

Delivering quality care more efficiently. Deakin Health Economics response to the Productivity Commission Interim report.

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(<https://iht.deakin.edu.au/our-research/deakin-health-economics/>). Our response is related to the Productivity Commission 'Delivering quality care more efficiently' Interim report's recommendation to develop a National Prevention Investment framework (Framework).

We would like to congratulate the Productivity Commission on an excellent Interim report. The key requirements of an effective and efficient investment Framework, in particular for preventive health, are well covered in the draft recommendations. Here we offer some feedback on how the Framework could be improved and respond to the information requests.

Opportunities to improve the National Prevention Investment Framework

- The Interim report proposes that the Framework will cover the whole spectrum of interventions across primary, secondary and tertiary prevention. We agree that there is a need for increased funding in all these areas however, we recommend that the Framework is focused on primary prevention for the following reasons:
 - Primary prevention takes longer to demonstrate benefits compared to secondary and tertiary prevention
 - Primary prevention is not as amenable to gold standard study designs compared to secondary and tertiary prevention
 - Secondary and tertiary prevention interventions for health sit within the health sector and the requirement and opportunity for cross sectoral action is limited

Including all levels of prevention may reinforce current thinking and perception that primary prevention is less urgent, and more risky when compared to secondary and tertiary prevention, despite offering excellent value for money. It may perpetuate status quo of underinvestment in primary prevention.

- The Interim report seems to focus on the cost-saving nature of prevention initiatives. A large number of preventive health measures are cost-saving, however governments should also be willing to invest in interventions that improve wellbeing, even if they are not cost-saving. The same decision rules that apply to other interventions across other sectors should be applied – i.e. does the intervention represent net benefits to society. The focus should be on value-for-money and not solely on the potential to save money for the health system.

- The Framework seems to emphasise investing in effective and cost-effective programs. The most cost-effective interventions across various preventive health risk factors are *policies* that require political will and strong legislation.
 - WHO NCD Best Buys
<https://www.who.int/publications/i/item/9789240091078>
 - ACE Prevention https://public-health.uq.edu.au/files/571/ACE-Prevention_final_report.pdf
 - ACE-Obesity Policy
<https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0234804>
- The lessons from the 2008-2018 National Partnership Agreement on Preventive Health and Australian National Preventive Health Agency funding and defunding/abolishment are crucial to ensure the Framework has durability. Governance measures that ensure bipartisan support and safeguarding of decision-making independence are critical. This is particularly important when the most cost-effective policies (e.g. taxes, marketing restrictions, reducing availability, see above links) are also politically challenging.

Response to information requests

Information request 3.1:

When prioritising different proposals, how should factors such as overall net benefits, net fiscal effects, cost-effectiveness, equity, ease of implementation, timescale and the value of future benefits and costs be weighted? Are there existing frameworks that do this well?

How could a diversification strategy be designed to ensure that prevention programs from different sectors and with benefits across different timeframes are funded?

- We have developed priority-setting frameworks based on the work by Professor Rob Carter on the development of the Assessing Cost-Effectiveness (ACE) approach to priority setting
(<https://www.tandfonline.com/doi/full/10.1586/14737167.8.6.593?scroll=top&needAccess=true>)
 - In the [ACE-Obesity Policy](#) study we used the following criteria (we called them ‘implementation considerations’): strength of evidence, equity, acceptability to the general public/government/industry, feasibility, and sustainability. Based on the literature we assessed how well the intervention met these criteria (high, medium, low). Presenting these [results](#) alongside the cost-effectiveness results could help decision-makers weigh up these different considerations.

- We are currently conducting a scoping review of priority-setting criteria for obesity prevention and nutrition intervention priority-setting (<https://doi.org/10.17605/OSF.IO/W58BC>). We hope to submit this paper for academic publication by November 2025. We are happy to provide initial results to you in confidence.
- We are commencing a project with Preventive Health SA to develop a priority-setting framework for obesity prevention. As part of this project, we will engage decision-makers to select the most appropriate criteria for their context, and also ascertain the respective weights for these criteria. We will have results for this project by May 2026.
- In addition to criteria to assess whether each preventive health initiative should be funded, there are considerations that are relevant when designing the Framework as a prevention investment strategy. This should balance investment across different risk factors, sectors, populations impacted (including priority populations), magnitude of investment across government sectors and tiers, and levels of risk (taking a portfolio approach where high-risk high-reward investments are balanced with low-risk low-reward strategies (that still produce net benefits)). This may be achieved by having different focus areas over different funding periods.
- In finalising the priority-setting framework, decision-makers across government sectors and tiers of government need to determine the relevance and weighting of each criterion (there are multi-criteria decision analysis [tools](#) that can be used, and we are currently using these tools to develop a priority setting framework for obesity prevention with Preventive Health SA). The priority-setting framework should also reflect community values. There has been limited engagement of the general public in determining their values and in including them in priority-setting exercises in Australia (<https://www.sciencedirect.com/science/article/pii/S0168851019302994>).

Should there be minimum cost-effectiveness and/or cost-benefit ratios and how should they be set?

Our response is related to developing cost-effectiveness thresholds for preventive health interventions. Although PBAC and MSAC have implicit thresholds for decision-making – which is appropriate - we believe that an explicit priority-setting framework including cost-effectiveness decision rules should be developed for preventive health decision-making.

- The most appropriate framework for preventive health decision-making where the range of interventions and policies may span a broad range of sectors is [cost-benefit analysis](#) – where all outcomes are monetised. Monetising health is challenging.
- There are two approaches to estimating the willingness to pay threshold for health impacts of policies and interventions. A more detailed discussion of these methods can be found in the following link [Chapter 5, page 54](#) and in this [paper](#).

- The opportunity cost approach is a supply side approach that represents the opportunity cost of the disinvestment required to fund the new initiative. In Australia, the opportunity cost of a quality-adjusted life year (QALY) was estimated at \$28,033 (2018 values) (<https://link.springer.com/article/10.1007/s40273-017-0585-2>). This approach is appropriate when making investment decisions within a fixed budget. The values used for decision-making by PBAC and MSAC are not stated explicitly but are likely much larger (<https://link.springer.com/article/10.2165/00019053-200119110-00004>). This method has several challenges to inform decisions related to prevention that occur in portfolios other than health. For example, what should the value of a QALY be for public transport interventions that improve health but are implemented by the Transport sector?
- The willingness to pay (WTP) approach is used to value the morbidity and mortality benefits of policies and programs. It is the method recommended by Treasury (<https://www.nsw.gov.au/sites/default/files/noindex/2025-03/tpg23-08-nsw-government-guide-to-cost-benefit-analysis.pdf>). The value of a statistical life year could be used to value a QALY (<https://www.mdpi.com/1660-4601/18/11/6168>; <https://oia.pmc.gov.au/resources/guidance-assessing-impacts/value-statistical-life>; <https://crawford.anu.edu.au/ttpi/content-centre/research/value-life-revisited-special-reference-australia>). A key question is whether it is affordable to use WTP values in preventive health decision-making. To balance this, the budget impact of interventions (affordability) could be included in the priority-setting framework.
- Other considerations when determining decision rules for prevention
 - Methods used to value benefits not traded in the free market (e.g. health, environmental impacts) should be applied consistently
 - Where does the funding for the Framework come from?
 - Will the budget be fixed?
 - Who will make recommendations for preventive health intervention funding. Who will make the final decisions on investment?
 - What evaluation frameworks will be used to ensure achievement of benefits and how will divestment decisions be made (and by whom?)

How should decision makers balance the need to assess early effectiveness of programs with the need to maintain consistent long-term funding for programs with long-term benefits?

- There should be a requirement for funded initiatives to articulate program logics (using theory of change) backed by evidence that demonstrate the pathway to

realisation of long-term benefits. In the economic analyses of these projects – uncertainty analyses should reflect the level of confidence in the evidence linking the steps in the logic model. This would allow decision-makers to assess the level of risk involved in the investment.

- There must be adequate funding for long term evaluation and data collection. This should include indicators of the fidelity of intervention implementation-, short-, medium- and long-term outcome indicators. Key cross-sectoral impacts should also be collected. Programs should be reviewed regularly with a view to improve programs to ensure effective implementation at scale prior to outcome evaluation. Processes should be in place to divest from programs and policies that do not offer value-for-money (acknowledging that prevention benefits are accrued many years into the future, adequate time for benefits realisation is required prior to divestment).
- It is important that post scaled-up implementation, ex-post economic evaluations are undertaken to assess whether the costs and benefits predicted in the ex-ante evaluation were realised. This will add to the international evidence base of effectiveness and cost-effectiveness of scaled-up preventive health policies. It will also assist in improving future ex-ante economic analyses that inform investment decisions.
- The Australian Centre for Evaluation should take a leading role in developing effectiveness and economic evaluation frameworks for prevention. This would improve understanding of the specific challenges in evaluating prevention interventions and foster stronger collaboration between agencies. Our research identified the lack of collaboration between health and central agencies as a key challenge that limits the use of economic evidence in preventive health decision-making (<https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0274869>).

Information request 3.1:

How should a National Prevention Investment Framework be implemented? What is the best way to incentivise Australian, state and territory governments to invest in prevention to improve future outcomes and avoid future costs? What changes if any to the existing budget operational rules would be needed to support consideration of recommendations from the Prevention Framework Advisory Board? Should alternative approaches be considered for governance of the framework, including institutional setting, processes for arriving at co-funding arrangements, decisions and evidence requirements? What considerations would ensure that the framework works together with existing prevention programs funded by states and territories? How can the framework encourage governments to keep supporting existing effective prevention programs?

- Information request 3.1 addresses vital issues that will determine the appetite within governments for the development of the Framework and to ensure adequate funding for prevention.
- However, this is best determined by those working within government structures who understand the key barriers to cross-sectoral and cross-jurisdictional engagement and decision-making. The PC report should recommend the development of a cross-sectoral and cross-jurisdictional working group to navigate these issues and ensure the governance arrangements will provide the right incentives for key stakeholders to engage with the Framework.

Evidence requirements for prevention

- The traditional hierarchy of evidence used in evidence-based medicine, where randomised controlled trials (RCTs) provide the highest quality of evidence, is too narrow to assess the quality of the evidence base for prevention interventions.
- For the [ACE-Obesity Policy study](#) we considered the balance of evidence based on study type and quality, the consistency of findings across studies and the proximity of the outcome measured to health outcomes (e.g. changes in BMI is more proximal to health outcomes than changes in attitude towards healthy/unhealthy foods) (<https://link.springer.com/article/10.1007/s13679-020-00376-z>).

The development of the National Prevention Investment Framework provides an exciting opportunity to enhance health, wellbeing and productivity. However, the development of the ideal Framework will likely be an iterative process. We recommend that an interim framework is implemented as soon as practical with processes in place to iteratively improve the Framework over time.