DELIVERING QUALITY CARE MORE EFFICIENTLY

Response to the request for consultation

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The recommendation to establish a Prevention Framework Advisory Board (PFAB) with the authority to consider action taken in sectors of government beyond health is game-changing and very welcome. It lays the foundation to address a widespread conundrum: if prevention is so good why do governments spend so little on it.[1]

In this response I make two suggestions in relation to the PFAB funding mechanism before addressing the specific points for discussion contained in the Productivity Commission's interim report.

Suggestion 1: The PC consider supplementing PFAB with a second funding mechanism that would assess the merits and determine funding for those preventive interventions that can be implemented by health services, and which do not require extensive inter-sectoral input or complex evaluations. To distinguish this from PFAB in what follows, we'll refer to it as the Public Health Advisory Committee (PHAC). This would be better if it were separate from PFAB and sat alongside the PBAC and MSAC, but it could be a sub-committee of PFAB.

This would allow the PFAB to concentrate on inter-sectoral interventions across the whole of government that are preventive in nature even if there are no health benefits: the rationale being that the factors that stymie spending on preventing ill-health also apply to efforts to improve other social programs such as housing, education, social security and criminal justice.

Suggestion 2: The PC consider working to the definition of public health which the AIHW use in reporting spending on prevention and health protection, augmented to include primordial intervention (as recommended by the Australian Prevention Partnership Centre in their submission). The AIHW definition includes primary prevention and that part of secondary prevention concerned with early detection. It specifically excludes tertiary prevention as this is more correctly treated as health care and chronic disease management. It also excludes primordial prevention, hence the need for the Productivity Commission to adopt that terminology to better describe the scope of work for PFAB.

1. Stretching PFAB's remit to include inter-sectoral programs tackling the social determinants of health, *as well as* the host of relatively mundane clinical and behavioural health promotion / preventive programs that will also need to be evaluated, risks undermining the work of the Board.

[1] Cairney P, St Denny E. Why isn't government policy more preventive? Oxford University Press, 2020

2. The PC rightly points out that cross-sectoral programs such as early child development and housing support are just as important in preventing disease as more traditional health promotion programs such those designed to get people to eat better, exercise more, and drink less alcohol etc., but these are characteristically different types of intervention. In particular, the latter do not usually require sectors other than health to be actively involved, nor are they likely to have a substantial impact on equity. This makes it easier to evaluate their merits, and decision making does not require the same inter-sectoral, cross-jurisdictional governance structures as the upstream programs. Priority setting can be handled within the health sector just as it is with pharmaceuticals and medical services, though it would require a formal mechanism for evaluating the merits of programs and recommending which should be funded.[2]

3. Establishing a second funding mechanism, separate from and in addition to, PFAB, that focused on clinical and community-based behavioural prevention programs would ensure that the greater number of such programs and the relative ease with which they can be evaluated, does not crowd out consideration of more complex policies promising action on the social determinants of health. It would also lessen the possibility of kick back from representatives of other (non-health) agencies on PFAB, who might otherwise feel that their time and resources are being commandeered by health programs.

4. Bringing tertiary prevention into the mix, as suggested in Figure 3.1 of the PC's interim report, magnifies the risks of crowding out and kickback. Tertiary prevention is better regarded as good clinical management of disease and injury, and rehabilitation. Its inclusion within the remit for PFAB further increases the likelihood that complex, upstream interventions get crowded out. There are already mechanisms in place to review and fund such activities within the health care sector and so there is no need to divert PFAB's attention away from what should be its *raison d'etre* – the evaluation and funding of complex, cross-governmental, preventive interventions.

5. In comparison, the AIHW uses a narrower definition of prevention in its health expenditure database. This includes all primary prevention and those parts of secondary prevention that relate to organised efforts to detect disease (i.e. screening programs). Tertiary prevention and the remaining parts of secondary prevention (that is the treatment of conditions uncovered by screening) are both excluded on the grounds that they are counted as health care.

6. Adopting the AIHW definition of public health would bring a welcome degree of consistency to the field. It would also mean that the AIHW's health expenditure database could be used to monitor and make transparent jurisdictional health spending on prevention.[3]

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[2] Such a mechanism (which was to be called PHEBAM) was first explored by the Australian Government in 1990 (Woodley, 2001, p13). Unspecified technical difficulties prevented it going further. The idea was revisted by Harris and Mortimer (2009) in a paper that addressed many of the challenges. The experience of NICE in the UK also indicates how public health activities can be evaluated to determine their funding.

[3] The AIHW will soon restart their annual report on public health spending, which will include a breakdown of jurisdictional spending by sub-categories of public health practice.

SPECIFIC FEEDBACK SOUGHT BY THE PRODUCTIVITY COMMISSION

Evaluation

When prioritising actions, how should different factors (e.g. overall net benefits, equity, cost effectiveness) be weighted?

Equity is key here. It sits alongside maximising population health as one of two equally important objectives of the Australian health system and yet it is so often neglected and missing from economic evaluations of cost and benefit. Just making the impact on equity *visible* in the evidence being considered (and commissioned) by both PHAC (within the health system) and PFAB (across government sectors) is therefore a major step forward, and a necessary one before thinking about how to weight the different impacts.

This could be done relatively simply. The ACE Obesity study[4] evaluated the cost-effectiveness of16 policies and programs to prevent obesity, reporting each intervention's impact on equity descriptively as positive, negative or neutral according to whether it closed the relevant health gap, widened it or left it unaffected. When the data allowed, the authors also reported the cost-effectiveness results stratified by the indicators of social or economic status.

While insightful, the simple approach overlooks the health-related opportunity costs that arise from the decision to fund one intervention over another. This refers to the potential health gains and reductions in inequity that will be forgone elsewhere in the health system, if resources were to be allocated to one intervention rather than another. To address this problem, Richard Cookson has led the development of what he calls Distributional Cost-Effectiveness Analysis (DCEA).[5] In essence, this involves modelling the distribution of health before and after the intervention (for the whole population, not just those who benefit from the intervention), and then ranking the performance of competing interventions before analysing any resulting trade-offs between reducing inequity and increasing population health.[6] In the UK, the weights that allow this trade off to be quantified have come from surveys of the public's aversion to inequality, but they could also come from judgements by decision makers.

The National Institute for Health and Care Excellence (NICE) is cautious about the DCEA approach, largely because the NHS cannot discriminate on the basis of a patient's social or economic circumstances.[7] This ethical concern seems not to apply to public health, where programs are frequently targeted to favour particular social groups, or are delivered universally but with differing degrees of scale or intensity to address unequal needs (proportionate universalism)[8] but it might be relevant for some of PFAB's deliberations about interventions in agencies outside public health.

The evaluative task for PFAB is much more complicated as there will be a larger number of disparate, possibly even incommensurate, outcomes to consider. The academic literature addressing this issue has grown rapidly in recent years, but has yet to develop a consensus, let alone a framework for evaluating complex policy issues.[9] There is more evidence to digest but

[4] Ananthapavan J et al., 2018.
[5] See Cookson et al., 2017, Cookson et al., 2020, and Cookson et al., 2021.
[6] See Griffin et al., 2019 for an application of the approach to public health programs in England
[7] NICE, 2025.
[8] Francis-Oliviero et al., 2020.
[9] Milhorance et al., 2022.

in the meantime, PFAB should proceed carefully, building a body of case law so to speak of varied inter-sectoral preventive interventions that can be used to distil the principles that should guide priority setting.

What minimum cost effectiveness and/or cost benefit ratios should be used?

The Public Health Advisory Committee (PHAC) should work to the same thresholds as the PBAC and MSAC to avoid distortions among the three sectors. The thresholds are not immutable and can interpreted flexibility to accommodate relevant factors not already included within the summary economic metric. In the UK, for example, NICE captures this idea of flexibility by including consideration of five 'modifiers' in the formal evaluation process. Among other things these cover uncertainty around the cost-effectiveness result, and concerns about whether the outcome measure includes important dimensions of quality of life or captures relevant non-health objectives.[10]

PFAB could adopt the same cost per Quality-Adjusted Life-Year approach to capture the impact that inter-sectoral interventions have an impact on health, while promoting the research necessary to develop equivalent summary measures of output in other sectors.

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

There need be no conflict here. Early signs that a program or policy is having its anticipated effects should be a condition for continued funding. Those early signs will not always be changes in health outcome however, or even health behaviours, though some will be. What is important is to recognise that some interventions will take longer to reveal their full impact and so the nature of the indicators will evolve across the forward estimates of successive budgets. Depending on the theory of change that underpins each program's logic, early indicators of effect (that is within the forward estimates) might need to include changes in structure or process rather than outcomes. In later funding cycles, evidence of improved outcomes will come to the fore in the forward estimates.

<u>Funding</u>

What changes to the existing budget operational rules would be needed to support more prevention programs?

No comment

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

Does the Federal Funding Agreements framework not already provide the architecture to allow PHAC and PFAB to operate? This recognises state and territory responsibility for public health and acknowledges the need for federal funding. Existing payment channels through the

[10] Rumbold et al., 2017.

National Health Reform Agreement and National Partnership Agreements provide mechanisms for matching the type of funding to different types of activity (e.g., block funding for infrastructure and targeted funding for specific preventive programs), and for requiring state and territory contributions to particular activities.[11] Added to this, would transparent reporting of spending be enough to enable electorates to hold their state or territory government accountable for meeting their obligations?

Implementation

What is the best way to incentivise Australian, state and territory governments to invest in prevention to improve future outcomes and avoid future costs?

One supportive measure is through greater transparency to make public in a standardised and consistent manner how much each jurisdiction is spending on which types of prevention. This is not possible currently within the health sector because of the use of idiosyncratic definitions of what counts as preventive spending and the lack of annual reporting.

The idiosyncrasies could be eliminated if jurisdictions were required to use the AIHW's definition of public health when they announce new spending initiatives or report budgets. The AIHW has also begun to address the second obstacle, resurrecting its annual public health expenditure series. Consideration could now be given to ways to increase the value of this information.

One suggestion is to amend the categories that the AIHW will use to disaggregate total spending. Currently, any investment that health agencies make either to lead inter-sectoral action on the social determinants of health or to build community strengths will be obscured by being included within a 'public health – not further defined' bucket. Making this spending visible would better reflect contemporary public health practice and make the accounts more useful for managerial and priority setting purposes.

The classification that they are using obscures health department spending on leadership in support of efforts to address the social determinants of health, and local action to engage and empower communities, and it excludes spending on clinical prevention in primary care. Finessing the classification system to make these activities visible is consistent with contemporary public health practice and would better enable the expenditure data to be used for priority setting and public accountability.

A second suggestion is to exploit the facility for adding satellite accounts to the AIHW database, which would enable a more complete picture of prevention spending to be reported whilst maintaining the fidelity of past reports. Satellite accounts could examine spending on clinical prevention (which is currently attributed to primary care) and spending by agencies other than health on interventions to tackle social determinants (which is currently excluded from the AIHW definition of prevention, but is something that would support PFAB's deliberations).

Such standardised and consistent reporting of preventive spending by health agencies will help hold jurisdictions to account for their investment decisions.

[11] Shiell et al., (2024).

Should alternative approaches be considered for governance of the framework?

PHAC could sit within health, alongside MSAC and PBAC. Funding should probably be capped and allocated to states and territories, or primary health networks in ways that reflect geographic inequalities. The cross-government nature of PFAB's work suggests it would be better located in Premier and Cabinet.

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