Deakin University Faculty of Health Submission to the

PRODUCTIVITY COMMISSION: Have your say on how to deliver quality care more efficiently

The Deakin University response was submitted using the online portal. Have your say | Delivering quality care more efficiently | Engage - Productivity Commission

Section 1. About you and/or your organisation

In this section, we want to understand how you interact with the care economy, including which sectors and in what jurisdiction(s).

You will also be asked to select the reform area(s) you are interested in responding to.

Contact information

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May we contact you about your response?

- Yes
- No

If yes:

How would you prefer we contact you?

- Email
- Phone
- Other (please specify)

Attribution

Whose views does your response represent? (Please include the full names of applicable individuals, groups or organisations).

This can be the name of one or more individuals (including yourself), or the name of one or more organisations. Ensure that you have permission to attribute the submission to all individuals/organisations named.

This submission is made on behalf of Deakin University's Faculty of Health including input from the following institutes and research centre:

- Institute for Physical Activity and Nutrition (IPAN)
- Institute for Health Transformation (IHT)
- SEED Centre for Lifespan Research

Do any of the attributed parties identify as Aboriginal or Torres Strait Islander/are any identified organisations an Aboriginal and/or Torres Strait Islander organisation?

- Yes
- No
- Prefer not to say

Under the National Agreement on Closing the Gap, an Aboriginal and Torres Strait Islander organisation (other than an Aboriginal and Torres Strait Islander community-controlled organisation):

- *is a business, charity, not-for-profit organisation, incorporated under Commonwealth, state or territory legislation*
- *has at least 51% Aboriginal and/or Torres Strait Islander ownership and/or directorship and is operated for the benefit of Aboriginal and Torres Strait Islander communities.*

Consent

Do the attributed parties consent to the PC publishing your response on our website and referring to it in our reports?

- Yes, with attribution
- Yes, without attribution
- No, do not publish my response or refer to it in your reports

We will only publish your response if it meets our community guidelines. We are unable to refer to unpublished responses within our report.

For further information on how we handle your information visit our Privacy Policy and Information Policy.

Guidelines and policies agreement

- I have read and agree to the above guidelines and policies.

Providing supporting documents (optional)

At this stage of the inquiry, we are only accepting and reviewing supporting documents that meet the following criteria:

- They contain data, charts and supporting information relevant to the policy areas and questions we are asking in this round of consultation
- The attributed participant(s) hold the copyright for the information contained in the documents
- The documents don't include any personal or identifying information.

There will be an opportunity to provide submissions on our policy reform ideas when we release our interim report.

Will you be providing any documents to support your response?

- Yes
- No

How to provide a supporting document

Once you have submitted your response via the 'Submit' button below, you will receive a confirmation email from us. Please reply to this confirmation email with your supporting documents attached. REFERENCE LIST emailed post-submission as requested.

For accessibility reasons, we prefer Microsoft Word documents.

Once we receive your supporting documents, we will review them alongside your response. If your contributions meet our community guidelines, and you have provided consent, we will publish them to engage.pc.gov.au within 14 days.

For the purposes of this consultation, which of the following best describes you:

- I am a consumer or user of care services (consumer)
- I am a carer of someone who uses care services (carer)
- I am a care worker
- I am an organisation that provides or coordinates care services
- I am an industry or advocacy organisation, professional association or peak body
- I am a government department/agency
- I am an interested community member
- Other – University / Research Institutions

Which of the following care sectors will your feedback relate to? Please select all that apply.

- Aged care
- Disability
- Early childhood education and care
- Health
- Veterans
- Aboriginal Community Controlled
- Other (please specify) – Education

What kind of care supports, services and programs do you have experience with, and in what jurisdictions?

Deakin University's Faculty of Health is one of the largest and fastest growing health faculties in Australia. Our five schools work to address inequalities across the life-course in the communities we serve, through dynamic learning experiences and world-class research. The Faculty of Health places high emphasis on solutions-led research. We work closely with community, industry and the government to put findings into practice.

This submission was prepared by researchers across a number of our research institutes and centres:

- The Institute for Physical Activity and Nutrition (IPAN) is a world-leading, multidisciplinary research institute. We're focused on the role of active living, sport, food and nutrition to create healthy, thriving communities, and to reduce the rates of chronic health conditions. Institute for Physical Activity and Nutrition | IPAN
- The Institute for Health Transformation (IHT), we address today's most complex and compelling health challenges through excellence in collaborative research that transforms how we design and deliver prevention and care. Institute for Health Transformation | IHT
- The SEED Centre for Lifespan Research conducts world-leading research on social and emotional development across the lifespan; from infancy to adulthood and into the next generation. World-leading research on social development | SEED Lifespan

Deakin researchers across these Institutes and Centres focus on collaborative / partnership research in prevention / preventative health across multiple sectors to benefit the community. For example, our research supports and involves the maternal

and child health system, the education system (including workforce capacity building for teachers), hospitals, community health and the health system more broadly.

The Deakin University Faculty of Health also train the future workforce, including dietitians, exercise physiologists, psychologists, nurses, teachers and health promotion officers.

We are seeking responses to questions on three policy reform areas.

Which policy reform areas would you like to respond to?

- **Reform of quality and safety regulation to support a more cohesive care economy**

The care economy workforce and providers are subject to a suite of rules, standards and policies that are intended to ensure safe and high-quality care.

While there are good reasons for this, it can also add to complexity and costs when navigating multiple sectors and jurisdictions.

We are interested in your views on the extent to which this is a concern and what you might change.

- **Embed collaborative commissioning to increase the integration of care services**

Collaborative commissioning is the process of organisations working in partnership to identify care needs, design solutions, procure services and evaluate outcomes.

We are interested in opportunities to improve collaborative commissioning across care sectors – such as health, disability and aged care – to reduce gaps and achieve better outcomes.

As a starting point, we are interested in the potential for greater collaboration between Primary Health Networks (PHNs), Local Hospital Networks (LHNs) (also known in some jurisdictions as Health Service Providers, Hospital and Health Services, Local Health Districts, Local Health Networks or Local Health Service Networks) and Aboriginal Community Controlled Health Organisations (ACCHOs).

- **A national framework to support government investment in prevention**

Governments can often underinvest in prevention and early intervention because the benefits of these programs can take a long time to materialise, can be hard to measure and can be spread across different areas and levels of government.

We are interested in exploring policy approaches that support greater government investment in prevention activities and that measure and incorporate the long-term and community-wide benefits.

Section 4.

A national framework to support government investment in prevention

In this section, we are seeking feedback on how to support government investment in evidence based prevention programs that improve long-term outcomes for the community and reduce demand for future care services. Care services can play an important role in reducing or eliminating the effects of preventable problems.

Prevention activities can reduce risk factors before problems arise, help detect issues early or slow their progression during initial stages. Despite this, governments can be reluctant to invest in prevention because it requires up-front spending and the benefits often take a long time to materialise, can be hard to measure and can be spread across different areas and levels of government.

Deakin University Faculty of Health Responses

The consultation poses three questions for the prevention reform area:

12. ***What are the main barriers to governments investing in evidence-based prevention programs across the care economy?***

There are a number of barriers to governments investing in evidence-based prevention programs.

Firstly, there are limited resources allocated to the health portfolio overall, and with healthcare pressures on Governments, they have a tradition of spending on treatment and hospitals rather than investing in preventive health measures to stop people getting sick in the first place (PHAA, March 2025). For example, when the Australian Centre for Disease Control was initiated, the first priority was disease control, not disease prevention.

Secondly, the short-term political cycles do not match the long-term benefits realised from investment in prevention. Economic appraisals for government decision-making are required to use short time horizons and high discount rates that diminish benefits attained many years into the future. This makes it challenging to secure investment for prevention.

The benefits of prevention, such as reduced disease burden and healthcare costs, can be hard to quantify in the short to medium term. Moreover, changes in health behaviours require supportive environments that require the implementation of a suite of interventions, making attribution of benefit to single policies/programs difficult. Together these challenges associated with evaluation further disadvantage prevention in the investment decision-making process.

Thirdly, the Australian political system has a shared responsibility for health funding across the federal, state and local levels. This makes a coordinated approach more challenging and enables cost and blame shifting. It also hampers data linkage efforts which are required to better understand how to drive change across primordial, primary and secondary prevention. Even within levels of government, prevention efforts span multiple government departments, requiring investment and action by sectors other than health. This adds further complexity, opportunity for cost-shifting, and often means that those bearing the cost don't always bear the benefit.

Furthermore, community led initiatives, in place, should be prioritised. Too little governance is given to local communities to be 'expert' in finding local solutions to local problems. This is the 'place based' agenda that puts community in a leadership role and government in the support act role. The research community play a role in this too by supporting high quality research in areas to help communities gain the least biased picture of local needs.

Workforce is also key. The public health and community health workforce is often spread thin or impacted by short term funding or funding cuts resulting in a lack of continuity and sustainability of successful programs (for example, refer to Healthy Together Victoria as a case study).

It is critically important to consider prevention as more than just programs. Prevention must also be addressed with government-led policies that target the structural and commercial determinants of health. Commercial interests are a major barrier to adoption and implementation of evidence-based prevention strategies. Many effective primary prevention initiatives (e.g. marketing restrictions for unhealthy products, fiscal health policies) impact powerful industries (Big food, gambling, tobacco/vapes) and are actively opposed through lobbying and political influence. A common tactic is the 'personal responsibility' narrative, which suggests that people should take responsibility for their own health behaviours. This framing ignores the significant influence of the environments, which shape one's capacity to make healthy choices. If we are serious about prevention to improve population health and reducing inequities, structural policies that counter commercial influence is critical.

Evidence-based prevention programs and behaviour change initiatives are vital to public health as they proactively reduce the burden of disease, promote healthier lifestyles, and address health disparities before they escalate. These are needed, alongside policies, to provide practitioners and individuals with tangible solutions. However, prevention programs and behaviour change initiatives need to be designed to be implemented at scale to ensure maximum population impact and reduce the inequity divide.

Together, these approaches form a comprehensive strategy that not only treats symptoms but also addresses root causes, leading to more equitable and lasting improvements in population health.

Finaly, there is no dedicated funding stream for prevention and population health at any level of government. This leaves preventive health chronically under-resourced compared to acute and clinical care, despite clear evidence of its long-term economic and social benefits. The absence of sustained, ring-fenced funding undermines the ability to plan and implement coordinated, long-term strategies to reduce the burden of chronic disease, address health inequities, and improve community wellbeing. Without a stable funding base, prevention remains vulnerable to political cycles, short-termism, and fragmented program delivery.

13. ***What are some examples of successful prevention programs (including any that have been discontinued)? Including:***

- ***Who funded and delivered the program***

- ***Outcomes achieved***
- ***Any reasons for discontinuation***
- ***Any evaluations undertaken***

Evidence shows that establishing healthy behaviours in early childhood significantly reduces the risk of chronic diseases such as obesity, diabetes, and cardiovascular conditions later in life. Interventions during the early years, including prenatal care, breastfeeding support, and early childhood nutrition and movement programs, lay the foundation for healthier habits that persist through adolescence and adulthood. These early efforts not only improve individual health outcomes but also yield substantial economic benefits by reducing long-term healthcare costs and enhancing productivity.

There are many hundreds of effective programs. For example, Deakin University's SEED Centre for Lifespan Research's "living review" of evidence-based programs for promoting emotional and relational health alone has identified over 200 effective programs that could be delivered into populations from early childhood to young adulthood. A set of these are programs we have developed and are now published and available. All have solid RCT evaluation data and could be implemented, per required need in local communities, with high confidence that a positive health dividend would be realised. Some examples of effective programs/initiatives are detailed below.

The challenge for these successful prevention programs is the lack of funding support for ongoing, sustainable implementation across the country. Once the research funding comes to an end, there are currently limited opportunities for sustained funding to maintain and grow the impact of these programs and initiatives.

Example 1: TransformUs

One example is from Deakin University's Institute for Physical Activity and Nutrition (IPAN). The TransformUs initiative (www.transformus.com.au) supports primary and secondary students of all abilities to be more active and more engaged in their learning (Salmon et al 2011). TransformUs is backed by 16 years of scientific evidence (Salmon et al 2023; Verswijveren et al 2022) showing the program is effective in improving student engagement, and health and wellbeing (e.g., significantly lower body mass index, waist circumference, etc). An economic evaluation found that TransformUs represents good "value for money and could lead to…healthcare cost-savings arising from the prevention of chronic disease in later life if intervention effects are sustained" (Brown et al 2024).

TransformUs is a whole-of-school, active pedagogical education initiative, that targets the classroom, the broader school environment (such as playgrounds) and the home (by providing strategies for active homework). TransformUs supports teachers to

activate classrooms and engage students, using movement, to maximise learning outcomes and student health and wellbeing. It provides schools and teachers with online professional learning and hundreds of lesson plan resources designed to improve student learning in maths, science, English, geography and history. All TransformUs resources are linked to the Australian Curriculum.

TransformUs offers a solution to support the Australian Government to achieve targets and health priorities:
• Better and Fairer Schools Agreement (BFSA);
• Australian Student Wellbeing Framework;
• National Preventive Health Strategy;
• Australian 24-Hour Movement Guidelines for Children and Young People; and
• National Obesity Strategy.

TransformUs Outcomes achieved
TransformUs is reaching over **850 schools** around Australia, including primary, secondary and special schools.

- 85% of teachers reported their students experienced greater concentration after an active break.
- 79% of teachers reported their students' time-on-task improved after an active break.

Compared to non-TransformUs schools delivering traditional lessons, children in the TransformUs schools:

- Spent up to 63 minutes less time sedentary and 5 minutes more active on school days.
- Had lower Body Mass Index (BMI), waist circumference and blood pressure and higher vitamin D levels. Given that overweight and obesity is now the leading preventable cause of health loss and disease burden, investments in programs to reduce obesity early in life are critical.

Who funded and delivered the program
TransformUs is based at the Institute for Physical Activity and Nutrition (IPAN), Deakin University. TransformUs has received 16 years of research funding, totalling more than $4 million from:

- the National Health and Medical Research Council (NHMRC);
- VicHealth;
- Diabetes Australia
- the Victorian Department of Education.

TransformUs has also successfully secured grants for pilots in Tasmania (Tasmanian

Department of Health & Human Services), Saudi Arabia (Prince Faisal bin Fahad Award for Sports Research) and Victorian secondary schools (Victorian Department of Education). Throughout, the program has been supported by in-kind contribution of a team of IPAN researchers and support staff. Delivery was supported by a strong network of partner organisations.
This evidence supports the generalisability and scalability to different populations.

Any reason for discontinuation
Our research shows TransformUs can be implemented successfully in a range of settings (metropolitan, regional and remote). IPAN, Deakin University, are continuing to support ongoing implementation and reach of TransformUs with existing research funding. To achieve sustainable impact and reach all Australian children, TransformUs needs support for ongoing implementation in 2026.

Evaluation undertaken
Evaluation of TransformUs has been extensive over the 16 years, including health outcomes, economic evaluation and qualitative evaluation with users and interested parties (some results listed below).

Outcomes achieved
IPAN tested the impact of TransformUs over two and a half years with around 600 primary school children. Compared to non-TransformUs schools delivering traditional lessons, children in TransformUs schools:

- Spent up to 63 minutes less time sedentary
- 5 minutes more active on school days
- Had lower body mass index (BMI), waist circumference and blood pressure and higher Vitamin D levels.

An economic evaluation of TransformUs found it was good 'value for money and could lead to health benefits and healthcare cost-savings arising from the prevention of chronic disease in later life if intervention effects are sustained (Brown et al, 2024). Health economic research shows when the health benefits demonstrated are applied to the broader Australian population it would have **healthcare cost-savings of over $600 million**.

For more information visit transformus.com.au

Example 2: INFANT

IPAN, Deakin University, also developed INFANT (www.infantprogram.org) an effective, universal intervention that enhances existing Maternal and Child Health services, with evidence based approaches to feeding, nutrition, active play and reduced screen time

for parents with young children (birth –18 months). Research tells us that the first 1000 days – the period between conception and a child's second birthday – are critical for establishing lifestyle behaviours that will determine a person's risk of developing obesity and chronic diseases. INFANT helps families to establish health behaviours in the early years with related health, social and economic benefits and budget savings for the health system, immediately and long-term.

INFANT – laying the foundation for health and wellbeing in the early years

- Timely support for parents with four group sessions provided by trained health and early years professionals, together with the INFANT app and evidence-based resources.
- Builds social and community connection between parents during a time of new challenges and life changes, via group-based parenting support.
- Early support is available through the INFANT app, including breastfeeding support which has been found to be acceptable and useful, particularly for women with lower levels of education.
- INFANT also improves mothers' dietary intakes, as role models for their child's health behaviours.

Who funded and delivered INFANT

The original randomised controlled trial of INFANT was trial was funded by a National Health and Medical Research Council (NHMRC) grant (GNT425801). The follow up of outcomes for children in the trial at 3.5 and 5 years of age was also funded by NHMRC grant (GNT1008879). From 2021, INFANT has been scaled up across Victoria with implementation support funded by Victorian Government Department of Health, Vic Health and Deakin University supported by a strong network of partner organisations. The evaluation of the scale up is funded by a NHMRC Partnership grant (GNT1161223), VicHealth and in-kind contributions from a range of partner organisations and Deakin University. Local delivery of the program is not funded, rather the program is integrated into existing service delivery such as Maternal and Child Health and Community Health Services.

National endorsement of INFANT

INFANT is approved as an evidence-based program in the Australian Institute of Family Studies' Guidebook for Communities for Children Facilitating Partners (since 2020) enabling eligible (high needs) local communities to access funding to support set up and delivery.

International endorsement of INFANT

The US Centers for Disease Control (CDC) found in a key 2023 review that INFANT is "... *the strongest model for translating findings from a Randomised Control Trial to wide-spread implementation of an intervention in the community*." (US CDC Complementary Feeding Review)

The US National Cancer Institute lists INFANT as a recommended evidence-based program, rating it highly for research integrity and dissemination capability. It is the only program in its database of 207 endorsed healthy lifestyle programs that starts from birth.

Any reason for discontinuation

The implementation of INFANT continues in 2025-26 with the support of Victorian Health Promotion Foundation and Victorian Government Department of Health. However, further funding is needed beyond this period to ensure ongoing sustainability throughout Australia.

INFANT Outcomes achieved and evaluation
Extensive evaluation of INFANT has undertaken over the 15 years, including health outcomes, economic evaluation and qualitative evaluation with users and interested parties. INFANT has reached more than **15,000 families** with new babies so far.

The research conducted by IPAN, Deakin University shows:

- **Young children** eat more fruit and vegetables and drink more water, with reduced sugar-sweetened beverage intake (Campbell et al 2013, Spence 2013) and less television watching - these healthy habits are sustained when they're getting ready for school, at 5 years of age (Delisle Nystrom et al 2021, Hesketh et al 2020).
- **Mothers** have healthier diets, improved knowledge and more confidence in their parenting, as well as improved social connection with other parents and local health services (Lioret et al, 2012, Love et al 2018).
- **Families** from diverse backgrounds have better access to critical health information - INFANT parent resources are available in six priority languages, supporting more families to raise healthy, happy children at the time they need it most.
- **Health economic modelling** shows a one-serve reduction in discretionary food per week results in approximately $1.298 billion savings in healthcare costs during a lifetime and could prevent more than 50,000 cases of type 2 diabetes and 20,000 cases of heart disease nationally. INFANT trial results show a 1.7 serve reduction in discretionary foods per week at age 5 years (compared to children not receiving the program).
- **Reduced health service use** by Parents engaged with INFANT who were less likely to seek advice on feeding, activity or growth across the first nine months of

life from health services, including parent helpline, GPs and paediatricians (Laws at al 2024), with significant health cost savings estimated at $6.9 million annually from fewer GP and paediatrician visits alone (calculations modified for Victoria based on Brown et al 2017).

Visit the INFANT website infantprogram.org or contact infant-study@deakin.edu.au

Example 3: RESPOND

The **RESPOND (Reflexive Evidence and Systems interventions to Prevent Obesity and Non-communicable Disease)** (Allender et al, 2024) program was funded by the National Health and Medical Research Council (NHMRC) and led by Deakin University's Institute for Health Transformation. Implemented in ten local government areas in regional Victoria, RESPOND used a community-led systems approach to prevent childhood obesity. Evaluations showed improvements in children's health behaviours, particularly increased water consumption and better psychosocial wellbeing. A mixed-methods evaluation framework confirmed the program's effectiveness. RESPOND concluded in 2024 when the NHMRC funding period ended, rather than due to program failure. Its discontinuation highlights the challenge of ensuring sustained funding for prevention initiatives, despite clear evidence of their effectiveness.

12. ***How can governments better support investment in prevention activities that have broad and long-term benefits for the Australian community?***

A dedicated funding stream for prevention

There are low-cost policy and environmental strategies that can be implemented to support prevention. Prevention must be elevated within government structures through national leadership, independent oversight, and interjurisdictional coordination. This includes delivering on the recommendations within the NPHS, meeting national targets, investing in data and monitoring systems, and supporting community-led approaches that respond to local needs and priorities. Addressing the commercial determinants of health is also essential. This means tackling commercial political influence, harmful marketing practices, unfair pricing practices, and the widespread availability of unhealthy products through government-led regulation. Programs alone will only ever have limited effectiveness unless these broader structural and systemic drivers of poor health are addressed.

For population programs and initiatives, an ongoing dedicated funding stream for prevention is urgently required. This funding must be committed to prevention and not compete with other areas of the health budget. To achieve this we must build a compelling narrative that can gain political and public support for prevention.

For decades there has been a lack of political appetite to introduce taxes to fund preventive health measures. The Public Health Association of Australia (PHAA) recently proposed a 'Preventive Health Future Fund' that could store and release funding for preventive health programs, campaigns, early detection, and other practical investments. Such a fund would resemble the system by which funding for health and medical research is already provided for by the Government through the Medical Research Future Fund (MRFF). A fund model works to support the investment goal of 5% of health spending allocated to prevention (PHAA, January 2025).

PHAA goes on to highlight that one source of revenue to support a prevention fund would be proceeds from the national excise taxation of gambling (particularly sports betting), tobacco, alcohol, and sugar sweetened beverages (SSB). Even a modest portion of the existing levels of tobacco taxation, which at present raises around $13 billion per annum in federal revenue, would quickly and effectively establish a fund (PHAA, 2024).

Despite decades of lobbying by health groups, the Australian government has been resistant to implementing a sugar sweetened beverages tax. Yet internationally over 130 jurisdictions have implemented sugar sweetened beverages taxes at the national or subnational level (Andreyeva et al 2022).

While there has been a plethora of health promotion and prevention strategies written over the past two decades, there has been a lack of clearly identified source of funding to implement any of these strategies. For example, the National Preventive Health Strategy was released in 2021 and yet the promised Blue Print for Action has yet to be made public and no real funding has been allocated to enable actions to be met. This is despite all major parties supporting the delivery of the National Preventive Health Strategy 2021-30.

Bipartisan (or multi-partisan) agreement to long-term investment in prevention

Attaining bipartisan (or multi-partisan) agreement to long-term investment in prevention will have significant benefits for the health system, overcoming the uncertainty of political cycles and funding cuts that often occur. This could involve an independent agency (similar to Pharmaceutical Benefits Advisory Committee (PBAC) and the Medical Services Advisory Committee (MSAC)) that assesses the economic credentials of health and medical interventions, with authority to recommend governments invest in cost-effective policies and programs. This function could be undertaken by the Australian Centre for Disease Control (CDC).

Investment in scale up of evidence-based solutions

Governments should provide funding for the scale up of successful evidence-based prevention initiatives. They already invest significantly in the research sector to develop these evidence-based initiatives but then there is a lack of translation pathway for the modest investment required to enable the benefits of the research to reach the community across the nation and realise the benefits and return on investment from their research funding allocations.

Develop and utilise a transparent priority setting framework to invest in effective and efficient policies/programs. This should include the use of a framework that can assess the effectiveness of preventive health interventions that considers the program logic of how prevention works.

True prevention activities need to be **embedded across sectors and settings**, not just in the health care system, and have cross-government engagement and support (for example Education, Transport, Social Services, etc), with dedicated funding and clear accountability.

Because of the nature of prevention and public health, the investment from Government must not be limited to the health budget. Prevention delivers benefits across many portfolios and cross sectoral funding models should be committed.

Furthermore, there is insufficient investment in the living systematic reviews of the global literature on evidence based preventive interventions in populations. Deakin University's SEED have established several systematic reviews relating to mental health and wellbeing but lack ongoing funding to ensure they are 'living reviews'. SEED have also built AI software to accelerate reviews and facilitate ongoing updates. It is recommended that the community be given access to a menu of evidence-based interventions to inform their local place-based planning (Please note the SEED living reviews portal can be provided upon request).

Partnerships and collaboration across the health system (beyond health care and tech solutions)

An investment in collaboration and partnerships between government agencies, non-government organisations (NGOs) and academia to ensure adoption of evidence-based interventions and programs that work. Partnerships that focus on the local implementation of successful evidence-based initiatives should be prioritised. This will ensure precious resources are used wisely and focus on impact for the local community. Providing adequate funding for cultural adaptation of successful prevention initiatives will also help overcome health inequities.

We also strongly advocate for "Community Based Participatory Research" approaches, first developed in the 1940s as a way of empowering communities to drive investment in preventive health care in collaboration with government and research groups. The approach starts with community led epidemiological surveys to ensure precision targeting of intervention resources to areas of measured need. This local knowledge is then coupled with knowledge of evidence-based interventions provided by the scientific community, that together builds a case for investment from government (state and federal).

Workforce capacity, Medicare rebates and referral pathways for preventive health

Healthcare professionals who may be involved in preventive care include general practitioners, medical specialists, nurses, Accredited Practising Dietitians, Accredited Exercise Physiologists, Accredited Exercise Scientists, physiotherapists, and psychologists. However, primary care is often overburdened and lack the time (and sometimes the training) required to provide preventive health advice and skill development. Extending referral systems for prevention would also help.

Data linkage from Medicare Benefits Schedule (MBS) data and other healthcare services and population health surveillance efforts could inform where and how to invest from the earliest stages of life into adulthood. Expanding or extending Medicare rebates for preventive health care / allied health care would enable more access to the right care at the right time and lessen the health inequities embedded in the health system. For example, the MBS could be expanded to include comprehensive child health consultations. These would focus on monitoring and promoting healthy behaviours and optimal growth during the first five years of life. They could also support early intervention through referrals to allied health professionals and evidence-based community programs. Since health behaviours are formed early in life and often continue into adulthood, and more than 1.5 million children aged 0 to 4 years visited a GP in 2022 to 2023, this presents a critical opportunity for prevention and chronic disease prevention. Private health insurers could also provide greater rebates and services to their members to help with preventive health.

REFERENCE LIST

Allender S, Gaskin CJ, Becker D, Jackson M, Orellana L, Hayward J, Bell C, Nichols M, Brown V, Hillenaar M, Moodie M, Peeters A, Brown AD, Whelan J, Swinburn B, Strugnell C. (2024) Three-year behavioural, health-related quality of life, and body mass index outcomes from the RESPOND randomized trial. Public Health. 2024 Dec;237:344-353. doi: https://doi.org/10.1016/j.puhe.2024.10.015. Epub 2024 Nov 9. PMID: 39515219.

Andreyeva T, Marple K, Marinello S, Moore TE, Powell LM. (2022) Outcomes Following Taxation of Sugar-Sweetened Beverages: A Systematic Review and Meta-analysis. JAMA Netw Open. 2022 Jun 1;5(6):e2215276. Available https://pubmed.ncbi.nlm.nih.gov/35648398/

Brown, V., Moodie, M., Baur, L., Wen, L.M. and Hayes, A. (2017), The high cost of obesity in Australian pre-schoolers. Australian and New Zealand Journal of Public Health, 41: 323-324. https://doi.org/10.1111/1753-6405.12628

Brown V, Sheppard L, Salmon J, Arundell L, Cerin E, Ridgers ND, Hesketh KD, Daly RM, Dunstan DW, Brown H, Gatta JD, Chinapaw JMM, Moodie M. (2024) Cost-effectiveness of reducing children's sedentary time and increasing physical activity at school: the Transform-Us! intervention. Int J Behav Nutr Phys Act. 2024 Feb 12;21(1):15. doi: 10.1186/s12966-024-01560-3. PMID: 38347579; PMCID: PMC10860323.

Campbell, K. J., S. Lioret, S. A. McNaughton, D. A. Crawford, J. Salmon, K. Ball, Z. McCallum, B. E. Gerner, A. C. Spence, A. J. Cameron, J. A. Hnatiuk, O. C. Ukoumunne, L. Gold, G. Abbott and K. D. Hesketh (2013). "A parent-focused intervention to reduce infant obesity risk behaviors: a randomized trial." Pediatrics 131(4): 652-660. DOI: 10.1542/peds.2012-2576

Delisle Nyström C, Cameron AJ, Campbell KJ, Hesketh KD. (2021) Variation in Outcomes of the Melbourne Infant, Feeding, Activity and Nutrition Trial (INFANT) According to Maternal Education and Age 2 and 3·5 Years Post-Intervention. Public Health Nutr (2021) 24(6):1460–8. doi:10.1017/S1368980021000045

Hesketh KD, Salmon J, McNaughton SA, Crawford D, Abbott G, Cameron AJ, et al. (2020) Long-Term Outcomes (2 and 3.5 Years Post-Intervention) of the INFANT Early Childhood Intervention to Improve Health Behaviors and Reduce Obesity: Cluster Randomised Controlled Trial Follow-Up. Int J Behav Nutr Phys Activity (2020) 17(1):95. https://doi.org/10.1186/s12966-020-00994-9

Laws, R., Hesketh, K., Ball, K. et al. (2016). Translating an early childhood obesity prevention program for local community implementation: a case study of the Melbourne INFANT Program. *BMC Public Health*, 16:748. ncbi.nlm.nih.gov/pmc/articles/PMC4977772/

Laws R, Zheng J, Brown V, Lymer S, Campbell K, Russell G, Taki S, Litterbach E, Ong K, Denney-Wilson E. (2024) The impacts of an mHealth intervention targeting parents on health service usage and out of pocket costs in the first 9 months of life: The Growing healthy app. Maternal and Child Nutrition Oct;20(4):e13662 DOI: 10.1111/mcn.13662

Lioret, S., S. A. McNaughton, D. Crawford, A. C. Spence, K. Hesketh and K. J. Campbell (2012). "Parents' dietary patterns are significantly correlated: findings from the Melbourne Infant Feeding Activity and Nutrition Trial Program." Br J Nutr 108(3): 518-526. DOI: 10.1017/S0007114511005757

Love, P., Laws, R., Litterbach, E., & Campbell, K. (2018). Factors Influencing Parental Engagement in an Early Childhood Obesity Prevention Program Implemented at Scale: The Infant Program. Nutrients, 10(4), 509. MDPI AG. https://doi.org/10.3390/nu10040509

Public Health Association of Australia (PHAA), (January 2024) Budget Priorities for Public Health 2025-26. https://www.phaa.net.au/common/Uploaded files/Briefing papers/Budget attachments 2025-2026/PHAA Budget Submisson 2025-26 - appendix 5 - implementing prevention strategy.pdf PHAA Budget Submisson 2025-26 final.pdf. Accessed June 2025.

Salmon J, Arundell L, Cerin E*, et al* (2023) Transform-Us! cluster RCT: 18-month and 30-month effects on children's physical activity, sedentary time and cardiometabolic risk markers *British Journal of Sports Medicine* 2023;**57:**311-319. http://dx.doi.org/10.1136/bjsports-2022-105825

Salmon, Jo; Arundell, Lauren; Hume, Clare; Brown, Helen; Hesketh, Kylie; Dunstan, David; et al. (2011). A cluster-randomized controlled trial to reduce sedentary behavior and promote physical activity and health of 8-9 year olds : the transform-us! study. *BMC public health*, vol. 11, no. 759, pp. 1-14 http://www.biomedcentral.com/1471-2458/11/759

Spence, A. C., S. A. McNaughton, S. Lioret, K. D. Hesketh, D. A. Crawford and K. J. Campbell (2013). "A health promotion intervention can affect diet quality in early childhood." J Nutr 143(10): 1672-1678. DOI: 10.3945/jn.113.177931

Verswijveren et al. (2022) Intervention effects on children's movement behaviour accumulation as a result of the Transform-Us! school- and home-based cluster randomised controlled trial. *The international journal of behavioral nutrition and physical activity*, *[s. l.]*, v. 19, n. 1, p. 76, 2022. https://doi.org/10.1186/s12966-022-01314-z