The Australian Prevention Partnership Centre

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Response to the Australian Productivity Commission Interim Report

15 September 2025

Introduction

The Australian Prevention Partnership Centre (Prevention Centre) is a national collaboration that brings people, ideas and evidence together to build a stronger, more connected prevention system. We work with policy makers, researchers and practitioners to provide a coordinated voice for prevention, incubate solutions and support real-world action that improves population health. Our mission is to improve the equity, efficiency, and effectiveness of the chronic disease prevention system.

The Prevention Centre convenes a national network of stakeholders, including the Commonwealth Government, national NGOs, and state and territory governments. We also partner with national research institutions to ensure our work is informed by the best available evidence and reflects the full spectrum of preventive health. Through these collaborations, we support cross-sector initiatives, bringing prevention into the broader public policy agenda.

We welcome the Productivity Commission's recognition of prevention in its consultation on delivering quality care more efficiently. The interim report highlights prevention as one of the most effective ways to improve Australia's productivity and strengthen the care economy. It notes that even a modest 10% reduction in preventable hospitalisations could save $600 million a year through better collaborative commissioning. Importantly, stronger investment in prevention could significantly improve health outcomes, reduce inequities, and enhance wellbeing and quality of life across the Australian population.

The Prevention Centre strongly supports the report's recommendation (3.1) to establish a *National Prevention Investment Framework* and Prevention Framework Advisory Board to support investment in prevention. This framework would guide government investment in prevention, ensuring that interventions with the greatest impact on the wellbeing of Australians are prioritised.

We welcome the opportunity to contribute to shaping the framework. This submission sets out the Prevention Centre's response to Recommendation 3.1 in the interim report, along with our suggestions on the Commission's specific requests for further information. We see the development of a *National Prevention Investment Framework* as a landmark opportunity to strengthen and reform the prevention system and are committed to working with the Productivity Commission to help shape and implement it.

Response to the interim report

The Prevention Centre strongly supports the establishment of a *National Prevention Investment Framework* (hereby in referred to as the Framework) and Prevention Framework Advisory Board (PFAB) to support investment in prevention. This reform presents a significant opportunity to reshape how governments invest in prevention, shifting the focus from short-term efficiency to long-term wellbeing, equity, and sustainability.

Given our role in collaboration and convening the voice of prevention stakeholders across the national prevention network, the Prevention Centre is well placed to reflect the views and thinking of leaders about opportunities to strengthen the system. One example is our Partnering for Prevention project[1] which has already engaged more than 50 senior leaders from across the prevention landscape (government, NGOs and research) to identify leverage points for strengthening Australia's chronic disease prevention system. Early insights from this work (unpublished interim findings) highlight that Australian prevention leaders strongly support the need for such a Framework having specifically identified the action to "*Establish a dedicated, long-term prevention fund with clear investment targets and protections within the budget process*", which directly aligns with the Productivity Commission's recommendation. Other priority actions identified by leaders are also critical to the Framework including:

- establishing clear governance to set priorities and oversee funding
- working cross-sectorally, supported by frameworks to drive collaboration, accountability, and joint investment across portfolios.

The proposed Framework has the potential to deliver on these urgent priority reforms clearly articulated by Australia's top leaders in chronic disease prevention.

To maximise the Framework's impact, the Prevention Centre recommends:

1. Prioritising upstream and structural prevention measures
2. Expanding evaluation and embedding equity at the core of decision-making
3. Establishing strong governance arrangements with clear accountability across sectors and organisations

Recommendations

Recommendation 1: Prioritising upstream and structural prevention

The Prevention Centre welcome's the Productivity Commission's broad view of prevention, recognising its cross-sectoral nature and the need to address the determinants of health to achieve lasting change. We recommend however that the Framework place greater emphasis on these upstream factors, rather than spreading the focus across the full spectrum of prevention.

The report itself acknowledges that "preventing a problem from developing can be a more efficient use of resources than addressing it after it happens" (p. 54), yet the proposed framework is positioned to cover all levels of prevention from primary to acute. While each level of prevention has an important role, the framework should place stronger emphasis on upstream prevention – addressing the social, environmental, and economic determinants of health that reduce risks before they arise (see point on definitions below). These types of interventions are consistently shown to be the most effective in improving long-term health outcomes[2] given their effects across multiple sectors, yet they remain under-represented in current funding arrangements. Because these approaches require coordinated action across multiple sectors, not just health, there is limited capacity to resource solutions and responsibility for funding and accountability is not clear-cut. As a result, governments rarely prioritise these interventions. The limited public health funding that is available is typically directed towards secondary or tertiary prevention, where short-term pressures are most obvious. Even then, the design and delivery of interventions are often constrained by a biomedical model, with value measured mainly through impacts on the health system. This leaves little room for approaches that benefit population health and address the wider social and structural determinants of health. Such underinvestment is particularly concerning for priority populations, including Aboriginal and Torres Strait Islander peoples, who are disproportionately affected by inequities in the social and economic conditions.

The Framework presents an opportunity to address this imbalance through a focus on supporting upstream prevention initiatives (often referred to as primordial and primary prevention). Without this focus, there is a risk of replicating current practice, where secondary and tertiary interventions focused on the detection and management of disease are prioritised. Upstream prevention demands a coordinated cross-sectoral approach that no single sector can deliver alone – an approach the Framework is uniquely positioned to support. Thus, in practice, it should be considered that the Framework only be applied when implementation and outcomes are relevant across more than one sector. Where prevention activity (such as acute and tertiary prevention efforts) is delivered and reap benefits from a single sector, then that sector should be responsible and held accountable for delivering these activities, using existing sector-relevant mechanisms for funding and oversight.

Definitions of prevention

It is important to clarify the definition of prevention when determining the scope of the Framework, as different sources use the term in different ways. For example, Figure 3.1 in the interim report describes primary prevention as including measures such as access to childcare and economic

support for families. In much of the preventive health literature however, these would be considered primordial prevention – upstream population-level strategies that expose the whole population or subgroups to conditions that support health and often address socioeconomic factors. By contrast, primary prevention is more commonly defined as interventions that address risk factors for ill-health, such as poor diet, physical inactivity, and alcohol or tobacco use, and are often achieved through policy and legislation, infrastructure changes, mass media campaigns and education programs.

To avoid confusion, the Productivity Commission should draw on definitions of prevention that are widely used in public health and consider adopting or promoting a common term to support shared understanding. Further, the definition refinement could consider adopting less complex language categorisation, which might better support action across multiple sectors, such as upstream and downstream prevention.

Inclusion of structural interventions

Finally, the interim report focuses heavily on programs, while underplaying structural interventions such as taxation, regulation and fiscal measures, which are among the most effective, equitable, cost-effective and sustainable forms of prevention. The World Health Organisation's NCD Best Buys explicitly identify regulation and policy measures as high-value prevention strategies, alongside structural approaches such as urban design that enable healthier environments.[3] From an equity perspective, structural interventions should also include anti-racism policies, justice reforms and land rights protections, which Indigenous communities identify as fundamental to health outcomes. The Framework should include and prioritise this broader suite of prevention approaches, beyond simply programs, to maximise breadth and impact of interventions funded.

Recommendation 2: Expanding evaluation and embedding equity at the core of decision-making

The interim report rightly highlights the difficulty of evaluating prevention initiatives, noting that their impacts take years to emerge and that benefits are spread across sectors, with "the agency and level of government that funds a prevention program is not always the same as those that benefit (through future avoided costs)" (p. 58). Currently, there is no integrated infrastructure to capture cross-sector outcomes and access to existing data, and fit-for-purpose interoperable data, is challenging. As a result, the evidence needed to demonstrate the long-term economic and social value of prevention is often lacking, creating a significant barrier to sustained investment.

To address these gaps, the Framework should adopt an approach to evaluation and decision-making that recognises the full range of benefits that prevention delivers across sectors. If the focus is only on cost-savings, the most important outcomes are overlooked: improvements in health, wellbeing, and equity. While financial efficiency is important, it should not be the only test. For example, prevention can often relieve pressure on acute care by reducing waiting times and improving healthcare access, even if overall hospital spending stays the same. This remains a valuable outcome, as healthier populations and more effective health services are benefits in their own right.

This broader view reflects the principles of a Wellbeing Economy, in which the success of economic management is judged not only by fiscal balance sheets but also by its capacity to improve people's health, equity, and quality of life.[4] From this perspective, governments should be prepared to invest in prevention because of their responsibility to protect the health and wellbeing of people and communities, with fiscal savings treated as an additional benefit rather than the central test. At the same time, robust economic evaluation remains essential. Cost-effectiveness analysis, which considers both the costs and the benefits of interventions, allows decision-makers to weigh trade-offs between efficiency, equity, and the resources society is willing to commit to prevention. Evaluation should therefore combine economic analysis with broader principles such as equity, feasibility, acceptability, sustainability, and strength of evidence (see Information Request 3.1 for more details).

Of these considerations, equity must be central to monitoring, evaluation, and decision making. While the interim report acknowledges vulnerable populations, it frames equity as a factor to be considered "where relevant", for example, alongside feasibility or distributional impacts. Equity, however, is not an optional add-on. The *National Preventive Health Strategy* identifies improving health equity as one of its four central aims, recognising that population averages can conceal widening gaps[5]. Monitoring and evaluation approaches must therefore capture not only overall improvements in health outcomes, but also their distribution across groups such as Aboriginal and Torres Strait Islander peoples, rural and remote communities, culturally and linguistically diverse populations, and those experiencing socioeconomic disadvantage.

Upstream prevention activity (as discussed in Recommendation 1) is proven to deliver the strongest equity benefits,[6] yet because their impacts take longer to show and extend across multiple sectors, these interventions are often undervalued without explicit equity-focused evaluation. Embedding equity in the Framework's metrics would ensure accountability for fair outcomes across populations and prioritise investment in interventions that reduce disparities. In relation to Aboriginal and Torres Strait Islander peoples, this also means embedding a principles-based approach to evaluation that respects self-determination, cultural authority, and data sovereignty. The *Framework for Governance of Indigenous Data*[7] developed by the National Indigenous Australians Agency provides a model for how values such as transparency, accountability, and Indigenous data sovereignty can guide decision-making. Drawing on such approaches would ensure that equity is not only measured but also seen as central to the delivery of prevention initiatives.

Another model for embedding equity is the ACE Obesity study[8] which assessed 16 interventions, classifying each as positive, neutral or negative for equity, and where possible stratifying cost-effectiveness results by socioeconomic status. This shows that equity can be incorporated into evaluations in a systematic way. Importantly, many interventions that are highly cost-effective are not equitable, which is why equity must be embedded as a formal weighting criterion alongside cost and benefit. For further consideration of other opportunities to understand opportunity costs, please refer to submissions provided by Deakin Health Economics and Emeritus Professor Alan Shiell.

To support the collection of broader metrics, evaluation and monitoring approaches capable of measuring complex, system-change interventions need to be built in from the outset. Allocation of funding for evaluation and monitoring is essential, as recommended in the interim report (p. 64), to ensure the collection of high-quality data is adequately resourced. However, the level of investment

should be proportionate to the type of evaluation required. For some interventions, particularly complex, system-level reforms, evaluation may need to focus on long-term monitoring and adaptive feedback to detect early signals of success or failure. For others, especially where effectiveness is already established, the primary need may be to assess fidelity and implementation in practice. Importantly, evaluation methods should also draw on composite tools, such as the *Framework to Assess the Impact of Translational Health Research*, which combines multiple metrics to capture broader system change and impact.[9] Above all, evaluation should be designed for the long term and remain adaptive as interventions mature. This includes the use of logic models and theories of change to clarify expected pathways of impact, as well as the monitoring of broader system shifts such as changes in environments, policies, or behaviours, that may only become evident over many years (see Information Request 3.1 for more details).

Importantly, equity considerations should be embedded into commissioning processes from the start, not added retrospectively at the evaluation stage. Emerging work on Indigenous evaluation highlights the value of approaches that incorporate equity, self-determination, and cultural authority upfront in commissioning and design.[10] Embedding this kind of adaptive, equity-focused, and longitudinal evaluation will not only strengthen the evidence base, but also provide a clear line of accountability, ensuring that governments are responsible for sustained progress over time rather than short-term outputs alone.

Recommendation 3: Establishing strong governance arrangements with clear accountability across sectors and organisations

Effective prevention requires a systems perspective in which individuals, communities, organisations, and governments work together across sectors to develop solutions from different vantage points.[11] The power of systems approaches lies in their ability to turn this collaboration into coordinated action that addresses upstream determinants and reflects the complexity of real-world health challenges. The Framework provides an opportunity to embed this approach, enabling policies that are sustainable, equitable and capable of improving population health while delivering benefits across society.

It is important to note that we are not starting from scratch in the development of the Framework but rather building on valuable lessons from past prevention funding efforts. The *National Partnership Agreement on Preventive Health* showed the benefits of sustained funding: it enabled states and territories to expand programs, trial new approaches, strengthen the workforce, and improve evaluation and accountability, while also fostering cross-jurisdictional and external partnerships. At the same time, its weaknesses were evident: the Commonwealth was often seen as a funder rather than a partner, governance for chronic disease prevention remained unclear, and early termination meant much of its potential was lost.[12] The Australian National Preventive Health Agency likewise demonstrated the value of national leadership and coordination, but its short lifespan underlined the need for stable institutional arrangements.[12] Together, these experiences show that dedicated funding, governance stability and independence are enabling conditions for success, while short-termism and fragmentation undermine progress.

Building on these lessons, a key strength of the interim report is its recognition that the Framework will require formal agreement between the Australian, state and territory governments, through a new National Partnership Agreement for Public Health. We strongly support this proposal, as it offers the long-term value of a partnership approach, maximises use of resources, and reduces the risk of duplication across jurisdictions or that prevention being seen as the sole responsibility of the Commonwealth.

Equally important is the report's recognition that the Framework must not be confined to the health sector. As discussed extensively in this submission, prevention delivers benefits across multiple sectors and much of the most effective and sustainable upstream prevention opportunities need to occur outside the health sector. Bringing all sectors into both the design and delivery of the Framework will ensure prevention approaches are more comprehensive, better coordinated, and more effective in addressing the underlying determinants of health. By embedding a cross-sector approach, the Framework has the potential to unlock opportunities that no single sector could achieve alone and deliver population-wide gains.

To take a genuine systems approach, the Framework should also consider how it engages with key system actors outside of government, including community organisations and NGOs. Prevention works best when responsibility is shared across the whole system, rather than concentrated in one portfolio or level of government. NGOs and community organisations play a vital role in delivering prevention at the community level, so funding mechanisms must also enable them access to resources.

Aboriginal Community Controlled Health Organisations are especially critical. As self-determining primary health providers with deep community governance and trust, they play a central role in prevention, yet their role is often under-recognised in national policy. Giving these organisations proper recognition – and ensuring that communities, particularly priority populations, are genuinely involved through co-design that reflects local priorities and needs – is essential. Without this breadth of engagement, the Framework risks overlooking the very partners best placed to drive sustainable and equitable change.

That said, we recognise that broadening responsibility across governments, sectors and organisations represents a significant shift from current practice, and achieving this important level of coordination will take time and resources. However, this should not become a reason to delay implementation of the Framework. Coordinated governance arrangements and opportunities for early adoption should be built into the development phase to ensure genuine progress from the outset.

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?

- Cost-benefit analysis is essential for consistent cross-sector decision-making, but conventional health tools such as cost-effectiveness analysis or cost-utility analysis don't adequately capture the full range of preventive health benefits or long-term impacts across sectors,[13] such as gains in productivity, education, and social participation. Instead, a Framework that balances economic evaluations with broad societal benefits should be used. The Prevention Centre supports the recommendations raised in submissions from VicHealth and the Public Health Association of Australia regarding embedding the Framework within a wellbeing economy approach.
- Short-term indicators such as ease of implementation and timescale can provide early signals of effectiveness, but they must be balanced against the broader, long-term returns of prevention. Interventions that address upstream determinants and reduce health inequities are often more complex and slower to show results, yet they deliver the greatest return on investment and the most significant improvements in population wellbeing over time. Early assessment processes must therefore give these initiatives appropriate weight, rather than favouring only those with immediate outcomes.
- Equity needs to be central to the Framework and be seen as a priority, rather than a secondary factor, as per Recommendation 2.

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

- Please see Recommendation 1 for commentary around the prioritisation of interventions focused on upstream prevention.
- Programs should be evaluated not only for their effect on the general population but also for their impact on priority populations experiencing disadvantage, including Aboriginal and Torres Strait Islander populations. This ensures equity is embedded in decision-making and that prevention contributes to reducing, rather than widening, health inequalities.
- The framework must ensure that investment is spread across jurisdictions, with transparent criteria for weighting need, capacity, and potential impact. Smaller jurisdictions with fewer partners or less prevention capacity should not be disadvantaged in the allocation process.

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

We recommend that the Commission draw on the expertise of specialist submissions, such as those from Deakin Health Economics, which provide detailed perspectives on appropriate benchmarks for cost-effectiveness and cost-benefit ratios.

How can the need to assess early effectiveness of programs be balanced with the need to maintain consistent long-term funding?

- Interventions should be funded against clear theories of change that map expected short-, medium- and long-term outcomes. Early signs of progress (often structural or process changes rather than shifts in health outcomes or behaviours) should be used as the basis for continued funding within the budget's forward estimates, signalling whether a program is on track. In later funding cycles, stronger evidence of improved outcomes will become critical. Regular monitoring must be a requirement of funding, providing decision-makers with timely evidence of momentum and allowing resources to be redirected where programs are not meeting expectations.
- Because meaningful systems change in prevention takes time to become visible, a set of agreed metrics should be developed to capture early signals of progress, while also valuing approaches that will progress meaningful shifts in the system. Agencies such as VicHealth[14] and Health and Wellbeing Queensland[15] are already exploring this through their evaluation activities, and the Prevention Centre has developed a Theory of Change focused on assessing system-level shifts in prevention. In 2026 we will host a PhD student to advance methods for identifying early signals of system change. This work is expected to be nationally significant in showing how prevention efforts contribute to long-term impact.
- The framework should use diverse tools to inform funding decisions. This includes linked administrative datasets, as well as emerging technologies such as machine learning and AI to identify cohorts at higher risk (as noted in the interim report). In addition, modelling should be used to forecast the long-term benefits of programs, helping to make visible the outcomes that may only become apparent many years into the future.
- Securing bipartisan commitment is essential to ensure prevention funding is sustained across election cycles. Treasury should advocate for cross-party agreement from the outset of the Framework so that promising interventions are not derailed by political change. At the same time, building political understanding of the long-term value of prevention will help maintain funding stability while evaluations are underway.

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?

- The Prevention Centre supports the Productivity Commissions' adoption of a whole-of-systems approach that embeds prevention across governments and sectors to address the complex social, economic, and environmental determinants of health. As discussed in Recommendation 3, we recommend the Commonwealth works in collaboration with state and territory governments, other departments, NGO's and community organisations to establish PFAB and implement the Framework. It also needs to be considered how community members, and particularly priority populations are involved in the design and delivery of prevention strategies that affect them. Importantly, the inclusion of external stakeholders cannot be used as a reason to delay and strategies to manage this risk should be built into the planning phase.

- The framework must be iterative and flexible, underpinned by strong governance to ensure decisions are consistent, fair and transparent. Decisions made by PFAB should be guided by clear criteria for what is funded and what is not, with applicants given the opportunity to respond to or contest decisions. For funded programs, PFAB should distinguish between initiatives that are genuinely underperforming and those that require more time for their impacts to become visible, ensuring early accountability without penalising long-term prevention. At the same time, mechanisms must be in place to redirect funding away from ineffective programs and towards those proven to deliver greater impact.
- Funding and performance arrangements within the federation should draw on approaches that have already proven effective. As highlighted in Recommendation 3, the 2008 National Partnership Agreement on Preventive Health showed the value of dedicated resourcing, flexibility for jurisdictions, and support for locally tailored action.[12] The Framework should embed these strengths by linking funding to clear performance measures, ensuring transparency across governments, and holding all parties accountable for outcomes.

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

- The interim report identifies a fundamental structural barrier: current budget rules assess costs and benefits over a four-year forward estimates period, while prevention requires long-term investment with benefits that accrue over decades. Budgeting rules also limit decision-makers' ability to account for savings that accrue to other departments or agencies. If prevention is expected to be the responsibility of every agency, another challenge arises: funding and accountability are still organised along sector lines. This makes it difficult to see how much is really being invested in prevention across government, or to ensure that benefits are recognised and reinvested rather than disappearing into separate portfolios. To overcome these barriers, several changes are required.
    - Extend the timeframe of budget assessments beyond the current four-year forward estimates to capture long-term benefits.
    - Recognise and capture the broader fiscal ripple effects of prevention initiatives, not just the immediate costs and savings to the funding agency. This will require more sophisticated analytical tools and capability within government, so that second-round fiscal impacts (such as reduced hospital, justice, or welfare costs in other portfolios) are properly identified and factored into decisions.
    - Suspend or reform the current 'financial offset' rule, which requires new expenditure to be matched by equivalent cuts elsewhere – a constraint that disproportionately affects prevention given its already low funding base.
    - Incorporate flexibility into funding models, for example a mix of block funding for locally tailored initiatives, co-funding for state and jurisdiction priorities, and tied funding for national priorities.
- We support the suggestion that a National Prevention Investment Fund be established as a quarantined funding mechanism, separate from agencies' core budgets. Treating prevention funds as distinct from core departmental resources would protect them from being redirected to short-term operational pressures and ensure they remain dedicated to prevention priorities. A dedicated fund would also provide governments with the certainty to plan, scale and evaluate

initiatives over time, while maintaining visibility and accountability of investment across jurisdictions. Potential revenue streams could include levies or excise on tobacco, alcohol and sugar-sweetened beverages, consistent with international practice and reinforcing government commitment to improving population health.

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

- The Prevention Centre supports the interim report's recommendation for an independent Prevention Framework Advisory Board (PFAB) to assess prevention funding requests and develop consistent evaluation models. A core benefit of PFAB would be its independence from day-to-day departmental processes, giving it the space to offer clear, evidence-based advice without being constrained by annual budget rounds or shifting political priorities. Such independence would also strengthen transparency, with published recommendations that make government decisions more accountable, and provide a credible national voice to keep prevention on the agenda. However, independence on its own is not enough. To be effective, PFAB must have clear lines of accountability to government and be backed by secure, ongoing funding. There is also a risk that if PFAB were entirely independent the advice produced could be sidelined, if not well integrated into existing policy and budget processes. An independent statutory authority could balance independence with integration into government, ensuring transparency, accountability for evidence-based decision making, and collaborative ability across sectors.
- We also support PFAB taking on a role somewhat comparable to the Pharmaceutical Benefits Advice Committee (PBAC) in identifying "best buy" interventions. However, prevention is different in important ways including programs are aimed at communities and populations rather than individuals, the evidence base is broader and often relies on long-term modelling, and the benefits are spread across sectors beyond health. PFAB will therefore need to use a wider set of decision criteria than those applied to pharmaceuticals, including equity, feasibility, and system-wide impact as discussed in Information Request 3.1. To be effective, PFAB must also be backed by secure, ongoing funding so it can deliver this role without the need for continual advocacy.
- We agree that membership of PFAB should include a broad mix of expertise including representation from multiple sectors, and from disciplines such as economics. It should also include prevention specialists with diverse expertise in systems thinking, equity, implementation science, and evaluation, to ensure all evaluation metrics discussed in Information Request 3.1 can be realised. Equity expertise, in particular, should be regarded as essential to PFAB as clinical expertise is for the Medical Services Advisory Committee and the Pharmaceutical Benefits Advice Committee. We also agree that mechanisms should also be established to include perspectives from community and consumers, to promote a systems approach, as per our discussion in Recommendation 3. In particular, Aboriginal and Torres Strait Islander peoples should have a genuine say in what prevention looks like: what they want, what they see as important, and what is ultimately delivered. Without this, the Framework risks being shaped only by government priorities rather than by the needs and aspirations of the people it is intended to serve.

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 prevention programs?

- The Framework should be co-developed with state and territory agencies, drawing on existing metrics and programs already delivering shared outcomes. A preliminary environmental scan of current initiatives and their effectiveness should inform assessment processes to support consistency, comparability, and avoid duplication.
- Building workforce capability in systems thinking, evaluation, and implementation science is essential to design, scale and sustain effective approaches. The National Centre of Implementation Science (NCOIS)[16] demonstrates the value of institutional expertise in supporting long-term impact. Strengthening health economics capability within government would further enable consistent understanding and assessment of costs and benefits nationally and locally.

Conclusion

Prevention is widely acknowledged as one of the most effective investments governments can make, yet it has consistently struggled to attract evidence-based, sustained, and adequate funding. The Productivity Commission's proposal for a *National Prevention Investment Framework*, supported by an independent Prevention Framework Advisory Board, offers a significant opportunity to change this trajectory. By embedding prevention as a shared, long-term priority across all levels of government and sectors, the Framework can help shift the focus from treating illness after it occurs to creating the conditions that keep people and communities well.

The Prevention Centre strongly supports this proposal and recommends that the Commission strengthen the Framework by:

- Prioritising upstream and structural prevention that focus on the socioeconomic determinants of health
- Strengthening evaluation and decision making with equity at its core
- Establishing robust governance and shared accountability across sectors and organisations, learning from previous prevention experiences.

We thank the Commission for the opportunity to provide input and look forward to staying engaged as the Framework develops.

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