, economic, environmental, and behavioural determinants (Nichols et al., 2024; Baum et al., 2013). Prevention is effective when it is cross-sectoral and embedded in everyday settings including schools, workplaces, transport, housing, and local communities, not just the health system (Baum et al., 2013). The Health in All Policies (HiAP) approach, supported by the WHO and trialled in South Australia, demonstrates how intersectoral collaboration can deliver co-benefits across portfolios such as education, planning, and environment (WHO, 2013; Baum et al., 2013).

Build and sustain the health promotion workforce
Prevention cannot succeed without a skilled and adequately supported workforce (Crawford et al., 2019; Freeman et al., 2021). Investment in health promotion workforce planning, training, and professional development, especially in rural, remote, and underserved areas, is essential (Masters et al., 2017; Crawford et al., 2019; Freeman et al., 2021; Robinson & Lin, 2005). AHPA's national register of health promotion practitioners, in partnership with the International Union for Health Promotion and Education (IUHPE), supports professional recognition and capability development.

Embedding health promotion roles in primary health care teams, local government, and education systems will extend reach and effectiveness (Crawford et al., 2019; Freeman et al., 2021).

Establish long-term and protected funding mechanisms

AHPA calls on governments to honour their commitment to allocate at least 5% of total health expenditure to prevention - a pledge outlined in the National Preventive Health Strategy 2021–2030. Despite this commitment, investment remains well below target. Urgent action is needed to align policy with international best practice and deliver on what has already been promised (Smith et al., 2025).

Short-term or politically vulnerable funding undermines continuity and impact (Freeman et al., 2021). Governments should create protected, ring-fenced budgets for prevention - separate from acute care funding, and aligned with population health needs (McDaid, 2018). This would enable long-term planning, workforce development, and community trust.

Prioritise transparent evaluation and accountability

The use of high-quality data and research is vital for evaluating outcomes, informing policy decisions, and addressing emerging challenges such as misinformation and health inequities. Broadening the outcome measures to include health, social, environmental, and economic outcomes will further underscore the value of prevention and strengthen the case for ongoing investment. Adequate investment, strategic implementation, and robust evaluation are needed to achieve transformative improvements in health equity, economic productivity, and overall well-being for all Australians.

Cover sheet: Supporting document #1

Australian HEALTH PROMOTION Association

Health Promotion and Illness prevention **save lives, money** and deliver the best public return on investment in health[1,2]

Every **$1 invested** delivers **$14.30** in **benefits** [3,4]

HEALTH PROMOTION

Australia spends **LESS THAN 2%** of all health spending on **PREVENTION**[5]

Australia is ranked **20th** in the world for per capita expenditure on **preventive health**[2]

We call on all Australian governments to commit **at least 5%** of the health budget to **Health Promotion and Illness Prevention**.

INVESTMENT in a skilled and competent **HEALTH WORKFORCE** is vital[1,2]

HEALTH EQUITY

Health Promotion benefits those **MOST IN NEED** by tackling the underlying **ROOT CAUSES** of ill-health and inequity[6]

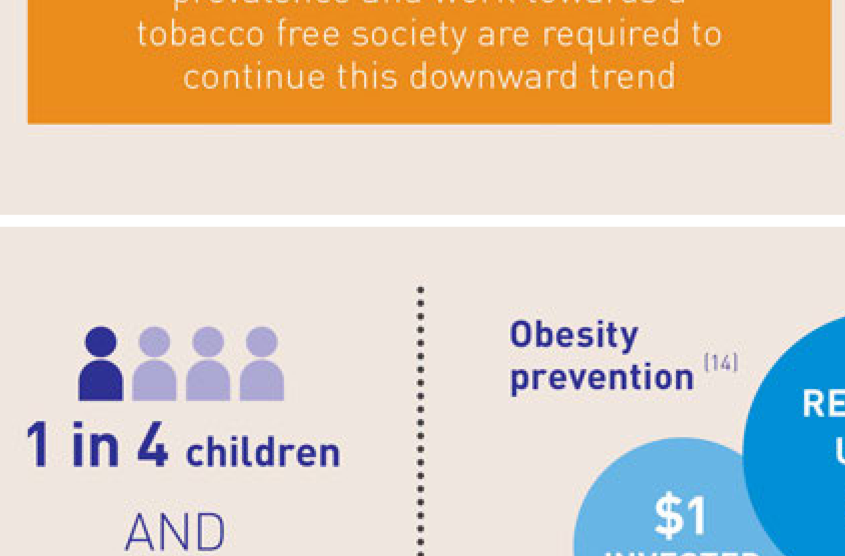
Household wealth is unequally shared. The **richest 10%** of households has an average of $6.1 million and **almost half of all wealth (46%),** while the **lower 60%** (with an average of $376,000) **has just 17% of all wealth**[8]

In Australia **1 in 8** adults and **1 in 6** children live **BELOW THE POVERTY LINE**[7]

GLOBALLY, inequality contributes to the death of at least one person every **FOUR SECONDS**[9]

Health Promotion works to address inequities.

SMOKING



Accelerated efforts to reduce smoking prevalence and work towards a tobacco free society are required to continue this downward trend

HEALTH PROMOTION STRATEGIES like mass media campaigns, banning advertising and promotion, and rigorous implementation of smoke-free legislation and policies **ARE CRUCIAL.**[11]

OVERWEIGHT AND OBESITY

1 in 4 children AND **2 in 3 adults** are above a healthy weight [12]

Obesity prevention [14] **$1 INVESTED RETURNS UP TO $6**

Overweight and obesity cost Australia **$39.9bn** or 1.89% of GDP* in 2019. This is set to **RISE TO $234bn** or 3.3% of GDP by 2060[13]

Health Promotion **INCREASES PHYSICAL ACTIVITY & HEALTHY EATING** in the places where Australians live, work, learn and play.

*Gross Domestic Product

ALCOHOL USE

Alcohol products cause significant harm and COSTS AUSTRALIA $66 BILLION ANNUALLY[15]

Health Promotion can help to **prevent more than 5,000 deaths** and **157,000 HOSPITALISATIONS** that occur every year due to harmful alcohol use[15]

Health Promotion works with all populations to ensure all people know about the risks of alcohol use, to restrict alcohol advertising and access outlets, and protect and dissuade young people.

CLIMATE CHANGE

Climate change will cause approximately **250,000** additional deaths per year between **2030-2050** [16]

The **direct cost** of climate change to health will be **$3-6 BILLION** per year by 2030[16]

Climate change affects the **social and environmental determinants** of health.

Urgent action is crucial to save Australian lives[17] and will bring **long-term economic and health gains**[18]

HEALTHY BUILT ENVIRONMENTS

Health Promotion **works with OTHERS** to create liveable, **health promoting environments.**

Green spaces **reduce premature mortality** and disease.

25% OF GLOBAL DISEASE could be avoided through management of **green cover** [19]

Green spaces **improve physical and mental health** [20, 21] and reduce inequalities[19]. **Every $1** invested in green spaces **returns $2-6** [22]

We call on all Australian Governments to commit **at least 5%** of health budget to Health Promotion and Illness prevention.

Australian HEALTH PROMOTION Association

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