2023: the Year to Deliver on Public Health

Strategic Directions / Pre-Budget Submission for the 2023-24 Budget

Contact for recipient:
Budget Policy Division, Treasury
Langton Cres, Parkes ACT 2600
E: PreBudgetSubmissions@treasury.gov.au

Contact for PHAA:
Terry Slevin – Chief Executive Officer
A: 20 Napier Close, Deakin ACT 2600
E: phaa@phaa.net.au **T:** (02) 6285 2373

January 2023

Contents

Overview 1

Summary of recommendations 3

Summary of fiscal impact 4

The CDC is the key issue for 2023 5

Socio-economic overview 9

Economic overview ... 9

The economic significance of the population's health ... 10

The importance of preventing chronic illness ... 12

Climate change and the population's health ... 13

Aboriginal and Torres Strait Islander health ... 14

Budget development and framing 16

Designing a wellbeing approach ... 16

Policy Alignment ... 17

Development of the public health workforce 19

Implementing the national strategy for preventive health investment 21

Revenue proposals 24

Tobacco ... 24

Alcohol ... 25

Sugar-sweetened beverages ... 26

Summary of revenue measures ... 27

Investment proposals 28

Reducing tobacco use and nicotine addiction ... 28

Promoting healthy weight and reducing obesity ... 29

Reducing alcohol related harm ... 31

Oral health preventive care ... 31

Summary of investment measures ... 32

Conclusion 33

References 34

20 Napier Close Deakin ACT Australia, 2600 – PO Box 319 Curtin ACT Australia 2605
T: (02) 6285 2373 **E:** phaa@phaa.net.au **W:** www.phaa.net.au

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 Australians.

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.

20 Napier Close Deakin ACT Australia, 2600 – PO Box 319 Curtin ACT Australia 2605
T: (02) 6285 2373 **E:** phaa@phaa.net.au **W:** www.phaa.net.au

Overview

In this submission we highlight three priorities for the coming Budget:

- To deliver on key government election commitments, including:
  - the creation of a national Centre for Disease Control and Prevention
  - the implementation of the National Preventive Health Strategy
- To recognise that sound public health policy is sound economic policy, especially in regard to policies which prevent diseases and other threats to health.
- To deliver on the commitment to frame Commonwealth Budget planning around the idea of 'wellbeing', and use fiscal strategies to create a 'wellbeing economy'

Election commitments

In regard to election commitments, we note in particular the commitment to the establishment of an Australian Centre for Disease Control and Prevention (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

We elaborate on issues surrounding the creation of the CDC on pages 5 to 8 of this submission, in recognition that it the largest public health issue arising in this Budget.

Regarding the National Preventive Health Strategy (NPHS), the delivery of a 10-year investment strategy cannot seriously be left to start in year 3 of the Strategy's decade. The former government adopted no budget initiatives at all in year 1 of the strategy, and none were forthcoming in the special October 2022 Budget. Serious investment in programs to address chronic disease drivers should be launched at the latest in the May 2023 Budget, if the Government is to be seen to meet its commitment. Our submission provides examples of affordable, effective programs to start delivering the NPHS.

The economic case for prevention

In this submission we also present 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 Government has an opportunity to present Australia as a world-leader in health economic management. The obstruction 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. We urge the Government to rise above that hurdle, move away from an approach based on short-

term expenditure, and adopt a longer-term return-on-investment approach to budget choices in the preventive health field. Adopting new approaches to financial planning that value investment in health and disease burdens would help to explain the case for early preventive investment to the Australian people. Adopting a 'wellbeing economy' policy-making approach would also assist.

Framing the Budget around wellbeing

Regarding 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 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 in Budget documents 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. We welcome the Treasurer's expressed commitments to a framework of measures and indicators launched in the October 2022 Budget and the consultations currently being undertaken by the Treasury to develop his direction.

However, the *best* use of this modern wellbeing thinking is to appreciate that wellbeing is 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."*[1]

This higher vision of wellbeing economics is what the Albanese Government should now aim for. Recognising that the October 2022 Budget came just weeks into the Government's term of office, we appreciate that a full recasting of budgetary framing and decisions could not be expected last year. But through the 2023-24 Budget, the Government should signal with great clarity that the 'wellbeing' approach is no mere packaging exercise. PHAA will vigorously support the Government in such a direction.

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

We look forward to being able to do so on Budget Day.

Summary of recommendations

Government election commitments

1. The Budget fund the establishment of an Australia Centre for Disease Control with a commitment of at least $200 million per annum from the first full financial year, 2024-25.
2. The Budget should fund real action to implement the 2021-30 National Preventive Health Strategy, including by leading all governments towards the commitment that a minimum of 5% of Commonwealth, state and territory health expenditure should be directed to preventive health investments by 2030.

General economic and social policy

3. Government economic policies and projections should be based on a fundamental premise that a healthy population is essential for a healthy and vital economy and for the ongoing management of all preventable diseases, injuries and other impacts on health.
4. Government economic policies should recognise the need to reduce inequality and inequity, taking into account the social, cultural, environmental and commercial determinants of health.
5. In line with the Treasurer's commitment to a 'wellbeing' Budget focus and budget-development practices, the Budget should frame new Budget initiatives in terms of their capacity to achieve key indicators of community wellbeing. It should also clarify how future budget decision-making will be framed to pursue wellbeing outcomes.

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 invest through 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* on pages 24-27).
10. The Budget should include specific investments in a range of measures to address key preventable chronic diseases (see the *Investment Proposals* on pages 28-32).

Pandemic economic response

11. The Budget should ensure that social and health equity by strengthening Australia's social security system by increasing income support payment levels, improving access for people requiring support, and removing unproductive compliance policies.

Summary of fiscal impact

PHAA is proposing revenue measures with an estimated net fiscal impact over 4 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	1,171.0
Volumetric equalisation of alcohol excises	2,900.0	2,987.0	3,076.0	3,168.0	12,133.0
Sugar-sweetened beverages excise	738.0	723.0	696.0	677.0	2,835.0
TOTAL	**3,816.0**	**3,980.0**	**4,133.0**	**4,206.0**	**16,139.0**

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	25.0	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
TOTAL	**241.0**	**393.0**	**405.0**	**418.0**	**1,447.0**

Improved bottom line

	2023-24	2024-25	2025-26	2026-27	total
Revenue measures	3,816.0	3,980.0	4,133.0	4,206.0	16,139.0
Investment measures	241.0	393.0	405.0	418.0	1,447.0
TOTAL	**3,575.00**	**3,587.00**	**3,728.00**	**3,788.00**	**14,692.00**

The CDC is the key issue for 2023

The Government has given clear demonstrations of energy and early progress on its election commitment to create a national Centre for Disease Control. The indications are that the CDC will be legislated for in 2023, and operations would begin by the end of the 2023-24 financial year. This would represent the most significant enhancement to our national management of population health needs in several decades.

Crucially, there is a clear consensus behind the CDC having a major role in the prevention of chronic, non-communicable diseases in our population. As the Prime Minister stated in 2020, "Australia's CDC would play a role in preventing health threats posed by chronic disease, as well as infectious diseases".[2] PHAA has previously advised that that the entity should be titled the Centre for Disease Control *and Prevention* for this reason.

PHAA is actively engaged with the work already underway within the health portfolio on the establishment of the CDC. Our organisation is working collaboratively with the Department of Health and Aged Care, 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 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. To encourage community engagement with the project, our online publication *Intouch* has run a series of articles by expert commentators and interested parties under the 'CDC Corner' tag.

We will continue to champion the CDC project, anticipating that the CDC 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.

The 2023-24 Budget should fund the new institution both by funding the institutional operation of the CDC, and by funding programs of chronic disease preventive health to be administered *through* the CDC.

Legislation and functions of the CDC

One of the first issues to face in 2023 is the legislation that establishes the CDC. The CDC needs to be both able and confident to provide independent, trusted, authoritative, evidence-based advice, irrespective of any Government's willingness to hear such advice.

In late 2022 the Department of Health and Aged Care released its *Role and Functions of an Australian Centre for Disease Control* Discussion Paper with the objective of guiding development of the purpose, scope and functions of the CDC.[3] The summary of scope and budgets of international counterparts provided in the Discussion Paper is useful in considering what should be in and out of scope for the CDC.

Functions that should be in scope to value add to Australia's health protection landscape at a national level, rather than duplicate existing government systems and services, include:

- Biosafety and radiation protection
- Collaborating with research institutions and labs
- Design and implement national public health programs
- Disease prevention and control (including infectious and chronic disease)
- Disease surveillance, evaluation, and data analysis
- Emergency preparedness and response

- Expert advice and guidance
- Health promotion
- Health workforce education and development
- International collaboration on public health.

The new institution's operational structure should reflect a hub-and-spoke model, with a properly resourced administrative centre, to coordinate its activities and functions, and enable international collaborations. These should include jurisdictional offices for regional coordination and engagement, in much the same way as the Public Health Agency of Canada is structured, staffed with funded positions to capacitate national functions.

We welcome that the agency is being established by a government that demonstrates commitment to improving and expanding public health capacity. But the CDC must be able to endure the circumstances of any future government that might be indifferent or hostile to the value of public health advice and expertise. This requires that the CDC should be established as a new statutory body, similar in governance arrangements to entities such as the Australian Commission on Quality and Safety in Healthcare. That commission has an independent, expert governance board rather than an advisory board, with clear independence mechanisms.

The CDC Board membership should come from a diversity of disciplines and segments of Australian society, and have unquestionable public health expertise and credentials. This would create the balance between the need for independence from government, maintain accountability, and encourage jurisdictional buy-in across our federal system.

Budget Funding for the CDC

The new agency must also be placed on a financially sustainable footing. The October 2022 Budget, the new Albanese Government's first, contained a very modest line item for the CDC of just $3.2 million, largely to facilitate the consultation and planning process.

The 2023-24 Budget allocation will be much more revealing. This year's Budget will transparently indicate the Government's degree of commitment to the new agency. Recognising that the agency will only commence partway through the 2023-24 financial year, the exact sum allocated for the first financial year's allocation is not the real test. The Budget will also allocate estimates for 2024-25 and years beyond. It is here that the scale of the Government's commitment to the CDC will be disclosed.

The Budget allocation will need to be aligned with the agency's yet-to-be-determined scope. To have a strong capacity to drive prevention of the many increasingly prevalent forms of chronic disease in Australia, the agency's budget must be substantial.

There is likely to be some internal reallocation of existing budget funding, with funds already committed in the Department of Health and Aged Care and other agencies reallocated to the CDC as existing functions are transferred. For example, it has already been foreshadowed that the National Medical Stockpile will be transferred into the CDC. This is a reasonable responsibility for the CDC to hold. PHAA is advised that the exact extent of resourcing is considered a national security issue and so is not publicly available. The CDC is also expected to incorporate the roles of the Communicable Diseases Network Australia and Public Health Laboratory Network as part of its scope to plan for and, where necessary, lead response to infectious disease outbreaks. However, we note that any such transferred funding should not be confused with *new funding for new functions*. A large dollar budget estimate for the CDC made up entirely of transferred past allocations would not constitute a real commitment to the new organization.

CDC efforts to work constructively with states and territories – where substantive public health powers lie – will also require new resourcing. Co-operation with the jurisdictions is far more likely to be effective if funds are provided to boost jurisdictional capacities on issues such as public health workforce development, emergency planning and preparation, outbreak investigation and management including use of genome data in disease surveillance, end-to-end contact tracing, data exchange, technology, community communication, and community confidence.

Overall, there will be a broad range of operating and program areas that need to be appropriately resourced if the CDC is going to be effective and sustainable. Although costings can only be tentative until the precise scope of the centre is agreed, we have conservatively estimated that a significantly scaled Centre would require funding of around $200 million per annum.

Our estimate of Commonwealth expense to operate the institution is therefore at least the following:

Expense ($m)	2023-24	2024-25	2025-26	2026-27	total
Establish an Australian Centre for Disease Control	75.0	200.0	210.0	220.0	705.0

If the CDC is to genuinely fulfil its potential, the budget allocations for 2024-25 and onwards will need to be in the hundreds, not tens, of millions of dollars. It is this figure, in particular the figure from 2024-25, that will be the test when the Budget is released in May 2023.

Delivering preventive health policy commitments through the CDC

During the 2022 election campaign, the Government committed to the NPHS, which has received broad bipartisan support, very broad endorsement by national health organisations, and recognition by state and territory governments.

The NPHS is a 10-year strategy, nominally to be delivered from 2021-22 to 2030-31. But the first Commonwealth Budget following the Strategy's publication (which was the 2022-23 Budget, in May 2022) saw no preventive health initiatives whatsoever launched for 'year 1' of that decade-long timeframe. The October 2022 Budget also did not address the NPHS, but we appreciate that this was a transitional economic statement by the new Government.

As a result of this delay in action the coming full 2023-24 Budget will represent 'year 3' of the NPHS decade, and it is obviously essential that 2023-24 also does not again see no investment effort for preventive health measures in the Budget.

Later in this submission we identify a selection of commencement-ready preventive health programs. We urge the Government to see such programs as, in the long-term, budget-positive for the Commonwealth, given that they reduce disease prevalence in the community, reduce in turn health system treatment costs, and boost economic productivity of individuals able to enjoy better health.

If the CDC is to lead the enactment of the NPHS to tackle issues like alcohol, tobacco, and obesity, then proper resource allocation is essential. By way of reference point for previous investment in preventive health we can look at the *National Partnership Agreement on Preventive Health* signed by the Rudd government will all States and Territories in 2008.[4] A total of $564 million was allocated from 2009-10 through to 2014-15. The Abbott Government eliminated this whole program in the 2014 Budget, but at its peak there were $218 million allocated under the agreement for the 2012-13 year, and this amount was for chronic disease prevention programs alone.

As it happens, a modest source of program funding already exists, appropriated for preventive health programs over a decade ago. The recent Budget statement reveals that a sum of $12 million remains as unspent funds within the account of the Australian National Preventive Health Agency (ANPHA). These

funds have been locked away and diminishing only through the annual audit cost since 2013, when the Abbott Government discontinued funding for the agency which the Rudd-Gillard Government had established. These funds were originally allocated for the purpose of programs to prevent chronic diseases, and can now be redirected to new preventive health programs, providing at least partial resourcing for the measures recommended below, or other preventive health initiatives. As a part of the process of establishing the CDC, the Government should transfer the legislated functions and appropriated funds of the ANPHA into the CDC from the outset.

It is vital that chronic disease prevention is clearly established as an important priority from day one of this vital public health agency. As discussed above, the Government has already indicated that the CDC will have a key role to play in preventive health program delivery. The Department of Health's recent CDC Consultation Discussion Paper outlines the importance of the NPHS and how the CDC would be able to support it as a function. The Paper acknowledges that the CDC could provide expert-lead governance and "provide the platform for a whole-of-systems approach to prevention that is evidence-based, promotes health equity, and provides advice on current, emerging, and future priorities in prevention".[3]

To benefit from the economic goal of stronger population health, and indeed to have any hope of achieving real outcomes by 2030, the Government should ensure that NPHS implementation is a founding function of the CDC, and that the CDC is provided with substantial program funding to begin implementation of NPHS programs.

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 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 the pandemic have been dramatic, as have the fiscal impacts on government budgets across the nation. To build back healthier, government strategy should recognise that the way in which we manage populations 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 major strategic theme in the 2023-24 Budget.

From a longer-term perspective, the Treasury's *Intergenerational Report* projections, updated in 2021 to take account of pandemic factors, foresees 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).[5]

Noting the current economic circumstances globally, it is clearly in the economic interests of Australia to improve the health of our population – a goal that has been estimated conservatively by the Productivity Commission to potentially increase GDP by $4 billion per year.[6]

The Government is therefore under pressure to identify financial initiatives which will enhance the productivity of the workforce, 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, there exist some quite significant opportunities to increase revenue as a by-product of specific health policies.

Launching decisive public health policy measures through 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.

20 Napier Close Deakin ACT Australia, 2600 – PO Box 319 Curtin ACT Australia 2605

T: (02) 6285 2373 **E:** phaa@phaa.net.au **W:** www.phaa.net.au

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.[7]

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.[8] 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*."[9]

The OECD's *Heavy Burden of Obesity: The Economics of Prevention* report (2019), examined 52 developed member nations.[10] 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.[11]

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.[12]

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.[13] 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.*[14] *It was estimated that a $1 investment in public health generated $14 in return,*[15] *in addition to the return of the original investment, back to the wider health and social economy*."[16]

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.[17] 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.[18]

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.[19]

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.[20] 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.[21]

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).

Climate change and the population's health

PHAA welcomes the statement by the Minister for Health in August 2022 that the Government is working on a national strategy on climate change, health and wellbeing.[22] 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)[23], the *MJA-Lancet Countdown report* (2021)[24], the *Report of the WA Climate Health Inquiry* (December 2020)[25], and the *Climate and Health – Preparing for the Next Disaster* report by the Grattan Institute (December 2020)[26]. 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).[23] The previous Australian Government committed this international policy commitment both at Paris and at the COP26 meeting in Glasgow. Yet by 2020 the situation had reached an estimated average increase compared to mid-20th century levels, according to different reports, of between 1.0°C [27] and 1.7°C [28] 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.[29]

The impacts of climate change on the health of Australians are enormously significant,[30] 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[31]
- 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.[32]

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.[33] The health benefits from meeting Australia's climate goals more than repay the costs.[34]

The new Albanese 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 late 2022 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 supports 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 Australian Health Protection Principal Committee (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 2 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*",[35, 36] and it is widely believed that the target cannot be achieved within the present Closing the Gap timeframe.[37]

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.[38] However, 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. Alarmingly, 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 5 and 8 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.[39] 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*".[40]

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*."

Regarding 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 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*.

Budget development and 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.

This is not without precedent in Australia, with the ACT Government 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 annual budget deliberations.

There are various forms that a wellbeing framing could take. The OECD provides advice to member governments on wellbeing approaches, and from 2019 a cluster of governments including New Zealand, Finland, Iceland, Scotland, Wales and Canada formed a network to explore such 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 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,

> *"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?, Alexandra Jones, Senior research fellow at The George Institute for Global Health, Dec 2021*

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 that would be 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, as well as providing a downward force on budget expenditure pressures into the future. We encourage the Government to ensure that the proposed wellbeing framing has real substance, and is more than merely a presentational change or a planning framework alone.

PHAA is making a separate submission to the Treasury's consultation on the **Measuring What Matters** project. The Treasury's consultation material states that the Government will release a more developed Measuring What Matters statement in 2023, presumably as part of the 2023-24 Budget statements.[41]

The October 2022 Measuring What Matters statement has a heavy focus on the OECD Framework for Measuring Health and Wellbeing. The statement rightly points out the limitations of this Framework, including the lag caused by indicators that are published with a delay, issues with comparability of indicators between jurisdictions, and the use of averages (which do not capture inequalities). The statement also notes that the OECD Framework is not tailored to Australia's circumstances, and does not incorporate all our national priorities.

The Treasury's consultation material states that the 2023 Measuring what Matters Statement will draw on the work of the OECD, but will be unique to the Australian context, and that the consultation will allow contributors to have a say on the application of the OECD framework to Australia. The anticipated 2023 Statement can be adapted to the Australian context and can draw from the OECD framework while going beyond its limitations.

Policy Alignment

Alignment with existing national and inter-governmental policy directions

The National Preventive Health Strategy was developed with a very strong element of external expert advice.[42] The final NPHS 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 good enough to survive transition to a new national government. As noted above, in response to PHAA election surveys the 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. But too much time

– indeed, two Commonwealth Budgets – has passed since the NPHS was released, with no announcement yet of actual health investment programs.

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 management, but the whole interrelated effort of chronic disease 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 such as 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.[43] 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.[44] 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.[45]

The National Preventive Health Strategy has set a clear direction for the nation, and 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),[46] the strong prevention direction in the *State Public Health Plan for Western Australia 2019 - 2024* (2019),[47] the *Final Report of the Climate Health WA Inquiry* (2020),[48] and the *South Australian Health and Wellbeing Strategy 2020 - 2025* (2020),[49] and Queensland's *The Health of Queenslanders 2020* statement.

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.

T: (02) 6285 2373 **E:** phaa@phaa.net.au **W:** www.phaa.net.au

Development of the public health workforce

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 well-established NSW Public Health Officer Training Program (PHOTP), that provide multidisciplinary workplace-based training in public health competencies.

However, for many years our workforce has simply been insufficient in size to address all the population health challenges facing the nation. The COVID pandemic 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 December 2021 the Government stated a policy commitment on this matter in the NPHS:

> *"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..."* [50]

Yet in rounds of Commonwealth, state and territory budgets released from 2020 to 2022, no government announced specific measures to act on these commitments. Decisive Commonwealth budgetary leadership is clearly needed.

PHAA argued that the establishment of temporary pandemic registers for a surge workforce was required to respond to the COVID-19 pandemic, because practitioners of most public health disciplines are either unregulated or not specifically regulated for public health practice in Australia. Recruiting from the general health workforce and drawing on departmental staffing or defence force personnel was therefore necessary as it was impossible to identify those workers trained and qualified in public health – a major flaw in our national response to the pandemic.

Australia therefore urgently needs to professionalize and enumerate its public health workforce through accreditation of core public health education programs, enabling graduates to become registered as public health practitioners under a yet to be determined registration scheme. In turn, the requirement to maintain continuing professional development can be enforced through an associated credentialing program for regular re-registration. Only then will we be able to draw on those with appropriate training and qualifications for emergency preparedness and response.

In May 2022, the WHO launched a roadmap for strengthening the public health and emergency workforce, designed to guide a "coherent approach to the development and management of this critically needed category of workers."[51] The roadmap 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.

In October 2022 the WHO published its *Action Plan 2022-2024*, outlining the immediate activities and deliverables anticipated in the first two-year period of the Roadmap, to meet the following targets:

- By the end of June 2023, all tools and guidance are available for country contextualization and endorsed by the participating organizations.
- By the end of June 2024, at least 100 countries have benchmarked themselves on the three action areas and developed action plans for implementation.[52]

PHAA has representatives on both the Steering Committee and Technical Working Groups responsible for implementing this roadmap through WHO member states, including Australia. The roadmap provides a timely opportunity to consolidate evidence and build on existing resources, to collaborate with global partners, and to inform and guide the development of a national public health workforce policy/plan that will strengthen public health and emergency capability in Australia, under the remit of the CDC.

Meanwhile, a national PHOTP can be immediately implemented by the Australian and state and territory governments to create a pipeline of highly trained public health professionals. The existing NSW PHOTP should be appropriately adapted to the jurisdictional circumstances. The program should 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).

This would assist with Australia's urgent public health workforce needs, as well as create an important source of future expert senior officers in public health leadership positions, for all Australian jurisdictions. 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 could be managed through the Australian Health Protection Principal Committee (AHPPC) or other mechanisms.

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

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 2022 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 Australia's keynote current 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 policy is an 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, the 2023-24 Budget should set in motion 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.[53] 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.[54] (The recently available figure for 2020-21 is over 3%, but this is demonstrably driven by including specific COVID-19 response expenditure including the national vaccination program.)

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.[55] And the Commonwealth has also adopted this target (for the year 2030) through the NHPS.

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.*"[56]

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 without any further delay. 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)

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.[57] 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*."[58]

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.[59] Increases additional to 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 Centre for Disease Control, discussed above. The CDC 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.[60] 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.[61] 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 range from $3.8 to $4.2 billion per annum, totalling over $16.1 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.[62] The social cost for tobacco use has been estimated at $136.9 billion.[63]

Evidence shows that high tobacco prices are the single most effective and cost-effective measure for reducing tobacco use.[64] 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 RYO tobacco sold in small pouches in order to avoid price rises in manufactured cigarettes. [65]

Among several best practice recommendations, the World Health Organization and World Bank strongly endorses equal taxation of all tobacco products in order to prevent such substitution.[66] 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.[67] This measure proposes that the tax on a RYO cigarette would increase on 1st 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 $178m in 2023-24, increasing to $361m by 2026-27.

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 [68]	178.0	270.0	361.0	361.0	1,171.0

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.[69] The highest costs are associated with productivity losses (42.1%), traffic crashes (25.5%) and the criminal justice system (20.6%).[70]

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.[71, 72, 73] There is evidence that mid to high levels of drinking substantially increases cardiovascular diseases.[74]

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.[75]

However, Australia’s current approach to alcohol taxation is flawed, and does not adequately recognise the extent of harms that result from alcohol consumption.[76] 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.[77] The 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 based on the high costs of excessive alcohol consumption.[78]

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.[79] 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.[80]

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.[81] 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.[82]

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	12,133.0

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.[83]

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

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. [84, 85] 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.[86] 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.[87] The AIHW has as recently as April 2022 identified obesity as the most expensive risk factor facing hospitals.[88] 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.[89]

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 because for several reasons[90], 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[91]
- Consumption of sugar-sweetened beverages is high in Australia, particularly among adolescents, young adults, Aboriginal and Torres Strait Islander people and low-income groups[92]. 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[93]
- Authoritative health organisations recommend limiting sugar-sweetened beverage consumption.[94]

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.[95] 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.[96] 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.[97]

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.[98]

The AMA has modelled the impact of an excise tax on select sugar-sweetened beverages based on sugar content, set at $0.40 per 100 grams of sugar (per unit of product). This aligns with the WHO recommendation that a tax on sugar-sweetened beverages would need to raise the retail price by at least 20 per cent in order to have a meaningful health effect.[99] Under this proposed tax rate, the amount of tax paid on a 375 mL can of soft drink with 40 grams of sugar (sugar content of 10.6 grams per 100mL) would be $0.16.[100] The modelling indicates that a tax on select SSBs would reduce consumption by 12 to 18 per cent, which is 27,596 to 43,804 tonnes of sugar, and raise revenue of $749 million to $814 million.[101]

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.[102] Opinion polling has identified that most Australians supporting a health levy on sugary beverages.[103]

We recommend that the Government consider a minimum 20% health levy on sugar-sweetened beverages. The revenue estimates 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	2,835.0

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	1,171.0
Volumetric equalisation of alcohol excises	2,900.0	2,987.0	3,076.0	3,168.0	12,133.0
Sugar-sweetened beverages excise	738.0	723.0	696.0	677.0	2,835.0
TOTAL	**3,816.0**	**3,980.0**	**4,133.0**	**4,206.0**	**16,139.0**

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.[104]

However, over the past decade investment in quit smoking campaigns has declined.[105] 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,[106] 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 an 80. Approximately 55,000 premature deaths were prevented.[107]

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	25.0	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.

Nicotine vaping products

Scientific evidence is building on the health harms of nicotine vaping products (NVPs) and other novel tobacco products. NVPs play a role in increasing smoking uptake, particularly among young people, and there are indications that e- cigarette use may depress overall smoking cessation rates.[108] PHAA strongly supports the commitment of all Australian governments to a precautionary approach to e-cigarettes.[109]

In December 2022 the Government announced that urgent work was being undertaken, led by the Therapeutic Goods Administration, on policy reforms to limit the uptake of vaping (and nicotine addiction) by new users, especially young users.[110] Strengthening border controls – is clearly the most important and urgent objective. The critical situation to be addressed is the massive quantity of NVP products circulating illegally in Australia. Stronger regulations, and resourcing of effective enforcement, should be put in place urgently to dramatically reduce the illegal availability of NVPs. The regulations should limit product importation into Australia only to that needed to accommodate the limited use that is legal – that is, the cessation-aid prescription use (noting that the health care rationale even for this use is not without controversy and remains under active study).

The cost-benefit rationale for regulating NVPs is very strong. Future costs to the health system driven by NVP usage is a major emerging national health issue, and the rapid expansion of usage seen in recent years creates an urgent need to reassess future health cost estimations. We look forward to initiatives to control nicotine addiction via vaping being resourced in the forthcoming Budget.

Promoting healthy weight and reducing obesity

National Obesity Prevention Strategy

PHAA supports the work of the Commonwealth and state and territory governments to develop a National Obesity Prevention 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.[111]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.[112] 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.[113]

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.'[114] 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*)."[115]

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)[116], 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.[117]

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. [118]

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.[119] 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.[120]

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.[121]

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 years) are consuming alcohol by 2030
- At least a 15% decrease in the prevalence of recent illicit drug use (≥14 years) by 203.0

Oral health preventive care

PHAA supports the work of the National Oral Health Alliance (NOHA), which advocates for the Australian Commonwealth Government to commit to delivering universal access to affordable oral healthcare. NOHA proposes a national roadmap to implement this, which includes the development and implementation of Australia's next National Oral Health Plan 2025-2034. The plan should be co-designed by consumer stakeholders, health organisations and professional associations.

In alignment with NOHA, PHAA supports a preventative-focused and integrative approach to oral health funding to reduce preventable hospitalisations relating to oral diseases and improve general health and wellbeing outcomes. Oral health is integral to overall general health, wellbeing and quality of life. A healthy mouth enables people to eat, speak and socialise without pain, discomfort or embarrassment. Dental conditions and oral diseases place a considerable burden on individuals, families and the community, with consequential costs to the healthcare system and government budgets.

Oral health inequities are caused by the conditions of daily living, the political, social, cultural and physical environments, which in turn influence the choices and options open to people.[122] In particular, children and adults living in rural and remote Australia experience higher rates of oral diseases. There is an inadequate supply of dental practitioners working in remote and regional Australia to provide equitable oral healthcare.[123] The fragmentation and exclusion of universal access to affordable oral healthcare in Australia is costly and a significant gap in primary health care.

The initiatives which PHAA supports include the following:

- Appoint a Commonwealth Chief Dental Officer
- Implement the oral health recommendations by the Royal Commission into Aged Care Quality and Safety (Royal Commission),[124] including:
    - the establishment of the Seniors Dental Benefits Scheme (SDBS). Recommendation 19: Urgent review of the Aged Care Quality Standards, in particular best-practice oral care, with sufficient detail on what these requirements involve and how they are to be achieved.
    - Recommendation 38: Residential aged care to employ or retain at least an allied health professional, including oral health practitioners.
    - Recommendation 60: Establish a Senior Dental Benefits Scheme for people who live in residential aged care or in the community.
    - Recommendation 79: Review Certificate III and IV courses to consider including oral health as a core competency.
    - Recommendation 114: Immediate funding for education and training to improve the quality of care, including oral health.
- Commit to increased funding by the Commonwealth government for public dental services to support the immediate urgent needs of priority populations.[125]
- Complete and implement the National Oral Health Plan 2025-2034.

As the development of the National Oral Health Plan is ongoing costings for these measures are not included in this submission.

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	25.0	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
TOTAL	**241.0**	**393.0**	**405.0**	**418.0**	**1,447.0**

Conclusion

This submission has highlighted three priorities for the coming Budget:

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

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

PHAA has a strong record of positive engagement with government agencies and Ministers in helping it deliver government public health commitments, and we and the many expert members of our Association will continue to assist.

We thank you for your consideration of this submission.

Adjunct Professor Terry Slevin
Chief Executive Officer

January 2023

References

1 Is a wellbeing economy the solution to our ills?, Alexandra Jones, Senior research fellow at The George Institute for Global Health, Dec 2021, https://www.theage.com.au/national/is-a-wellbeing-economy-the-solution-to-our-ills-20211202-p59e40.html

2 Anthony Albanese MP, 5 October 2020, at https://anthonyalbanese.com.au/anthony-albanese-chris-bowen-media-release-safeguarding-our-future-with-an-australian-cdc-tuesday-6-october-2020

3 Department of Health and Aged Care. Australian Centre for Disease Control [Internet]. Canberra: Australian Government; 2022 [cited 10 Nov2022],at: https://www.health.gov.au/initiatives-and-programs/australian-cdc

4 https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-07/health_preventive_NP.pdf

5 2021 Intergenerational Report: https://treasury.gov.au/sites/default/files/2021-06/p2021_182464.pdf

6 Productivity Commission, Shifting the Dial: 5 year productivity review, 2017, https://www.pc.gov.au/inquiries/completed/productivity-review/report

7 Deloitte, Economic reality check – Adapting Australia for climate-resilient growth (January 2022): https://www2.deloitte.com/au/en/pages/economics/articles/economic-reality-check.html

8 Productivity Commission, Shifting the Dial: 5 year productivity review, 2017, supporting paper 4, Why a better health system matters, 11, at https://www.pc.gov.au/inquiries/completed/productivity-review/report

9 Crosland P, Ananthapavan J, Davison J, et al. The economic cost of preventable disease in Australia: a systematic review of estimates and methods. Australian and New Zealand Journal of Public Health 2019;43:484-495.

10 https://www.oecd.org/health/health-systems/Heavy-burden-of-obesity-Policy-Brief-2019.pdf

11 Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra, chapter 3, page 149; https://www.pc.gov.au/inquiries/completed/mental-health/report

12 2021 Close the Gap Report, Lowitja Institute: https://www.lowitja.org.au/page/services/resources/Cultural-and-social-determinants/culture-for-health-and-wellbeing/close-the-gap-report-2021

13 Assessing Cost Effectiveness (ACE) in Prevention Study - School of Public Health - University of Queensland: https://public-health.uq.edu.au/research/centres/past-centres/assessing-cost-effectiveness-ace-prevention-study

14 Owen L, Fischer A. The cost-effectiveness of public health interventions examined by the National Institute for Health and Care Excellence from 2005 to 2018. Public Health 2019;169:151-162.

15 Masters R, Anwar E, Collins B, et al. Return on investment of public health interventions: a systematic review. Journal of Epidemiology and Community Health 2017;71:827-834

16 Queensland Health. The health of Queenslanders 2020. Report of the Chief Health Officer Queensland. Queensland Government. Brisbane 2020

17 World Health Organisation: https://www.who.int/nmh/countries/aus_en.pdf?ua=1

18 Council on Foreign Relations (2021) Noncommunicable Diseases Kill Slowly in Normal Times and quickly in COVID-19 times https://www.cfr.org/article/noncommunicablediseases-kill-slowly-normal-times-and-quickly-covid-19-times

19 Crosland P, Ananthapavan J, Davison J, et al. The economic cost of preventable disease in Australia: a systematic review of estimates and methods. Australian and New Zealand Journal of Public Health 2019;43:484-495.

20 For example, Cairns G, Angus K, Hastings G, Caraher M. Systematic reviews of the evidence on the nature, extent and effects of food marketing to children. A retrospective summary. Appetite. 2013;62:209-15

21 Clark, Helen, et al. "A future for the world's children? A WHO–UNICEF–Lancet Commission." The Lancet 395.10224 (2020): 605-658. Available from: https://www.thelancet.com/commissions/future-child

22 See report at https://www.caha.org.au/220803

23 The 2020 report of The *Lancet* Countdown on health and climate change: responding to converging crises, Nick Watts et al: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)32290-X/fulltext

24 The 2020 special report of the *MJA–Lancet* Countdown on health and climate change: lessons learnt from Australia's "Black Summer", Ying Zhang, Paul J Beggs, Alice McGushin, Hilary Bambrick, Stefan Trueck, Ivan C Hanigan, Geoffrey G Morgan, Helen L Berry, Martina K Linnenluecke, Fay H Johnston, Anthony G Capon and Nick Watts; Med J Aust 2020; 213 (11): 492.e2-492.e10, doi: 10.5694/mja2.50869 : https://www.mja.com.au/journal/2020/213/11/2020-special-report-mja-lancet-countdown-health-and-climate-change-lessons

25 Final Report of the Climate Health WA Inquiry, Tarun Weeramanthri: https://ww2.health.wa.gov.au/Improving-WA-Health/Climate-health-inquiry

26 Climate change and health: preparing for the next disaster, Grattan Institute 2020, Stephen Duckett, Will Mackey, Anika Stobart: https://grattan.edu.au/report/climate-change-and-health-preparing-for-the-next-disaster/

27 Statistica,com, Global Climate change – statistics and facts: https://www.statista.com/topics/1148/global-climate-change/#dossierKeyfigures

28 US National Oceanic and Atmospheric Administration, Climate.gov site, Climate Change: Global Temperature: https://www.climate.gov/news-features/understanding-climate/climate-change-global-temperature

29 MJA-Lancet Countdown on health and climate change, 2020

30 Australian Academy of Science. The risks to Australia of a 3°C warmer world. (2021) 98p. Available from: https://www.science.org.au/supporting-science/science-policy-and-analysis/reports-and-publications/risks-australia-three-degrees-c-warmer-world

31 PWC (report for Commonwealth Government), Protecting human health and safety during severe and extreme heat events, A national framework (2011): http://www.pwc.com.au/industry/government/assets/ extreme-heat-events-nov11.pdf.

32 Global mortality from outdoor fine particle pollution generated by fossil fuel combustion: Results from GEOS-Chem, Karn Vohra et al, Environmental Research, vol 195, April 2021, 110754: https://www.sciencedirect.com/science/article/abs/pii/S0013935121000487

33 Melbourne Sustainable Society Institute, Australia's Clean Economy Future: Costs and Benefits, 2021: https://sustainable.unimelb.edu.au/publications/australias-clean-economy

34 WHO, Health benefits far outweigh the costs of meeting climate change goals, 2018: https://www.who.int/news/item/05-12-2018-health-benefits-far-outweigh-the-costs-of-meeting-climate-change-goals

35 2019 Closing the Gap report, 122

36 2019 Closing the Gap report https://humanrights.gov.au/sites/default/files/document/publication/2022_close_the_gap_report.pdf

37 Reconciliation Australia, https://www.reconciliation.org.au/budget-ignores-closing-the-gap-despite-overhaul/

38 NACCHO, https://www.naccho.org.au/4-4-billion-gap-in-funding-for-aboriginal-and-torres-strait-islander-health/

39 Commonwealth of Australia, Department of Health, National Aboriginal and Torres Strait Islander Health Plan 2013-23: https://www.health.gov.au/resources/publications/national-aboriginal-and-torres-strait-islander-health-plan-2013-2023

40 COAG Joint Council on Closing the Gap: https://www.closingthegap.gov.au/joint-council-closing-gap

41 The Treasury, https://budget.gov.au/2022-23-october/content/bp1/download/bp1_bs-4.pdf

42 https://www.health.gov.au/resources/publications/australias-long-term-national-health-plan

43 https://public-health.uq.edu.au/files/571/ACE-Prevention_final_report.pdf

44 See the updated Appendix 3 of the WHO Global NCD Action Plan 2013-2020. http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_R11-en.pdf

45 World Health Organization, 2021: Saving lives, spending less: the case for investing in noncommunicable diseases: https://www.who.int/publications/i/item/9789240041059

46 https://www2.health.vic.gov.au/about/publications/policiesandguidelines/victorian-public-health-wellbeing-plan-2019-2023

47 https://ww2.health.wa.gov.au/Articles/S_T/State-Public-Health-Plan

48 https://ww2.health.wa.gov.au/climate-health-wa-final-report

49 South Australian Health and Wellbeing Strategy 2020 – 2025: https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/about+sa+health/health+and+wellbeing+strategy+2020+2025/the+south+australian+health+and+wellbeing+strategy+2020+-+2025

50 Commonwealth of Australia, Department of Health, National Preventive Health Strategy 2021-2030: https://www.health.gov.au/resources/publications/national-preventive-health-strategy-2021-2030 , page 38

51 National workforce capacity to implement the essential public health functions including a focus on emergency preparedness and response (who.int)

52 Action plan: National workforce capacity to implement the essential public health functions including a focus on emergency preparedness and response, https://www.who.int/publications/i/item/9789240060364

53 AIHW, Health Expenditure Australia 2019-20: https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2019-20/contents/about

54 OECD Date, Health Spending: Melbourne Sustainable Society Institute: https://data.oecd.org/healthres/health-spending.htm

55 Sustainable Health Review (2019). Sustainable Health Review: Final Report to the Western Australian Government. Department of Health, Western Australia. Recommendation 1.

56 Commonwealth of Australia, Department of Health, National Preventive Health Strategy 2021-2030: https://www.health.gov.au/resources/publications/national-preventive-health-strategy-2021-2030, page 9

57 Wutzke S, Morrice E, Benton M, et al., 2017. What will it take to improve prevention of chronic diseases in Australia? A case study of two national approaches. Aust Health Rev. 41(2): p. 176-181.

58 Commonwealth of Australia, Department of Health, National Preventive Health Strategy 2021-2030: https://www.health.gov.au/resources/publications/national-preventive-health-strategy-2021-2030, page 36

59 Scollo, M., Bayly, M. (2022) 13.6 Revenue from tobacco taxes in Australia. In Scollo, MM & Winstanley, MH (editors). Tobacco in Australia: Facts and issues. Cancer Council Victoria.

60 AIHW, Australian Burden of Disease Study 2018: key findings, August 2021: https://www.aihw.gov.au/getmedia/d2a1886d-c673-44aa-9eb6-857e9696fd83/aihw-bod-30.pdf.aspx?inline=true

61 World Health Organisation, Health Taxes: https://www.who.int/health-topics/health-taxes#tab=tab_1

62 AIHW, Australian Burden of Disease Study 2018: key findings, https://www.aihw.gov.au/getmedia/d2a1886d-c673-44aa-9eb6-857e9696fd83/aihw-bod-30.pdf.aspx?inline=true

63 Identifying the Social Costs of Tobacco Use to Australia in 2015/16, National Drug Research Institute, Curtin University, May 2019, https://ndri.curtin.edu.au/NDRI/media/documents/publications/T273.pdf

64 WHO report on the global tobacco epidemic 2021: addressing new and emerging products (2021): https://www.who.int/publications/i/item/9789240032095

65 Wilkinson AL, Scollo MM, Wakefield MA, Spittal MJ, Chaloupka FJ, et al. Smoking prevalence following tobacco tax increases in Australia between 2001 and 2017: an interrupted time-series analysis. Lancet Public Health, 2019. Available from: https://www.ncbi.nlm.nih.gov/pubmed/31759897

66 World Health Organization (2021). WHO technical manual on tobacco tax policy and administration. Geneva, WHO. https://www.who.int/publications/i/item/9789240019188.

67 Branston JR, McNeill A, Gilmore AB, Hiscock R, and Partos TR. Keeping smoking affordable in higher tax environments via smoking thinner roll-your-own cigarettes: Findings from the International Tobacco Control Four Country Survey 2006-15. Drug Alcohol Depend, 2018; 193:110-116. Available from: https://www.ncbi.nlm.nih.gov/pubmed/30352334

68 Based on estimated made by Cancer Council Australia (2022-23 Budget Submission, forthcoming)

69 The societal costs of alcohol misuse in Australia, Manning, Matthew, Smith, Christine and Mazerolle, Paul, Australian Institute of Criminology, 2013: https://www.aic.gov.au/publications/tandi/tandi454

70 PHAA, policy position statement on Alcohol, 2019: https://www.phaa.net.au/documents/item/3781

71 AIHW, Australian Burden of Disease Study 2018: Interactive data on risk factor burden: https://www.aihw.gov.au/reports/burden-of-disease/abds-2018-interactive-data-risk-factors/contents/alcohol-use)

72 World Health Organization, Global status report on alcohol and health 2018, https://www.who.int/publications/i/item/9789241565639

73 FARE / VicHealth / Turning Point report on Alcohol's Burden of Disease in Australia: https://fare.org.au/wp-content/uploads/Alcohols-burden-of-disease-in-Australia-FINAL.pdf).

74 Chengyi Ding, Dara O'Neill, Steven Bell, Emmanuel Stamatakis & Annie Britton, Association of alcohol consumption with morbidity and mortality in patients with cardiovascular disease: original data and meta-analysis of 48,423 men and women, BMC Medicine volume 19, Article number: 167 (2021): https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-021-02040-2

75 PHAA Position Statement on Alcohol: https://www.phaa.net.au/documents/item/3781

76 Alcohol and tax — time for real reform, Mike Daube and Julia Stafford, Med J Aust 2016; 204 (6): 218-219. || doi: 10.5694/mja16.00022: https://www.mja.com.au/journal/2016/204/6/alcohol-and-tax-time-real-reform

77 Alexander C Wagenaar, Matthew J Salois, Kelli A Komro, Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies, Addiction, 2009 Feb;104(2):179-90, doi: 10.1111/j.1360-0443.2008.02438.x.

78 The Australia's Future Tax System Review, Treasury, 2010: https://treasury.gov.au/review/the-australias-future-tax-system-review

79 Thomas F. Babor and others, Alcohol: No Ordinary Commodity – a summary of the second edition: https://doi.org/10.1111/j.1360-0443.2010.02945.x

80 Obesity Policy Coalition, http://www.aceobesitypolicy.com.au/results/intervention-reports/

81 WHO evidence-based SAFER strategies: https://www.who.int/initiatives/SAFER) and the National Alcohol Strategy 2019-2028 and https://www.health.gov.au/sites/default/files/documents/2020/11/national-alcohol-strategy-2019-2028.pdf

82 Foundation for Alcohol Education and Research (FARE) 2018-19 budget submission: https://fare.org.au/wp-content/uploads/FARE-Pre-budget-submission-2018-19.pdf)

83 Increasing the Price of Alcohol as an Obesity Prevention Measure: The Potential Cost-Effectiveness of Introducing a Uniform Volumetric Tax and a Minimum Floor Price on Alcohol in Australia, Ella Robinson and others, Nutrients 2020, *12*(3), 603; https://doi.org/10.3390/nu12030603: https://www.mdpi.com/2072-6643/12/3/603/htm

84 Australian Bureau of Statistics, 2020, National Health Survey: First results, key findings for health statistics including long-term health conditions; mental wellbeing; and health risk factors: https://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey-first-results/latest-release

85 Australian Bureau of Statistics (2018). National Health Survey: State and Territory Findings, 2017-18. Retrieved 29/06/2021 from: https://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey-state-and-territory-findings/latest-release

86 PwC Australia (2015). Weighing the cost of obesity: A case for action. pp4-5, 61-63. Retrieved 22/12/2020 from: https://www.pwc.com.au/pdf/weighing-the-cost-of-obesity-final.pdf

87 Withrow, D. & Alter, D.A. (2011). The economic burden of obesity worldwide: a systematic review of the direct costs of obesity. Obesity Reviews 12, 131-141. Doi: 10.1111/j.1467789X.2009.00712.

88 AIHW https://www.aihw.gov.au/reports/health-welfare-expenditure/health-system-spending-per-case-of-disease-and-oth/contents/about

89 Australian Medical Association, 2021, A tax on sugar-sweetened beverages: What the modelling shows: https://www.ama.com.au/articles/tax-sugar-sweetened-beverages-what-modelling-shows

90 PHAA policy position statement on a Health Levy on Sugar Sweetened Beverages, 2020: https://www.phaa.net.au/documents/item/4636

91 National Health and Medical Research Council, Australian Dietary Guidelines, https://www.nhmrc.gov.au/adg

92 Australian Bureau of Statistics2020, National Health Survey: First results, key findings for health statistics including long-term health conditions; mental wellbeing; and health risk factors: https://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey-first-results/latest-release

93 Have we reached a tipping point for sugar-sweetened beverage taxes?, Public Health Nutrition, 2016 Dec;19(17):3057-3061, doi: 10.1017/S1368980016003086.

94 World Health Organisation, 2015, Guideline: sugars intake for adults and children

95 Pedraza LS, Popkin BM, Batis C, Adair L, Robinson WR, et al. The caloric and sugar content of beverages purchased at different store-types changed after the sugary drinks taxation in Mexico. Int J Behav Nutr Phys Act, 2019; 16(1):103: https://pubmed.ncbi.nlm.nih.gov/31718664/

96 Public Health England, Sugar reduction: report on progress between 2015 and 2019 (publishing.service.gov.uk), October 2020.

97 Obesity Evidence Hub, Case for a tax on sugar-sweetened beverages (SSBs) in Australia, https://www.obesityevidencehub.org.au/collections/prevention/the-case-for-a-tax-on-sweetened-sugary-drinks

98 Veerman JL, Sacks G, Antonopoulos N, Martin J, “The impact of a tax on sugar-sweetened beverages on health and health care costs; a modelling study”, (2016) PloS One, 11(4).

99 World Health Organization (2016). Fiscal policies for diet and prevention of noncommunicable diseases. Technical Meeting Report. 5-6 May 2015, Geneva, Switzerland. WHO: Geneva. pp9, 24. Retrieved 21/01/2023 from: https://apps.who.int/iris/bitstream/handle/10665/250131/9789241511247- eng.pdf?sequence=1

100 Australian Medical Association (2021). A tax on sugar-sweetened beverages: Modelled impacts on sugar consumption and government revenue. Retrieved 12/01/2023 from: https://www.ama.com.au/articles/tax-sugar-sweetenedbeverages-what-modelling-shows-0

101 Australian Medical Association, Why Tax Sugary Drinks?, January 2023, https://www.ama.com.au/articles/why-tax-sugary-drinks

102 Australian-first Deakin study shows most young people support sugar tax, Deakin University, 2018: https://www.deakin.edu.au/about-deakin/news-and-media-releases/articles/australian-first-deakin-study-shows-most-young-people-support-sugar-tax

103 Most Australians want sugar tax on drinks – Guardian Essential poll, The Guardian, 16 Jan 2018: https://www.theguardian.com/australia-news/2018/jan/16/most-australians-want-sugar-tax-on-drinks-guardian-essential-poll

104 Australian Bureau of Statistics. 4364.0.55.001 - Australian Health Survey: First Results, 2014-15. Canberra: ABS; 2015.

105 Grogan P, Banks E. Far from ‘mission accomplished’: time to re-energise tobacco control in Australia. Public Health Res Pract. 2020;30(3): e3032016.

106 Australian Institute of Health and Welfare (AIHW). Burden of cancer in Australia: Australian Burden of Disease Study 2011. Australian Burden of Disease Study series no. 12. Cat. no. BOD 13. Canberra: AIHW; 2017.

107 Cost-effectiveness of the Australian National Tobacco Campaign, SF Hurley and JP Matthews, Tobacco Control, 2008 Dec;17(6):379-84. doi: 10.1136/tc.2008.025213.

108 Banks E, Yazidjoglou A, Brown S, Nguyen M, Martin M, Beckwith K, Daluwatta A, Campbell S, G. J. Electronic cigarettes and health outcomes: systematic review of global evidence. Report for the Australian Department of Health. Canberra: National Centre for Epidemiology and Population Health, 2022.

109 Department of Health and Aged Care, Policy and regulatory approach to electronic cigarettes (e-cigarettes) in Australia, 2018, https://www.health.gov.au/resources/publications/policy-and-regulatory-approach-to-electronic-cigarettes-e-cigarettes-in-australia

110 Therapeutic Goods Administration, Potential reforms to the regulation of nicotine vaping products consultation paper, 2022

111 Australian Bureau of Statistics, National Health Survey: First Results, 2017-18.

112 World Health Organization, Obesity: preventing and managing the global epidemic, Report of a WHO consultation. Technical Report Series 894. Geneva, 2000; The InterAct Consortium. Consumption of sweet beverages and type 2 diabetes incidence in European adults: results from EPIC-InterAct. Diabetologia PMID, 2013.

113 Australian Institute of Health and Welfare. 2021. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2018. Canberra, Australia.

114 World Obesity Federation. Obesity and COVID-19 policy statement. 2020. Available from: http://s3-eu-west-1.amazonaws.com/wof-files/Obesity_and_COVID_policy_statement_final_JulyUpdate_(002).pdf

115 Australian Medical Association, 2021. A tax on sugar-sweetened beverages: Modelled impacts on sugar consumption and government revenue, Canberra, Australia. Available from: https://www.ama.com.au/articles/tax-sugar-sweetened-beverages-what-modelling-shows.

116 Australian Bureau of Statistics, National Health Survey: First Results, 2017-18.

117 https://livelighter.com.au

118 Morley B, Niven P, Dixon H, Swanson M, McAleese A, Wakefield M. Controlled cohort evaluation of the LiveLighter mass media campaign's impact on adults' reported consumption of sugar-sweetened beverages

Morley B, Niven P, Dixon H. Assessment of Potential Unintended Consequences: Evaluation Results "LiveLighter" campaign, 2012 to 2014. 2014.

Coomber K, Morley B, Dixon H, Swanson M, Szybiakb M, Wakefield M. Investigating potential negative consequences of an adult-targeted obesity prevention media campaign in Australian adolescents.

Gascoyne C, Scully M, Wakefield M. Sugary drink consumption in Australian secondary school students. Research brief, prepared for Cancer Council Australia. 2019.

119 https://alcoholthinkagain.com.au

120 Smith J, Dunstone M, Elliott-Rudder M. 'Voldemort' and health professional knowledge of breastfeeding - do journal titles and abstracts accurately convey findings on differential health outcomes for formula fed infants? ACERH Working Paper Number 4. Canberra: Australian Centre for Economic Research on Health, Australian National University; 2008.

121 Dunstone K, Brennan E, Slater M, Dixon H, Durkin S, Pettigrew S, et al. Alcohol harm reduction advertisements: a content analysis of topic, objective, emotional tone, execution and target audience. BMC Public Health. 2017(17):312.

122 Watt, R.G. and Sheiham, A. Integrating the common risk factor approach into a social determinants framework. Community Dent Oral Epidemiol, 2012. 40(4):289-96.

123 National Oral Health Alliance. Oral Health Policy - Rural and Remote Australia. 2018. Available from https://oralhealth.asn.au/sites/default/files/Rural%20and%20remote%20policy.pdf

124 Royal Commission into Aged Care Quality and Safety. Final Report: Care, Dignity and Respect. 2021. Available from: https://agedcare.royalcommission.gov.au/publications/final-report

125 Duckett, S., et al. Filling the gap: A universal dental scheme for Australia. 2019.