Productivity Commission – Delivering quality care more efficiently

Cancer Council Australia

15 September 2025

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Cancer Council is the peak, non-Government cancer control organisation in Australia. As the national body in a federation of eight state and territory member organisations, Cancer Council Australia works to make a lasting impact on cancer outcomes by: shaping and influencing policy and practice across the cancer control continuum; developing and disseminating evidence-based cancer information; convening and collaborating with cross sectorial stakeholders and consumers to set priorities; and speaking as a trusted voice on cancer control in Australia.

At a national level, Cancer Council Australia's cancer control policy lays out evidence-based positions across the cancer control spectrum, including cancer prevention, and cancer early detection and screening.

Across the country, Cancer Councils in each State and Territory:

- deliver prevention programs including in skin cancer prevention, tobacco control, cancer screening and immunisation, nutrition, physical activity, alcohol prevention, obesity prevention, and reducing occupational and environmental exposures to carcinogens;
- provide supportive care information and services to people affected by cancer;
- in some jurisdictions provide accommodation and transport services to support people to attend cancer treatment and care in large centres.
- Undertake and invest in life saving research to find ways to better prevent, detect and treat cancer.

Cancer Council acknowledges 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.

Overview and key summary

Cancer Council is pleased to provide a response to the Productivity Commission consultation on Delivering quality care more efficiently. We congratulate the Productivity Commission on an excellent Interim report, that has prevention at its core. We wholly support the draft recommendations across the three key reform areas.

This submission sets out Cancer Council's response on how to strengthen and enhance the recommendations in Recommendation 1: Reform of quality and safety regulation to support a more cohesive care economy; Recommendation 2: Embed collaborative commissioning to increase the integration of care services; and Recommendation 3: A national framework to support government investment in prevention. We also provide our suggestions on the Commission's specific requests for further information.

Prevention is fundamental to achieving world-leading cancer and overall optimal health outcomes. With two in three Australians experiencing chronic disease, prevention activities are vital to creating a sustainable health system, supporting productivity and a stronger economy. Australia currently has one of the lowest rates of preventive health spending (as a proportion of all health spending) of any OECD nation. Investment in preventive health has been less than 2% of health expenditure for at least the past 10 years[1], and stood at only 1.7% in 2019-20[2]. Improving investment in preventive health is essential to improving population health and wellbeing outcomes.

In responding to the Commission's interim report, Cancer Council's submission should be read alongside, and in support of, submissions from the following organisations:

- Public Health Association of Australia
- Deakin Health Economics
- Centre for Policy Development
- Australian Prevention Partnership Centre; and
- VicHealth.

Cancer Council is committed to working with the Productivity Commission alongside other public health colleagues to help shape and implement outcomes from this process.

Consultation Questions

Information request 1.3

What are the potential benefits and costs of aligning regulatory requirements across aged care and NDIS services for the development of behaviour support plans?

The Interim report acknowledges the significant number of informal carers and care responsibilities of Aboriginal and Torres Strait Islander peoples in their communities. It also acknowledges that improved productivity in the care economy lies in delivering better quality care that leads to better outcomes. However, it does not acknowledge how reforms across the care economy may be extended to informal carers to ensure they are supported to provide quality care and recognised for the significant value they contribute to health care support.

People in a caring role for someone with cancer can experience disruption to their education, employment and social interactions. Carers may by unable to work, work fewer hours or in a lower paid job to meet their caring commitments.[3] Unpaid care remains a mostly invisible job, despite being fundamental to healthcare in Australia. Unpaid carers often care for people at different times of the day and do not have traditional 'time off' from this role. While many people are caring for loved ones and value the role of caring, it can be mentally and physically tiring, and some feel obliged to care for someone when there are no other options.

Cancer carers play a significant role in helping people navigate their care in a hospital setting, supporting patient treatment decision making, coordinating access to care and services, and advocating for those in their care and their needs.[4] In March 2024, the Australian Government Standing Committee on Social Policy and Legal Affairs released their report 'Recognising, valuing and supporting unpaid carers', with 22 recommendations, as an outcome from their inquiry into the recognition of unpaid carers.[5] Several recommendations relate to formally recognising carers in legislation and laws, and establish rights for carers that acknowledge them as partners in care, involve them in planning and policy development, be provided with information regarding the person they care for in order to provide care, and accessing flexible work arrangements. The Productivity Commission report should reflect these recommendations by formally recognising the role of unpaid carers in a productive health and care system. Further discussions regarding opportunities to reduce duplication across NDIS and My Aged Care could be extended to include integration with the Carer Gateway.

Information request 2.3

What else needs to be considered to implement the reform? How should the mismatched boundaries between LHNs, PHNs, ACCHOs and other organisations be addressed in implementing the different elements of the proposed reform?

Care can be more integrated and seamless if non-government organisations are recognised as a critical collaborator and provider of care services and brought into collaborative commissioning alongside government agencies. People with cancer often access multiple care providers, across public, and private sectors and from non-government organisations. Non-government organisations provide significant and valuable contribution to the capacity and quality of care delivered across the health and social services systems. Their involvement improves accessibility to and availability of quality cancer care locally, and through working collaboratively with state and territory governments, planning for locally delivered services can be more informed by local needs, and connected. One example is through navigation to relevant cancer services and support. Cancer Council's 13 11 20 information and support service connects people to quality services across the non-government and government sectors. Uplifting this service is a core component of the Australian Cancer Nursing and Navigation Program which aims to ensure all people with cancer have access to high quality and culturally safe care.[6] The Department of Health, Disability and Ageing has committed $166 million towards the program, which supports at least 15 non-government organisations across all program components.[7]

The Australian Cancer Plan acknowledges that, to succeed in improving cancer outcomes for all Australians, the implementation of the Plan is a shared responsibility and will require joint efforts from the entire cancer control sector.[8] The Australian Cancer Plan also highlights actions towards reducing inequity in cancer outcomes experienced by people living in Australia with poorer cancer outcomes. Planning for service provision and accessibility of appropriate services to support engagement with health services, requires involvement of representatives with lived experiences and organisations providing community-based services and support. Often these representative groups are not found within government.

Many people are unable to work due to cancer and or it's treatment. In addition to this, out-of-pocket costs related to medical costs, and costs related to accessing care such as transport, can leave individuals with cancer and their family in a poorer financial position following a diagnosis of cancer. People with cancer often do not qualify for financial support through NDIS or My Aged Care supports due to their age or any impairments related to their function not meeting required program eligibility. While a systemic solution is needed, non-government organisations currently guide people to other potential financial support options such as Centrelink, or community grants, link them to legal and financial services for advice or fill these gaps through their own service provision. Without including non-government organisations in collaborative commissioning, fragmentation and inefficiencies in delivering care will continue.

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?

When prioritising preventive health actions, the Framework should be agile and responsive, while still weighing overall net benefits, cost-effectiveness, and health equity. Above all, it must ensure particular focus on priority populations who face persistent disadvantage, including Aboriginal and Torres Strait Islander peoples and others experiencing structural barriers to good health.

Best practice involves making equity considerations explicit, employing robust frameworks such as equity impact analysis and equity trade-off analysis. This transparent approach recognises that, in some instances, interventions may be less cost-effective by standard economic measures but critically important for advancing equity; in these cases, transparent justification and quantification of trade-offs are required.

We note that the Interim report proposes that the Framework covers the spectrum of interventions across primary, secondary, and tertiary prevention. While we acknowledge the need for increased funding across all these areas, we recommend that the Framework focuses on primordial and primary prevention, given that these take longer to demonstrate benefits compared to secondary and tertiary prevention and are not as amenable to gold standard study designs in comparison to secondary and tertiary prevention. Further, secondary and tertiary prevention interventions for health sit within the health sector and therefore the requirement and opportunity for cross-sectoral action is limited.

By including all levels of prevention, this may reinforce the current thinking and perception that primordial or primary prevention is less urgent and riskier when compared to secondary and tertiary prevention, despite providing excellent value for money. Further, including all levels of prevention may perpetuate the status quo of underinvestment in primordial and primary prevention.

It is also important that the Productivity Commission adopts a definition of prevention which aligns with existing frameworks and established literature, to ensure consistency and comparability of data. Currently, the Interim Report classifies some preventive health measures as primary prevention (for example access to childcare, and economic support for families). However, measures such as these would typically be classified as primordial prevention. The WHO prevention definition (*approaches and activities aimed at reducing the likelihood that a disease or disorder will affect an individual, interrupting or slowing the progress of the disorder or reducing disability*)[9] is well supported by evidence and experts,

already used and referenced by Australian Governments, and significant work has been completed enabling rapid operationalisation for the Australian context.

Prioritising cancer prevention through an equity lens fulfils Australia's commitments under the Closing the Gap agreement and the National Preventive Health Strategy 2021–2030, while also aligning with the World Cancer Declaration and UICC recommendations. These frameworks collectively call for targeted action to reduce avoidable disparities, invest in proven population-wide measures, and ensure that hard-to-reach groups, including remote and low-socioeconomic communities, share equally in the benefits of prevention.

The disparities driven by the social determinants of health, including socio-economic position, conditions of employment, social support and inclusion, housing, access to healthy food, and transportation have a significant impact on a person's health[10] and lead to inequities in access to cancer prevention, screening, cancer care, and outcomes. Co-ordination across governments and departments is required to address factors outside the health system, such as supporting food security to reduce cancer risk from unhealthy options and ensuring fair and accessible access to social security payments for people unable to work due to their cancer experience.

The most disadvantaged members of the community experience higher rates of illness, hospitalisation and death than other Australians. [11] Aboriginal and Torres Strait Islander peoples aged 15 and over are three times more likely to be a current smoker and 1.2 times more likely to exceed the NHMRC alcohol guidelines than non-Indigenous Australians.[12] In 2022-23, people living in regional and remote areas were more likely to engage in risky activities, such as smoking and alcohol use, than people living in major cities. Individuals living in the lowest socioeconomic area in Australia were 3.3 times as likely to smoke daily [11], were more likely to have obesity (68% vs 60%)[13] and were more likely to not meet the physical activity guidelines (45% vs 37%)[13] as those living in the highest socioeconomic area. In 2021, nearly half (42%) of the total cancer burden was attributable to personal and behavioural risk factors such as tobacco use and overweight. [12] It was estimated that 16,700 cancer deaths and 41,200 cancer cases could be prevented in Australia each year if people's exposures to 20 causal factors were aligned with levels recommended to minimise cancer risk.[14]

This inequity in health outcomes is exacerbated by industries promoting and selling unhealthy lifestyle choices targeting disadvantaged communities. [15] It is therefore essential that the Productivity Commission considers how to ensure that the resourcing and delivery of cancer prevention programs and cancer care is universal and able to be scaled up to reduce the barriers of access for underserved populations. The contributors to inequity are cumulative, and addressing the root causes of inequitable cancer outcomes will require whole of government policies, strong interjurisdictional co-operation and collaboration with communities.

Place-based considerations, such as the feasibility, acceptability, and cultural relevance of interventions, should be part of the assessment, ensuring proposed actions align with the specific needs and values of priority communities.

Another key consideration should be that actions demonstrate meaningful engagement and co-design with local stakeholders and/or lived experience representatives. Interventions developed in partnership with affected communities are more likely to succeed, foster trust, and deliver outcomes that are sustainable and culturally appropriate.

Finally, it is critical to note, this Framework can't just focus on programmatic actions but needs to prioritise and incorporate a policy focus alongside structural interventions. The World Health Organisation's NCD Best Buys[16] explicitly identify regulation and policy measures as high-value prevention strategies. This Framework should include and prioritise this broader suite of policy tools in order to maximise breadth and impact of interventions funded. For example, Cancer Council's National Cancer Prevention Policy lays out evidence-based priorities across cancer prevention, early detection and screening, and aligns with those national policy priorities set out in the National Preventive Health Strategy, the National Tobacco Strategy, the National Obesity Strategy, and the Australian Cancer Plan.

There are also examples of accepted frameworks internationally that can be drawn upon to support preventive health efforts, including Canada's recently introduced Tobacco Charges Regulations[17]

whereby tobacco industry is required to reimburse the Canadian Government's annual costs in tobacco control efforts.[18] In Australia this would translate to funding implementation of National Tobacco Strategy elements such as education campaigns, cessation supports and programs, government overhead costs for relevant policy teams, and enforcement.

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

We recommend that there is no rigid formula applied. While a reference threshold of around $50,000 per QALY gained can help guide decisions, preventive health investments require even greater flexibility than the approaches typically used by MSAC or PBAC. Context, distributional impacts, and implementation realities must be considered.

As highlighted in the ACE-Prevention project, interventions that exceed reference thresholds may still warrant funding if they address serious equity gaps, significant unmet needs, or pressing social justice concerns.[19] For example, modelling of lung cancer screening through MSAC demonstrates the importance of sometimes trading efficiency for equity.[20]

Internationally, organisations such as ICER recommend that single cost-effectiveness thresholds not be used as a blunt rule but as part of a broader set of considerations, including equity and impact on priority populations.[21]

Strict cost-effectiveness thresholds should not be determinative. Where prevention targets the most disadvantaged, thresholds should be flexibly applied and can include explicit equity weights to reflect societal values and legislative priorities.

Governments should be willing to invest in interventions that improve wellbeing even if these are not cost savings, or where cost savings are not immediate. The focus should be on the value for money, rather than solely on the potential of the intervention to save money for the health system. For example, the Measuring What Matters framework (2023)[22], provides governments with the framework necessary to consider Australians' individual and collective wellbeing across all phases of life. Its development and endorsement is an opportunity for the Australian Government to shift toward policies that better meet the needs of current and future Australians and take a more holistic and wellbeing-oriented view of policy decision making. Embedding the Measuring What Matters framework as planned at its launch, would support investment in prevention activities as they have such powerful and long-lasting positive impacts on the health and wellbeing of individuals and communities.

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?

Prevention must be understood as a long-term investment. The challenge is to accept that uncertainty is inherent and to focus on what can be reasonably measured in the early years. Balancing the assessment of early effectiveness with the need for consistent long-term funding in prevention relies on judicious use of short-term indicators while maintaining a commitment to longer-term outcomes and investment.

Health economists such Professor Louisa Collins from Cancer Council Queensland have highlighted the importance of developing and tracking shorter-term intermediate indicators as a bridge to maintain political and funder confidence until long-term impacts can be demonstrated.

Intermediate outcomes may include:

- Process indicators (e.g., program uptake, early behaviour changes, service delivery fidelity) to show early momentum.
- Modelling of proximal outcomes that are expected to lead to health or productivity gains, such as increased screening rates, attitudinal changes, or shifts in risk behaviours.

Outcomes-based funding through risk-sharing agreements offers governments a practical way to link investment to measurable progress while supporting long-term impact. This approach has been demonstrated through initiatives such as the Federal Outcomes Fund[23] and, at the state and territory level, the newly established Office of Social Impact in Queensland and the Office of Social Impact Investment (OSII) in New South Wales. For preventive health, however, outcomes-based funding must extend beyond direct economic returns to include non-monetary intermediate outcomes such as uptake, participation rates, and changes in risk behaviours. Such measures are critical to evaluating preventive interventions, as many of the most important benefits, such as healthier lifestyle choices or increased screening, take time to deliver cost savings and population-level health gains.

Victoria's Early Intervention Investment Framework (EIIF)[24] demonstrates how aligning short-term indicators to program logic models can reinforce the practical value of outcomes-based funding, especially for preventive health where non-monetary intermediate outcomes are crucial.

Annual targets and process measures can be incorporated into government reporting and inform staged funding release. Regular, transparent reporting of intermediate and process indicators builds government confidence and justifies sustained funding even when population-level or economic effects are not yet visible. Embedding rigorous data collection and adaptive evaluation ensures early signals of progress (or barriers) are quickly detected, allowing timely mid-course corrections that protect long-term investment.

Securing rapid access to high-quality, deidentified data is critical for governments to effectively monitor, evaluate and refine outcomes-based preventive health investments, ensuring non-monetary intermediate impacts are measured and valued alongside long-term gains. Current limitations, such as restricted access to data or long delays hamper the measurement, evaluation, and ongoing improvement of early intervention investments. Reform in this area is urgently needed to enable a more agile, transparent and effective National Prevention Investment Framework.

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

A priority setting framework could also consider how the strategy could be diversified to include different sectors. It is important to acknowledge that different preventive health strategies may be required to address the needs of specific populations, and they should be involved in a collaborative approach to the design and implementation of such strategies.

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 most effective way to ensure implementation is through a single, overarching National Prevention Investment Framework that sets nationwide priorities, goals and standards, while allowing states and territories to tailor initiatives according to local needs and contexts. The development of the Framework should be an iterative process, with options to improve the Framework over time. We also recommend that the Commission consider the recommendations for implementation outlined in The Australian Prevention Partnership Centre Synthesis Report. [25]

The Assessing Cost-Effectiveness of obesity prevention policies in Australia (ACE-Obesity Policy) study provided an assessment of the key considerations for policy implementation, which can be used as criteria to help inform decision making and implementation. The implementation considerations include the strength of evidence, equity, acceptability to the general public, government and industry, and the feasibility and sustainability. [26]

While it would be ideal for all states and territories to adopt complementary prevention frameworks and for intergovernmental governance structures to be established, this should not be a precondition for progress. Such alignment can occur once the National Prevention Investment Framework is operational and national priorities have been agreed in consultation with representative stakeholders.

Finally, it is essential that the Framework does not inadvertently disincentivise state investment in preventive health. As the Framework is rolled out, overall prevention effort across jurisdictions must be maintained or strengthened. PFAB should embed mechanisms that actively encourage states and territories to sustain funding for existing effective programs, ensuring that new Commonwealth investment complements rather than replaces their own commitments. Clear differentiation will be required between state-delivered services and nationally led programs.

A systems approach should also be adopted, which ensures that prevention is embedded across sectors, and is not just limited to the health sector, to address the social, economic and environmental determinants of health.

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

There is a need for increased and quantified funding investment, with a clear funding mechanism that is inter-governmental. To support greater investment in prevention programs, Australia's budget operational rules should be updated to prioritise long-term outcomes, cross-sector benefits, and stability beyond short, electoral cycles:

- Extending funding timeframes beyond four years to multi-year and even decade-long funding agreements will support evidence-based planning, robust evaluation, and the realisation of health and productivity benefits that emerge over time.
- Updated budget assessments should count downstream effects like reduced healthcare costs, improved productivity, and social equity, not just immediate departmental savings.
- It is necessary to suspend the financial offset requirement in order to support the genuine expansion of government prevention efforts.
- Permit budgets to account for long-term, cross-sector benefits such as better population health and increased workforce capacity, which are typically excluded in current operational rules.

Given that the substantial benefits of evidence-based prevention programs are not realised until several years or decades following the delivery of the program, the Budget Process Operational Rules (BPORs) can act as a significant barrier to the implementation of evidence-based prevention programs and discourage investment in programs which have significant long-term benefits for society.

Not considering second-round fiscal effects in policy proposals has three primary consequences relevant to evidence-based prevention programs:

- It acts as a barrier to line agencies developing and proposing programs that have higher upfront costs but deliver cost savings over their lifespan (such as behaviour change strategies to drive down smoking and vaping prevalence, or to encourage participation in cancer screening programs).
- It discourages line agencies from working together on cross-portfolio budget bids where the benefits from the policy led by one department/agency will deliver cost savings or revenue for another department (such as building active transport corridors where benefits are realised in a healthier population with a lowered cancer risk).
- It can under-represent the long-term costs to government of some policy proposals where cost savings in one area can generate negative impacts for other portfolio areas over time (such as funding reductions to financial counselling services restricting access for people affected by cancer leading to more people post-cancer needing to access the social security system).

Prevention programs and initiatives typically deliver savings that are primarily classified as second round fiscal effects and so can be unfairly deprioritised as they do not deliver the level of first round effects of other policies where benefits are delivered earlier. This is the case even if they represent a very low cost or provide cost savings when these second-round fiscal effects are taken into account. This is relevant for many evidence-based cancer prevention programs (and also supportive care programs for people affected by cancer) where the individual benefits and savings delivered to the

system, due to the long latency of cancers, are delivered twenty of thirty years into the future. Additionally, without being able to consider future fiscal savings, such new policy proposals compete directly with current departmental expenditure – for example, a skin cancer prevention program competing with skin cancer treatment that is required due to UV exposure accumulated in an individual over the past thirty years. Cancer Council endorses recommendations regarding changes to the BPORs provided by the Centre for Policy Development in their 2024 report, Banking the Benefits[27].

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

A long-term ambition for the Framework should be to support preventive investment across multiple portfolios, recognising that almost all areas of government have a role to play in shaping health outcomes. However, it is important to balance this ambition with practical implementation.

Requiring a cross-sector approach from the outset risks delaying action and diluting momentum. Instead, a staged approach is recommended: the Framework should initially be applied to the health portfolio, with other domains incorporated progressively as capacity and readiness grow. This will allow lessons to be learned, governance structures to mature, and confidence to build before the Framework is expanded more broadly.

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?

Investment in preventive care is currently not transparent or sustained and is below recommended levels. Australia has one of the lowest rates of preventive health spending (as a proportion of all health spending) of any OECD nation. Investment in preventive health has been less than 2% of health expenditure for at least the past 10 years, accounting for only 1.7% in 2019-20. Canda, New Zealand and the United Kingdom, who have comparable health systems to Australia in many ways, allocate approximately 5% of total health spending to preventive health.

The National Preventive Health Strategy 2021-2030[28] has been endorsed by all Australian Governments and lays out actionable, evidence-based prevention initiatives that if implemented will improve the health and wellbeing of all Australians. The Strategy was developed using the best evidence available and addresses the third pillar of Australia's Long Term National Health Plan and aligns to the current National Health Reform Agreement. The National Preventive Health Strategy remains alarmingly underfunded with minimal implementation activity, and as such we are not on track to meet many of the targets outlined within the Strategy. It is not necessary to re-review any evidence, consider acceptability or feasibility of any interventions, or involve community members in co-designing and prioritising interventions. This has all been done within the development of the National Preventive Health Strategy. Governments must commit to funding the programs and initiatives identified within the Strategy and at a more basic level, prioritise the long-term health and well-being of the Australian community.

A robust governance structure, led by PFAB, is essential to provide national coordination, and transparent oversight. It is recommended that PFAB actively engage with all relevant stakeholders, including government, non-government organisations, and peak bodies, during the early design phase to systematically map existing preventive health programs across jurisdictions. This collaborative mapping process is essential to ensure we identify and address service gaps, avoid duplication, and direct new investment to areas of greatest need. Importantly, the Framework should prioritise underlying risk factors that cut across multiple diseases, rather than focusing narrowly on single-disease prevention.

There are key learnings which can be applied from the Australian National Partnership Agreement on Preventive Health (NPAPH). [29] Opportunities to develop partnerships between States and Territories has been described as a real strength of the NPAPH. Whilst State and Territory health departments welcome long term Commonwealth investment in prevention, it is important that there is true partnership between the Commonwealth and States and Territories, and that this extends beyond the Commonwealth purely existing as a funding mechanism. [29]

References

1. Shiell A, Garvey K, Kavanagh S, Loblay V, Hawe P. How do we fund Public Health in Australia? How should we? Australian and New Zealand Journal of Public Health. 2024;48(5):100187.
2. Australian Institute of Health and Welfare. Health expenditure Australia 2019-20. Canberra: AIHW; 2021.
3. Ferrant G, Pesando LM, Nowacka K. Unpaid Care Work: The missing link in the analysis of gender gaps in labour outcomes OECD Development Centre; 2014.
4. Williams LA, Moeke-Maxwell T, Wiles J, Black S, Trussardi G, Kerse N, et al. How family caregivers help older relatives navigate statutory services at the end of life: A descriptive qualitative study. Palliat Med. 2018;32(6):1124–32.
5. House of Representatives Standing Committee on Social Policy and Legal Affairs. Recognising, valuing and supporting unpaid carers. Canberra: Parliament of Australia; 2024.
6. Department of Health Disability and Ageing. Australian Cancer Nursing and Navigation Program: Commonwealth of Australia; 2025 [Available from: https://www.health.gov.au/our-work/australian-cancer-nursing-and-navigation-program.
7. Biggest investment in cancer nurses on record [press release]. Commonwealth of Australia 2023.
8. Cancer Australia. Australian Cancer Plan: Cancer Australia; 2025 [Available from: https://www.australiancancerplan.gov.au/welcome.
9. World Health Organization. Health promotion and disease prevention through population-based interventions, including action to address social determinants and health inequity: WHO; 2025 [Available from: https://www.emro.who.int/about-who/public-health-functions/health-promotion-disease-prevention.html.
10. Australian Institute of Health and Welfare. Social determinants of health. Canberra: AIHW; 2024.
11. Australian Institute of Health and Welfare. Australia's health 2024 Canberra: AIHW; 2024.
12. Australian Institute of Health and Welfare. Cancer in Australia. Canberra: AIHW; 2021.
13. Australian Institute of Health and Welfare. Overweight and obesity. Canberra: AIHW; 2024.
14. Wilson LF, Antonsson A, Green AC, Jordan SJ, Kendall BJ, Nagle CM, et al. How many cancer cases and deaths are potentially preventable? Estimates for Australia in 2013. International Journal of Cancer. 2018;142(4):691–701.
15. Brown V, Ananthapavan J, Veerman L, Sacks G, Lal A, Peeters A, et al. The Potential Cost-Effectiveness and Equity Impacts of Restricting Television Advertising of Unhealthy Food and Beverages to Australian Children. Nutrients. 2018;10(5).
16. World Health Organization. Tackling NCDs: 'best buys' and other recommended interventions for the prevention and control of noncommunicable diseases. WHO; 2017.
17. Tobacco Charges Regulations (SOR/2025-80), (2025).
18. Cunningham R. Tobacco Control. 2025. Available from: https://blogs.bmj.com/tc/2025/05/30/canada-polluter-pays-tobacco-industry-required-to-reimburse-annual-costs-in-governments-national-tobacco-control-strategy/.
19. Vos T, Carter R, Barendregt J, Mihalopoulos C, Veerman JL, Mangnus A, et al. Assessing Cost-Effectiveness in Prevention (ACE-Prevention): Final Report. University of Queensland and Deakin University 2010.
20. Cancer Australia, Lung Cancer Policy Network Secretariat. Using an economic model to assess cost-effectiveness and build commitment to a national screening programme. Lung Cancer Policy Network; 2025.
21. Institute for Clinical and Economic Review. ICER 2019 Perspectives on Cost-Effectiveness Threshold Ranges. ICER; 2019.
22. The Treasury. Measuring what matters 2023 [Available from: https://treasury.gov.au/policy-topics/measuring-what-matters.
23. Department of Social Services. Commonwealth Outcomes Fund 2025 [Available from: https://www.dss.gov.au/social-impact-investing/commonwealth-outcomes-fund.
24. Victoria State Government. Early Intervention Investment Framework 2024 [Available from: https://www.dtf.vic.gov.au/early-intervention-investment-framework.

25. Wolfenden L, Nathan N, Turon H, McCrabb S, Stickney B, Signy H, et al. Implementing policies and programs in prevention: Synthesis of knowledge from the Australian Prevention Partnership Centre and CERI. Sydney, Australia: The Sax Institute 2024.
26. Ananthapavan J, Sacks G, Brown V, Moodie M, Nguyen P, Veerman L, et al. Priority-setting for obesity prevention—The Assessing Cost-Effectiveness of obesity prevention policies in Australia (ACE-Obesity Policy) study. PLOS ONE. 2020;15(6):e0234804.
27. Gaukroger C, Phillips T. Banking the Benefits: Better Aligning Budget Process Rules with Measuring What Matters. Centre for Policy Development; 2024.
28. Department of Health. National Preventive Health Strategy 2021-2030. 2021.
29. Wutzke S, Morrice E, Benton M, Milat A, Russell L, Wilson A. Australia's National Partnership Agreement on Preventive Health: Critical reflections from States and Territories. Health Promot J Austr. 2018;29(3):228–35.