Public Health Association
AUSTRALIA

Submission to the Productivity Commission on a national framework to support government investment in prevention

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The **Public Health Association of Australia** (PHAA) is Australia's peak body on public health. We advocate for the health and well-being of all individuals in Australia.

We believe that health is a human right, a vital resource for everyday life, and a key factor in sustainability. The health status of all people is impacted by the social, commercial, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the root causes of poor health and disease. These determinants underpin the strategic direction of PHAA. Our focus is not just on Australian residents and citizens, but extends to our regional neighbours. We see our well-being as connected to the global community, including those people fleeing violence and poverty, and seeking refuge and asylum in Australia.

Our mission is to promote better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.

Our vision is for a healthy population, a healthy nation and a healthy world, with all people living in an equitable society, underpinned by a well-functioning ecosystem and a healthy environment.

Traditional custodians - we acknowledge the traditional custodians of the lands on which we live and work. We pay respect to Aboriginal and Torres Strait Islander elders past, present and emerging and extend that respect to all other Aboriginal and Torres Strait Islander people.

Introduction

PHAA very much welcomes the opportunity to provide input to the Productivity Commission's examination of a potential "**national framework to support government investment in prevention**".

We have been calling for such a framework for several years, and we have previously examined the policy options in this area and made recommendations to the Government. We refer you to:

- Our most recent (Jan 2025) annual Budget Submission to the Treasury - Public Health: Prevention is the Priority (Pre-Budget submission for the 2025-26 Commonwealth Budget)
- A paper associated with that submission, specifically addressing the subject of Commonwealth Budget framing to pursue public health strategies

We welcome the expressed goal of your consultation, where you propose to develop:

> *"A framework that measures and incorporates the long-term benefits of prevention could encourage greater investment in evidence-based prevention programs. Such an approach could improve outcomes for people through timely and effective support and enhance the sustainability of the care economy."*

You also write that:

> *"We will consider the features of a framework that would allow for investment in prevention based on a broad and long-term assessment of potential benefits."*

All these comments are very welcome. PHAA believes that Australia is losing very significant economic productivity – as well as other social goods including good population health – through poor policy choices which allow needlessly increased burdens of disease across our society. But conversely, these failings mean that there are very clear gains in productivity available to be achieved in this field.

The structural inhibitions on making better policy are relatively simple to understand, and can be solved. The federal Government, and some state governments, have already set policy directions to achieve better preventive health outcomes through strategic investment, but these goals are not being met.

We believe that the Productivity Commission has both a role and a responsibility to make clear and robust recommendations to the Government on this subject. Our organisation, armed with abundant evidence in this field, stands ready to assist the Commission in any way we can to advance the productivity agenda which the Treasurer has commissioned.

Your survey questions

Your consultation paper seeks:

> *"…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. … 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."*

This statement nicely encapsulates the policy challenge that hinders greater investment in and commitment to preventive health measures.

You pose three questions in this section (numbered questions 12, 13 and 14), and for your convenience we make our comments under those headings.

Q12. Barriers to governments investing in prevention

There should not be any insurmountable barrier to government making preventive health investment decisions, or scaling up the limited number of existing programs. All that is needed is the political decision-making will to serve the public interest and make corresponding investments through the Budget.

Australia is very well-supplied with expertise and evidence bases to support a wide range of preventive health investment choices. Across the fields of tobacco-nicotine, food-nutrition-overweight, alcohol harm, cancer prevention, and other major disease knowledge areas, we are blessed with strong academic and expert evidence. Happily, the best measures put forward by public health experts are not highly costly in up-front budgetary investment, and indeed often generate revenue.

Prevention of the burden of disease at the scale that is possible (estimated at 1/3rd of the current degree of burden) would bring major productivity and other benefits across the whole of the economy.

Australian and international research also supports our directions and proposals. Over a decade ago the work of the *Assessing Cost Effectiveness in Prevention* (ACE) study (2010) by the University of Queensland School of Public Health and Deakin University demonstrated that many disease prevention initiatives have strong benefit-cost outcomes.[1] The World Health Organization (WHO) *Tackling Non-Communicable Diseases: Best Buys* report (2017) has provided governments with a benefit-cost assessed smorgasbord of public health investments, all with positive economic returns.[2] The more recent WHO *Saving lives, spending less: the case for investing in non-communicable diseases* report (2021) provides estimated returns on investment for a range of disease prevention measures.[3]

Key barrier: absence of a government financial policy framework

A key barrier arising from government financial practices is the reluctance to adopt long-term planning, but instead an almost total reliance on short term, 4-year Budget financial planning.

At present the Government simply lacks an adequate decision-making framework to assess, prioritise, develop, Budget-fund, and measure the outcomes of preventive investment proposals. Governments are not making adequate investments, with the predictable result that we are losing national productivity potential, because they have built no adequate mechanisms to do so. We discuss possible solutions below.

Key barrier: influence of industries sapping political will

There is a significant *political* barrier to productivity-enhancing prevention investment: the blocking influence of the various 'harmful industries' active in these fields. We discuss possible solutions below.

Key barrier: benefits of prevention accruing across different sectors and/or tiers of government

A further structural problem is that the division of governing responsibilities between the three levels of government, as well as between silos within governments, means that the perceived 'burden' of decisions (including their expenditure cost) is not aligned with each government or agency's perception of their 'benefit' from a successful outcome.

In the particular case of national productivity, the benefits, which significant, are highly diffuse, such that governments and agencies do not 'feel' the immediate benefit flowing from investment costs they should ideally make. This is a structural barrier which the Productivity Commission should be specifically concerned to solve.

Key Barrier: Economic Discounting of future benefit driving Treasuries to exclude investment in Prevention

Economic discounting, which reduces the value of future costs and benefits, significantly hinders preventive health investments, such as vaccines and other programs and policies, by devaluing long-term health gains and making short-term cost savings seem more attractive. This leads to budget-setting policies that prioritise immediate costs over the long-term benefits of vaccines, delaying or derailing vital prevention policies ad program that are likely to improve future health outcomes.[4]

A specific recent example is the case made for adult vaccination in Australia.[5] The argument made by pharmaceutical company GSK obviously promotes their business and financial interests, but the principles articulated are accurate and apply well beyond vaccines.

The pharmaceutical sector, through its representative body Medicines Australia, make the argument that the current discount rate of 5% applied to investment decisions in many Australian governments structurally excludes many long term preventive health investments from consideration by Treasury analysts nationally and in jurisdictions.[6] This rate is the highest in the OECD, with many comparable nations adopting much lower discount rates.

Medicines Australia recommends a discount rate of 1.5%. This recommendation deserves serious consideration to become a specific Productivity Commission recommendation to government. If such a change to discounting rates is implemented it will remove one of the most significant barriers to policies and programs that are likely to drive long term health benefits and associated productivity improvements.

Resources

The following resources on the economics of preventive health investment may assist the Commission:

- *How do we fund Public Health in Australia? How should we?* – link – Alan Shiell, Kate Garvey, Shane Kavanagh, Victoria Loblay, Penelope Hawe, 2024
- *Prevention: A Productivity Superpower* – link – Glaxo Smith Kline, 2024
- *Reimagining Prevention for a Healthier, More Prosperous Society* – link – Office of Health Economics (UK), Grace Hampson, Margherita Neri, Matthew Napier, Graham Cookson, 2023
- *Revenue, capital, prevention: A new public spending framework for the future* – link – Demos, Andrew O'Brien, Polly Curtis, Anita Charlesworth, 2023
- World Health Organization (WHO) *Saving lives, spending less: the case for investing in non-communicable diseases* report – link – 2021.

Q13. Examples of successful prevention programs

There have been many demonstrations of the effectiveness of prevention. Perhaps the largest and most visible is the enormously positive social, health, economic, and (for *governments* as well as individuals) financial impact of the reduction of smoking over the past five decades, an intervention which has been demonstrated by many studies to have greatly increased our wellbeing and our lifespans, and made our nation significantly more economically productive.

The following is a selection of papers and reports which demonstrate the cost effectiveness of particular preventive health programs.

- *Cost-effectiveness analysis and return on investment of SunSmart Western Australia to prevent skin cancer* – link – Louisa G Collins, Carolyn Minto, Melissa Ledger, Sally Blane, Delia Hendrie, *Health Promotion International*, Volume 39, Issue 4, 2024
- *Building an economic model to assess alcohol interventions* – link – a project of the Australian Prevention Partnership Centre (part of the Sax Institute) - 2023
- *Cost-effectiveness of LiveLighter®- a mass media public education campaign for obesity prevention* – link – Jaithri Ananthapavan, Huong Ngoc Quynh Tran, Belinda Morley, Ellen Hart, Kelly Kennington, James Stevens-Cutler, Steven J. Bowe, Paul Crosland, Marj Moodie, PLoS ONE, 2022
- *Economic evaluation of the Western Australian LiveLighter® campaign* – link – Jaithri Ananthapavan, Huong Ngoc Quynh Tran, and Marj Moodie, 2021
- *Forty years of Slip! Slop! Slap! A call to action on skin cancer prevention for Australia* – link – Walker H, Maitland C, Tabbakh T, Preston P, Wakefield M, Sinclair C, Public Health Research and Practice, 2021
- *Mass media public education campaigns: an overview* – link – Tobacco in Australia, page 14.1, 2019
- World Health Organization (WHO) *Tackling Non-Communicable Diseases: Best Buys* report – link – 2017
- *Economic evaluations of tobacco control mass media campaigns: a systematic review* – link – Edwinah Atusingwize, Sarah Lewis, Tessa Langley, Tobacco Control, Vol 24 (4), 2015
- *Assessing Cost-Effectiveness in Prevention* – link – Theo Vos, Rob Carter, Jan Barendregt, Cathrine Mihalopoulos, Lennert Veerman, Anne Magnus, Linda Cobiac, Melanie Bertram, Angela Wallace, ACE Prevention team, University of Queensland and Deakin University, 2010
- *Cost-effectiveness of interventions to prevent alcohol-related disease and injury in Australia* – link – Linda Cobiac , Theo Vos, Christopher Doran, Angela Wallace, Addiction, 2009

PHAA has highlighted the many success stories in public health in Australia with the report *The top ten successes in public health in Australia I the past 20 years*.[7]

Q14. Government actions to better support investment in prevention

Policy actions that should be taken broadly fall into three categories:

- Policy interventions to reduce the adverse impact of lobbying by harmful industries
- The establishment of 'mechanism' of internal processes by key agencies to assess and advance the optimal preventive health investment proposals
- Setting appropriate targets for funding an adequate investment In prevention

Reducing the impact of lobbying

It is clear than in many fields of policy, the impact of industry lobbying for commercial benefit (including regulatory benefit) contrary to the public interest occurs. industry lobbying for commercial benefit (including regulatory benefit) contrary to the public interest occurs. Prominent examples include the tobacco and vaping, alcohol, unhealthy or junk food, and gambling sectors. This is of course an endemic problem worldwide.

Some Australian state jurisdictions have implemented legislation covering lobbying transparency, limitation of political donations from harmful or corruption-inducing industries. However at the Commonwealth level, the regulatory frameworks on these topics are weak or absent. We recommend that the Productivity Commission take note and of the link between the impact of such lobbying and constraints on the potential for a productivity agenda to achieve its goals.

PHAA has made recommendations for reform at the Commonwealth through our statement on Unhealthy Political Influence (2021).

What is needed are robust public policy interventions that *protect* government decisionmakers – ministers, their advisers, and officials – from industry influence. We recommend that the Commission include in any recommendations to government specific and strong proposals for reform in this area.

Improving government assessment of benefits of effective prevention

Despite the work being done in academic and expert bodies, there is surprisingly little investment in *evaluation* occurring within government health departments and treasuries. There are signs that this is beginning to change within the federal Treasury and the Department of Health. PHAA encourages both agencies to establish a 'mechanism' for developing, assessing and advancing preventive health investment bids for budget funding.

We offer a metaphor with the long-established expert panels which assess changes to listings on the Medicare Benefits Schedule (through the Medical Services Advisory Committee), and the Pharmaceutical Benefits Scheme (through the Pharmaceutical Benefits Advisory Committee). These mechanisms, providing governments with expenditure-controllable funding pipelines and an expert gatekeeper function to ensure funds are invested effectively and efficiently, underpin those major pillars of our national health treatment system. A similar pipeline, along with a gatekeeper expert panel, could support work to confirm effective preventive health investment and assess proposed programs, Such a process must begin within the Department of Health before progressing through Treasury and Department of Finance processes in Budget-making.

We also note the impending establishment of the permanent Australian Centre for Disease Control, according to the Government's commitment. The Australian CDC could be an alternative location for a benefit assessment unit, supported by an expert panel, tasked with evaluating preventive health investment proposals.

A key consideration here is the long-term nature of the outcomes resulting from investment in preventive health. It remains common that proven effective interventions in chronic disease risk factors such as

tobacco, alcohol, healthy eating, physical activity, sun protection and more, attract short term program funding, only to have investment cease as pressure on budgets to support acute health care program attract greater attention and resources. In essence, "the urgent trumps the important." This plays out in all too many election campaigns, but is also endemic to present budget decision making processes.

We note the progress of the Treasury in establishing the Australian Evaluation Centre, which is focussed on decision-making frameworks similar to what we propose. We encourage this work. However, we recommend that an integrated framework that crosses departmental boundaries and supports preventive investment decisions from evidence-based initiation and development (presumably within the Health department) through evaluation and prioritisation (whether in the Health department or in the Treasury, or both) through to Budget decisions of Cabinet, and then followed up by impact evaluation (wherever located). The framework must function without hindrance by departmental gaps and different interests. We urge the Productivity Commission to include in its recommendations on this subject clear advice that such hindrances must be overcome, if a successful productivity outcome is to be achieved.

Setting appropriate targets for funding of prevention

There is evidence that around 1/3rd of the burden of disease is preventable. This represents a very large opportunity for strategic investment that would greatly reduce national health treatment expenditure, and similarly increase economic productivity of the Australian workforce. This makes the case that there is currently severe underinvestment in comparison to the level of investment that would be financially, economically and socially optimal.

In fact, the Government *has* set targets for a high-level shift in the profile of government expenditure on health to achieve more prevention, and in turn constrain long-term health expenditure overall. This was the first recommendation of the *Sustainable Health Review* commissioned by the Western Australian government in 2018.[8] An Independent expert panel led by Robyn Kruk was tasked with the challenge of recommending how the WA government could make its health system Sustainable. Its first recommendation was to "Increase and sustain focus and investment in public health, with prevention rising to at least five per cent of total health expenditure by July 2029." Since that report's acceptance, the WA Government has recommitted to that target prior to both the 2021 and 2025 state elections.

The Commonwealth Government echoed this theme through the *National Preventive Health Strategy* (2021) (NPHS), adopted in full by the present Albanese Government. However, the Commonwealth Government Budgets since 2021 have not taken significant action to implement this strategic statement.

As the evidence abundantly shows, investing in prevention is significantly positive for government financial, economic and other outcomes into the long term. (It should be noted that in a subset of fields, such as relating to accident and injury harm reduction and prevention, there are financial and other benefits even in the short term). From the weak position of prevention investment in Australia at present, the greater the near-term investment in prevention, the better. We urge the Government to implement existing government policy by at minimum achieving, through Budget decisions, the NPHS target that 5% of total health expenditure is on preventing programs by the year 2030.

Conclusion

PHAA welcomes the decision of the Productivity Commission to focus on preventive investment, particularly in the health field. We are particularly keen to highlight the following points:

- Australia is losing very significant productivity through poor policy choices which allow needless burdens of disease across our society; conversely, there are very clear gains in productivity to be achieved in this field.
- The structural inhibitions on making better policy are relatively simple to understand, and can be solved.
- The federal Government, and some state governments, have already set policy directions to achieve better preventive health outcomes through strategic investment, but these goals are not being met.
- The Productivity Commission has both a role and a responsibility to make clear and robust recommendations to the Government on this subject.

Our organisation, armed as it is with abundant evidence in this field, stands ready to assist the Commission in any way we can to advance the productivity agenda which the Treasurer has commissioned.

Please do not hesitate to contact me should you require additional information or have any queries in relation to this submission.

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6 June 2025

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1 https://public-health.uq.edu.au/files/571/ACE-Prevention_final_report.pdf

2 See the updated Appendix 3 of the WHO Global NCD Action Plan 2013-2020. http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_R11-en.pdf

3 World Health Organization, 2021: *Saving lives, spending less: the case for investing in noncommunicable diseases*: https://www.who.int/publications/i/item/9789240041059

4 *Discounting in Economic Evaluations Pharmacoeconomics*, https://pmc.ncbi.nlm.nih.gov/articles/PMC5999124/, Arthur E Attema, Werner B F Brouwer , Karl Claxton, 2018 May 19;36(7):745–758. doi: 10.1007/s40273-018-0672-z

5 https://au.gsk.com/media/6926/the-economic-value-of-adult-vaccination-in-australia-october-2024-final.pdf

6 Medicines Australia, Submission to the PBAC on the Base Case Discount Rate, 2022; https://www.medicinesaustralia.com.au/wp-content/uploads/sites/65/2022/02/Medicines-Australia-submission-to-PBAC-Discount-Rate-Submission-January-2022.pdf

7 PHAA, *Top 10 public health successes over the last 20 years*, PHAA Monograph Series No. 2, Canberra: Public Health Association of Australia, 2018; https://nacchocommunique.com/wp-content/uploads/2018/11/phaa-top-10-public-health-successes_final.pdf

8 https://www.health.wa.gov.au/~/media/Files/Corporate/general-documents/Sustainable-Health-Review/Final-report/sustainable-health-review-final-report.pdf