15th September 2025

Prevention Research Collaboration Sydney School of Public Health, and
The Charles Perkins Centre,
The University of Sydney

Submission to the Productivity Commission: Delivering Quality Care More Efficiently - Interim Report

Dear Commissioners Roberts, Stokie, and Jackson,

We, the Prevention Research Collaboration and the Charles Perkins Centre, the University of Sydney, welcome the opportunity to comment on the Australian Productivity Commission's Delivering Quality Care More Efficiently Interim Report. The Prevention Research Collaboration is nationally and internationally recognised as experts with over 20 years' experience in prevention research, evaluation, and planning. The Charles Perkins Centre is a world leading multidisciplinary initiative committed to easing the burden of chronic disease, where the Prevention Research Collaboration is based. We strongly support the Commission's inquiries to identify and report on priority reforms in each of the areas under the Government's five pillar productivity growth agenda, and the inclusion of health, and particularly, preventive health care in this inquiry. In this submission, we provide feedback on the *Delivering Quality Care More Efficiently Interim Report Section 3: A National Framework to Support Government Investment in Prevention* and highlight opportunities for further improvement.

Draft recommendation 2.1 Governments should embed collaborative commissioning, with an initial focus on reducing fragmentation in health care to foster innovation, improve care outcomes and generate savings

We strongly support the need to strengthen governance arrangements between Local Hospital Networks, Primary Health Networks and Aboriginal Community Controlled Health Organisations to foster collaboration, share knowledge, and reduce duplication. Collaborative commissioning has the potential to reduce fragmentation, drive innovation, reduce waste, and improve outcomes. However, real gains in outcomes and productivity must be underpinned by appropriate expertise and resources. To be effective, **collaborative commissioning recommendations should explicitly include academics with relevant expertise** in prevention, evaluation, health economics and implementation, ensuring that decisions are evidence-informed and impacts are measurable. Equally important is the **provision of infrastructure and investment to support the administration and management of collaborative resources**, particularly administrative support and secure data sharing systems. Without additional resourcing, the expectation that complex cross-sector collaborations will commence and sustain themselves is unrealistic, and risks undermining the very objectives of commissioning reform.

Draft recommendation 3.1 Establish a National Prevention Investment Framework to support investment in prevention, improving outcomes and slowing the escalating growth in government care expenditure

Australia's health care system is designed to care for those who are unwell, and by global standards, it is one of the best in the world. However, its focus on acute care has resulted in underinvestment in upstream population health and chronic disease prevention. Australia's health care expenditure is growing at an unsustainable rate, and with an aging, growing population, we need to build a system that achieves better population health outcomes, prevents people from becoming unwell, and improves wellbeing across the life course. Through this inquiry, the Australian Productivity Commission's recommendations can reorient the way we think about health care by being specific about how they define prevention, clarifying the meaning of prevention in practice, and indicating the level of prevention considered. While the interim report includes definitions and examples across the health care spectrum from primary prevention (modifying health-compromising behaviours or exposures) to acute care, primordial prevention is not explicitly mentioned. Given that the top risk factors in the 2024 Australian burden of disease (e.g., obesity, tobacco use, dietary risks) are all unequally distributed across social groups, including by socioeconomic position and rurality, primordial prevention, which focuses on preventing problems by establishing, maintaining, or improving social conditions, should be a central focus.

The Productivity Commission interim report includes definitions and examples of the health care spectrum from primary prevention to acute care. **Primordial prevention, the prevention of exposure to risk factors for chronic disease, must be explicitly included in this report and in this healthcare spectrum**. Focusing primordial prevention in a National Prevention Investment Framework is essential to recognise and value efforts to address the root causes of poor health (e.g., education, income poverty, employment conditions, housing condition, racism, ageism), reduce costs, and maximise quality of life and productivity gains by preventing risk factors from arising in the first place. Any framework for investing in prevention should explicitly accommodate investment in primordial prevention, along with its implementation and evaluation, when recommending actions and defining impact measures. This ensures that resources are directed not only to individual behaviour change but also to the upstream social and economic drivers of income, housing, and employment, which fundamentally shape health outcomes.

We strongly support the development of a National Prevention Investment Framework, however, to realise productivity gains and improve efficiency in health care **the Investment Framework must take a whole of society perspective, beyond patient-level outcomes and acute care costs**. A new investment framework provides a structure to redefine how we prioritise and value intersectoral outcomes associated with investment in prevention. Prevention can make the care sector more efficient, however prioritising efficiency above all else is recognised as problematic given not all prevention intervention outcomes map neatly to economic metrics such as cost, quality of life, or resource use. For example, physical activity interventions for school aged children, interventions that ensure guidelines for healthy eating are adhered to in childcare centres, implementing social prescribing models of care that reduce social isolation and

loneliness do not map neatly to metrics that can be monetised in a cost-benefit analysis or have measurable willingness to pay thresholds, meaning their measures of efficiency (often incremental cost effectiveness ratios) are challenging to interpret for policy, and apply to investment decision making and practice. Efficiency in healthcare is also subject to the quality of the data available, the perspective and time horizon of the analysis, and the incentive of those commissioning the evaluation. The absence of high quality, longitudinal evidence supporting investment in prevention is a barrier to understanding the true economic costs and benefits of sustained improvements in population health. Prioritising efficiency and evidence that fits actuarial analytic models may risk biasing away from interventions that produce diverse, complex, intersectoral benefits. Evidence of efficiency must be triangulated with broader, whole-of-society considerations of the benefits associated with prevention.

In addition to redressing the way we view investment in prevention, including primordial prevention, there are health promotion and disease **prevention interventions supported by level one evidence that could provide significant health, social, and economic benefits that are not being implemented into practice due to insufficient investment.** Australia has invested in generating high-quality, contextually relevant level one evidence yet fails to actualise the benefits of this investment by not routinely implementing this research into health care policy and practice. The Investment Framework must contain mechanisms for funding the implementation of existing preventive evidence, and funding routine evaluation of the outcomes, costs, and sustainability of these outcomes. For example,

- There is overwhelming international and national evidence that **taxing sugar sweetened beverages could improve health outcomes without exacerbating existing socio-economic inequities.** Yet industry opposition, lack of political support and ideological resistance stymie health promotion and prevention efforts to implement a sugar sweetened beverage tax. The Productivity Commission's definition of prevention, and thus, scope of practice for recommendations must include primordial prevention and leverage its cross-sector remit to prioritise health as integral to economic productivity across all sectors and support the implementation of this tax.
- **The assumption that falls are an inevitable side effect of aging is flawed. Falls are preventable.** Falls are the leading cause of injury-related hospital admissions and aged care admissions, costing the healthcare system more than $5 billion annually. There is significant level one evidence supporting falls prevention for people living in the community, in residential aged care, and in acute care settings. Evidence that prevention interventions decrease falls risk, improve health outcomes and reduce health care costs, yet are not being implemented into routine practice.
- **There is overwhelming evidence demonstrating cardiac rehabilitation post heart event reduces mortality, hospital readmissions, and improves health related quality of life.** Yet there is insufficient governance and financing of tertiary prevention to support routine implementation of this evidence into practice, and Australian rates of cardiac rehabilitation uptake are low. The Heart Foundation reports that a recent study of 49,000 patients showed that only 30% of patients were referred to cardiac rehabilitation and of these only 28% attended. This is a missed opportunity for readily improving health outcomes, reducing acute care utilisation, and improving productivity.

Other examples of missed opportunities for maximising our return on investment in health and medical research, improving patient outcomes, reducing health care costs and improving productivity include implementing preventive mental health models, and preventive oral health care into routine practice.

Central to the effective implementation of level one evidence into routine practice are appropriate governance structures and accountability mechanisms. Currently, there is a lack of governance around population health at the local level, amongst those responsible for overseeing the implementation of prevention strategies and de-implementation of ineffective prevention strategies. **It is essential to equip local health districts and primary health networks with financing and governance mechanisms to implement prevention strategies and achieve outcomes aligned with prevention.** These mechanisms must be separate and complementary to clinical care governance structures and accountability mechanisms.

We commend the Productivity Commission on the *Delivering Quality Care More Efficiently Interim Report* and encourage the final report to reflect chronic non-communicable disease prevention and health promotion as central levers for efficiency, equity, and long-term sustainability of Australia's economy – not just healthcare system. We would be pleased to provide further evidence or expertise to support the Commission's work.

Yours sincerely,

Dr Zoe Szewczyk, Dr Saman Khalatbari-Soltani, Professor Ben Smith, and Professor Philayrath Phongsavan.

On behalf of the Prevention Research Collaboration, Sydney School of Public Health, and
The Charles Perkins Centre,
The University of Sydney.