Name: The Australian Prevention Partnership Centre

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.

   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?

The importance of preventing poor health is widely recognised among prevention stakeholders, and a brief summary of the supporting evidence is included in the evidence section of this submission. Despite this shared understanding, systemic and structural barriers continue to limit government investment in evidence-based prevention across the care economy. Key barriers include:

•Chronic underfunding of prevention and lack of dedicated budget lines.
The core challenge to strengthening government investment in evidence-based prevention is the persistent underfunding of preventive health actions at the national, state and local government levels. Despite clear evidence of its effectiveness in increasing productivity, reducing long-term healthcare costs and improving population health, Australia has one of the lowest rates of preventive health spending of any OECD nation, with less than 2% of total health expenditure for most of the past decade. (1) This chronic underinvestment creates a gap between policy intentions and actions. For example, the NSW Special Commission of Inquiry into Health Funding Report (2) calls out that funding the primary prevention of chronic disease “should be a top priority” and also discussed how the National Health and Hospitals Reform Commission in 2009 recommended the establishment of an independent National Health Promotion and Prevention Agency to ensure primary prevention and early intervention were integrated into all aspects of health, but this has yet to be implemented. The same report referred to how the 2017 Council of Australian Governments’ National Strategic Framework for Chronic Conditions outlined prevention-focused goals that are still evolving in practice. A similar pattern has been seen with the National Preventive Health Strategy, where actions have been outlined, but no plans for implementation or evaluation have progressed.

•Short-term funding cycles that favour immediate, visible outcomes.
Governments are typically constrained by short-term funding cycles which prioritise immediate, visible outcomes over the long-term benefits of prevention, which may take years to realise. There is often an absence of specific budget allocations for preventive health, (3) and there is persistent uncertainty around when funding will become available. This makes it difficult for states and territories to commit to implementing evidence-based programs, employing or retaining staff, or planning for sustainability. As a result, many initiatives falter due to discontinued funding. Even when funding is provided, it is often tied to rigid guidelines and key performance indicators that leave little room for local adaptation. This restricts the ability of jurisdictions to tailor programs to the specific needs of their populations, ultimately reducing the relevance and effectiveness of the interventions. Compounding this, funding across many national and state governments is skewed towards acute care, with reactive resource allocations to emerging pressures in hospitals and clinical services further de-prioritising investment in prevention.

•Failure to capture cross-sector co-benefits in investment decisions.
While prevention delivers multiple co-benefits beyond the health sector, including improved educational outcomes, (4) increased workplace productivity (5) and environmental gains, (6) these co-benefits are not always recognised in decision-making

processes. As a result, other sectors may be reluctant to invest in prevention initiatives when the primary benefits are perceived to accrue to the health sector. For example, increasing physical activity in schools supports both health and learning, and promoting active transport reduces emissions while improving health through increased physical activity. However, the absence of mechanisms to assess and communicate the value of cross-sectoral outcomes makes coordinated investment challenging, limiting both the scale and sustainability of prevention efforts. In the absence of shared accountability or joint funding arrangements, the health sector is often left to bear the costs alone, despite already operating under significant financial constraints

•Fragmented governance and siloed decision-making across sectors.
Effective prevention strategies require a broad, multifaceted approach across a range of sectors like health, education, social services, environmental sustainability and community organisations. However, government budgeting and decision-making often happens in silos, with competing interests and a lack of governance and coordination mechanisms, making it difficult to align efforts and develop integrated approaches across all of government.

•System complexity and limited capacity for implementation and scale-up.
Although many prevention approaches are supported by strong evidence, systemic barriers often hinder the adaption of practice as new evidence emerges, leading to implementation and scaling challenges that cause prevention programs to fail. This can be due to the complexity of integrating evidence into existing systems, competing priorities, limited resources, and time needed to brief decision-makers. Essential steps to ensure health equity such as building local capacity, tailoring interventions to specific contexts, and involving communities are also constrained by resourcing and capacity which hinders the scaling and sustainability of equitable prevention efforts. Particular challenges exist for implementing legislation, fiscal measures and creating healthy environments. For example, despite strong evidence of effectiveness and a raft of preventive health policy directions in Australia, there has been very little or limited progress in relation to food composition standards, restrictions on food advertising or taxes on unhealthy foods. (7)

•Inadequate data, monitoring and economic evidence to support investment cases.
Without good data, it’s harder to track progress, make improvements and build a compelling case for continued investment. Generally, there is limited economic evidence demonstrating the long-term cost-effectiveness of prevention interventions (8) and the economic evaluation methods that do exist often rely on short timeframes and high discount rates (9), making it harder to demonstrate the long-term value of prevention investments. Additionally, the epidemiological modelling used in preventive health cost-benefit analyses, showing how small changes to population risk factors can greatly reduce disease incidence, is often unfamiliar to government decision-makers. As a result, some decision-makers are sceptical on whether projected outcomes are realistic, further stalling investment decisions.

•Insufficient adaptation of prevention approaches to cultural and equity needs.
Many current models of prevention are based on Western perspectives and assume a universalist approach, which doesn’t always take into account the unique needs, cultural contexts and lived experiences of Aboriginal and Torres Strait Islander people, as well as other marginalised groups. This can result in prevention strategies that are not only

less effective, but potentially harmful. Additionally, the focus on short-term cost savings often makes it challenging to maintain investment in culturally appropriate, long-term solutions, which, despite requiring upfront investment, are essential for addressing health inequities over time and deliver longer term cost savings when inequities are reduced.

•Commercial opposition from vested interests and ideological framing of health as individual responsibility.
Broader societal, commercial and economic factors play a role in government investment in prevention. Powerful industries, including tobacco, alcohol, and unhealthy food sectors, as well as the investors that profit from them, ignore the serious negative externalities their businesses create and resist and attempt to weaken prevention policies that could affect their profits. This resistance is compounded by some existing ideological views that individuals are solely responsible for their own health, which can undermine efforts to address the powerful social, economic and environmental determinants of health.

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

Effective prevention approaches requires system-level action
Effective prevention action requires a systems approach that considers the broader social, economic and environmental factors influencing health. These include communities, food systems, education, transport, housing and workplaces, and how each of these interacts to create environments that support or hinder healthy behaviours.

Australia's world-leading prevention success in tobacco control demonstrated the value of co-ordinated, long-term action. A combination of regulatory and fiscal policies (for example, smoking bans and excise tax), mass media campaigns, and healthy lifestyle programs to promote smoking cessation have seen a large reduction in smoking from 24% of people smoking daily in 1991 to 11% in 2019. (10) These achievements, despite ongoing opposition from the tobacco industry, confirm the evidence that the greatest impact comes from multi-strategy, multi-sector and multi-jurisdictional efforts sustained over time.

National frameworks supporting prevention
The National Preventive Health Strategy 2021–2030 (11), developed and released by the Australian Government Department of Health and Aged care, sets an overarching direction for preventive health in Australia, emphasising the importance of addressing the social determinants of health and health equity. It builds on international evidence and frameworks, such as The Marmot Review (12), which highlights that a systems-based and collaborative approach that addresses the broader social and economic drivers of health, such as education, employment, housing, food security and equity, is essential for long-term impact.

The National Preventive Health Strategy offers a strong national framework to reduce the burden of preventable disease and ill-health across the community, workforce and economy. However, after more than three years since its release, investment, governance and accountability for primary prevention remain unchanged at both national and state and territory levels.

The need for strengthened investment and governance for primary prevention is further reinforced by existing national frameworks, including the National Obesity Strategy 2022–2032, (13) the National Tobacco Strategy 2023–2030, (14) the National Alcohol Strategy 2019–2028, (15) the National Injury Prevention Strategy 2020–2030, (16) and the National Suicide Prevention Strategy 2025–2035, (17) all of which place a strong emphasis on prevention and early intervention. These strategies identify priorities and actions, but without sufficient funding for implementation, their impact is limited.

Policy and legislative interventions

Legislative approaches are a critical, cost-effective and sustainable component of successful prevention. For example, the Office of Health Economics' (OHE) 2023 report, Reimagining Prevention, (18) highlights tobacco control measures and alcohol taxation as prime examples of cost-effective and impactful preventive policies in the United Kingdom. Tobacco control programs, including taxation, public smoking bans and mass media campaigns, have successfully reduced smoking rates, leading to declines in tobacco-related diseases. These reductions translate into significant healthcare savings and productivity gains, demonstrating that investment in prevention can yield positive returns over time.

Similarly, alcohol taxation policies that increase the price of alcoholic beverages have been shown to reduce harmful consumption and associated outcomes such as liver disease and accidents. (19) The OHE report notes that such policies not only improve health outcomes but also reduce the burden on health services and social systems, ultimately saving public expenditure.

The Food Policy Index, (20) developed by The Global Centre for Preventive Health and Nutrition Research (GLOBE), identifies the comprehensive suite of policy approaches recommended to improve nutrition, as a key risk factor of chronic disease. It highlights regulatory measures such as sugar-sweetened beverage taxes and restrictions on advertising unhealthy foods and demonstrates the actions that state/territory and federal governments are taking to promote healthy diets, benchmarked against global best practice. The monitoring and benchmarking of government action is important for accountability but can also incentivise best practice action.

The NSW Special Commission of Inquiry into Health Funding underscored the importance of such regulatory interventions, including sugar-sweetened beverage taxes, advertising/marketing restrictions, and reforms to food environments, as essential levers to reduce the chronic disease burden and address health inequities. While Australia has yet to implement a national sugar-sweetened beverage tax or a comprehensive ban on junk food advertising, several states and territories have made significant strides in health promoting government settings. For instance, jurisdictions such as Victoria, New South Wales, South Australia, Queensland and the ACT have adopted Healthy Food and Drink Policies targeting government-run facilities like hospitals, schools, and sporting venues. Evaluations in Victoria (21) have shown these policies improve the availability and promotion of healthier options, although national consistency and comprehensive implementation remain challenges. Most notably, South Australia has recently led the way by implementing a government-wide ban on unhealthy food advertising across its public sector, covering advertising on government-owned property and through official communication channels.

Further, policies and legislation that promote active transport and healthy urban planning

are instrumental in creating environments that support physical activity and overall wellbeing. A study published in the Journal of Physical Activity and Health (22) examined physical activity policies across 49 countries and found that stronger national strategies, urban planning legislation, and transport-related policies were linked to better population-level outcomes in physical activity. Specifically, policies promoting walking and cycling infrastructure, land-use planning with access to green space, and integration of physical activity into schools and workplaces were associated with increased movement and reduced sedentary behaviour. These findings reinforce the importance of embedding health considerations into transport, infrastructure and urban development decisions.

Programmatic examples of successful prevention

In addition to policy approaches, programmatic responses are critical in creating environments that better support the community and individuals to make healthier choices. A wide range of programs have demonstrated effectiveness in addressing key risk factors for chronic disease across different settings. Systematic reviews provide a strong evidence base for these interventions with groups such as Cochrane Public Health publishing reviews on interventions to prevent childhood obesity, (23) prevent e-cigarette use by children, (24) increase physical activity in community and school settings, (25) improve healthy eating in early childhood settings, (26) and improve community access to food, (27) amongst many others. Four examples of effective and scalable preventive health programs have been provided as an attachment.

Embedding implementation science to support scaling

Embedding implementation science and scaling strategies is essential to ensure that prevention interventions are effectively translated from research to practice, adapted to diverse contexts, and sustained at scale to deliver lasting health benefits. Leading this effort is the National Centre of Implementation Science (NCOIS), a collaboration between universities and health agencies backed by NHMRC and other grants. NCOIS embeds implementation science principles into every stage of work to ensure interventions are contextually adapted, scalable and sustainable. Its projects are underpinned by rigorous evaluation frameworks that assess fidelity (how closely an intervention adheres to its original design), effectiveness (whether the intended health outcomes are achieved) and sustainability (whether the intervention can continue to deliver results over time). This approach ensures that lessons learned from pilot or early-stage programs can be scaled up, adapted and maintained in diverse settings.

Preventive Health Program Examples

The following four examples illustrate effective and scalable preventive health programs, while also highlighting the challenge of sustaining impact without ongoing commitment and investment.

Program: RESPOND (Reflexive Evidence and Systems interventions to Prevent Obesity and Non-communicable Disease)
Provider/funder: Deakin University’s Institute for Health Transformation, funded by the National Health and Medical Research Council (NHMRC).

Outcomes: Implemented in ten local government areas in regional Victoria, RESPOND

used a community-led systems approach to prevent childhood obesity. Evaluations showed improvements in children's health behaviours, particularly increased water consumption and better psychosocial wellbeing.

Evaluation: A mixed-methods evaluation framework confirmed the program's effectiveness.
Current status: RESPOND concluded in 2024 at the end of its NHMRC funding period ended, not due to program failure. Its discontinuation highlights the ongoing challenge of ensuring sustained funding for prevention initiatives, even when strong evidence of effectiveness exists.

Program: INFANT (INfant Feeding, Active play, and NuTrition) an evidence-based early childhood intervention

Provider/funder: Deakin University's Institute for Physical Activity and Nutrition (IPAN); supported by funding from the NHMRC and the Victorian Department of Health.

Outcomes: Delivered through maternal and child health services, INFANT supports parents of infants aged 3 to 18 months to establish healthy eating and active play habits from the start of life. Evaluations have shown that children participating in INFANT consume more fruits and vegetables, drink more water and have reduced intake of sugar-sweetened beverages and sweet snacks at ages 3.5 and 5 years. The program also enhances parents' knowledge and confidence in feeding practices, with high levels of engagement reported.

Current status: INFANT is currently being scaled up across Victoria, with over 30 local government areas implementing the program, supported by funding from the NHMRC and the Victorian Department of Health.

Program: Transform-Us! is a school-based physical activity program for primary school-aged children.

Provider/funder: IPAN, in partnership with schools and supported by grants from the NHMRC and other collaborators.
Outcomes: This program uses a combination of curriculum changes, environmental modifications and social support strategies to encourage movement both during and outside school hours. Evaluations demonstrated significant reductions in sedentary time, increases in moderate-to-vigorous physical activity levels and improvements in students' overall health and wellbeing.

Current status: Despite its demonstrated effectiveness, widespread scale-up has been limited, likely due to funding challenges.

Program: Physically Active Children in Education (PACE) , a school-based implementation strategy designed to help New South Wales primary schools meet mandated physical activity policies.

Provider/funder: Developed by researchers at the University of Newcastle

Outcomes: PACE combines in-school champions, educational outreach and technical

assistance to support schools in delivering quality physical activity. A 2022 economic evaluation published found PACE to be a cost-effective intervention, with an incremental cost of $29 per additional minute of activity scheduled per school each week. The study demonstrated that PACE not only improves policy implementation but also offers good value for money.

Current status: Despite its strong evidence base, broader implementation remains limited, underscoring the need for mechanisms to scale cost-effective prevention strategies in schools.

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

Strengthening government investment in long-term, evidence-based prevention requires a commitment to sustainable funding for prevention with a focus on systemic change. The Australian Prevention Partnership Centre's 'Partnering for Prevention' project (32) has engaged over 30 leaders from across the prevention landscape to identify leverage points for improving the chronic disease prevention system in Australia. Early insights from the project (unpublished interim findings) highlight eight priority areas that leaders across the Australian prevention landscape agree could transform prevention efforts.

1. Prevention Policy and Governance Structures
Priority needs to be placed on formal governance and accountability for the leadership of prevention action in Australia. This includes transparent and systematic reporting of investment in prevention activity across government silos and levels, alongside stronger alignment between state and federal policy priorities. Existing initiatives known to deliver value could be better coordinated, implemented and evaluated, building on existing frameworks such as the National Preventive Health Strategy.

Collaborative action across state and federal governments, supported by bipartisan commitment, would help to ensure long-term consistency and impact. Sustainable action may also be supported by incorporating prevention into policy and legislation. For example, implementing sugar-sweetened beverage taxes and restrictions on junk food advertising. Adopting a Health in All Policies (HiAP) approach, where health considerations are embedded across sectors, can ensure social, environmental and commercial determinants of health are systematically addressed. South Australia's HiAP model provides a strong example of this type of cross-government integration.(33)

2. Data systems and use for prevention
Developing and strengthening integrated data systems, that include equity-focused and real-time data, would support scaled action, enable comprehensive tracking of prevention efforts, and highlight gaps. Establishing shared data sets across government agencies and sectors and consistent indicators to track prevention efforts would support more effective coordination, identify trends, and strengthen the evidence base for sustained investment in prevention.

To further strengthen this infrastructure, governments can support timely access to data for researchers and practitioners and invest in the development of decision support tools that translate data into actionable insights for policy and program improvement.

3. Cross-sector engagement, collaboration and networks

Whole of government action for prevention could be a priority of central government across commonwealth, state and local governments. Establishing formal structures and mechanisms that enable cross-sector collaboration, bringing together representatives from different sectors including health, disability, education, housing, Aboriginal-controlled organisations and industry could allow more streamlined prioritisation and coordination of prevention action. Sustaining such cross-sectoral action requires clear accountability arrangements, shared policy priorities and agreed indicators to monitor progress.

4. Prevention workforce development and capacity
To support sustained prevention efforts, focus can be put on building capacity and capability in the prevention workforce. Capabilities in systems thinking, equity, collaboration, use of evidence and policy leadership are critical. Building the capability of policy actors across government in the role of prevention and systems approaches would also support national system leadership and coordination.

5. Prevention leadership, political will, and advocacy
Building and sustaining bipartisan political support for prevention is crucial to progress a long-term vision. This could be supported by strengthening capacity of national collaborations across government, research, industry, and community, to champion prevention priorities and monitor progress.

Alongside this, efforts to strengthen public understanding and support for prevention would help to keep prevention on the agenda of decision makers, while coordinated advocacy from key stakeholders would help maintain momentum across election cycles.

6. Prevention evidence and knowledge translation
Supporting the development of policy-relevant evidence is critical to further advancing prevention efforts. This can be strengthened by establishing collaborative mechanisms between research, policy, practice and the community to enhance co-design, develop research-policy outputs and improve evidence translation.

To further overcome barriers in translating evidence into practice, health systems should build capacity to adapt and evolve based on emerging evidence. The Learning Health System approach, (34) developed by Professor Luke Wolfenden and colleagues, offers a practical model. By integrating systems science, data science, and implementation science, Learning Health System creates real-time feedback loops that allow researchers, practitioners and communities to collaborate closely, quickly analyse data and adjust prevention efforts.

Crucially, approaches like these fosters strong partnerships between researchers and policy makers, enabling the co-identification of evidence gaps, co-creation of research and shared ownership of outcomes.

7.Prevention funding and investment
Sustained and dedicated investment for prevention is essential to achieve long-term health impacts. Preserving existing funding and increasing ongoing investment, including consideration of allocating at least 5% of total healthcare expenditure to prevention as recommended by the Public Health Association of Australia and other key stakeholders, would help secure the long-term benefits of prevention. To help safe-guard

investment for prevention into the future, potential levers such as bi-partisan support and legislative frameworks could be explored.

There have been calls for a dedicated prevention investment fund modelled on the Medical Research Council Future Fund (35) that would store and release funding for preventive health programs, campaigns, early detection innovations and other practical investments. One potential source of revenue to support this fund is excise taxation on tobacco, alcohol and sugar-sweetened beverages. Even a modest proportion of tobacco taxation, which currently raises around $13 billion annually, could provide a strong financial foundation for the fund.

Some proposals suggest a formal governance structure, modelled after the Pharmaceutical Benefits Advisory Committee and the Medicare Benefits Advisory Committee, could transparently assess and prioritise preventive health interventions, focusing on priority health and equity needs. (36),(37),(38)
The National Partnership Agreement on Preventive Health39 offered a valuable example of a funding model. It demonstrated how a performance-based funding approach can set clear national goals while giving states and territories the flexibility in how to deliver and tailor prevention strategies to local contexts, including equity considerations, within a defined budget. This structure supported targeted and responsive implementation, while also providing the Commonwealth greater assurance that investments were being used effectively and aligned with national prevention priorities.

8. Equity-led and community-driven prevention
Prevention efforts must be designed with and led by communities, sharing power and building trust. The focus for prevention must continue to move away from individual responsibility toward a broader societal and governmental responsibility to create solid social, cultural and economic foundations that enable communities to thrive within supportive environments. The use of policy and legislation to support equity considerations is important. In addition, embedding community co-design principles into funding and delivery models could help ensure prevention efforts are responsive, effective and sustainable.

Value of The Australian Prevention Partnership Centre in supporting these eight areas
To better support investment in prevention activities with broad and long-term benefits, governments need infrastructure that enables coordination, sustained action, and the practical application of evidence in real world settings. The Australian Prevention Partnership Centre (Prevention Centre) offers a model for how this can be achieved. The Prevention Centre strengthens national capacity to deliver effective, scalable and equitable prevention by building systems leadership, developing workforce capability, generating policy-relevant research and translating evidence into practice.
It's collaborative approach builds on trusted partnerships with policy makers, prevention agencies, researchers, practitioners and communities, to support complex systems change and deliver coordinated, co-designed solutions that respond directly to real-world implementation challenges.
As governments consider pathways to strengthen prevention investment and infrastructure, the Prevention Centre is well placed to contribute expertise, partnerships, systems-informed insights and evidence to inform investment decisions, support national coordination, and deliver meaningful, long-term health outcomes for the Australian community.