Response to the Australian Productivity Commission Interim Report – Delivering quality care more efficiently

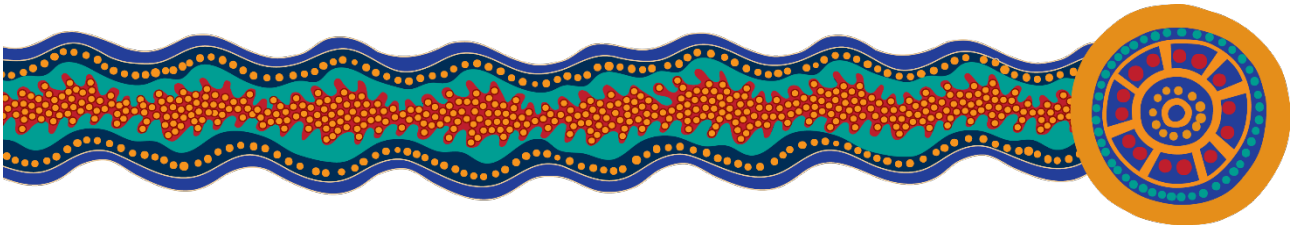
15 September 2025

Contact for Queensland Health submission

Mark West

Executive Director, Prevention Strategy Branch

[REDACTED]



The Queensland Government respectfully acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional and Cultural Custodians of the lands on which we live and work to deliver healthcare to all Queenslanders and recognises the continuation of First Nations peoples' cultures and connection to the lands, waters and communities across Queensland.

Introduction

Prevention Strategy Branch

Prevention Strategy Branch (PSB) has a broad and strategic policy role in chronic disease prevention, delivering policies, programs, services that work towards ensuring our built, natural, commercial and health service environments promote health, address lifestyle risk factors and provide opportunities to intervene before chronic disease conditions develop or worsen. PSB supports prevention activities in the public health system and works in partnership with stakeholders within and outside the health system.

Health and Wellbeing Queensland

Health and Wellbeing Queensland (HWQld) is statutory agency under the health portfolio. It has a legislated remit under the Health and Wellbeing Queensland Act 2019 to reduce the burden of chronic disease by addressing risk factors such as physical inactivity, poor nutrition and obesity through a range of functions including policy development and advice, programs, and partnerships.

This document combines responses from **Prevention Strategy Branch** and **Health and Wellbeing Queensland** to questions related to the third policy reform area of the Delivering quality care more efficiently interim report:

A national framework to support government investment in prevention.

General comments

- The establishment of a National Prevention Investment Framework (the Prevention Framework) which aims to improve population health outcomes and slow the escalating growth in government health and social care expenditure is strongly supported. This recommendation has potential to overcome longstanding barriers to prevention and will strengthen the Australian Government's vision for more efficient, high-quality care.
- Investment in prevention offers significant and wide-ranging benefits, including reducing demand on our overburdened hospital systems. Approximately 6.4 million hospitalisations per annum (55% of total hospitalisations) are due to chronic diseases. An estimated 36% of the burden of disease in Australia in 2024 was attributed to modifiable risk factors, which could have been avoided or reduced (AIHW Australian Burden of Disease Study 2024).
- The National Preventive Health Strategy recommends an ongoing, long-term prevention fund, with a goal of 5% of total health expenditure across Commonwealth, state and territory governments by 2030.
- The Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025 – Final Report (2023) recommended a renewed focus on prevention activities to address the rising burden of chronic disease, complementing the National Preventive Health Strategy and work of the Australian Centre for Disease Control.
- Recognition of the broader social determinants of health, including commercial determinants, is crucial to effective and balanced prevention investment. The design of the framework must prioritise primordial and primary prevention and pursue equity.
- Prevention of chronic disease through primary prevention interventions targeting the risk factors of tobacco use and nicotine addiction, unhealthy diets, physical inactivity, risky alcohol intake, gambling and promoting and protecting mental health, is cost-effective, supported by a wealth of evidence, and should be a high priority for investment.
- Policy and regulatory prevention measures are highly cost-effective in addressing the social and commercial determinants of health, are cross-sectoral in nature, and most levers sit at the federal level in Australia.

Responding to the questions outlined in the interim report

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?

Balance economic outcomes with long term benefits and equity

The purpose of the prevention investment framework is to reduce demand for future acute services (social and health), therefore the potential for proposed actions to achieve intersectoral benefits should carry highest weight. The expected economic outcomes and benefits of prevention in the medium and longer term should be balanced with achieving equity and fairness. Actions that can cut across multiple social issues for the most disadvantaged cohorts are most effective at achieving equity. These actions are also likely to see the greatest gains in reducing acute service demand, despite what may be perceived as smaller scope and higher implementation costs in the short term.

Clear assessment criteria aligned with key national strategies and frameworks

A clear set of assessment criteria should guide decision-making, including the option to rank or prioritise interventions, with built-in flexibility to capture the diverse merits of a range of prevention initiatives. The potential of an initiative to address one or more of the key chronic disease modifiable risk factors of tobacco use and nicotine addiction, unhealthy diets, physical inactivity, risky alcohol intake, gambling and promoting and protecting mental health should be highly regarded. Evidence supports a multi-strategy approach with a mix of intervention types, and alignment with key national strategies and frameworks such as the National Preventive Health Strategy, National Obesity Strategy, National Tobacco Strategy, National Dementia Action Plan, National Alcohol Strategy, and the Measuring What Matters Framework should also be considered.

Reducing the prevalence of chronic disease will increase productivity

In the context of productivity, the potential for an intervention to boost economic gains in the medium to longer term is vital. Chronic disease accounts for 64% of the total burden of disease in the Australian population, with levels of multimorbidity increasing (AIHW Multimorbidity in Australia 2025). People living with multimorbidity often have more complex health needs and experience poorer overall quality of life than people without multimorbidity. In 2022, the proportion of people aged 18–64 who were working or seeking work was lower among those with multimorbidity (77%) compared with those with no long-term health conditions (87%). It has been estimated that lost labour force participation from chronic diseases is

projected to cost $67.7 billion by 2030, representing 459,000 lost productive life years (AIHW Health expenditure in Australia 2022-23). A large proportion of this burden is preventable.

Whole of population policy/intervention, in preference to individual, behaviour-focused programs

Prevention interventions that have reach over the whole have much greater potential for return on investment than programs targeting specific population cohorts, settings or geographic locations. For example, the 2010 Assessing Cost-Effectiveness in Prevention study demonstrated that introducing tax increases on tobacco (30% increase), alcohol (30% increase) and unhealthy foods (10% increase), alongside mandatory salt limits on processed foods, it was estimated that $6 billion of net savings could be made to the health system through a reduction in direct healthcare costs (https://public-health.uq.edu.au/files/571/ACE-Prevention_final_report.pdf).

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

Minimum cost-effective ratio not recommended

The Medical Services Advisory Committee (MSAC) and the Pharmaceutical Benefits Advisory Committee (PBAC) do not set minimum cost-effectiveness ratios to allow flexibility to recognise other factors such unmet need or disease impact. Given the range of sectors in which prevention activities may be proposed and the range of anticipated outcomes, setting minimum levels of cost-effectiveness may hamper the assessment of initiatives' true value, or the funding of initiatives that target specific inequities.

The range of potential prevention policies, programs, and regulatory initiatives are very broad and setting a minimum cost-effectiveness or cost-benefit ratio is unlikely to be practical. The opportunity cost for a QALY in the health sector is $28,033 (https://link.springer.com/article/10.1007/s40273-017-0585-2) and while this may be considered good value for money, this threshold may undervalue prevention interventions which target population-level outcomes with longer time horizons for benefits.

Consider implementation factors

The availability of economic evidence to guide decision-making on prevention policy and programs is increasing. For example, the Assessing Cost-Effectiveness methodology was developed as a priority-setting tool to facilitate evidence-based decision-making (https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0234804). It combines technical rigour in the cost-effectiveness analyses with other considerations that influence policy decision-making. In addition to cost-effectiveness, the six implementation factors considered were strength of evidence for intervention effect, equity impacts, acceptability of the intervention to various stakeholders (including the community being targeted), feasibility of intervention implementation and sustainability of the intervention once implemented. Cross-sectoral gains should also be considered.

Primordial/primary prevention has a higher return on investment

Every dollar invested in preventive health saves around $14 in health care and other costs (cost benefit ratio), however measuring the efficacy of preventive health investment is complex and depends on many factors, including proximity to disease. Upstream approaches based in the primordial or primary end of the prevention spectrum have greater potential for high return on investment (ROI). Within primary care and health settings, secondary and tertiary prevention interventions have some benefits, however due to lower ROI, are recommended as a lower priority for funding. If supported, secondary and tertiary prevention interventions should be based on a high level of evidence for effectiveness from the peer-reviewed literature. For example, an economic evaluation of a lifestyle (structured antenatal diet and physical activity) intervention to reduce adverse pregnancy outcomes demonstrated an estimated $4.75 for every dollar spent (https://pmc.ncbi.nlm.nih.gov/articles/PMC9449797/)

The University of Queensland (UQ) Health and Wellbeing Centre for Research and Innovation conducted an economic evaluation of UQ Health Care's Logan Healthy Living lifestyle management program in 2025. Overall, the program returned a value of $1.82 for every dollar invested, or an 82% return on investment. Due to most program participants already experiencing longstanding, often complex diabetes on entry to the program, this program reflects tertiary prevention. Whilst demonstrating a good return on investment, the program would likely have demonstrated a greater ROI if delivered instead to a cohort of participants in the rising risk/prediabetes category.

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?

Theory of Change and Program Logic

Proposed prevention interventions should use program logic and theory of change frameworks to identify short-, medium- and long-term outcome measures of success, or indicators, to be monitored regularly throughout implementation. This is key to prevention initiatives where positive results may take years or even decades to measure, with cumulative impact on multiple health outcomes over time. There is significant evidence for the long-term effectiveness of health promotion and public health approaches that are grounded in robust theories of change and logic models, despite a lag of up to 17 years between the creation of evidence in the research, to translation in practice. Assessing early effectiveness should consider process, with requirements to demonstrate adherence to proposed activities grounded in strong theoretical foundations. Consideration of outcomes-based or milestone payment arrangements may be useful to spread the risk between the applicant and government, and to tie ongoing investment to positive outcomes. For new and innovative interventions, a degree of tolerance for setbacks or divergence from expected outcomes should be built into the monitoring framework to avoid discontinuation of programs that deviate from expected early outcomes.

Using Systems and Implementation Science

The emerging field of systems science identifies the criticality of system dynamics, context and other implementation factors in the complex area of prevention. Consideration of piloting before scaling and testing system dynamics will allow programs to be assessed and can generate early learning and evidence to inform whether a program is ready to expand, without committing up front to large-scale funding. Implementation science addresses the gap between knowing what works, and consistently applying it in real-world practice, therefore may also be useful for measuring iterative quality improvements, impacts and outcomes. To be scalable and sustained, prevention initiatives need to address system factors, use an implementation science approach, and be well integrated within settings, leveraging other healthcare and community supports, services and activities.

Australian Centre for Evaluation

The Australian Centre for Evaluation within Australian Treasury aims to embed good evaluation principles and practices across government. Utilising expertise within ACE would assist in improving the quality of evaluation evidence to support better policy and programs for prevention and would also improve understanding of the complexity of evaluation of prevention initiatives within central government agencies.

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

The purpose of the Prevention Framework is to reduce demand for future acute services, therefore the potential of any proposed initiative to achieve cross-government benefits should be prioritised. Broad criteria should assess whether the initiative:

- addresses one or more modifiable risk factors for illness, disability, or social disadvantage
- aligns with key national strategies and frameworks
- targets priority cohorts
- delivers benefits for different sectors, tiers of government, and jurisdictions.

Parameters around funding allocation for different sectors could enforce diversification at the approval stage. Considerations include:

- initiatives that are representative across various sectors such as health, education, and justice to avoid over-concentration in one policy area and ensure a mix of interventions across government portfolios.
- a balance of funding, preferencing primordial/primary over secondary and tertiary prevention to ensure funding is not focused only on acute, crisis-response issues.
- a combination of initiatives that deliver rapid, measurable benefits (such as vaccination campaigns or road safety education), as well as those with evidence-backed longer-term benefits (such as chronic disease risk reduction and chronic disease prevention to reduce risk during critical life stages such as pregnancy).

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?

State-based health systems are required to respond to the immediate and complex demands of acute service delivery, with little budget and capacity to invest in long term preventive health solutions. Strong federal government leadership is required, with multi-year funding commitment beyond the forward estimates.

The National Partnership Agreement on Preventive Health (NPAPH) is an example of a previously funded, health focused funding agreement. An Australian study investigating elements of the NPAPH and the unfunded National Chronic Disease Strategy (https://pubmed.ncbi.nlm.nih.gov/27305656/) concluded that the elements of successful national action were:

- strong Australian Government leadership and coordination
- setting a common agenda
- national alignment on priorities
- evidence-informed implementation strategies
- partnerships within and across governments and other sectors, and
- funding and infrastructure to support implementation.

Considerations for implementation include:

- a package or suite of interventions, i.e. programs, policies, regulations, with extended timeframes to assess benefits, and process evaluation built into design
- across the heath, employment, social services, education and housing sectors
- applicants could be public health community, not-for-profits, non-commercial entities
- assessments based on societal effects, ROI, cost-benefit, budget impact, equity and spillovers into other sectors
- need to look long-term, beyond forward estimates and political cycles
- trial interim framework with iterative improvements over time.

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 benefits of prevention accrue across tiers of government, jurisdictions and sectors. Current Federal Budget rules don't allow for forecasting or consideration of financial and productivity benefits beyond the four-year estimates period. This inability to consider second round fiscal effects can act as a barrier to policy proposals that have significant, long-term benefits for society, such as those offered by prevention policies. Adequate investment will require reform to government budget and fiscal decision-making processes to allow for consideration of financial and productivity benefits beyond the four-year estimates period and single portfolio or level of government. Evaluation and costing of prevention policy and program proposals should consider impacts up to a 25 years' timeframe.

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

Establishment of the National Prevention Investment Fund needs bipartisan support and should be legislated to afford protection through political cycles. Because the benefits of effective prevention would be realised across multiple sectors and tiers of government, the Prevention Framework should be subject to an intergovernmental agreement between the Australian, state and territory governments with co-funding based on expected benefits and separate to core business.

The proposed Prevention Framework Advisory Board (PFAB) offers benefits through independence and expert-led structure. Decision-making independent from government will assist in reducing political pressure, however integration of operations with central agencies, particularly Treasury, remains necessary to effectively action recommendations.

At the jurisdictional level, it is recommended that governance be led by the Health Department, with cross-government representation at Director-General level.

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?

The Prevention Framework has the potential to strengthen and build on prevention activities occurring at the state and territory level. New funded initiatives should either fill identified gaps, scale up proven pilot initiatives, or align with and expand existing effective state programs, rather than duplicating or displacing efforts. Establishing data-sharing arrangements between national and state agencies, and primary and acute care, will also ensure needs assessments accurately identify population health needs, service gaps, and areas of overlap.

Co-funding arrangements should incentivise states and territories to maintain or expand current evidence-based prevention investments, rather than replacing existing resources. This might include establishing intergovernmental agreements that protect existing state prevention funding, or consideration of maintenance-of-effort provisions, where existing, effective state-level policies or programs are maintained or enhanced.