



**Public Health Association**  
AUSTRALIA

# Better health through an evidence informed Wellbeing Budget

**Strategic Directions /  
Pre-Budget Submission  
for the October 2022 Budget**

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July 2022

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The **Public Health Association of Australia** (PHAA) is recognised as the principal non-government organisation for public health in Australia. It is the pre-eminent voice for the public's health in Australia, working to promote the health and well-being of all in Australia.

The PHAA works to ensure that the public's health is improved through sustained and determined efforts of our Board, National Office, State and Territory Branches, Special Interest Groups and members.

**We believe** that health is a human right, a vital resource for everyday life, and a key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions that underpin people's health. The health status of all people is impacted by the social, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease. These determinants underpin the strategic direction of the Association.

**Our mission** as the leading national organisation for public health representation, policy and advocacy, is to promote better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health. Members of the Association are committed to better health outcomes based on these principles.

**Our vision** is for a healthy population, a healthy nation and a healthy world, with all people living in an equitable society underpinned by a well-functioning ecosystem and a healthy environment, improving and promoting health and wellbeing for all.

The reduction of social and health inequities should be an over-arching goal of national policy, and should be recognised as a key measure of our progress as a society. Public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.

## Overview

We make this submission – directly to the Treasurer, rather than through the normal annual channel to the Treasury department – to highlight three priorities for the framing of the coming Budget:

- To welcome and support the decision to frame the Budget towards a ‘wellbeing’ focus – indeed to urge the Government to use the Budget and related policies to create a ‘wellbeing economy’.
- To acknowledge the need to deliver on key government election commitments, including the creation of a national Centre for Disease Control, and implementation of the National Preventive Health Strategy (“NPHS”).
- To highlight the fact that sound public health policy is sound economic policy, especially regarding policies which prevent diseases and other threats to health.

In regard to the **wellbeing approach**, the Government has options ranging from basic to better to best. A very *basic* version of such an approach would be to simply package and present a number of budget decisions under headings which have some relation to wellbeing improvement. Initiatives, for example, relating to mental health, young people’s welfare, or the advancement of wellbeing for Aboriginal and Torres Strait Islander people might appear in the Budget. No doubt many such measures would be welcomed. But packaging and presenting is not the real deal.

A *better* version would be to set serious strategic goals, with measurable indicators and targets, regarding wellbeing for all Australians. A system of 5- and 10- year objectives might be adopted, together with accountabilities to be borne by identified Ministers, and other related strategic policy drivers. Over time, this might indeed lead to outcome improvements. But the track record of such government approaches is, despite good reasoning and best intentions, only mixed.

The *best* use of this modern wellbeing thinking is to appreciate that wellbeing is actually the fundamental goal of the economy itself, and the end point of all the levers that governments pull to influence the vitality of the economy. A wellbeing economy *“reorients and reorganises traditional economic and business practices to support a prosperous economy [and] to account for things that really matter: our physical and mental health, the resilience of our environment, the cohesiveness of our communities, and how fairly economic wealth is distributed in our society.”*<sup>1</sup>

This higher vision of wellbeing economics is what the Albanese Government should aim for. Recognising that the October budget comes just weeks into the Government’s term of office, we appreciate that a full recasting of budgetary framing and decisions cannot be expected. But we urge the Government to signal with great clarity that the ‘wellbeing’ approach is no mere packaging exercise. PHAA will loudly support and applaud the Government in such a direction.

In regard to **election commitments**, we note in particular the commitments relating to the delivery of the National Preventive Health Strategy, and for the establishment of an Australian Centre for Disease Control and Prevention (“ACDCP”, but often elsewhere referred to as “CDC”):

*“An Albanese Labor Government would support the implementation of the National Preventative Health Strategy.”* – Labor campaign statement April 2022

*“The CDC will:*

- *Ensure ongoing pandemic preparedness;*
- *Lead the federal response to future infectious disease outbreaks; and*
- *Work to prevent non-communicable (chronic) as well as communicable (infectious) diseases.”*  
– ALP Policy Platform 2021

In regard to the NPHS, the delivery of a 10-year investment strategy cannot seriously start in years 3 or later. The former government adopted no budget initiatives at all in year 1 of the strategy. Serious investment in programs to address chronic disease drivers should be launched in October 2022, or at the latest in the May 2023 Budget, if the government is to be seen to meet its commitment.

The Government has given clear signals of energy and early progress on the commitment for a centre for disease control. This is very welcome. PHAA is already working effectively with the Department of Health and Aged Care on this project, and we are actively engaged with state agencies including chief health officers, helping to encourage engagement, draw out different options, and seek collaboration across the relevant sectors to assist the Government.

PHAA is well aware that work is already underway within the Health portfolio to deliver on the establishment of the ACDCP. PHAA has contributed advice and proposals on how to proceed and will continue to marshal the expert knowledge within our organisation to provide useful advice to the Minister and the Department. For the October 2023 Budget, the least that should be invested would be the costs of the establishment task force and related processes. But by the time of the 2023-24 Budget a clear position on the early-year full funding of the institution will be needed, and major decisions on the broad role and scope of the new entity will need to have been made.

We will champion the ACDCP project and continue to urge that the centre become a major national institution, capable of driving significant change regarding the development of the national public health workforce, the implementation of the NPHS, and other elements of the national health promotion and protection agenda.

In this submission we explain the strong ***economic case for prevention*** in health. There is already ample evidence that preventing and reducing the burden of diseases has a much higher economic value than failing to do so and incurring economic and budgetary costs in treating illness. Disease burdens also tend to cause and/or reinforce significant social inequalities.

The problem, of course, is that governments face the timing issue that budget costs and economic impacts deferred to the future seem to be less of concern than investment expenditure sought in the near term. To make Australia a healthier society, we need your Government to rise above that hurdle, and move away from an approach based on short-term expenditure avoided, and towards a deeper return-on-investment approach to budget choices in the preventive health field.

Adopting new approaches to financial planning that valued investment in health and disease burdens prevented would help to explain the case for early preventive investment to the Australian people. We note that the more advanced versions of wellbeing framing of the Budget would do the same. The Government has the opportunity to present Australia as a world-leader in national economic management.

As always, PHAA will be closely engaged with the Government, its agencies and other stakeholders in these public debates. We are well-renowned for always urging governments to do more, but we also stand ready to loudly praise good policy decisions and investments.

We look forward to being able to do so on 25 October.

## Summary of recommendations

### General economic and social policy

1. Government economic policies and projections should be based on a fundamental premise that a healthy population is essential for a healthy and vital economy, with respect to both the short- and medium-term management of the pandemic, including recovery, and the ongoing management of all preventable diseases, injuries and other impacts on health.
2. The proposed 'wellbeing' framing of the Budget is very welcome, and should be used to help clarify budgetary and economic policy priorities.
3. Government economic policies should recognise the need to reduce inequality and inequity, taking into account the social, cultural, environmental and commercial determinants of health.

### Government election commitments

4. The Budget should commence the establishment of an Australia Centre for Disease Control and Prevention.
5. The Budget should commence action to implement the National Preventive Health Strategy (2021), including by leading all governments towards the commitment that 5% of Commonwealth, state and territory health expenditure (in aggregate) should be directed to preventive health investments by the year 2030. Establishing a Preventive Health Future Fund should be part of such action.

### Preventive health policy

6. The Budget should urgently address the need for an expanded public health workforce for Australia, taking into account education, training, permanent resourcing and retention issues.
7. The Budget should continue the pattern of recent years of increasing investment, directed to the Aboriginal Community-Controlled Health Organisations (ACCHO), towards better Aboriginal and Torres Strait Islander health, towards achieving the agreed Closing the Gap targets, with the wider goal of adequately addressing ongoing systemic disadvantage through investment in appropriate housing, education and employment programs.
8. The Budget should make major investments in emissions reduction strategies, including a transition to reduced fossil fuel use across transport, industry and energy sectors, with a particular focus on ending fossil fuel subsidies and tax breaks, and growing the renewable energy sector.
9. The Budget should embrace revenue policies relating to alcohol, tobacco, and sugar-sweetened beverages, simultaneously achieving public health goals while generating revenue to offset resourcing for other public health investments (see the *Revenue Proposals* section).
10. The Budget should include specific investments in a range of measures to address key preventable chronic diseases (see the *Investment Proposals* section).

### Pandemic economic response

11. The Budget should ensure social and health equity through our national pandemic response by strengthening Australia's social security system through increasing the adequacy of payment levels, improving access for people requiring support, and removing unproductive compliance policies for job seekers.

## Summary of fiscal impact

PHAA is proposing revenue measures with an estimated net fiscal impact over four years of \$16.1 billion in additional revenue, offset by \$1.4 billion in new expenditure, for a net positive fiscal improvement of \$14.7 billion to the Budget balance.

### Summary of revenue measures

Revenue (\$m)	2023-24	2024-25	2025-26	2026-27	Total
Equalisation of excise and customs duties on 'roll your own' tobacco products	178.0	270.0	361.0	361.0	1,170.0
Volumetric equalisation of alcohol excises	2,900.0	2,987.0	3,076.0	3,168.0	12,131.0
Sugar-sweetened beverages excise	738.0	723.0	696.0	677.0	2,834.0
<b>TOTAL</b>	<b>3,816.0</b>	<b>3,980.0</b>	<b>4,133.0</b>	<b>4,206.0</b>	<b>16,135.0</b>

### Summary of investment measures

Expense (\$m)	2023-24	2024-25	2025-26	2026-27	Total
Establish a National Centre for Disease Control and Prevention	75.0	200.0	210.0	220.0	705.0
Public Health Officer Training program for Australia	50.0	52.0	54.0	57.0	213.0
National Tobacco Campaign	46.0	46.0	46.0	46.0	184.0
National Smoking Cessation Strategy	10.0	10.0	10.0	10.0	40.0
Targeted smoking reduction programs for groups experiencing the highest levels of disadvantage	15.0	15.0	15.0	15.0	60.0
Live Lighter national campaign	20.0	40.0	40.0	40.0	140.0
Reducing Alcohol Related Harm Program	15.0	30.0	30.0	30.0	105.0
<b>TOTAL</b>	<b>231.0</b>	<b>393.0</b>	<b>405.0</b>	<b>418.0</b>	<b>1,447.0</b>



# Budget framing

## Designing a wellbeing approach

PHAA welcomes the announcement that future Australian Budgets will adopt a ‘wellbeing’ framing. The mission of PHAA is to advance wellbeing for the whole community through a range of dimensions, prominently including health, but also in terms of human rights and freedoms, fulfilment of cultural goals, the sustainability of the natural world we live in, and other goals.

We note that this is not without precedent in Australia, with the ACT adopting such a framework a few years ago. Many of the existing state and territory Public Health Acts include a legislated focus on wellbeing, a good example being the recently refreshed South Australian legislation. Unfortunately, these legislated functions and goals do not necessarily flow directly into Budget deliberations.

As yet, the details of the proposed Commonwealth Budget wellbeing framing have not been announced. There are various forms this framing could take. We note that the OECD provides advice to member governments on what is essentially ‘wellbeing’ framing, and that from 2019 a cluster of governments including New Zealand, Finland, Iceland, Scotland, Wales and Canada formed a network to mutually explore wellbeing approaches.

One form, adopted by the Government of Wales in 2015, is essentially a legislated strategic planning exercise, with high-level goals stated in various domains of government responsibility (healthcare, education, etc), linked to a formal structure of ministerial reporting and delivery responsibilities. This approach can clarify the work of government, but unless the outcome measures go into richer detail, it is not inherently different from other forms of effort by governments to strategically plan their directions.

Another form is that adopted by New Zealand in recent budgets, with a sharper focus on selecting a small number of better-defined priorities, such as ‘improving mental health’, ‘reducing child poverty’ and the like. This gives more direct framing to Budget decisions and program investment priorities, as well as providing a framework for indicators of outcome success against which investment effectiveness might be measured. This also is a worthwhile course of action, although it is inevitably premised on governments selecting only a small number of signature ‘priorities’.

Better than either of these approaches – although perhaps taking both the above structural tools on board in some way – would be to reframe the presentation of budgets and related government strategic statements around a broader and deeper conception of human wellbeing. Such an advanced approach to ‘wellbeing budgeting’ would commit to the process of budget framing expanding beyond the traditional recording and management of fiscal actions and results, and broader also than a vision of economic management limited only to financial management and measures, but to recall that

*“A wellbeing economy moves beyond just economic growth as a marker of progress. It considers the long-term impact of policy on people’s lives and pursues solutions that have holistic benefits for individuals, communities and society.*

*A wellbeing economy reorients and reorganises traditional economic and business practices to support a prosperous economy. It moves beyond the tyranny of gross domestic product as a sole measure of progress to account for things that really matter: our physical and mental health, the resilience of our environment, the cohesiveness of our communities, and how fairly economic wealth is distributed in our society.*

*A wellbeing economy protects our most marginalised, while also protecting the planet’s finite resources. It puts responsibility on decision-makers to meet the needs of present [populations], without compromising the ability of future generations to continue to thrive.*

*It flips our current situation of people and planet acting as an input to economic growth, and instead puts our economy in service of what people and planet need.”*

*– [Is a wellbeing economy the solution to our ills?](#),  
Dr Alexandra Jones, Senior research fellow at  
The George Institute for Global Health, Dec 2021*



the term *economic* literally refers to the entire management of the household, not merely its fiscal performance. In such a vision, the notion of ‘prosperity’ is not limited to measures such as growth, productivity, and profitability, but also to health enjoyed (not merely illness treated), cultural richness, and the capacity of individuals to enjoy choice in many aspects of their lives which provide them with safety, opportunity and self-fulfilment.

Such a Budget framing could include dedication to measurable outcomes in respect of the maintenance of health (not merely the treatment of illness). We urge that **‘the reduction of the major burdens of disease’** is included as a goal in such a Budget framing, together with specific measurable outcome indicators. Such a commitment should in turn lead to yearly Budget commitments to make the investments in programs necessary to achieve targets associated with such measures.

The proposed wellbeing framing of Budgets is closely connected with arguments for disease prevention as itself being a long-term social good that provides downward force on budget expenditure pressures into the future. We encourage the Government to ensure that the proposed wellbeing framing has substance, and is more than a presentational change or a planning framework alone.

## Policy Alignment

### Alignment with existing national and inter-governmental policy directions

In November last year the former government launched its National Preventive Health Strategy.<sup>2</sup> This strategic statement was developed with a very strong element of external expert advice. It managed to transcend political partisanship, being welcomed by Labor party spokespeople and subsequently endorsed during the 2022 election campaign. This is a rare case of a strategy that can survive transition to a new national government, and indeed as noted above, in response to PHAA election surveys the Australian Labor Party and the Greens both indicated endorsement of the NPHS in their commitments. State and territory governments also have policy directions that are strongly NPHS-compatible.

The NPHS lays out plans for significant new policies and an evidence-based investment with a direction-setting ‘mechanism’. Crucially, the Commonwealth has adopted as a policy goal the target of investing 5% of national health expenditure towards disease prevention (with the remaining 95% continuing to be consumed by illness treatment costs) by the year 2030. This is a historic policy decision.

The stated NPHS direction is that the 5% goal is an aggregate target to be achieved between the Commonwealth, state and territory governments. Given the centralised nature of the major Australian revenue taxes, and the consequent downward disbursement of funds to be expended through state and territory governments, it is sensible that this target be an aggregate one, not one set separately (and differently) by different governments. But to achieve this objective, a direction must be emphatically set through the Commonwealth Budget’s investment choices.

Also essential will be an enhanced approach to measuring and reporting such investment, drawing on the definitions and comparative analysis capability of the Australian Institute of Health and Welfare (AIHW).

In addition, bipartisan and inter-governmental commitments announced through the National Cabinet process in 2020 clearly identified the need for an expanded Australian public health workforce. Led by the Department of Health and Aged Care, work is currently underway involving all governments to reform the landscape of that workforce, in terms of attraction, education and training, career structure, and long-term commitment to expanded workforces. This workforce planning needs to cover not only communicable disease prevention and management, but the whole interrelated effort of chronic disease prevention,

management and minimisation. The Commonwealth Budget has a major role to play in resourcing this vital national strategic effort.

## Alignment with other strategic advice to the Government

There is strong collegiality on a range of public health principles and strategic directions. PHAA's voice has been supported by a wide range of other non-government organisations, including the Cancer Council, Obesity Policy Coalition, Heart Foundation, Australian Medical Association, the Foundation for Alcohol Education and Research (FARE), and the National Aboriginal Community Controlled Health Organization, as well as welfare organisations such as the Australian Council of Social Service (ACOSS), climate organisations including the Climate and Health Alliance (CAHA), and others.

Australian and international research also supports our directions and proposals. A decade ago the work of the Assessing Cost Effectiveness in Prevention ("ACE") study by the University of Queensland School of Public Health demonstrated that many disease prevention initiatives have strong benefit-cost outcomes.<sup>3</sup> The World Health Organization (WHO) *Tackling Non-Communicable Diseases: Best Buys* report (2017) has provided governments with a benefit-cost assessed smorgasbord of public health investments, all with positive economic returns.<sup>4</sup> And even more recently the WHO's *Saving lives, spending less: the case for investing in noncommunicable diseases* report (December 2021) provides estimated returns on investment of a range of disease prevention measures.<sup>5</sup>

The National Preventive Health Strategy has likewise set a clear direction for the nation, but the state and territory governments have also demonstrated policy commitment, as well as good alignment with the Commonwealth and among each other. These include the *Victorian Public Health and Wellbeing Plan 2019–2023* (2019),<sup>6</sup> the strong prevention direction in the *State Public Health Plan for Western Australia 2019 - 2024* (2019),<sup>7</sup> the *Final Report of the Climate Health WA Inquiry* (2020),<sup>8</sup> and the *South Australian Health and Wellbeing Strategy 2020 - 2025* (2020),<sup>9</sup> and Queensland's *The Health of Queenslanders 2020* statement<sup>10</sup>.

This broad alignment of directional commitments indicates that the Government has an opportunity for collegiate action in this policy space, with minimal political or jurisdictional impediments.

## Socio-economic overview

### Economic overview

Every Budget sets a national strategic direction. We urge the new Government to recognise that the future of the Australian economy as a whole will depend more than ever on building a society with strong population health.

Australia's strategic position – and its resulting budgetary position – are at a potential tipping point. The economic and wider social impacts of COVID have been highly dramatic, as have their fiscal impacts on government budgets across the nation. To build back healthier, government strategy should recognise that the way we manage the population's health is a major driver of our economic wellbeing.

Population health in all its manifestations – but primarily in respect of the major determinants of chronic disease and their impacts on economic productivity – should therefore be a key strategic theme in the October 2022 Budget.

Australia's Budget position is obviously under great strain, with the pandemic presenting the Government with both extraordinary expenditures and significant reductions in revenue. The *2022 Pre-election Economic and Fiscal Outlook* statement (April 2022) forecasts Budget deficits unprecedented in our peacetime history of \$78 billion for 2022-23, \$56B for 2023-24, and \$47B for 2024-25.<sup>11</sup>

From a longer-term perspective, the Treasury's *Intergenerational Report* projections, updated in 2021 to take account of pandemic factors, foresee that *"the Australian economy is projected to grow at a slower pace over the next 40 years than it has over the past 40 years ... Slower population growth is the main reason for the expected slowdown"* (p.viii). However, *"Health and aged care are projected to be the fastest growing areas of spending over the next 40 years. Growth in these areas reflects pressures from the ageing of the population as well as non-demographic factors such as technology, changing consumer preferences and rising incomes"* (p.89).<sup>12</sup>

The Government is therefore under pressure to identify financial initiatives that enhance workforce productivity, improve the health of the population, and increase revenue. This Submission offers proposals for achieving all of those aims.

The economics of investment in *public health* – which is not to be confused with the far greater public financial expense of *illness treatment services* – offers the Government opportunities to reduce expenditure over the long-term, by means of modest investments in key areas of population health in the short term. Essentially, as we show later in this Submission, the return on investments in public health is positive, and in many cases powerfully so.

In addition, public health provides some significant opportunities to increase revenue as a by-product of specific health policies.

Launching decisive public health policy measures through the October 2022 Budget, or preparing such initiatives for the 2023-24 Budget, offers the prospect of significant gains for the community in health, social, economic and environmental wellbeing – all of which should be strongly prioritised by the Government.

## The economic significance of the population's health

The economic case for public health investment is simple and powerful: prevention (or minimisation) of disease in the community saves governments – and the private economy – very significant costs in financial and labour resources.

The economic cost of the rate of prevalence of major diseases is so great that significant shifts upward – or downward – in such rates present major economic and financial challenges (or opportunities) that governments should consider.

Similarly, investments to build disaster resilience and prepare for extreme weather events such as heatwaves and bushfires not only save lives and livelihoods, they would also avoid \$380 billion in worsening economic costs from climate change over the next 30 years.<sup>13</sup>

The benefits of having stopped something from happening are often difficult to perceive. However, the pandemic has provided a tragically clear demonstration of the economic impact of disease. In rebuilding out of the pandemic response, we must learn from experience and focus greater resources towards public health.

According to the Productivity Commission, on average, Australians live 13.2% of their lives in ill health – one of the highest proportions of any OECD nation, exceeded only by people in Turkey and the United States.<sup>14</sup> National economic and fiscal policy must be framed to address this major economic and social challenge.

Years spent in ill health present two major forms of economic loss: the opportunity cost of lost productivity during working years, and the direct cost (often increasingly expensive) of treatment and care. The reality is that we will inevitably expend resources on 'health'. Our choice lies in whether we decide to spend efficiently on *preventing* disease and maintaining wellbeing, or more expensively and less efficiently on *treating* illness once it manifests.

The degree of wellbeing and health – or alternatively, the extent of disease – across the population is also a major driver of its economic vitality, to say nothing of the social importance of wellbeing. Further, population health significantly influences the inflow and outflow of government revenue and expenditure.

Many studies have demonstrated the economic significance of disease burdens in our population. A 2019 study of the economic cost of preventable disease found that *"estimates of the annual productivity loss that could be attributed to individual risk factors were between \$840 million and \$14.9 billion for obesity; up to \$10.5 billion due to tobacco; between \$1.1 billion and \$6.8 billion for excess alcohol consumption; up to \$15.6 billion due to physical inactivity and \$561 million for individual dietary risk factors."*<sup>15</sup>

The OECD's *Heavy Burden of Obesity: The Economics of Prevention* report (2019), examined 52 developed member nations.<sup>16</sup> This study calculated the economic impact of overweight and obesity, which is one of modern society's most common forms of ill-health, and a driver of several major disease conditions. The report put the estimated economic cost to Australia at an astonishing 3.1% of GDP, including lowered labour market outputs equivalent to the productive output of 371,000 full-time workers, as well as an average reduction in lifespan by 2.7 years per person.

The November 2020 *Report of the Productivity Commission inquiry into Mental Health* gave an estimate of the economic cost (measured in 2018-19) of mental illness in Australia (comprising direct expenditure on mental healthcare and support services, lower economic participation, and cost of replacing the support provided by carers) at up to \$70 billion per annum.<sup>17</sup>

These costs clearly form some of the largest economic and financial burdens facing Australia's governments. They are drivers of continual pressure on national and state/territory governments to make our health systems (or more accurately, our *illness treatment* systems) more financially 'sustainable'.

However, the concept of fiscal sustainability should be understood not merely as an excuse for government expenditure constraint, but rather as making a case for a holistic approach to ensuring that higher socio-economic policy goals can be delivered in a manner which can be reliably maintained over many years. In fact, too much *constraint* on investing in disease prevention can be financially counter-productive in the long term, by increasing the extent of chronic disease and other illness and injury in the population.

In addition to the growing *scale* of problems of disease, their *spread* is becoming more socially uneven. Australia faces a steadily growing problem of economic inequality and inequity, including specifically inequity of health status and outcomes. While this is true of the population as a whole, the greatest challenges to wellbeing in Australia are witnessed in the conditions faced by Aboriginal and Torres Strait Islander peoples, Australians of lower socio-economic status and resources, and Australians living in rural and regional areas. Socio-economic determinants such as housing, education, justice matters, and cultural security also powerfully affect equality in Australia.

Inequality also has a compounding effect, perpetuating and worsening conditions for those least well off. Socio-economic disadvantage results in persistent inability to take healthy actions, resulting in poorer health outcomes and inability to access services to deal with illness perpetuating a vicious cycle of ill health and poverty.<sup>18</sup>

Public health investment has very strong benefit-cost value. A decade ago, the ACE study provided a comprehensive analysis of the comparative cost-effectiveness of preventive intervention options addressing the non-communicable disease burden in Australia, with a specific focus on Indigenous Australians.<sup>19</sup> The study evaluated the cost-effectiveness of 150 preventive health interventions, addressing areas such as mental health, diabetes, tobacco use, alcohol use, nutrition, body weight, physical activity, blood pressure, blood cholesterol and bone mineral density.

Across these areas of preventive intervention, the ACE study identified 23 'dominant' program interventions that both improve health and achieve net cost savings, as well as over 50 further interventions in 'very cost-effective' and 'cost-effective' categories. The study remains a policy road-map for Australian Government budgetary investments in preventive health.

More recently, a report on *The Health of Queenslanders 2020* found that:

*"There is growing evidence that public health interventions are cost-effective with up to 75% of UK public health interventions from 2005 to 2018 meeting this criterion.<sup>20</sup> It was estimated that a **\$1 investment in public health generated \$14 in return,**<sup>21</sup> in addition to the return of the original investment, back to the wider health and social economy."<sup>22</sup>*

The evidence therefore clearly supports the case for public health investment having a powerfully positive impact on Budget outcomes into the future.

## The importance of preventing chronic illness

Investing in chronic illness prevention and control, through affordable, cost effective, high-impact policies and legislative measures will deliver the greatest possible health impact in reducing illness, disability, and premature death. Chronic diseases such as cancer, diabetes, heart disease, chronic respiratory diseases and cardiovascular disease have a major impact on health and wellbeing and are responsible for around 89% of deaths every year.<sup>23</sup> These diseases and the major risk factors that contribute to them (tobacco use, alcohol use, unhealthy diet and lack of physical activity) also have significant negative consequences on economic productivity and financial stability for individual, households and society, as a whole.

The present pandemic will also trigger significant additional health problems, both directly from COVID infection but also from the indirect impact of many delayed preventive treatments for other forms of disease, including the often-unseen impact of chronic diseases. Diabetes, heart disease and hypertension, cancer, lung diseases, and obesity all significantly worsen the effects of COVID-19, increasing the risk of serious illness or death.<sup>24</sup>

The National Preventive Health Strategy indicates that it will be followed by an implementation plan for program initiatives, with a 10-year timeframe. The roll-out of public health measures should begin immediately through the Budget, with commitments to programs including:

- Cessation of tobacco use, and reduction in uptake by new users.
- Reduction of alcohol consumption, especially for those consuming alcohol at risky levels.
- Reduction of sugar-added beverage consumption.
- Reduction of junk food consumption.
- Reduction of harm associated with gambling.
- Promotion of healthy diets and dietary patterns.
- Better maternal and childhood health.

Cost estimates of chronic disease in Australia continue to mount. As noted above, estimates of the annual productivity loss that could be attributed to individual risk factors relating to obesity, tobacco, alcohol, physical inactivity and dietary risks totalled in aggregate up to \$47 billion.<sup>25</sup>

The Government should also address practices used by the private sector to promote products and choices that are detrimental to health. In 2020, the WHO-UNICEF-*Lancet* Commission on Child Health noted that commercial marketing of products that are harmful to children is one of the most underappreciated risks to their health and wellbeing. It concluded that industry self-regulation does not work, and the existing global frameworks are not sufficient. Industries selling unhealthy products are highly active in trying to shape individual behaviours towards the consumption of these unhealthy but often highly profitable products.<sup>26</sup> Such marketing practices do not affirm individual choice, but instead deliberately manipulate and undermine real personal choice. Arguments about commercial ‘freedom’ are often simply justifications for unhealthy product suppliers to manipulate consumers and dominate marketplaces.

A far stronger and more comprehensive approach to regulation is required to protect children from the marketing of tobacco, alcohol, formula milk, sugar-sweetened beverages, gambling, and potentially damaging social media, and the inappropriate use of their personal data.<sup>27</sup>

Sustained programs to help people make healthy consumption choices have proven effective in many domains in the past. Effective and sustained social marketing campaigns and related programs have helped people to achieve reductions in harmful consumption habits (tobacco, alcohol, sugar-added beverages, junk food, etc), and increase healthy activities (physical activity and promoting healthy eating).



## Managing the COVID-19 pandemic

The alarming surge in cases and mortality in recent weeks reminds us that the course of the COVID-19 pandemic can change rapidly. We record here some broad principles which should underly the economic management and response to the near-term, and also ongoing, needs of the Australian community.

First, the Budget should ensure that social equity is front and centre through our national response to the pandemic. The social and economic determinants of health are powerful at all times, and they are exacerbated by the current disruption.

Specifically, the Budget should provide that social welfare support policies ensure that no Australian is left behind due to the economic and employment impacts of the pandemic. This should manifest in the maintenance of social welfare payment systems throughout the extraordinary impacts we are seeing on employment and the ability of the workforce to even attend employment.

Industrial relations and workplace safety policies should also continue to give priority to the emergency needs of pandemic control. Forcing workers to attend workplaces in circumstances where their health is at unreasonable risk is unethical, places unreasonable burdens on employers as well as employees, and may only result in propagating greater viral transmission, thereby increasing rates of community infection and further prolonging disruptions.

PHAA welcomes the recent extension by the Commonwealth, state and territory governments of additional sick leave support, but notes that this was only a three-month extension; the public health priority of allowing infected people to recover, and separating them from workplaces, will not diminish in any way if that support ends on an arbitrary date.

No person should be left behind without assistance due to the economic and employment impacts of the pandemic. PHAA supports previous proposals in this area by ACOSS, including calls to:

- Establish a minimum income floor in the income support system by lifting all income support payments to at least \$69 a day – which is the same level as the pension and pension supplement.
- Ensure there are supplementary payments that meet specific needs, including lifting Commonwealth Rent Assistance by 50%, providing a Disability and Illness Supplement of at least \$50 a week, and a Single Parent Supplement that recognises the costs of single parenthood.
- Abolish mandatory cashless debit and income management and set up a Social Security Commission to independently advise Parliament.
- Remove harsh and onerous unemployment payment compliance arrangements, including automated payment suspensions, excessive activity requirements, and a lack of discretion for employment service providers and Services Australia to withhold penalties, and replace with a strengths-based approach.

The financial burden of the pandemic on the Commonwealth and other governments has of course been massive. All governments are desperate to reduce expenditure. But every decision must still be taken in the light of what impacts policies will have on the overall health of the population, and crucially, with a view to the inequities of impacts of the situation on less well-off Australians.



## Climate change and the population's health

The connections between climate and health, and the importance of systemic changes in Australia to recognise and address them, have been highlighted repeatedly. Examples of recent reports include the *Lancet Countdown report (2021)*<sup>28</sup>, the *MJA-Lancet Countdown report (2021)*<sup>29</sup>, the *Report of the WA Climate Health Inquiry (December 2020)*<sup>30</sup>, and the *Climate and Health – Preparing for the Next Disaster* report by the Grattan Institute (December 2020)<sup>31</sup>. These reports make clear that health impacts are happening now and accelerating.

The 2015 Paris Agreement seeks to limit global warming to well below 2°C, and ideally to 1.5°C (IPCC, 2021).<sup>23</sup> The Government has joined in this international policy commitment both at Paris and at the recent COP26 meeting in Glasgow. Yet by 2020 the situation had reached an estimated average increase compared to mid-20<sup>th</sup> century levels, according to different reports, of between 1.0°C<sup>32</sup> and 1.7°C<sup>33</sup> globally.

Australia has not been doing enough, and we are running out of time to turn the tide. Australia is the only OECD nation to have worsened the carbon intensity of our energy supplies over the last three decades, and we are now 36% worse than the global average.<sup>34</sup>

The impacts of climate change on the health of Australians are enormously significant,<sup>35</sup> and include:

- 22% increase in exposure to fire in the past 15 years.
- Across Australia, more days over 39°C in 2019 than in the rest of the period since 1960 combined.
- More intense heatwaves resulting in excess ambulance demand, hospital admissions, and mortality, with heatwave-related deaths in Australia's cities predicted to more than double in the next 40 years.<sup>36</sup>
- Changing patterns of infectious disease.
- Rising food insecurity.
- The impacts on mental health, which will continue to increase and unfold as time goes on.
- Health costs associated with mortality due to air pollution that are estimated at \$5.3 billion per year globally, and are estimated to cause around 5000 deaths in Australia annually, or about 4% of annual deaths.<sup>37</sup>

The costs of emissions reduction are far less than the damages of inaction, with a recent study by the University of Melbourne estimating that developing a clean Australian economy would bring a net benefit of \$16.2 billion.<sup>38</sup> The health benefits from meeting Australia's climate goals would more than make up for the costs.<sup>39</sup>

The new Government has responded to the strong expectations of the Australian community for action, and has commenced work on a new architecture, starting with legislation in the first week of the new Parliament to commit to a reduction in emissions of 43% by 2030. This is of course an improvement, but we cannot as a nation settle for this being sufficient. We welcome the new direction the Government is setting, but urge it to increase its ambition towards the ultimate goal of a net zero economy.

PHAA support the recommendations of the Climate and Health Alliance (CAHA) to –

- Develop a National Strategy on climate, health and well-being for Australia.
- Conduct a national climate and health consultation.
- Establish an AHPPC subcommittee on climate and health.
- Establish a Sustainable Development Unit in the Commonwealth Department of Health.
- Develop a national roadmap for the health sector towards net zero emissions by 2035.

## Aboriginal and Torres Strait Islander health

Efforts have been made by the Commonwealth, state and territory governments in recent decades to improve Aboriginal and Torres Strait Islander peoples' health and wellbeing. Life expectancy has increased, with encouraging reductions in mortality rates from chronic diseases. Correspondingly, between 2012 and 2017, Aboriginal and Torres Strait Islander life expectancy at birth rose by over two years.

Yet the *gap* in overall life expectancy between Aboriginal and Torres Strait Islander people and other Australians remains largely unchanged. It is unacceptable that, according to the 2019 Closing the Gap report, *"the target to close the gap in life expectancy by 2031 is not on track"*,<sup>40, 41</sup> and it is widely believed that the target cannot be achieved within the present Closing the Gap timeframe.<sup>42</sup>

It remains vital that strong commitment and resourcing to further increase life expectancy is reinforced. It is also urgent that the underlying social, economic, commercial and cultural determinants of the gap are addressed. This must involve deliberate, coordinated and long-term commitments, developed and delivered with and by Aboriginal and Torres Strait Islander people.

Recent Commonwealth, state and territory Budgets have made investments in Aboriginal and Torres Strait Islander peoples' health, including mental health, and this is very welcome, but they are far from sufficient.<sup>43</sup> Serious health care challenges remain for Aboriginal and Torres Strait Islander people. Rheumatic heart disease, syphilis and otitis media continue to cause massive public health concern. Alarming, mortality from cancer is in fact rising, and the 'gap' in cancer mortality compared with the general population is growing. Rates of suicide remain far too high, particularly for young Aboriginal and Torres Strait Islander people.

The health conditions of young Aboriginal and Torres Strait Islander people should be a key focus. Aboriginal and Torres Strait Islander people have a younger age profile than the general population, with a median age of 23 compared with 38 (as at the 2016 Census). Over 60% of Aboriginal and Torres Strait Islander people are aged under 30.

There are existing programs working to prevent disease in very young Aboriginal and Torres Strait Islander people between five and eight years old. However, there is a lack of targeted attention to people from the adolescent years through to around age 25. This broad age group is formative of many lifelong health problems. Illnesses related to chronic disease risk factors (smoking, alcohol, sugar-sweetened beverages and junk food) resulting in diabetes, cardiovascular disease, oral health problems, as well as mental health problems, often have their genesis in this neglected period of adolescence and young adulthood. Specifically, there is evidence of a link between hearing loss in childhood and subsequent incarceration of Aboriginal people.

We note that the current *National Aboriginal and Torres Strait Islander Health Plan*, refreshed as recently as December 2021, has not in fact been adequately funded to achieve its outputs.<sup>44</sup> We recognise and welcome various initiatives in recent Commonwealth, state and territory budgets. However further work will continually be needed, and indeed no Budget in the near- or medium-term will be able to ignore the need for further initiatives to Closing the Gap. To give broad direction to such needs, the COAG Joint Council on Closing the Gap have set out priorities to accelerate improvements in life outcomes of Aboriginal and Torres Strait Islander peoples by:

- *"developing and strengthening structures to ensure the full involvement of Aboriginal and Torres Strait Islander peoples in shared decision making at the national, state and local or regional level and embedding their ownership, responsibility and expertise towards Closing the Gap;*
- *building the formal Aboriginal and Torres Strait Islander community-controlled services sector to deliver closing the gap services and programs in agreed priority areas; and*

- *ensuring all mainstream government agencies and institutions undertake systemic and structural transformation to contribute to Closing the Gap”.<sup>45</sup>*

PHAA urges the Government to adopt substantive and durable commitments aligned with the priorities identified by the National Health Leadership Forum (NHLF), the national representative body for Aboriginal and Torres Strait Islander peak organisations advocating for Indigenous health and wellbeing, which include:

- *“Promote self-determination across national institutions, through Constitutional reform and the recommendations that arose from the Uluru Statement from the Heart*
- *Close the gap in life expectancy and the disproportionate burden of disease that impacts Aboriginal and Torres Strait Islander people, through system-wide investment approach for the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan, with COAG Health Council*
- *Prioritise and escalate actions under the National Aboriginal and Torres Strait Islander Health Workforce Plan – to address the massive shortfall in this workforce across all professions and levels, and is essential to improve Aboriginal and Torres Strait Islander health and wellbeing*
- *Acknowledge the adverse impact of racism on the health and wellbeing of Aboriginal and Torres Strait Islander people, and aspects of the health system that prevent people from accessing and receiving the health care they require – and to work with the NHLF and other Aboriginal and Torres Strait Islander health experts in embedding co-design and co-decision making processes to embed culturally safe and responsive health practices and systems.”*

In regard to workforce development, Aboriginal Community Controlled Health Organisations (ACCHOs) should be the preferred training settings for the public health workforce (and be supported to provide this), complementing the extensive existing public health expertise in the ACCHO sector, and recognising that public health training is an important career pathway for Aboriginal Health Workers/Aboriginal Health Practitioners and others in the ACCHO sector.

Noting the vital need for Aboriginal and Torres Strait Islander people to lead health and other initiatives central to their own health, PHAA supports the funding of programs that are initiated and run by Aboriginal and Torres Strait Islander organisations such as the National Aboriginal Community Controlled Health Organisation (NACCHO), state and territory NACCHO affiliates, and NACCHO member services. However, there is insufficient funding of programs for key areas such as smoking cessation and cancer screening by ACCHOs. The Budget should continue to ensure health funding for Aboriginal and Torres Strait Islander communities is directed to the ACCHO sector, with the goal of adequately addressing ongoing systemic disadvantage through investment in appropriate housing, education and employment programs.

Finally, it should be noted that health is underpinned by a capacity for self-determination, for which reason PHAA strongly supports adoption of the recommendations of the 2017 Uluru Statement from the Heart.

## Major Budget measures

### Establishing a National Centre for Disease Control and Prevention

For some years now, PHAA and other health sector organisations have been calling for the creation of a Centre for Disease Control and Prevention for Australia.

The COVID-19 pandemic has exposed the weaknesses in Australia's federated health system and provided fresh impetus to strengthen the capacities and coordination of our workforce to deliver on essential public health functions and services, particularly in relation to emergency preparedness and response. A chronic underinvestment in public health impacted Australia's capacity to respond to the health, social and economic threats posed by the pandemic and take integrated action across our fragmented jurisdictions.

Although the pandemic precipitated the formation of the 'National Cabinet', its operation has highlighted the need for improved cooperation and coordination of the relevant agencies both within and between the states and territories, and the Commonwealth to achieve better public health outcomes. Inadequate coordination at the national level has led to duplication of effort across the jurisdictions that were left to respond to similar issues independently. The differences in legislation, in particular the respective public health Acts, and electoral whims has also led to inconsistent responses across jurisdictions, generating key challenges that have contributed to a widening of pre-existing health inequities.

Notably, the Australian Health Protection Principal Committee ('the Medical Expert Panel'), the Australian Technical Advisory Group on Immunisation (ATAGI), and various other existing committees have played important and visible advisory roles. Yet agreement has been a close and contested line between the health experts (inside or outside government), and the political decision makers. Inconsistent messaging has thus led to public confusion, distrust and even resistance to expert public health advice.

Strong public health leadership, with adequate resourcing and national infrastructure, and legislated authority is essential for effective national coordination of the public health workforce, to respond to the inevitable future threats to the health and wellbeing of the Australian public.

During the 2022 election campaign, the Government committed to establishing an Australian Centre for Disease Control and Prevention ("ACDCP"). According to the party's election policy platform:

*"The CDC will:*

- *Ensure ongoing pandemic preparedness;*
  - *Lead the federal response to future infectious disease outbreaks; and*
  - *Work to prevent non-communicable (chronic) as well as communicable (infectious) diseases."*
- ALP Policy Platform 2021

Work has already begun on delivering this vital initiative. Drawing on our public health policy expertise, PHAA has presented the Department of Health with a detailed proposal for the steps to be taken over the next year. The PHAA proposals include the establishment of a national expert taskforce, consultation, examination of options for scope and governance, preparation of recommendations for implementation, and nurturing of partnerships and relationships essential to the success of the project.

The ACDCP needs to be sustainable and enduring. To this end, a serious funding commitment should be established, and the inter-federal relationships between levels of government need to ensure that there is value and strong political buy-in from all governments as collaborative involvement of the states and territories will be essential. States and territories ought to see the ACDCP as a boost to their existing capabilities, helping them deliver on their roles and responsibilities.

In the first instance, through the October 2022 Budget sufficient resources should be made available in 2022-23 to undertake the work of the taskforce to establish the ACDCP. Additionally, a budget bid to secure adequate funding for the actual establishment of the ACDCP should be prepared for inclusion in the May

2023 Budget. Given recent international investments in disease control institutions, we anticipate that an ACDCP budget will be in the \$100s of millions per annum.

We have estimated that a significantly scaled Centre would require funding of around \$200 million pa. However, costings can only be tentative until the precise scope of the centre is agreed. For example, the Centre may in addition to its core services play a role in allocating funding for national public health workforce training and expansion. In addition, the ACDCP could also be the appropriate channel for major cost undertakings such as national vaccination programs.

Finally, there would be an additional advantage to accountability and investment measurement to be gained through such a national Centre having financial responsibility for as many public health investment programs as possible, to make clear exactly the scale of all population health investment initiatives undertaken through the Commonwealth Government’s leadership and financial support.

**Establish a National Centre for Disease Control and Prevention**

Expense (\$m)	2023-24	2024-25	2025-26	2026-27	total
Department of Health	75.0	200.0	210.0	220.0	705.0

## Development of the nation’s public health workforce

The charter of the ACDCP should include helping to grow and develop the Australian preventive and public health workforce to have the capability to respond to emerging issues and deliver results within all jurisdictions.

Australia’s existing public health workforce is highly educated, committed and effective in the tasks it is set. Current established training pathways include undergraduate and postgraduate public health, health promotion, as well as epidemiology and biostatistics qualifications. Furthermore, the Australasian Faculty of Public Health Medicine (AFPHM) provides accredited training for public health physicians. There are also state-based training programs, such as the NSW Public Health Officer Training Program, that provide multi-disciplinary workplace-based training in public health competencies.

In Australia, the Council of Academic Public Health Institutions of Australasia (CAPHIA) has developed a competency framework that enables the identification, and skills required, of the public health workforce. Yet there are currently no mechanisms by which we can enumerate or monitor the composition and location of the workforce.

Furthermore, for many years the workforce has been insufficient in size to address all the population health challenges facing the nation. The COVID pandemic has exposed this situation, not only in terms of communicable disease response capability, but in the inevitable diversion of public health-trained officials away from other population health concerns. It is strategically urgent that Australia take a coordinated approach to addressing this capacity gap.

In 2017 the Government received the *Joint External Evaluation of Australia’s compliance with the International Health Regulations (JEE)*.<sup>46</sup> Australia’s official response, the *National Action Plan for Health Security*, addressed the issue of our public health workforce, identifying three priority actions:

- “Use existing data sources, including relevant accreditation schemes, to define the public health workforce in order to conduct forward planning, recruitment of appropriate categories of staff (including toxicology and radiation specialists) and development of future credentialing schemes.
- Work with states and territories to ensure sustainable mechanisms for epidemiologists and other public health professionals at state, territory and local level.
- Develop a long-term strategy that uses current and new channels to increase the international experience of the public health workforce.”

In June 2020 PHAA, the Australasian Epidemiological Association and CAPHIA jointly provided the Commonwealth Department of Health with a proposal highlighting the attraction, education, training, and capability resourcing issues, drawing on the Action Plan and other proposals.

On 26 June 2020 the nation's nine governments, acting as the National Cabinet, published a commitment to:

- establish a national training program for surge workforce
- prioritise enhancing the public health physician workforce capacity
- consider options for developing a formal public health workforce training program.

In late 2020 National Cabinet tasked the Australian Chief Scientist Professor Alan Finkel to conduct an urgent review of the capability of governments to undertake the essential tasks of tracking and tracing the COVID outbreaks. The resulting *Report of the National Contact Tracing Review* (November 2020)<sup>47</sup> identified the need to integrate a response to tracking and tracing capability with the state of the overall public health workforce. Specifically, the report concluded that the workforce issues could not be successfully addressed by a capability limited by a 'surge' response approach.

As recently as December 2021 the Government stated a policy commitment to this matter in the National Preventive Health Strategy:

***“More than ever we need a sustainable public health workforce in Australia – COVID has highlighted this.”***

*COVID-19 has highlighted the importance of the public health workforce in Australia. The workforce is integral to the management of current and possible future communicable disease outbreaks, and to address the heavy burden of chronic conditions in Australia. Future public health workforce planning is vital, as is increasing the capacity and capability of the overall health workforce, including boosting their confidence in using digital health technologies to deliver health care safely, in order to be effective in prevention and public health emergencies. Strengthening the workforce requires support for digital health training and investment in digital infrastructure.”<sup>48</sup>*

However, during the subsequent rounds of Commonwealth, state and territory budgets released through 2020 and 2021, no government announced specific measures to act on these commitments. Decisive Commonwealth budgetary leadership is clearly needed.

In May 2022, the World Health Organization launched a roadmap for strengthening the public health and emergency workforce<sup>49</sup>, designed to guide a “coherent approach to the development and management of this critically needed category of workers.” It sets out three focus areas for action:

- Defining the essential public health functions and sub-functions for national contexts, including a focus on emergency preparedness and response
- Strengthening competency-based education for the provision of the essential public health functions
- Mapping and measurement of occupations delivering public health functions

The roadmap provides a timely opportunity to consolidate evidence and build on existing resources, to collaborate with global partners, in order to inform and guide the development of a national public health workforce policy or plan that will strengthen public health and emergency capability in Australia, under the remit of the ACDCP.

The pandemic has highlighted the state of public health infrastructure and the need to bolster the public health workforce capacity and systems, both nationally and at state and territory level. Building of the public health workforce is a clear and vital priority that must be urgently addressed.

A national Public Health Officer Training Program (PHOTP) can be immediately implemented by the Australian and state and territory governments. The existing NSW PHOTP should be appropriately adapted to the jurisdictional circumstances. It should be considered in addition to existing programs (for example, the Specialist Training Program), and not a substitute.



The PHOTP should be established to assess, recruit, train, retain and place both medically and non-medically trained staff to undertake a 3-year Full Time Equivalent training program (with an extension available to allow for a 12-month unpaid sabbatical) to create a pipeline of highly trained public health professionals. This will assist with Australia’s urgent public health workforce needs, as well as become an important source of future expert senior officers in public health leadership positions, for all Australian jurisdictions.

We estimate that funding of around \$50M per annum will be needed to make the substantial difference Australia needs to achieve an adequate future public health workforce.

There is existing machinery in place in some state and territory governments, providing an opportunity for the Government to play a co-ordinating/facilitating role. This may be via the Australian Health Protection Principal Committee (AHPPC) or other mechanisms.

**Public Health Officer Training program for Australia**

Expense (\$m)	2023-24	2024-25	2025-26	2026-27	total
Department of Health	50.0	52.0	54.0	57.0	213.0

## Implementing the national strategy for preventive health investment

During the recent election campaign all major parties supported delivering the NPHS. As noted above:

- “An Albanese Labor Government would support the implementation of the National Preventative Health Strategy.” – Labor campaign statement April 2022

The NPHS is one of our keynote national health strategy statements, and will be vital both to achieving sustained reductions in chronic disease among Australians, and also to keeping under control the ceaseless growth of national health care costs. Prevention health policy is a net financial investment, not a financial burden.

The heart of the Strategy is the target that at least 5% of total health spending will be dedicated to investments in preventive health, achieved by the year 2031. Direction of national health spending towards disease prevention programs and policies must start as soon as possible to reach that goal. To this end, both the coming October 2022 Budget and the 2023-24 Budget should set in motion early-win initiatives already known to be deliverable and yield value such as:

- Programs and campaigns to boost smoking quit rates and to prevent uptake of tobacco use.
- Programs and campaigns to halt the rise of obesity.
- Programs and campaigns to reduce the harms caused by alcohol.

On preventive health investment, the Australian Government needs to set the lead nationally, and in doing so also challenge the state and territory governments to match Commonwealth investments. Western Australia made a 5% investment commitment in early 2021. PHAA will be actively seeking political commitments from major parties in the Victorian and NSW election campaigns, and will advocate for all jurisdictions to commit to the 5% target, and establish reporting measures to track results.

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, and stood at only 1.5% in 2018-19 and in 2019-20.<sup>50</sup> Much stronger performances by Canada, New Zealand and the United Kingdom – nations with comparable health systems to Australia’s in many ways – are around 5% of total health spending.<sup>51</sup> (Needless to say, this comparison precedes the recent pandemic-related communicable disease control expenditures.)



Higher preventive health spending is sound long-term financial management. It means reduced disease – and with that reduced health system cost pressure on governments, especially with respect to long-term chronic disease – in future years and decades.

PHAA has therefore advocated for a standard that 5% of government budget expenditures on health should be directed to prevention at both Commonwealth and state/territory levels. The Western Australian Government announced a policy to reach this point by the year 2029.<sup>52</sup> And the Commonwealth has also adopted this target (for the year 2030) through the NPHS.

The NPHS sets goals for a healthier Australia, including a strong investment target:

*“Investment in prevention is increased. Health expenditure is currently spent primarily on the treatment of illness and disease. Investment in prevention needs to be enhanced in order to achieve a better balance between treatment and prevention in Australia, as outlined in Australia’s Long Term National Health Plan. Underpinned by: Investment in preventive health will rise to be 5% of total health expenditure across Commonwealth, state and territory governments by 2030.”<sup>53</sup>*

However, it is important to note that any strategy is only as good as its implementation, and in this case, the NPHS refers to its goals being pursued through a ‘Blueprint for Action’ (NPHS, p72), dealing with the implementation and monitoring of progress in terms laid out in the strategy’s Appendix (pp 73-76).

The NPHS is a 10-year strategy, and it would be absurd for no action to implement it to commence until the second or third year of the decade; action should start immediately, in 2022. The Strategy itself notes that the Government will not wait for the finalisation of the ‘Blueprint’ to start implementation:

*“A key focus of this Strategy is the need to mobilise the prevention system to ensure an enduring system into the future and it is important this commences in the first year of this Strategy. Therefore, parallel to the development of the Blueprint for Action, the implementation of the immediate priorities outlined in this Strategy will commence.” (p 72)*

The October 2022 Budget will be judged against this implementation commitment.

One obvious way to advance this policy direction is to use a ‘future fund’ approach. A ‘Preventive Health Future Fund’ would 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.

The NPHS makes the following points:

*“The most effective preventive health efforts in Australia have come from evidence-based approaches that have received sustained investment and commitment by governments, the health sector and the community. Enhanced governance structures are required to create a more resilient prevention system.”<sup>54</sup> This includes:*

- *an independent, expert-led mechanism that will advise the Australian Government, through an equity lens, on current, emerging and future priorities in prevention, and*
- *a governance mechanism within government, and across relevant portfolios, that have an influence on the health and wellbeing of Australians.*

*These mechanisms need to be underpinned by long-term and sustainable funding.*

***“It is time that funding and governance is ring-fenced for prevention. We need strong, independent institutions and financing and a decision-making mechanism.”***

*Australia needs to be able to assess, prioritise and direct action towards the best possible initiatives to have the greatest impact on health and ensure the best use of resources. This mechanism would: provide independent, expert-led, evidence-based assessment of the effectiveness and efficiency of preventive health programs; provide guidance on investment and implementation; enable monitoring of existing and emerging health issues; and enable cross-sectoral collaboration, including shared-decision making with Aboriginal and Torres Strait Islander people.*

***“A long-term and sustainable funding mechanism will be critical to success.”***

*There is a need to significantly enhance investment in prevention in order to achieve a better balance between treatment and prevention. A long-term, sustainable funding mechanism is essential to achieving the aims of this Strategy, including that investment in prevention is increased (Aim 4). It should be recognised that investment in the avoidance of illness is an investment in the avoidance of future treatment costs. The independent, expert-led governance mechanism would provide advice to Government on how the fund can be used to implement affordable, feasible and cost-effective prevention action.”<sup>55</sup>*

One source of revenue to support a prevention fund would be proceeds from the national excise taxation of tobacco, alcohol, and sugar sweetened beverages. Even a modest portion of the existing levels of tobacco taxation, which at present raises around \$13 billion pa in federal revenue, would quickly and effectively establish a fund.<sup>56</sup> Increases additional to the current tax settings could also be directed to the fund.

An evidence-based mechanism to oversee such a fund would be needed. An expert body styled after the Pharmaceutical Benefits Advisory Committee (PBAC) and the Medicare Benefits Advisory Committee (MBAC) could be established to oversee the fund’s investment directions in an evidence-based manner to maximise disease prevention outcomes, with a focus on the highest needs of the population.

Realising this vision would require cooperative work between the Commonwealth and the states and territories. The NPHS looks to achieve exactly such a collective, all-governments outcome. As mentioned above, policy alignment on public health directions is currently very strong. The role of the states and territories in delivering programs funded through a fund mechanism would be straightforward, with the Commonwealth Department of Health playing a role of coordination, standard-setting, and outcome monitoring. Treasury would have a role to play in measuring and reporting on investment outcomes in each jurisdiction, taking into account funding flows from the Commonwealth as the primary collector of revenue in the overall Australian fiscal system.

Finally, note that the achievement of the NPHS goals is logically tied up with the creation and mission of the Australian Centre for Disease Control and Prevention, discussed above. The ACDPC should have a mandate to drive and oversee the directions in the NPHS, including the need to help create an Australian preventive and public health workforce capable of delivering results within all jurisdictions.

## Revenue proposals

The human toll of chronic diseases in Australia includes cardiovascular diseases, cancer, diabetes and chronic respiratory diseases – all of which are the leading causes of death and disability in Australia.<sup>57</sup> Furthermore, they carry a huge cost that extends beyond health to undermine quality of life, education, workforce productivity, and economic prosperity.

As one part of a response to these health challenges, we recommend that the Government consider the introduction and expansion of health levies (as excise taxes and pricing policies on harmful products which are detrimental to health) that both improve public health, and also generate revenue to help fund investments in public health programs.

The multiple aims of health levies include: to raise awareness about unhealthy products, to reduce the consumption of unhealthy products, to reduce the associated negative health burdens and to create new revenue streams for public health investment. There is clear evidence that health levies are effective and efficient in reducing consumption of the relevant products.

Health levies on products that have a negative public health impact, such as tobacco, alcohol and sugar-sweetened beverages have multiple policy merits.<sup>58</sup> Health taxes are a high-return investment which save lives and prevent disease, while advancing health equity, averting healthcare expenditure, increase workforce participation, and boost revenue for the general budget.

The combined revenue captured by the measures proposed below over the 4-year Budget period 2023-2027 is estimated to be around \$4.2 and \$4.6 billion per annum, totalling over \$17.4 billion over 4 years.

### Tobacco

Tobacco use was the leading health risk factor for both males and females and contributed the most to fatalities, with almost 20,500 attributable deaths (13% of all deaths) in 2018.<sup>59</sup> The social cost for tobacco use has been estimated at \$136.9 billion.<sup>60</sup>

Evidence shows that high tobacco prices are the single most effective and cost-effective measure for reducing tobacco use.<sup>61</sup> High tobacco prices both prompt smokers to quit and reduce smoking initiation among young people and so help stop them from becoming addicted in the first place. Annual tax increases in Australia have helped to drive down smoking rates over the last decade. However, these increases were not as effective as they could have been—particularly among young people—because a large proportion of people who smoke shifted to ‘roll your own’ (RYO) tobacco sold in small pouches in order to avoid price rises in manufactured cigarettes.<sup>62</sup>

Among several best practice recommendations, the World Health Organization and World Bank strongly endorse equal taxation of all tobacco products in order to prevent such substitution.<sup>63</sup> We recommend that the Government end the current subsidy on excise and customs duties on ‘roll your own’ tobacco products and equalising the tax applied to this form of tobacco with that on ordinary manufactured cigarettes.

The excise/customs duty on RYO tobacco is currently equal to that on a factory-made cigarette when the RYO cigarette weighs 0.7 grams. However, smokers generally use much less tobacco than that in each cigarette—somewhere between 0.5 and 0.6 grams.<sup>64</sup> This measure proposes that the tax on a RYO cigarette would increase on 1<sup>st</sup> September 2022 so that it would be equal to that on factory-made cigarettes when

the RYO cigarette weighs 0.675 grams. The rate would increase each September over the subsequent three years so that it was equal at 0.65 grams, then 0.625 grams then finally 0.600 grams in 2025.

Cancer Council Australia estimates that this harmonisation would provide increased revenue of approximately \$88m in 2023-24, increasing to \$361m by 2025-26.

### Tobacco excise equalisation

Revenue (\$m)	2023-24	2024-25	2025-26	2026-27	total
Equalisation of excise and customs on 'roll your own' tobacco products <sup>65</sup>	178.0	270.0	361.0	361.0	1,170.0

## Alcohol

Alcohol is responsible for a substantial burden of death, disease and injury in Australia affecting not only drinkers but also children, families and the broader community. The social costs of alcohol misuse in Australia has been estimated to be \$14.4 billion.<sup>66</sup> The highest costs are associated with productivity losses (42.1%), traffic crashes (25.5%) and the criminal justice system (20.6%).<sup>67</sup>

Alcohol is responsible for 4.5% of the burden of disease in Australia (AIHW, 2018), and plays a role in more than 200 different chronic health problems including cancers, diabetes, nutrition-related conditions, cirrhosis, and being overweight and obesity.<sup>68, 69, 70</sup> There is evidence that mid to high levels of drinking substantially increases cardiovascular diseases.<sup>71</sup>

Harm from alcohol is preventable, and reducing the amount of alcohol consumed will reduce health and social harms in the Australian community. The costs of alcohol-related harms are significant and far exceed government revenue from alcohol taxation.<sup>72</sup>

However, Australia's current approach to alcohol taxation is flawed, and does not adequately recognise the extent of harms that result from alcohol consumption.<sup>73</sup> Alcohol is currently more affordable than it has been in the past three decades. There is strong evidence to demonstrate that the lower the real price of alcohol, the higher the levels of consumption, and therefore higher levels of alcohol-related harm.<sup>74</sup>

An increase in excise on alcoholic beverages is a proven measure to reduce alcohol use, while also providing the Government with revenue to offset the economic costs of alcohol use.<sup>75</sup> The evidence is strong that alcohol price signalling through taxation is the policy response with the largest impact on alcohol consumption and consequently on alcohol-related harm. Increasing tax on alcohol will also have benefits in reducing obesity, and is the recommendation from the ACE economic study that had the highest impact in limiting obesity.<sup>76</sup>

The Government's last comprehensive review of Australia's tax system, the Henry Review in 2008-10, identified alcohol taxation as an appropriate measure for improving social outcomes because of the high costs imposed by excessive alcohol consumption.<sup>77</sup>

We recommend that the Government shift to a system of volumetric taxation – that is, an excise levied on the alcohol content per volume of the product.<sup>78</sup> Taxing wine and cider the same as beer and lifting the rate by around 5¢ for a glass of beer would raise an estimated \$2.9 billion starting from 2023-24.<sup>79</sup>

### Alcohol excise reform – volumetric equalisation

Revenue (\$m)	2023-24	2024-25	2025-26	2026-27	total
Volumetric equalisation of alcohol excises	2,900.0	2,987.0	3,076.0	3,168.0	12,131.0

We appreciate the alcohol market has evolved somewhat since the estimates on revenue generated by the introduction of volumetric tax on alcohol were calculated. However, our core contention remains relevant. That a thorough going evidence based public interest focused review of the alcohol tax system in Australia is well over due.

It has been estimated that reform of the alcohol tax system reduce alcohol consumption by more than 9.4%, saving in excess of \$2.7 billion in future annual health expenditure.<sup>80</sup>

We also note that the Government's National Alcohol Strategy calls for spending more of the alcohol tax revenue on preventive health activities and AOD treatment.

## Sugar-sweetened beverages

(Note: 'Sugar-sweetened beverages' can be defined as any non-alcoholic beverage containing added sugar. These include sugar-sweetened soft drinks, flavoured mineral waters, fortified waters, energy and electrolyte drinks. Milk-based products, and 100% fruit and/or vegetable juice or non-sugar sweetened drinks and cordials are generally not termed as 'sugar-sweetened beverages', even though they contain sugar.)

One of Australia's most serious health problems is that around 14 million Australians are overweight or obese. 67% of Australian adults and 25% of children are overweight, while 31% of adults and 8% of children are obese.<sup>81, 82</sup> The prevalence of obesity in Australia is expected to continue to increase, such that 33% of the projected adult population will be obese by 2025.<sup>83</sup> Obesity is a major risk factor for chronic and preventable conditions including type 2 diabetes, heart disease, hypertension, stroke, gall bladder disease, osteoarthritis, sleep apnoea and respiratory problems, mental health disorders and some cancers.

The costs of obesity are high. People living with obesity have medical costs that are approximately 30% greater than 'healthy weight' people.<sup>84</sup> The AIHW has as recently as April 2022 identified obesity as the most expensive risk factor facing hospitals.<sup>85</sup> In respect of public costs, the Australian Medical Association (AMA) has estimated that if no action is taken to stem the obesity crisis, by 2025 the government budgets will bear a further \$29.5 billion (over four years) in direct costs of healthcare for people with obesity.<sup>86</sup>

While there are multiple causes of obesity, over-consumption of sugar is a major contributor. Over one-third of Australian adults and almost half of children consume sugar-sweetened beverages at least once a week. Adolescents and young adults are the highest consumers of sugar-sweetened beverages. Sugar-sweetened beverages are suitable for a health levy for several reasons<sup>87</sup>, including:

- They are a well-defined product category.
- They provide minimal or no nutritional benefit.
- Consumption has been associated with excess weight gain, dental decay leading to dental caries and other chronic diseases – all of which are high in prevalence in Australia.<sup>88</sup>
- Consumption of sugar-sweetened beverages is high in Australia, particularly among adolescents, young adults, Aboriginal and Torres Strait Islander people and low-income groups.<sup>89</sup> These consumers are also more price sensitive, so more likely to respond positively to a price rise.
- Strong and growing evidence demonstrating positive fiscal and health impacts of taxing sugary beverages.<sup>90</sup>
- Authoritative health organisations recommend limiting sugar-sweetened beverage consumption.<sup>91</sup>

The objectives of a health levy on sugar-sweetened beverages include:

- To increase the price of sugar-sweetened beverages, and through such price signalling reduce the purchase and consumption of these products.
- To provide an incentive for manufacturers to reformulate to lower the added sugar content of their products, improving the food supply for all (if the sugar-sweetened beverages levy is designed to be directly tied to the amount of ‘free’ or added sugar contained in the beverage).
- To increase consumer awareness of the need to reduce consumption of added sugar in their diet, and that regular consumption of sugar-sweetened beverages is contrary to a healthy diet.
- To generate revenue to reinvest back into population nutrition and health.

Many countries have adopted a health levy on sugary drinks, and research shows that these levies can be influential in improving diets across the population by encouraging companies to reformulate their products. Evidence from Mexico has found that its tax has reduced the amount of SSBs bought, with a 37% reduction in the total volume of SSBs purchased two years after the introduction of the tax in 2014.<sup>92</sup> In the UK, analysis shows that producers have reduced the sugar in their drinks to minimise the tax they pay, with a 43.7% reduction in the total sugar content per 100ml between 2015 and 2019 for the drinks subject to the levy.<sup>93</sup> The Obesity Policy Coalition, of which PHAA is a collaborator, presents consolidated evidence from the experience of other countries at the Obesity Evidence Hub site.<sup>94</sup>

There is good evidence that similar outcomes could be achieved in Australia. A 2016 modelling study estimated that a 20% health levy on sugary drinks could result in a 12.6% decline in consumption of sugary drinks and an overall decline in obesity of 2.7% in men and 1.2% in women. It was estimated that 1,600 Australians would have avoided death from obesity-driven causes in 25 years if a levy were introduced.<sup>95</sup>

In 2021 the AMA estimated that the rise in annual revenue from levies on sugary beverages could be between \$749 million to \$814 million.<sup>96</sup> We understand that the most recent estimates by AMA, taking into account anticipated reductions in consumption, are slightly more conservative, and are used in the table below.<sup>97</sup>

There is strong support for a levy among the Australian public. Research into the attitudes of young Australians aged 18-30 found that 74% of participants supported a levy on sugary beverages if the revenue was used to subsidise healthy foods.<sup>98</sup> Opinion polling has identified that most Australians supporting a health levy on sugary beverages.<sup>99</sup>

We therefore recommend that the Government consider a minimum 20% health levy on sugar-sweetened beverages. The revenue estimates shown below have been developed by AMA, and project the policy achieving its health goals through a steady decline in revenue as the policy has the effect of reducing sugar consumption.

#### Sugar-sweetened beverages levy

Revenue (\$m)	2023-24	2024-25	2025-26	2026-27	total
Sugar-sweetened beverages excise	738.0	723.0	696.0	677.0	2,834.0



## Summary of revenue measures

Revenue (\$m)	2023-24	2024-25	2025-26	2026-27	total
Equalisation of excise and customs duties on 'roll your own' tobacco products	178.0	270.0	361.0	361.0	1,170.0
Volumetric equalisation of alcohol excises	2,900.0	2,987.0	3,076.0	3,168.0	12,131.0
Sugar-sweetened beverages excise	738.0	723.0	696.0	677.0	2,834.0
<b>TOTAL</b>	<b>3,816.0</b>	<b>3,980.0</b>	<b>4,133.0</b>	<b>4,206.0</b>	<b>16,135.0</b>

## Investment proposals

### Reducing tobacco use and nicotine addiction

#### Implement the next National Tobacco Strategy (NTS)

Australia's national policies to this point have driven smoking prevalence in Australia to an all-time low, with statistics released in December 2018 showing that just under one in seven (13.8%) or 2.6 million adults were daily smokers in 2017-18.<sup>100</sup>

However, over the past decade investment in quit smoking campaigns has declined.<sup>101</sup> Smoking rates remain unacceptably high and – worryingly – rates of smoking decline have slowed in the last few years. Every year, over 18,000 Australians still die from their tobacco addiction,<sup>102</sup> and thousands more suffer from associated chronic diseases.

Smoking reduction campaigns have a very strong return on investment. The cost-effectiveness analysis of Australia's National Tobacco Campaign (NTC) found that the initial investment of \$9 million yielded healthcare cost savings exceeding \$740 million – an ROI value of more than 80. Approximately 55,000 premature deaths were prevented.<sup>103</sup>

We propose Budget measures to provide \$71 million per annum over four years for campaign and cessation programs to implement the next phase of the existing National Tobacco Strategy (NTS).

This investment would accelerate the decline in smoking in the population. It would specifically benefit Australians experiencing social and financial disadvantage, and therefore reduce the significant inequities caused by tobacco smoking. It will work to reduce the large and increasing Government health costs associated with treating preventable diseases in these groups and the broader community.

Investment can be allocated to the following initiatives:

- \$46m per annum (based on advice from Cancer Council Australia) to reinstate, and maintain for the period of the NTS, a population-based National Tobacco Campaign, targeting adult tobacco users in all states and territories which is evidence-based in both creative development and audience exposure, and supported with rigorous developmental research and campaign evaluation. This aligns with proposals made by Cancer Council Australia and other leading tobacco control agencies.
- \$10m per annum to create and fund a dedicated National Cessation Strategy within the NTS to facilitate a consistent, evidence-based national approach to smoking cessation service provision. This would



include the development and dissemination of national clinical guidelines and program support to embed the treatment of tobacco dependence into health services, primary care, and community and social service organisations as part of routine care, and the provision of a national Quitline™ as a referral, training and behavioural support provider.

- \$15m per annum to specific, targeted programs that will provide additional support to groups in the population experiencing the highest levels of disadvantage. This will primarily be done through partnerships with the public health and community service sectors to provide direct services to high needs populations.

### National Tobacco Campaign

Expense (\$m)	2023-24	2024-25	2025-26	2026-27	total
Department of Health	46.0	46.0	46.0	46.0	184.0

### National Smoking Cessation Strategy

Expense (\$m)	2023-24	2024-25	2025-26	2026-27	total
Department of Health	10.0	10.0	10.0	10.0	40.0

### Targeted smoking reduction programs for groups experiencing the highest levels of disadvantage

Expense (\$m)	2023-24	2024-25	2025-26	2026-27	total
Department of Health	15.0	15.0	15.0	15.0	60.0

Strategic alignment: These proposals support the Government’s *National Tobacco Strategy 2020-2030*, and work towards achieving outcome targets established in the National Preventive Health Strategy including:

- Achieve a national daily smoking prevalence of less than 10% by 2025 and 5% or less for adults (≥18 years) by 2030
- Reduce the daily smoking rate among Aboriginal and Torres Strait Islander people (≥15 years) to 27% or less by 2030.

## Promoting healthy weight and reducing obesity

### National Obesity Strategy

PHAA supports the work of the Commonwealth and state and territory governments to develop a National Obesity Strategy. The next steps should include development of an implementation plan together with funding.

The National Health Survey for 2017-18 reports that two-thirds (67.40%) of Australians are overweight or obese, and around one-quarter (24.9%) of children aged 5-17 are overweight or obese.<sup>104</sup> From a health perspective, these figures mean that a large proportion of the population is at heightened risk of chronic diseases including cardiovascular disease, type 2 diabetes and some cancers.<sup>105</sup> After tobacco use, the risk factors of overweight and obesity (8.4%) and poor diet (5.4%) are the highest contributors to Australia’s burden of disease.<sup>106</sup>

Obesity has an adverse impact on Australians’ experience of COVID-19. Studies have concluded that obesity is a risk factor for COVID-19 disease severity, with the World Obesity Federation stating that ‘Systematic reviews and meta-analyses overwhelmingly show that obesity is associated both with a higher risk for

intensive care unit (ICU) admission and poorer outcomes for COVID-19.<sup>107</sup> Further, research also shows a higher risk of developing Type 2 diabetes, together with other chronic diseases.

From an economic perspective, high rates of obesity and associated chronic disease cost the Government, as well as State and Territory governments, businesses and individuals, a significant amount. A significant part of these costs are direct healthcare costs. In a report released in 2021, the AMA estimated that

*“...if no action is taken to stem the obesity crisis, by 2025 taxpayers will have footed a further \$29.5 billion for the direct healthcare costs of obesity (over four years to 2024-25).”<sup>108</sup>*

As well as direct healthcare costs, obesity and associated chronic disease are also linked to indirect costs, such as loss of productivity and reduced workforce participation. An alarmingly high percentage of young adult Australians (46% of age 18-24 people)<sup>109</sup>, a key demographic for Australia’s workforce participation and economic productivity into the future, are above a healthy weight. As those Australians are at higher risk of chronic disease, this may have a significant effect on our workforce and create a large economic burden, in addition to affecting health outcomes, in years to come.

## Live Lighter

PHAA specifically calls for investment in a national Live Lighter program. Live Lighter is a proven healthy eating and physical activity campaign, with a decade of accumulated evidence of success in Western Australia.<sup>110</sup>

Evidence generated by the Live Lighter Campaign in Western Australia suggests that a sound public investment would be made in a sustained and well-run social marketing campaign focusing on healthy eating and prompting physical activity.<sup>111</sup>

A measurable metric attributable to the Live Lighter campaign is a reduction in the consumption of sugar-sweetened beverages by adolescents in Western Australia has occurred at a faster rate than has been the case nationally in the period 2012 to 2018. Such campaigns not only prompt individual and group behavior on behaviors that reduce weight gain, but also are important in promoting healthy public policy relevance to obesity prevention.

Recent funding for the Live Lighter campaign in Western Australia has to date been around \$3.5 million pa. The equivalent investment needed for a sustained and effective national campaign, allowing for some economies of scale, would therefore be around \$30 million pa.

### Live Lighter national campaign

Expense (\$m)	2023-24	2024-25	2025-26	2026-27	total
Department of Health	20.0	40.0	40.0	40.0	140.0

Strategic alignment: These proposals work towards achieving outcome targets established in the National Preventive Health Strategy including:

- Halt the rise and reverse the trend in the prevalence of obesity in adults by 2030
- Reduce overweight and obesity in children and adolescents aged 2-17 years by at least 5% by 2030
- Adults and children (≥9 years) increase their vegetable consumption to an average 5 serves per day by 2030
- Reduce the proportion of children and adults’ total energy intake from discretionary foods from >30% to <20% by 2030
- Reduce the average population sodium intake by at least 30% by 2030
- Increase the proportion of adults and children who are not exceeding the recommended intake of free sugars by 2030

- At least 50% of babies are exclusively breastfed until around 6 months of age by 2025.

## Reducing alcohol related harm

There is accumulating evidence, particularly in Australia, of successful social marketing campaigns in the area of alcohol consumption. The most sustained effort in this field is the Alcohol Think Again campaign undertaken in Western Australia.<sup>112</sup> In addition to evidence demonstrating change in drinking intentions, these campaigns also create an important vehicle to highlight and build support for the need for action on policies aimed at reducing alcohol related harm.<sup>113</sup>

National Health and Medical Research Council guidelines should be better communicated to the public through a communication strategy that informs Australians about the best health advice relating to alcohol consumption.<sup>114</sup>

### Reducing Alcohol Related Harm Program

Expense (\$m)	2023-24	2024-25	2025-26	2026-27	total
Department of Health	15.0	30.0	30.0	30.0	105.0

Strategic alignment: These proposals support the Government's *National Alcohol Strategy 2019–2028* and *National Drug Strategy 2017-2026*, and work towards achieving outcome targets established in the *National Preventive Health Strategy* including:

- At least a 10% reduction in harmful alcohol consumption by Australians (≥14 years) by 2025 and at least a 15% reduction by 2030
- Less than 10% of pregnant women aged 14 to 49 are consuming alcohol whilst pregnant by 2030
- Less than 10% of young people (14-17 year olds) are consuming alcohol by 2030
- At least a 15% decrease in the prevalence of recent illicit drug use (≥14 years) by 203.0

## Summary of investment measures

Expense (\$m)	2023-24	2024-25	2025-26	2026-27	total
Establish a National Centre for Disease Control and Prevention	75.0	200.0	210.0	220.0	705.0
Public Health Officer Training program for Australia	50.0	52.0	54.0	57.0	213.0
National Tobacco Campaign	46.0	46.0	46.0	46.0	184.0
National Smoking Cessation Strategy	10.0	10.0	10.0	10.0	40.0
Targeted smoking reduction programs for groups experiencing the highest levels of disadvantage	15.0	15.0	15.0	15.0	60.0
Live Lighter national campaign	20.0	40.0	40.0	40.0	140.0
Reducing Alcohol Related Harm Program	15.0	30.0	30.0	30.0	105.0
<b>TOTAL</b>	<b>231.0</b>	<b>393.0</b>	<b>405.0</b>	<b>418.0</b>	<b>1,447.0</b>

## Conclusion

This submission has highlight three priorities for the framing of the coming Budget:

- Delivers on the announced commitment to frame the Budget around the idea of 'wellbeing', and starts using Government fiscal strategies to create a 'wellbeing economy'.
- Delivers on key government election commitments, including the creation of a national Centre for Disease Control and Prevention, and implementation of the National Preventive Health Strategy.
- Recognises that sound public health policy is sound economic policy, by investing in prevention strategies that reduce the future burden of disease for all Australians.

Our recommendations, if adopted, would set the Government on course to be a world leader in health and economic policy.

PHAA is already engaged with government agencies and Ministers in helping it deliver on its commitments, and we and the many expert members of our Association will continue to assist.

We thank for you your consideration of this submission.



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July 2022

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