Public Health Association
AUSTRALIA

Productivity Commission

Delivering quality care more efficiently Interim Report – National Preventive Investment Framework

Contact for recipient:
E: https://engage.pc.gov.au/surveys/secure_form/survey/make-your-submission

Contact for PHAA:
Terry Slevin – Chief Executive Officer
A: 20 Napier Close, Deakin ACT 2600
E: phaa@phaa.net.au **T:** (02) 6285 2373

15 September 2025

Contents

Public Health Association
AUSTRALIA

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.

Key messages

> ***"The Australian Government should establish a National Prevention Investment Framework ("the Framework") to support government investment in prevention programs. Its aims would be twofold: to improve outcomes for individuals, with benefits for the wider community; and to reduce demand for future acute services."*** (Interim Report, page 62)

We wholeheartedly agree. Adoption of this recommendation by the Government could transform the health of Australia's population and make a major contribution to national economic productivity.

PHAA welcomes the opportunity to provide input to the Commission's interim report. While we recognise the other matters on which you are developing advice to the Government across multiple reports, we are entirely focused on one aspect of the interim report: draft recommendation 3.1 to "*Establish a National Prevention Investment Framework to support investment in prevention, improving outcomes and slowing the escalating growth in government care expenditure*."

The public health community in Australia is very strongly supportive of this direction, which aligns with proposals we have been making to government in our annual Budget submissions for several years. For example, see *Public Health: Prevention is the Priority* (our Pre-Budget submission for the 2025-26 Commonwealth Budget), and the additional information is set out in our paper *Budget Priorities for Public Health 2025-26: Commonwealth Budget framing to pursue public health strategies* (same location).[1]

We argue in this submission that the recommendation can be improved in three important ways:

- **MAKE THIS RECOMMENDATION ABOUT THE POPULATION, NOT THE AGENCIES**
  The case for the recommendation should be refocused on ***the health of the population***, not the fiscal interests of governments or agencies.

- **INTER-JURISDICTIONAL AGREEMENT THREATENS DELAY**
  The recommendation should focus on what changes the **Commonwealth Government** should make to its investment decision processes. The ***conditionality of the recommendation*** on a common framework being agreed by all nine governments is a significant risk. Co-operation with jurisdictions is highly valued and important and should be pursued, however pre-conditionality would be likely to lead to delay and could possibly derail progress altogether.

- **ALLOW SECTORS TO JOIN WHEN READY**
  While we support the ultimate delivery of a Framework which stretches across the full scope of government activity, preconditioning the commencement of the Framework on simultaneous participation by all departments and agencies will also create a substantial risk of delay and defeat. The recommendation should focus on early adoption of a mechanism for investment in prevention in the health domain – which is ready – and ***let each sector of government join 'when ready'***.

The goals of this recommendation should be about the population's health, not the agencies

➔ In our webinar discussing the interim report on 26 August 2025, one participant asked: "*How do you convince a Minister for Justice to invest in prevention programs in prisons when the long-term savings are likely to be realised by another (health) portfolio*?"

This question sums up the fundamental problem of government thinking being limited by its portfolio and department structure. The problem exists not only between agencies within governments, but between the Commonwealth and state-level government.

The public are interested in whether government policies and government investments in programs create an environment in which they can live healthier lives. They are not interested in whether internal government financial arrangements mean that a state government should somehow 'compensate' federal investment for any financial benefit that the state gains from the demand for health care being eased. Nor are they interested in whether such 'benefit sharing' is happening between agencies within governments.

We note the basic framing of the Victorian Early Intervention Investment Framework (EIFF) program. Much as the EIIF may be achieving good outcomes, its structural focus on state departments being allowed to keep fiscal 'benefits' (in terms of estimated future expenditure reductions) is a distraction from higher socio-economic goals.

We appreciate that most of the people who will read the final report, and may act on it, are political leaders and public officials deeply engaged with financial management systems, and immediately accountable for achieving near-term fiscal results. We acknowledge that the art of implementing public sector reform involves placing the correct incentives and accountabilities on agencies and officials.

However, the productivity challenge on which the Productivity Commission is making recommendations is not about governments and agencies per se. The goal of this exercise is NOT to maintain present levels of fiscal results for agencies. It is to ***make the population healthier***, and thereby reap many benefits, including economy-wide productivity gains.

We therefore urge you to go through the interim report and revise the arguments to focus with greater clarity on the real goal of improving population health, social and economic outcomes.

In the text of the interim report there is too much focus on the interests of Commonwealth and state/territory departments as financial actors, and on the artificially 'competing' interests in agencies and of the two levels of government. This is internally inconsistent, since the interim report itself tags inter-agency and inter-governmental rivalry as a major problem. In some places recognizes this issue must be addressed, and in other places appears to passively accept it.

The Framework you are asking Government to create needs to rise above government structural rivalries, not surrender to them. The final report would be much stronger with a framing focused on the social and economic wellbeing of the community.

The interim report may also be too strongly focused on *programs*, in the sense of budget bids involving expenditure, where the expenditure is the main issue. We suggest that the Framework should encourage agencies to support a wider range of possible *policy interventions,* rather than merely spending measures – including regulatory changes, legislative reforms, and alterations to government institutions and practices which free up capability for preventive health measures of all kinds.

Investing in prevention can improve outcomes and care sector efficiency

Prevention reduces the risk of future problems or slows their development (p 52)

We support what appears under this heading. Here you cover material beyond just the interests of departmental and agencies, and address outcomes for the Australian community.

On the other hand, you merge the above comments with discussion of the efficiency of *the care sector*. The more efficient and effective the care sector is, the better. Benefits in terms of public outcomes will be care provided faster, to more people, with lower consumption of resources. Those are public goods. It is also a public good that public sector expenditure are not dissipated on any inefficient activity. However, the greatest productivity (and other social) gains will flow from making the population healthier. Improving delivery efficiency of health care services is an entirely separate matter from prevention.

The issue of co-funding between governments

Limiting language about what entities are meant to benefit from reform

> ➔ Page 52: "*recognising that the benefits fall across sectors and levels of government*".

There is a persistent thread in the Commission's paper that focuses attention on the internal fiscal situation for government, or for departments within government. The ultimate beneficiary should be expressed to be not a government or an agency, but *the population*, in respect of its condition of health and wellbeing.

An outcome of policy change (such as greater investment in prevention) which has measurable community benefit but is neutral in terms of its departmental fiscal situation is still a good outcome. An outcome could still be of net benefit even if one or more agencies increase expenditure, provided that a large community benefit is judged to be greater in value that that expenditure cost. The language used is still tied to the shibboleth that agency budgets in the short term should be the focus of concern, and this language perpetuates the limited thinking that is the very subject of this report's criticism. We strongly urge the Commission to reconsider the language used at these points in its paper.

> ➔ Interim report recommendation (3rd dot point), page 52: "*The mechanism should support co-contributions from state and territory governments based on their expected benefits*, …"

It is certainly possible that state and territory governments might coordinate their policy and their own recurrent expenditure choices with the Commonwealth as part of achieving preventive health objectives. The framing you have used here basically converts this issue into a fiscal conflict between the levels of government. This is a recipe for years of argument before any Framework even commences, and for ongoing dispute afterward.

You might modify that recommendation to read:

> *The mechanism should provide a capacity for – but not be entirely reliant on – support co-contributions from state and territory governments based on their expected benefit*s.

If an identified program of investment by the Commonwealth makes long-term sense in terms of health gains in the population, with consequent economic and also fiscal benefits to the Commonwealth *or to any other government, or to individuals*, then it is a program that the Commonwealth should adopt and fund. It is should not be a barrier or condition that other expenditure contribution at state level might be made. Starting arguments that states should make fiscal contributions because their future budgets might benefit from reduced expenditure is a needless tripwire.

For example, if the business case for a specific prevention investment (targeted, say, at a reduction at future prevalence of diabetes) were assessed by the (proposed) Prevention Framework Advisory Board

(PFAB) to have a range of social, economic and long-term fiscal benefits sufficient to make the program investment supportable, but some of those fiscal benefits (reduced future expenditure) would accrue to the budget of *a state*, not the commonwealth, it would not make sense to delay commencing that intervention until the state had agreed to financially compensate the Commonwealth? This is the mode of thinking which all governments need to rise above.

Limiting language about reducing demand

> ➔ Page 52: "*The Framework will support governments to invest in prevention programs that improve outcomes and reduce demand for future acute care services*"

The proposed Framework's usefulness should not be limited only to programs which "*reduce demand for future acute care services*", good though such outcomes might be. The Framework will be of benefit to the community simply by reducing the prevalence of disease and other harms.

This point raises a key reason why an excessive focus on reducing future fiscal outlays is problematic for this Framework. In a world of scare resources, many of our expensive health care services – such as tertiary care provided through hospitals – currently experience queuing, resulting in protracted waiting times and often suboptimal care. Valid and rational preventive care investments may have the desirable effect of reducing the prevalence of a disease in the community, in turn reducing queuing lengths and waiting times for care. That is a good outcome both in more healthy individuals in the population (leading more economically productive lives), and in the beneficial impacts on the treatment system from having a shorter queue. But it *may not result in any expenditure saving at all*, if the same quantity of service is still being provided through hospitals and other facilities.

It is therefore unhelpful to specify that a future expenditure saving is a *mandatory* element of any approvable preventive health investment program. The Framework should accept that a variety of benefits are being sought, with fiscal benefit through reduced expenditure being only one of several objectives.

Similarly, investment in prevention efforts should not be expected to meet a higher test when it comes to assessment of value. The paramount expectation on an oncology unit or an emergency service is not to reduce health costs, it is to make sick people healthier. Prevention efforts should also be expected to make people healthier. There may in many cases be a cost-saving benefit, but this should not be a mandatory requirement when assessing the social and economic value of prevention proposals.

Reliance on intergovernmental agreement

> ➔ Page 52: "*The Australian Government should work with state and territory governments to establish a National Prevention Investment Framework.*"; the Framework should be implemented by establishing "*…an intergovernmental agreement between the Australian, state and territory governments…*".

In Australian public life, there are few things slower than developing agreements between all nine governments, and agreements that are about distributing relative fiscal benefits suffer from this syndrome worst of all. We emphasise that this recommendation should *not* limit the proposal to one which only takes effect when agreed by all nine governments.

The Commonwealth can develop the proposed Framework for its own processes. If each state and territory were to develop its own similar framework, so much the better, and it will be beneficial if they are coordinated. Indeed, a subordinate program should be undertaken to promote and incentivize action and co-operation from the states and territories. But it would be wiser for the Commission to simply recommend that the Commonwealth government initially create a Framework simply for its own use.

Prevention improves quality of care through better outcomes (p 53)

We generally support what appears under this heading.

➔ Page 53: "*ensuring long-term budget sustainability*".

'Budget sustainability' is a misleading concept. Almost any amount of expenditure can be sustained over many years if doing so is a sufficiently high political priority. The near-term budgets of the agencies concerned can be kept free of deficit simply as a matter of government decisions to allocate the necessary funds. The term 'unsustainable' is often used misleadingly by critics of some expenditure, meaning no more than 'we wish not to spend this much', for political or policy reasons. The term 'sustainability' used in this way connotes a political choice, not a scientific measure about capacity to continue.

➔ same page: "*While prevention is often associated with population health, we take a broader view, and include interventions in areas like housing, education, justice and family support services, recognising that actions in one policy area may have benefits in others*."

This statement appears to separate *population health* from action on social determinants of health. A small rewrite that would flag the need for the breadth of intersectoral interventions that could prevent ill health could read as follows (key changes in bold):

> ***We take a broad view, that prevention in population*** *health includes interventions in areas like housing, education, justice and family support services,* ***environment, and climate****, recognising that actions in one policy area may have benefits in others.*

Prevention can make the care sector more efficient (p 54)

➔ Page 56: "

Benefits from prevention are potentially substantial, both for governments and people that benefit directly. But they can accrue over a longer timeframe than governments usually budget for."

Yes, very much so. This simple point makes the case that *Budget Process Operational Rules* (latest edition Dec 2023) which limit proposals to estimates of impacts in the first 4 years are not a logical way to proceed. As you conclude later (page 69), it will serve the public interest if the *BPO Rules* are changed on this point alone, regardless of the wider benefits to flow from the Prevention Investment Framework that the Commission proposes. Governments should take a longer-term view – covering not merely immediate forward estimates years – and funding decisions should reflect that longer term view.

But the current process of funding prevention is inefficient (p 57)

➔ Page 59: "*Budgeting rules also limit the ability for decision-makers to consider savings that accrue to other departments or agencies*."

This is true, and it would clearly be for the best if agencies could consider expenditure savings that "accrue to other departments or agencies". But once again, such a 'benefit' is only a means, not an end in itself.

A different approach is needed (p 60)

We strongly support what appears under this heading. We further stress the need to include in the case for the Framework an emphasis on *addressing inequality* as a key social and economic goal. This would be an appropriate location to strengthen that case.

Inter-jurisdictional agreement threatens delay

> ➔ Page 52: "*The Australian Government should work with state and territory governments to establish a National Prevention Investment Framework*." A specific dot point adds that "*an intergovernmental agreement between the Australian, state and territory governments that outlines prevention funding arrangements and the roles and responsibilities of relevant parties. The agreement should be accompanied by federation funding agreement schedules that deliver Australian Government funding to states and territories for specific interventions*."

Respectfully, we disagree. Few processes in Australian governance are more prone to lengthy delay, degradation of goal and mission, frustration and defeat, than a project made conditional on a nine-government agreement in advance. When any element of expenditure-sharing is involved, those risks increase greatly. This is especially so if states and territories are expected to address the question of their engagement and investment in prevention across many portfolios. Such an additional level of complexity invites the whole project being derailed.

It is incorrect to regard the two levels of government as identical financial actors equally obliged to contribute financially to joint delivery of outcomes. In Australia's national financial system, states and territories are reliant for large flows of revenue collected at federal level. State financial resources often in fact *are* federal resources, already handed down. Moreover, there are significant differences in financial capacity between the state and territory jurisdictions.

Many programs that the Commonwealth might decide to fund will use a state government or agency as the vehicle for delivery. To the extent that this is seen as a 'gift' to a state government, the point is being missed. Inter-jurisdictional fiscal rivalry is a framing that needs to be set aside if this exercise is to work.

There will be other matters where the states and territories will *be the delivery agencies* for programs initiated and funded by the Commonwealth. The public are not interested in hearing that an economically rational preventive health program is not proceeding because state governments are not meeting a Commonwealth demand for financial compensation from state governments (whether '50/50', or any other arbitrary proposition). This is one of the key inhibitions to rational policy in our federal system. The interim report already recognizes the seriousness of the problem. The Commission, in its final report, should strongly recommend to Government that such inhibiting inter-jurisdictional financial competition should be entirely excluded from the proposed Framework.

You write (on page 61) that "*A new nation-wide approach, that addresses barriers, is needed to overcome the structural challenges prevention funding faces across multiple sectors and levels of government*." In the comments we have just made, we do not wish to reject the desirability of a 'nation-wide approach'. But such unity cannot be wished into existence, and we counsel strongly against making the recommendation for a prevention Framework pre-conditional on such a unity being present.

These criticisms do not mean that integration across all government is not a desirable goal for the longer term. Such alignment would be welcome, and we support efforts to create it. However it should not be a precondition (and potential major stumbling block) to begin investing in prevention at a national level.

It would be welcome for all governments to share knowledge, communicate well, and adopt similar frameworks for preventive investment decisions within their respective competencies. But the fact is that for some public policy domains, the Commonwealth can play the role of policy leader, and should do so.

Allow sectors to join when ready

While the current interim report is clearly based on the health sector, the paper quite correctly acknowledges the complexity of social and economic determinants of health and identifies that 'health' is not an isolated domain of the community's wellbeing and standards of living. There are elements of the interim report which describe the Framework operating across a range of agencies – potentially almost all agencies – in Commonwealth Government investment choices.

We fully understand and support that this as an ultimate goal. But in the near term, we cannot ignore the immense complexity of government structures and impediments to reform. Recommending to Government the design of a complex framework implemented *across all sectors* of portfolios of government has the real potential to delay implementation of preventive health initiatives, serving no beneficial economic or fiscal purpose. Bluntly, a proposal that the Framework commence with all agencies 'onboard' simultaneously creates a major potential for delay in implementing the reforms that the Commission calls for.

The solution is to follow a course of action where a preventive investment framework is launched, but only applied from commencement to those portfolios that are Framework-ready. Given the origins of this present interim report, and the state of readiness of health as a sector, a specific emphasis on using the health portfolio as the pilot is an obvious approach. Other portfolio areas can be included in the framework from commencement, or over time, on a '*when ready*' basis. A Framework that advances broad-based, cross-portfolio preventive policy interventions should be the ultimate vision.

This is really an issue of pragmatic implementation of the desired reform, in a context of agencies and sectors that have different degrees of readiness. It would be a mistake to advise that the Framework should only commence when all sectors are simultaneously ready. It might be otherwise if there were a genuine and substantial whole of government approach to this Framework, championed by core agencies (Prime Minister and Cabinet and the Treasury), and backed by a serious commitment of new funding.

Noting this issue, the Commission's advice should recommend the desired end-point for the Framework, but refrain from advising an all-agencies-ready precondition for commencement.

Health is ready now for prevention

The science of prevention in the health domain is quite well-developed in Australia and internationally. There is already a significant body of evidence behind many specific policy interventions and program investments that will prevent the future prevalence of many diseases, including the WHO NCD Best Buys work, the ACE Prevention study, and the ACE-Obesity policy work.[2, 3, 4] Systems of evidence-based assessment of these and more new proposals can be created with relative ease. 'Health' is ready for a prevention Framework of the kind you are proposing.

We therefore advise that you recommend the creation of a Framework which starts with a solution for health prevention. Adoption by other portfolios can follow, perhaps after lessons are learned from implementing a preventive health investment framework.

Wider policy considerations

Above we have examined what the interim report offers. We wish also to comment on what it does NOT address.

The draft proposals focus heavily on intra-governmental processes for making government expenditure decisions. These are of course important, and we largely agree with the thrust of the proposals about wiser ways to make government expenditure decisions.

But as currently framed, the recommendation is overlooking:

- The vital role in any comprehensive approach to preventive health of non-expenditure (or low expenditure) *policy interventions* – regulatory changes, law reform, or institutional improvements;
- The bigger picture, whereby we might pivot our management of the national economy towards policies that fundamentally support health, and prevent harm. The recommendation as made are set entirely within the current system of public economic and fiscal management.

As we have discussed already, the issue is that the interim report is largely concerned with *the financial value to government* of avoiding the future *costs* (in terms of recurrent expenditure) of health harm. We would like to hear more about the social value of avoiding those harms themselves. The interim report is too closely focused on *the fiscal interests of agencies*, not on *the wellbeing interests of the population itself*.

Social determinants and primordial prevention

While this interim report is framed as initially addressing the health sector, it is impossible to understand that sector in isolation. Public health thinking strongly emphasizes the interrelationships between the many social and economic determinants of health. Prevention of disease, injury and other harm often occurs in a setting which is not immediately recognizable as part of 'the health sector' – in matters such as education, housing, justice and the condition of the environment in which we live. It is common to speak of 'primordial prevention', (sometimes also referred to as 'upstream' or 'structural' prevention) which involves policy interventions that have beneficial effect in advance of individuals experiencing harm, as the best object of policies to create a healthier society. With respect to graphic 3.1 (p.53) which illustrates the multiple levels of prevention, we draw to your attention that primordial prevention is entirely missing.

We note that the Framework that the Commission is proposing is not really about secondary, let alone *tertiary,* prevention at all. These forms of prevention are about minimizing exacerbation of harm during the treatment of a health condition, and are correctly understood as responsibilities of providers of health care. Given the long history of treatment expenditure demands dominating the budgets of our government health agencies, we warn against allowing this innovative prevention Framework to become concerned with later-stage prevention matters.

Inequality

Another observation we would make is that the Framework should have a much stronger focus on socio-economic inequality.

Inequality, including the large and growing differences among Australian in access to resources and services, is a primary driver of differences in disease burdens across our society, and in the total burden of disease across all of society. There are too many elements of our current economic system that directly increase inequality, with a range of adverse social and economic outcomes, as well as being a driver of political disruption. It is vital that the final report, and the Framework that may result, does not drive health gains towards only those who are already well-off in our society. Without understanding the role of

inequality as a driver of disease and harm, overall whole-of-economy productivity gains are not going to be fully realized.

We therefore urge you to strengthen the degree to which addressing inequality is built into the Commission's advice as part of making the case for the adoption of the proposed Framework. In harmony with that message, the detailed administration of the Framework should ensure that fair distributional outcomes are built into the methodologies for calculating total costs and benefits of proposed preventive interventions.

A 'wellbeing economy'

We would also like to hear more from the Government – including through the Commission's advice to it – about the implementation of Treasurer Chalmers' visions for wellbeing, as a framing for the economy and as a rationale underlying all future government budgets.

In 2023 Treasurer Chalmers stated in his Measuring What Matters framework that "the measures are in addition to, not instead of, the more traditional ways we measure our economy like GDP, employment, inflation and wages," (our emphasis). We suggest that the Commission frame its advice to Government to more fully embrace the 'additionality' of health gains above and beyond agency fiscal interests.

While improving investment in prevention will support the Government's vision for a wellbeing-focused economy, the Commission's advice in the interim report does really address this vision. We would like to see the practical implementation of the Commission's recommendation for a Preventive Investment Framework integrate with a "Wellbeing Framework" driving government economic policy as a whole, based on a vision of economic management re-organised around sustaining wellbeing for all.

In short, the current discussion is too focussed on avoiding government expenditure as if that were in itself a goal, or a driver of productivity. Maintaining the short-term budget balance of governments – or of departments and agencies – is a means, not an end. The real goal – and potential driver of increased productivity – is a healthier population.

Implementation of the Framework

A national framework to support government investment in prevention

The Framework's governance structure

> ➔ Page 51: the interim report recommends "an *independent and cross-sectoral Prevention Framework Advisory Board that assesses and provides expert advice on requests for prevention funding*."

The Framework will need a governance structure. We urge the Commission's final advice to focus on:

- Changes to the Department of Finance *Budget Process Operational Rules*, confirming that second-round fiscal impacts, or longer term (beyond the current budget cycle) benefits, may legitimately be taken into account in agency expenditure investment proposals submitted through the Budget process
- The establishment of an entity (the proposed PFAB) to oversee the independent, expert assessment of public health outcomes for investment proposals. Various models drawing from the experience of Medical Services Advisory Committee (MSAC) and Pharmaceutical Benefits Advisory Committee (PBAC) have been suggested. We support using these well-established, evidence driven prioritizing mechanisms as a conceptual model for the Prevention Investment Framework.
- Establishment or enhancement of financial investment assessment competencies to oversee this Framework in (at least) the Treasury and the Department of Health, Disability, and Aged Care (DoHDA) – noting the Australian Centre for Evaluation (ACE) unit which has already been created within Treasury.
- Development of a capability for program effectiveness assessment into the future.

The management of risk in investing based on uncertainty

The interim report also refers to the 'risk' to government arising from the uncertainty of benefits for long-term programs. It is inherent in long-term investment programs that patience is needed to see exactly what outcomes occur. Programs will be deployed in complex environments where many factors outside of a specified program may boost or hinder outcomes.

However, the reference to 'risk' is of concern. All public program investment comes with some degree of risk as to outcomes. As a matter of public policy we all want to see programs succeed in their aims, and we appreciate that prioritization of limited resources requires that we favour investments that are more likely to succeed. But investment in preventive programs should not be subjected to a more restrictive risk model than other government investment choices, and in particular it would be a major mistake for the final report to create any sense that preventive investment must be no-risk, or low-risk, in nature.

The mechanisms in the recommended Framework for evidence-based 'risk' assessment in selecting programs, and ongoing processes for assessing their impact as they are delivered, needs to be well-crafted, and acknowledge that assessment itself is costly and uncertain. The Framework that emerges from the Commission's advice will not thrive if it is constrained by overly prescriptive and expensive assessment systems, and risk management expectations that are greater than apply to other areas of public investment, which result in ongoing refusal to invest in prevention interventions.

A national framework to support government investment in prevention

We strongly support the initial thrust of what appears under this heading. However in this section the interim report repeats the calls for a "cross-sectoral body", and call for the preform to be "*jointly progressed by Australian, state and territory governments*". Our pragmatic criticisms on this are discussed above.

> ➔ Page 62: "*The comparative value of programs should consider the costs and benefits of all levels of government, with co-funding arrangements based on estimates of expected benefits*."

It is appropriate that all costs and benefits should be considered, but this description seems to limit the scope of those costs and benefits only to those experienced by governments.

We also believe that a search for agreed "co-funding arrangements" is a distraction. We appreciate, as stated above, that persuading officials and political leaders to adopt reforms of this kind will most likely need some element of demonstrated fiscal benefit, and that fear of fiscal costs may diminish internal championing of otherwise desirable proposals. As we argued above, if a preventive investment passes assessment of its benefits for population health and for consequences including productivity gains, it should be less relevant which government or agencies budget accrues any future fiscal advantages.

A robust process to analyse programs (p 62)

We support what appears under this heading.

A pragmatic approach to evaluation (p 64)

We support what appears under this heading.

Implementing a prevention framework across government

Prevention Framework Advisory Board (p 65)

We support the thrust of what appears under this heading.

We have earlier criticized the notion that the Framework should commence only when a broad cross-sectoral system is ready. In the absence of strong leadership from Prime Minister and Cabinet and Treasury, and commensurate funding commitments, our approach can be summed up as "let sectors join when ready". As an endpoint, the Framework should have a core oversight entity in Treasury – the PFAB that you recommend – supported by units in each department/agency that becomes ready to participate in the Framework.

The groundwork for most proposals would only require each departmental Board to manage their own proposals. As such prevention panels become numerous, the central Board can provide support and leadership, set standards, and review the operation of the framework as a whole. The central PFAB could, perhaps, be tasked to manage specific investment proposals with a high degree of cross-sectoral impact.

Data and evaluation (p 67)

We support what appears under this heading.

Increasing investment in prevention (p 67)

We generally support what appears under this heading. But we note that the final sentence of this section speaks of the relative "contributions" of governments "depending on expected benefits". As discussed above, we disagree that such an approach should be regarded as a test of success, or be allowed to complicate the design of the model.

Both the Commonwealth (through the *National Preventive Health Strategy 2021-30*) and the Western Australian Government (through its adoption of the *Sustainable Health Review* of 2019) have committed to the goal that 5% of health spending should be directed to prevention by the year 2030. [5, 6]. In Western Australia this target has received unequivocal government commitment during two successive state election periods (2021 and 2025).

Possible funding mechanisms (p 68)

We support the thrust of what appears under this heading. We would welcome the creation of a "National Prevention Investment Fund", because it would allow a major increase in confidence that government is committed to this framework for the medium-long term.

Consistent with what we have written earlier, we disagree with the comment "*State and territory governments would be expected to co-fund programs that are proposed, based on their share of expected benefits*." (page 69). Co-funding may well happen, and is to be encouraged, but it should not be based on a model where benefits to governments are the predominant metric being used.

Responses to the 'information request' sections

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? All these factors seem to be relevant, although the second – "net fiscal effects" – raises the problem of the current Department of Finance *Budget Process Operational Rules* preventing agencies from inserting estimates beyond year 4 of a budget timeframe, on the basis that such fiscal effects are difficult to measure. The real issue is that cost-benefit analysis work done for proposed long-term preventive interventions needs to capture a wider scope of benefits (and costs), that apply further into the future, and across a wider field of government and non-government outcomes, than is accepted under present budget process rules. In addition, the Framework should provide for other key but harder-to-measure factors – 'equity' being a key example – to be given greater weight when calculating cost-benefit ratios.
Should there be minimum cost-effectiveness and/or cost-benefit ratios and how should they be set? A 'minimum' would not serve any helpful purpose. In principle, anything with a benefit/cost ratio more that 1 should be undertaken, subject to prioritisation of limited resources. On the assumption that such ratios are reliably calculated for a range of proposed programs, those with the highest ratios will be chosen first. Any minimum ratio is likely to be irrelevant in practice, as the focus of attention will naturally fall on the higher-rated proposals. Measures currently applied in MBS and PBS processes might be considered. An informal convention exists where interventions achieving an outcome at a cost of $50,000 per Disability Adjusted Life Year (DALY) are considered good value, and many interventions well above that price point are funded.
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? This goes to the heart of the long-term political patience needed to support preventive health interventions. The programs that will be most effective in preventing disease will need to be rolled out over long terms. Programs for 4 years only are likely to be those with less effective ultimate outcomes. The approach needed is to fund selected programs (which would have been assessed to have attractive benefit/cost ratios), with an ongoing commitment, build an appropriate evaluation and outcome measurement model, and be prepared to apply learnings about effectiveness as a preventive health funding commitment goes along. This should include being prepared to shift funding away from low-effectiveness programs should such results be detected.
How could a diversification strategy be designed to ensure that prevention programs from different sectors and with benefits across different timeframes are funded? It is not entirely clear what is being referred to by "a diversification strategy". While this sounds attractive, it could become a distraction. The Framework should ultimately encourage policy

intervention proposals which have effects across multiple 'sectors of government', and across aspects of society outside direct activity of government agencies.

Built into the program choice framework should be some element of equity and greatest-need weighting of programs to different parts of the Australian community (although some programs will be of benefit broadly across the community without particular distinctions). But adding any 'diversification' element (such as regional/urban 'fairness') may become a needless complication to the actual details of preventive programs as we already know them.

Information request 3.2

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?

This Framework should not be put forward as requiring all-nine-government agreement as a precondition. In particular preconditional agreement about 'fiscal benefit sharing' between governments would be a recipe for delay and failure.

If the framework is useful in guiding Commonwealth budget investment initiatives suitable to be funded, then it should simply be applied as a Commonwealth-only structural improvement.

That is not to say that cross-government agreement and coordination is not to be welcomed – only that it should not be set as a precondition for starting to implement a Framework at Commonwealth level. To avoid this trap, states and territories – and their agencies – should be welcomed over time through an opt-in model. Providing financial incentives for states and territories to participate is a long-standing mechanism to engage jurisdictions.

Further, the prospect that better health and reduced disease prevalence in the community has a fiscal benefit to state governments does not actually mean that a compulsory inter-governmental 'benefit-sharing' approach should be adopted. There is no reason to require contribution from state fiscal resources. Better population health is a good outcome absolutely, with consequential fiscal benefits flowing to all levels of government.

It may be that state governments consider copying the budget investment framework that the Commonwealth develops for this Framework. They should be assisted to do so. But state service delivery responsibilities are not the same domain of policy in interventions as national programs, so the character of their interventions will be different.

Further, it is not necessary that every jurisdiction uses an identical model. It will be useful if they adopt very closely similar measures of success and metrics. Advice regarding design and common standards could flow from a Commonwealth-only framework being developed.

What changes if any to the existing budget operational rules would be needed to support consideration of recommendations from the Prevention Framework Advisory Board?

The Department of Finance's *Budget Process Operational Rules* is the key government document. This guidance binds all departments as to how they make Budget bids for revenue and expenditure proposals.

The key changes that should be made are:

a. Suspend the 'financial offset' rule (that a department must identify an equal expenditure reduction elsewhere for any new proposed item of expenditure) for this framework.

b. Suspend the rule that 'second round fiscal effects' (roughly, estimates of expenditure or revenue changes beyond the 4th year of the bid timeframe) may not be taken into account.

c. Permit – indeed, encourage – agencies to identify not only fiscal gains but also social and economic benefits that accrue outside the agency's responsibilities, whether in the responsibilities of another government agency, or to our society and economy generally.

In short, the notion that the process of Budget bidding is all about the net fiscal position of one department at-a-time, so that impacts on the department's own budget position is they key measure of outcome, needs to be set aside. The real outcome to focus on is the resulting health of the population.

Should alternative approaches be considered for governance of the framework, including institutional setting, processes for arriving at co-funding arrangements, decisions and evidence requirements?

Both within Treasury and within Health (DoHDA), special units should exist to assess these benefit/cost long-term implications, separate from the Budget-bidding units of Department of Finance and DoHDA. In crude terms, this reform is proposed in the context of a cultural divide between *economists* – who think in long-term concepts – and year-to-year thinking *fiscal managers* within agencies. Both have their proper role, but the prospects of preventive health investment make the long-term economic perspective by far the more important.

What considerations would ensure that the framework works together with existing prevention programs funded by states and territories?

There are a range of existing programs that operate with both national leadership and state and territory delivery, relating to immunisation, cancer screening and other preventive interventions. There are also many programs where there is strong performance in some jurisdiction and a significant gap in others, skin cancer prevention being an example. In some cases the Commonwealth is providing strong leadership and substantially variable performance across jurisdictions.

However, there have been too few actual preventive health programs funded by government. Fear of conflict with 'existing programs' does not provide any basis for delaying or distorting the development of a new Commonwealth framework for decisions.

Specifically, to the extent that there are existing programs being trialled or delivered by states, their effectiveness and outcomes should be surveyed and become an input into national assessment of program options. There is no conflict or problem here, but rather an opportunity.

How can the framework encourage governments to keep supporting existing effective prevention programs?

A better means of capturing, reporting and scrutinising program in a range of preventive program is important. Sharing existing resources, results, outcomes and learnings, and greater adoption and adaptation of successes in various corners of Australia still happens too infrequently. To address this, the development of stronger evaluation capability is vital. The Government has already begun good work on this direction (the ACE unit, for example). There will need to be an expansion of such capability within the financial as well as other departments.

Conclusion

PHAA strongly supports the Commission's general direction and its important recommendation to create a National Prevention Investment Framework. This is potentially of historic importance.

We are pleased at the reaction and community discussion that the interim report has triggered. We were delighted that a webinar which we hastily organised and held on 26 August attracted within just three days the attention of over 200 viewers. We thank Commissioner Angela Jackson for attending and taking audience questions on that occasion.

We recommend revising the report in the following ways:

- Make this important recommendation be about a vision for the health of populations, not the finances of agencies
- Avoid the delay that flows from conditioning the proposal on inter-jurisdictional agreement
- Allow 'sectors' of governments to join the Framework *when ready*, working towards an ultimate vision that transcends portfolios altogether. We believe the health portfolio is ready now to advance preventive investment intervention proposals.

The PHAA appreciates the opportunity to make this submission, and we wish you well in crafting a powerful final Report that achieves Government adoption.

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

Terry Slevin

Chief Executive Officer
Public Health Association of Australia

15 September 2025

References

1 https://www.phaa.net.au/Web/Web/Advocacy/Briefing-papers.aspx?hkey=d8bd1c4f-5563-4541-a608-7f787499a285

2 https://www.who.int/publications/i/item/9789240091078

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

4 https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0234804

5 https://www.health.gov.au/resources/publications/national-preventive-health-strategy-2021-2030?language=en

6 https://www.health.wa.gov.au/improving-wa-health/sustainable-health-review