Getting Australia's Health on Track 2021

SECOND EDITION

TECHNICAL PAPER

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About us

The Mitchell Institute for Education and Health Policy at Victoria University is one of the country's leading education and health policy think tanks and trusted thought leaders. Our focus is on improving our education and health systems so more Australians can engage with and benefit from these services, supporting a healthier, fairer and more productive society.

The Australian Health Policy Collaboration is led by the Mitchell Institute at Victoria University and brings together health organisations and chronic disease experts to translate rigorous research to inform policy addressing significant health issues in the population. The national collaboration has developed health targets and indicators for preventable chronic diseases tailored to achieving reduced health impacts of chronic conditions on the Australian population.

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This report is the technical report to the *Getting Australia's Health on Track 2021* policy paper. The authors acknowledge the commitment and detailed contributions of expert working group members to *Getting Australia's Health on Track 2021.*

Acknowledgement of Country

Mitchell Institute acknowledges, recognises and respects the Ancestors, Elders and families of the Boonwurrung, Wadawurrung and Wurundjeri of the Kulin who are the traditional owners of University land in Victoria, and the Gadigal and Guring-gai of the Eora Nation who are the traditional owners of University land in Sydney.

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Abbreviations

AATSIHS	Australian Aboriginal and Torres Strait Islander Survey
AHPC	Australian Health Policy Collaboration
AHS	Australian Health Survey
AIHW	Australian Institute of Health and Welfare
BMI	Body Mass Index
COVID-19	Coronavirus disease of 2019
CVD	Cardiovascular disease
EWG	Expert working group
NATSIHS	National Aboriginal and Torres Strait Islander Survey
NCD	Noncommunicable disease
NDSHS	National Drug Strategy Household Survey
NHS	National Health Survey
PHIDU	Public Health Information Development Unit, Torrens University Adelaide
PPA	Priority policy action
SES	Socioeconomic status
UK	United Kingdom
USA	United States of America
WHO	World Health Organization

Data sources

The following data sources are referenced in this report:

- Australian Health Survey 2011-12, by Australian Bureau of Statistics
- National Health Survey 2014-15, by Australian Bureau of Statistics
- National Health Survey 2017-18, by Australian Bureau of Statistics
- Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13, by Australian Bureau of Statistics
- National Aboriginal and Torres Strait Islander Health Survey 2018-19, by Australian Bureau of Statistics
- National Drug Household Survey 2010, by Australian Institute for Health and Welfare
- National Drug Household Survey 2014, by Australian Institute for Health and Welfare
- National Drug Household Survey 2019, by Australian Institute for Health and Welfare

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Introduction

This technical report is a companion and reference tool for the *Getting Australia's Health on Track 2021* policy paper.

The Mitchell Institute at Victoria University is a leading education and health policy think tank focussed on improving equity of opportunity and outcomes in health and education for individuals and communities in Australia through the translation of evidence to policy and practice. The Institute has a strong focus on addressing the impacts of socio-economic disadvantage on health and education opportunity and outcomes.

The health program at the Mitchell Institute explores health policy challenges, seeking to advance policy reform and to contribute to improved health outcomes. The health program is focussed on chronic disease prevention, which has been identified as the biggest problem facing Australia's health system.

The Australian Health Policy Collaboration (the Collaboration) is led by the Institute and brings together health organisations and chronic disease experts to translate rigorous research into good policy that will prevent and reduce the impact of chronic diseases on the population. The Collaboration (AHPC) was established in 2014 with the aim of informing and influencing health and other public policy to embed prevention into the health system and services and into other areas of public policy that directly contribute to or adversely affect good health. The work of the Collaboration since then and has provided leadership and consensus based policy evidence, information and guidance to a whole of population approach in policies, funding, institutional arrangements and service models to better prevent and manage chronic diseases in Australia.

The Collaboration established a Blueprint for Preventive Action (2014) with three strategic priorities:

- Driving health behaviours and healthy environments
- Creating accountability for action and monitoring progress
- Generating community support for action on prevention.

Creating accountability was identified as the first area for attention and the Collaboration worked through 2015 to establish health targets and indicators for preventable chronic diseases to influence policies, services and practice to target prevention and reduction of the health impacts of chronic conditions on the Australian population. The targets align with the 2025 global targets for prevention and reduction of chronic diseases set by the World Healh Organisation (WHO).

Building on this work, the Collaboration has contributed to the following influential publications:

- ***Targets and Indicators for Chronic Disease Prevention in Australia* 2015, 2019**
- ***Australia's Health Tracker* 2016, 2019**

- ***Australia's Health Tracker by Area***
- ***Getting Australia's Health on Track: Priority policy actions for a healthier Australia, 2016 and 2021***
    - **Heart Health: the first step to getting Australia's health on track, *2017***
    - ***Active Travel: Pathways to a healthy future*, *2018***
    - ***Better Data for Better Decisions*: the case for an Australian Health Survey, *2018***
- ***Australia's Health Tracker by Socio-Economic Status* *2016 and 2021***
- ***Australia's Oral Health Tracker***
- ***Australia's Mental and Physical Health Tracker***
- ***Australia's Gender Tracker***

Targets and Indicators for Chronic Disease Prevention in Australia and *Australia's Health Tracker* and other Health Tracker reports are designed to be updated periodically in response to national data collections such as the Census and the national health survey (1,2). These informed *Getting Australia's Health on Track 2016*, which presents a suite of 10 evidence-based priority policy proposals tailored to enabling improvements in population health that will meet the health targets set by the Collaboration experts. Following release of *Getting Australia's Health on Track 2016,* a series of policy implementation papers, *Heart Health 2017; Active Travel 2018 and Better Data for Better Decisions 2018* were developed with Collaboration experts to provide detailed information on effective implementation of the policy proposals.

Revision process 2021 edition

Following the updated 2019 Targets and Indicators for Chronic Disease Prevention and Australia's Health Tracker publications, *Getting Australia's Health on Track 2021* reviewed and updated the priority policy actions identified in the 2016 edition. The expert working groups considered the following options:

1. Affirm/strengthen 2016 priority policy actions;
2. Affirm/strengthen 2016 policy actions and identify an additional priority for policy action; or
3. Establish a new priority policy actions.

Seven expert working groups (EWGs) were established in early 2021 to review the 2016 Getting Australia's Health on Track report. These groups follow-on from the seven groups which developed the policy priorities in the first report and are: Premature mortality and morbidity, Alcohol, Physical Inactivity, Salt, Tobacco, Obesity, and Mental Health.

A few changes in the EWGs were applied in the second edition. In 2021, diabetes was moved from the Obesity working group to the Premature Mortality group. In the 2016 edition, reduction of salt was a priority policy action presented by the Premature Mortality group, in the new edition, priority policy actions on salt reduction were moved from the Premature Mortality group to a dedicated Salt EWG.

This edition of Getting Australia's Health on Track also is intended to inform and support implementation of the forthcoming National Preventive Health Strategy that is to be released during 2021.

Targets and indicators

The targets presented in the *Getting Australia's Health on Track 2021* and this technical report were identified by the AHPC in *Targets and Indicators for Chronic Disease Prevention in Australia* (2015 and updated in 2019). These reports adopted 2025 as the target year for most chronic disease prevention targets with 2010 as the baseline year, except where otherwise indicated. This approach is in line with the WHO Global Action Plans.

The targets are supported by indicators, also presented in T*argets and Indicators for Chronic Disease Prevention in Australia 2019*. In considering targets and indicators, the Australian Health Policy Collaboration and colleagues used Australian Institute of Health and Welfare criteria which state that chronic disease indicators must:

- be relevant;
- be applicable across population groups;
- be technically sound (valid, reliable, sensitive (to change over time) and robust);
- be feasible to collect and report;
- lead to action (at various population levels, for example, individual, community, organization/agency);
- be timely; and
- be marketable.

Table 1 presents the targets and indicators proposed for implementation for Australia to meet the accompanying 2025 targets.

Table 1 Targets and indicators proposed for implementation in Australia as presented in Targets and Indicators for Chronic Disease Prevention 2019.

Framework Element	Proposed Australian target	Proposed Australian indicators
Mortality and morbidity		
Premature mortality from noncommunicable disease	1. 25% reduction in the overall mortality from cardiovascular diseases, cancer, chronic respiratory diseases and diabetes	• **Unconditional probability of dying between ages of 30 and 70 years from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases** • Age-standardised rates of unplanned admission for patients aged between 30 and 70 years admitted to hospital with a primary diagnosis of cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases • Age-standardised rates of unplanned readmission for patients aged between 30 and 70 years admitted to hospital with an initial primary diagnosis of cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases
	a. 25% reduction in the overall mortality from cardiovascular diseases and diabetes	• **Unconditional probability of dying between ages of 30 and 70 from cardiovascular diseases** • Unconditional probability of dying between ages of 30 and 70 from diabetes Age-standardised average blood pressure among patients with chronic kidney disease, and percent of adults aged 18 years or more with elevated blood pressure (≥ 140/90 mmHg)
	b. 25% reduction in the overall mortality from chronic respiratory diseases c. Elimination of asthma deaths in adults aged under 65 years	• **Unconditional probability of dying between ages of 30 and 70 from chronic obstructive pulmonary disease** • **Unconditional probability of dying between ages of 30 and 70 from asthma** • Percent of patients aged 30-70 years who are readmitted within 28 days of discharge following a hospital admission related to asthma or COPD
	d. 25% reduction in the overall mortality from cancer	• **Unconditional probability of dying between ages of 30 and 70 from cancer** • One-year survival rates for individuals diagnosed with the following cancers (individual indicators): lung, breast, colorectal, cervix, melanoma and prostate
	e. Reduction in the	• The suicide rate as an age-standardised rate per 100,000 population

	national suicide rate by 10% by 2020[1]	
Behavioural risk factors		
Harmful use of alcohol	2. At least 20% relative reduction in the harmful use of alcohol, with regard to: • Long-term risky drinking	• Long-term risky drinking: Proportion of the population (aged 15+) reporting average alcohol consumption of more than two standard drinks per day over the past year.
Physical inactivity	3. A 10% relative reduction in prevalence of insufficient physical activity	• Prevalence of insufficiently physically active children and adolescents aged 5–17 years defined as less than 60 minutes of activity daily Prevalence of insufficiently physically active adults aged 18+ is based on a physical activity recommendation of 150 minutes from five or more sessions per week. (Updated guidelines have removed the sessions requirement and thus the baseline prevalence and WHO target will need to be updated according to estimates based on the new guidelines.)
Salt/sodium intake	4. A 30% relative reduction in mean population intake of salt/sodium	• Age-standardised mean population intake of sodium expressed as salt grams per day
Tobacco use	5. A 30% relative reduction in prevalence of current tobacco use in persons aged 14+ years	• Adults: Age-standardised prevalence of daily smokers aged 14 years and older from National Drug Strategy Household Survey (NDSHS)

[1] WHO set targets and indicators relevant to mental health in the *WHO Global Mental Health Action Plan 2013-2020,* which contains six global targets and indicators for achievement by 2020

Biological risk factors

Raised blood Pressure	6. A 25% relative reduction in the prevalence of raised blood pressure	• Age-standardised average blood pressure and percent of adults aged 18 years or more with elevated blood pressure (≥ 140/90 mmHg) (also group 1)
Diabetes and obesity	7. Halt the rise in obesity	• Age-standardised prevalence of normal weight, overweight and obesity class I, II, III in persons 18 years or older (also group 1) • Prevalence of normal weight, overweight and obesity in children and adolescents (also group 1) • Age-standardised proportion of total energy intake from discretionary foods in persons aged 18 years or older and in children (2–17 years) • Prevalence of breastfeeding and exclusive breastfeeding
	8. Halt the rise in diabetes	• Age-standardised incidence and prevalence of diabetes in persons 25–65yrs • Use of HbA1c ≥ 6.5% in addition to fasting blood glucose <7.0 mm/L or taking blood glucose lowering medications as a tool for the early diagnosis of type 2 diabetes

Mental ill-health

Mental ill-health	Improve employment rates of adults over 18 living with mental illness, and participation rates of young people with mental illness in education and employment, halving the employment and education gap by 2025	• Participation rates by people with mental illness of working age in employment: general population. Participation rates by young people aged 16-30 living with mental illness in education and employment: General population

Note: indicators in bold were regarded as core by the morbidity and mortality working group

Table key

The priority policy actions presented in this report are designed to meet the targets presented in Table 1. Each target area compares the most recent and relevant data with the baseline year to determine good, no/limited, or poor progress towards the targets. The three levels of progress are captured in the table key (Table 2).

The progress towards the Australian targets set for 2025 are illustrated by three options. In some instances, there is no comparable or updated data sources available in which case the keys are not included.

If the most recent data demonstrate an improvement from the baseline year this is shown as positive progress towards the target and presented in green except where otherwise indicated.

If the most recent data does not demonstrate an improvement from the baseline year, it is assessed as no or limited progress towards the set target and indicated by a yellow icon.

The red icon indicates poor progress towards the target.

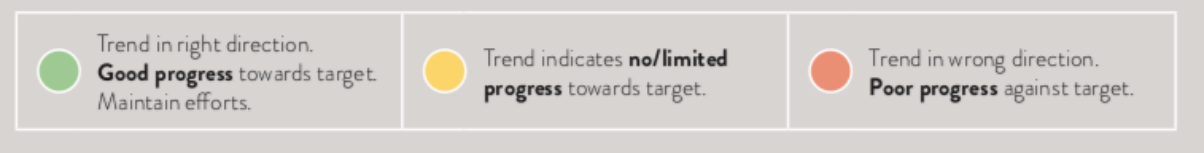

Table 2 The table key presents trends in the right direction (green), no/limited progress (yellow), and poor progress (red).

Aboriginal and Torres Strait Islander population data

In line with previous AHPC reports, this report draws from the most recent national health statistics for Aboriginal and Torres Strait Islander population groups. When comparing data from Indigenous and non-Indigenous Australians, differences in ages and survey questions must be considered.

Validation

The data included in the report card builds on the data presented in the *Australia's Health Tracker 2019* and are reviewed by expert working group members of the *Getting Australia's Health on Track 2021*. For Australia's Health Tracker 2019, PHIDU compiled the relevant data and undertook data analysis. The Mitchell Institute takes responsibility for the final publication, its content and data as reported.

Technical report format

This technical report follows the structure in *Getting Australia's Health on Track 2021* and provides the the health statistics presented in the policy paper.

Table 3 Overview priority policy actions presented in Getting Australia's on track *editions 2016 and 2021*.

Focus	Priority Policy Actions (PPAs)		Changes second edition
Healthier diets	**PPAs 2016**	Introduce a 20% health levy (**flat-rate valoric tax**) on sugar-sweetened beverages.	The Obesity EWG affirmed and strengthened the two 2016 PPA. The health levy is now advised in the form of tiered based on sugar content replacing the flat-rate valoric tax) and the marketing channels of unhealthy foods and drinks are extended to beyond TV advertisement. The Obesity EWG recommends a detailed implementation and evaluation plan of the National Obesity Strategy. The reduction of salt PPA is recommended by a dedicated Salt EWG. In the 2016 policy paper, salt was included in consideration of Heart Health by the Premature mortality group.
		Implement restrictions on exposure of children (under 16 years of age) to unhealthy food and drink marketing on free-to-air television up to 9pm.	
	PPAs 2021	Introduce a 20% health levy (**tiered based on sugar content**) on sugar-sweetened beverages.	
		Implement comprehensive and consistent national regulations to significantly reduce the exposure of children and young people under 18 years to the marketing of unhealthy food and beverages and related brands on television up until 9:30pm, on digital platforms at any time, in outdoor spaces, on product packaging and in relation to in-store marketing.	
		- National legislation is required to achieve effective and immediate reduction of sodium intake through mandatory large-scale reformulation of processed foods. - A national public health strategy is required to promote potassium as a sodium substitute in discretionary salt and in salt used by manufacturers in processed food. The strategy should address the needs of priority populations and be funded to evaluate population-wide impact of these measures.	
Reduce harm from alcohol	**PPAs 2016**	- Increase the current excise for all alcohol by 10%. - Apply consistent volumetric tax pricing – including wine, cider and other fruit-based alcohol products – at a rate for wine halfway between full-strength draught beer rate and the spirits rate, and for cider below 6% alcohol at the rate for draught beer, and for cider with 6% alcohol or above, at the rate for wine.	The 2016 PPAs focused on price changes to reduce harm caused by alcohol, in particular risky drinking. In 2021, the EWG members agreed on a more diverse set of PPAs including volumetric tax (reformulated 2016 PPA), restriction of late and concentrated supply and investment in evidence-based school-based alcohol prevention
	PPAs 2021	*Policy priority actions listed on priority* - Replace the Wine Equalisation Tax (WET) with a volumetric tax so it is consistent with taxation of other alcohol. - Restrict late supply and concentrated supply by preventing alcohol sales after 3am and providing local communities with more control over alcohol outlet density. Alcohol delivery should be restricted to between 10am and 10pm and should require a minimum of 2 hours between order and delivery.	

		- Invest in development and evaluation of evidence-based school-based alcohol prevention programs.	programs.
Reduce smoking	**PPAs 2016**	*Mass media campaigns* - Mass media campaigns should be funded to achieve a population reach and frequency proven to reduce smoking prevalence across Australia. - Some campaigns should be designed specifically to provide culturally relevant messages for aboriginal and Torres Strait Islander communities. - Funding for the campaigns could be supported from tobacco tax revenue (estimated at over $10 billion for the current year) – a move that attracts strong support from public opinion polls.	The 2021 EWG affirmed the 2016 PPAs and strengthened the dual focus on funding mass media campaigns that is inclusive and salient to priority populations (thereby going beyond the sole focus on Aboriginal and Torres Strait Islander peoples). The group agreed on two additional PPA's. 1) The group agreed that smoking cessation should be included in all usual routine health care. Removal of cigarette filters was considered by the group. Additives in cigarette filters have been shown to encourage uptake and continuation of smoking. On available evidence, an additional PPA therefore proposes the inclusion of public health information about the harmful impact of cigarette filters.
		Reduce health disparities - Increase funding for mass media campaigns to ensure they can effectively reach and influence people from disadvantaged groups. - Incorporating smoking cessation into routine care. - Ensuring smoke-free legislation is well implemented. - Where appropriate, incorporating smoking cessation targets in government funding agreements.	
	PPAs 2021	- Mass media smoking cessation campaigns should be funded and conducted to evidence-based levels under the National Tobacco Strategy to reach all Australians. They must be inclusive of and salient to priority populations. This is fundamental to ensuring Australia meets its national smoking prevalence target and prevents avoidable illness and premature deaths. - Smoking cessation treatment must be embedded in all routine healthcare with adequate resourcing, including funding support for evidence-based and tailored support services for priority populations. Smoking cessation policy and practice guidelines should be embedded in Hospital Quality Standards and PHN Commissioning Standards and guidelines. - Mass media campaigns should include public health information about the harmful impact of cigarette filters in support of the objectives of the plain packaging legislation to further reduce uptake of smoking and minimise misconceptions about the relative harms of different tobacco products.	

Increase physical activity	**PPAs 2016**	- Implement a framework for national physical activity and invest in the local implementation of active travel initiatives to and from school for all school-age groups. - This framework should include support for safe walking, scootering and cycling to and from school through current Road Safety and Black Spots programs.	The 2021 EWG retained the strong focus on the importance of developing and implementing a national physical activity plan. The national plan should include the implementation of active travel to school, and added in the second edition, it should include walking strategies for all aged and abilities and a voucher system to promote physical activity in low SES areas. An additional PPA proposes implementation of a national standardised surveillance system.
	PPAs 2021	- Develop and implement a national physical activity plan and invest in the following actions: - Local implementation of active travel initiatives to and from school for all school-age groups. - Local implementation of walking strategies (infrastructure and education) for all ages and abilities. - Use of existing infrastructure (e.g. Health Care Card Holders) to implement a voucher system to promote participation in sport and physical activity in children living in low socioeconomic areas - Implement a national standardised surveillance system for tracking physical activity behaviour across jurisdictions.	
Improve mental health	**PPAs 2016**	- Implement adequate and sustainable individual placement and support programs nationally for people with moderate and severe persistent mental illness. - Provide incentives to increase program fidelity to existing evidence and the eight key program principles - Address service and policy barriers that inhibit employment and constrain the implementation of supported vocational programs. - Invest in school completion programs for students with mental illness and build the evidence base to establish how to deliver effective supported education programs as pathway to employment.	The 2021 EWG affirmed and strengthened the 2016 PPAs that were focussed on individual placement and support for vocational programs. The EWG added an additional PPA to respond to poor physical health among people living with mental health conditions through

	PPAs 2021	- Include individualised physical checks as part of each mental health care plan, with appropriate referral to lifestyle interventions and smoking cessation programs to support the physical health needs of people with mental ill health. - Implement sustainable IPS programs nationally for people with moderate and severe persistent mental illness. - Invest in school completion/back into school programs through educational support programs for young people living with mental illness.	inclusion of individualised physical checks in all mental health care plans.
Reduce biomedical risk factors	**PPAs 2016**	*To reduce salt, the Healthy Food Partnership should:* - Adopt previous Food and Health Dialogue targets for selected product categories - Consult on the adoption of the UK 2017 salt content targets for the remaining food categories and agree on targets within a reasonable time frame. - Support independent monitoring of industry progress towards reaching these targets. - Ensure reports to highlight progress on salt reduction. - Promote product reformulation for salt reduction in the Quick Service Restaurants sector. *Heart health* - Implement targeted screening and treatment for absolute risk assessment of CVD for adults aged 45-74 years, and from 35 years for Aboriginal and Torres Strait Islanders, in line with guidelines. Strategies to increase engagement, particularly in disadvantaged communities, m be required (primary prevention). - Expand financial support and the use of care plans for optimal management of individuals at high risk of predictable CVD events, currently an estimated 970,000 (secondary prevention). - Invest in service infrastructure, including disease registers and care coordination, to support comprehensive and effective primary and secondary prevention.	The EWG affirmed and strengthened the 2016 recommended priority policy actions. The group highlighted immediate term policy priority actions that would lead to the greatest gain in reducing premature mortality rates, and identified long term strategies to reduce premature mortality and morbidity that are in train and others that will need to be given priority attention.

	PPAs 2021	- Implement a structured national screening and treatment program for absolute risk assessment of CVD for adults aged 45–74 years and from 35 years for Aboriginal and Torres Strait Islanders, in line with guidelines; with strategies to ensure 10% per annum increase in population engagement and coverage for all high risk groups; and with population based funding for primary care outreach and engagement support strategies targeting high risk populations. - Establish a national framework for effective implementation and achievement of population wide aCVR Assessment for high-risk individuals to reduce preventable poor health for these population groups. - Expand financial support and the use of care plans for optimal management of individuals at high risk of predictable CVD events, currently an estimated 970,000 (secondary prevention). - Invest in a national service infrastructure program including disease registers, decision support and care coordination, to support comprehensive and effective primary and secondary prevention	

Technical details policy briefs

To be inserted: table page 2 from report card when designed by Fenton.

- Almost 1 in 2 (47%) Australians have a chronic disease and 1 in 3 (38.5%) live with two or more chronic diseases (3).
- Cardiovascular disease, cancer and musculoskeletal conditions are the leading cause of illness, disability and death in Australia (4).
- One third of the burden of disease caused by chronic diseases throughout the population could be prevented by reducing modifiable risk factors such as tobacco use, overweight and obesity, dietary risk, and high blood pressure and diabetes (4).
- Only 1.34% of national health expenditure is dedicated to prevention (5).

Healthier diets

Health levy: Reduce sugary drinks consumption

The health levy priority policy action is accompanied by the latest statistics on overweight and obesity among adult Australians.

	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
Adults living with overweight or obesity	67%	61.1%	2007-08: 61.1% 2015-16: 63.4% 2017-18: 67%		74%

Adults living with overweight or obesity

Latest Australian data: Tthe 2017-18 National Health Survey reported that 67% of adults (people aged 18 and over) in Australia were overweight or obese (3).

Target: halt the rise in obesity.

Trend: Overweight and obesity rates are trending against the target. The baseline is set at an overweight/obesity prevalence rate of 61.1% based on the 2007-08 NHS (6). Rates of 63.4%were reported in 2015-16 and 67% in the 2017-18 NHS(3).

Latest indigenous data: The NATSIHS 2018-19, reported that 74% of Aboriginal and Torres Strait Islander Australians aged 18 and over were overweight or obese (7). This was an increase from 69% in 2012-13, as reported in the AARSIHS (8).

Protect children from unhealthy food marketing

The PPP recommending protection of children from unhealthy foods and drinks marketing is informed by overweight and obesity rates among children (aged 5-11) and young people (aged 12-17).

	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
Children (5-11) were living with overweight or obesity	26.2%	21.6%	21.6% in 2007-08 26.2% in 2017-18		37%^
Young people (12-17 years) living with overweight or obesity	23.2%	28.3%	28.3% in 2007-8 23.2% in 2017-18		

^Aged 2-14

Children

Latest Australian data: In the NHS 2017-18, 26.2% of children aged 5-11 were identified as overweight or obese (3) (PHIDU calculation).

Target: Halt the rise of obesity. The baseline of 21.6% from the NHS 2007-08 is the 2025 target (6).

Trend: Obesity rates are trending away from the target. Reported prevalence of overweight between 2007-08 and 2011-12 decreased with a lower rate of decrease reported from 2011-12 to 2017-18 (3).

Latest Indigenous data: According to the NATSIHS survey**, i**n 2018-19, 37% of the children aged 2-14 were overweight or obese (7), up from 30% in 2012-13 AATSIHS (8).

Young people

Latest Australian data: According to the NHS 2017-18, 23.2% of people aged 12-17 were living with overweight or obesity (3).

Target: Halt the rise of obesity. The baseline of 28.3% in 2007-08 is the 2025 target (2).

Trend: Prevalence rates appeared positive. However, the decrease of aggregated overweight and obesity rates is due to a drop in young people living with overweight while

there is little change in the obesity rates.(Ref required). The trend is therefore shown as amber.

Latest Indigenous data: According to the NATSIHS survey**,** in 2018-19, 37% of the children aged 2-14 were overweight or obese (7), up from 30% in 2012-13 as reported in the AATSIHS (8).

Reduce salt

The two priority policy actions were identified in light of the following latest data and target.

	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
Adults consuming too much salt	9.6g per day	5.7g per day	2012: 8.1g 2018: 9.6g	No comparable data available	Not available

Adults consuming too much salt

Latest Australian data: The latest data suggests a daily salt consumption of 9.6 g/day (9). The average Australian consumption is based on "31 published studies and one unpublished dataset that reported salt or sodium by Australian adults on the bases of 24-hour urine collections or dietary questionnaires" (9).

Target: A 30% reduction of salt consumption, based on the 2011 Victorian Health Monitor average of salt intake (8.1 g/day) (10), which translates to 5.7 g/day or 1 teaspoon per day. The average daily consumption was calculated from survey participants providing a urine sample, self-reported food frequency questionnaire and 24-hour dietary recalls. The 2011 monitor was the best available data at the time. The AHPC expert working groups agreed that the Victorian data should be used as a proxy for national data (2).

Trend: Although the trend cannot be assessed due to differences in methodologies, the higher reporting of daily salt consumption among Australian adults is nowhere close to the 2025 target.

Latest Indigenous data: not available.

Healthier living

Reduce harm from alcohol

The PPAs presented in the reduction of harm from alcohol section are informed by NDSHS data 2010-2019. For the purpose of this report and in line with *Getting Australia's Health on Track 2016*, the definition of life-time risky drinking as more than two standard drinks per day on average is used by AHPC. A new guideline component of a recommended ten standard drinks per week was added in 2020 (11).

	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATE AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
Risky drinking (more than 2 standard drinks per day on average)	16.8%	16.1%	2010: 20.1%, 2014: 18.2% 2019: 16.8%		20%

Risky drinking

Latest Australian data: The most recent NDSHS reports that in 2019, 16.8% of Australians aged 14 and over engaged in lifetime risky drinking by consuming more than two standard alcoholic drinks per day (11).

Target: The target agreed upon by the AHPC is 16.1% (2).

Trend: The previous NDSHS surveys (20.1% in 2010 (12), 18.2% in 2013 (13)) suggest positive progress towards the target in 2025. All surveys measure heavy drinking in Australians aged 14 years and over, with the exception of the 2010 survey which reported on people aged 12 years and over.

Latest Indigenous data: According to the 2018-19 NATSIHS 20% of people aged 18 and over consumed more than two standard drinks per day on average and thereby exceeded the lifetime risk guideline (7). This is the same as reported in the 2012-13 AATSIHS (8).

Reduce smoking

The PPAs are informed by the latest data on daily tobacco smoking prevalence among Australians aged 14 years and over and aged 15 and over for Aboriginal and Torres Strait Islanders.

	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
Daily smokers (aged 14 and over)	11%	5%	2013: 12.8% 2016: 12.2% 2019: 11%		40.2%^

^ Aged 15 years and over

Daily smoking

Latest Australian data: The 2019 National Drug Strategy Household Survey (NDSHS) (11) reported a daily smoking rate of 11%.

Target: The daily tobacco smoking target is 5% (2).

Trend: The latest data suggests positive progress towards the target. Previous NDSHSs reported a daily tobacco smoking prevalence of 12.8% in 2013 and 12.2% in 2016 (11).

Latest Indigenous data: According to the NATSIHS 2018-19 (7), 40.2% of Aboriginal and Torres Strait Islanders aged 15 and over reported smoking daily.

Increase physical activity

The physical activity policy recommendations are informed by National Health Survey physical inactivity data analysed by adults, young people and children.

	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
Physically inactive adults (18-64 years)	2017-18 44.6%	40%	2014-15: 44.5% 2017-18: 44.6%		2012-13: 62%
Physically inactive young people (12-17 years)	2011-12: 91.5%	82.6%	No new data since baseline	Inadequate to access trend	2012-13: 67%^
Physically inactive children (5-11 years)	2011-12: 70.8%	63.7%	No new data since baseline	Inadequate to access trend	2012-13 40.5%^^

^ 13-17 years
^^ 5-12 years

Physically inactive adults

As discussed in *Australia's Health Tracker 2019* (14), the 2017-18 National Health Survey changed the definition of physical activity from that used in earlier surveys. The results for adults reported in the 2017-18 survey are therefore not comparable to previous surveys.

Australia's Health Tracker 2019 (and this *Getting Australia's Health on Track edition 2021*) report against the benchmark of 150 minutes or more 'exercise only in the last week' (which is the only comparable question against three decades of the NHS) to measure trends over time and track Australia's progress against the 2025 target. This definition excludes some types of physical activity undertaken, and does not assess health-related walking, but in the opinion of the AHPC expert physical activity working group it is closest to the definition used in the 2011-12 survey (2). Therefore, due to this change in definition, we cannot measure trend but instead, will show progress towards the 2025 target.

Differences in measurement between the 2012-13 AATSIHS and 2018-19 NATSIHS should also be taken into account.

Latest Australian data: The 2017-18 NHS reported a physical inactivity rate of 44.6% among adults aged 18-64 years (3). Physical inactivity is defined as less than 150 minutes exercise per week (for details see 14).

Target: A 10% reduction in insufficient physical activity is based on the 2014-15 NHS data of 44.5% adults aged 18-64 years who engaged in less than 150 minutes of physical activity, is 40% prevalence of physical inactivity (14).

Since the AHPC's 2015 Targets and Indicators report, the physical inactivity target has been revised. The WHO has now set a 15% reduction in physical inactivity prevalence by 2030 (15). For consistency purposes, the *Getting Australia's Health on Track 2021* reports progress towards the 2025 target.

Trend: The data shows little progress towards the target. The NHS 2014-15 reports a physical inactivity rate of 44.5% (16), in 2017-18 the rate was up to 44.6% (3).

Latest Indigenous data: According to the 2012-13 AATSIHS, 38% of Indigenous adults 18-64 years living in non-remote areas met the physical activity guideline of at least 150 minutes od physical activity over five sessions in the 7 days prior to the interview (17). An estimated 62% did not meet those guidelines.

The 2018-19 NATSIHS reports on physical activity in people aged 18 years and over living in non-remote areas. Of Indigenous Australians living in non-remote areas aged 15 years and over, 89% did not meet the guidelines (with little difference between the age groups) (7). Please note: the 2014 physical activity guidelines applied to the NATSIHS 2018-19 survey and involve the following two guidelines below in the last week:

- accumulated at least 150 minutes of exercise over five sessions *and*
- did strength or toning activities on at least two days (18).

In the 2012-13 survey, the two guidelines were reported on separately as well as in combination. Then, 8.8% of Indigenous adults aged 18-64 met both guidelines and an estimated 91.2% did not.

Physically inactive young people

Latest Australian data: The most recent data on physical inactivity among young people (aged 12-17) is ten years old and reported in the AHS 2011-12 survey (19). The survey reported that 91.5% of young people did not meet physical activity guidelines. Data was not collected in the NHS 2014-15 or 2017-18 surveys.

Target: A 10% reduction in insufficient physical activity is based on the 2011-12 AHS data, which is 82.6% for young children.

Trend: There is insufficient data to assess the trend towards the target.

Latest Indigenous data: According to the 2012-13 AATSIHS, 33% of 13-17 years old living in non-remote areas did meet physical activity guidelines of 60 minutes or more physical activity per day in each of the three days prior to interview. That is, an estimated 67% did not (8,17).

The NATSIHS 2018-19 reported only on Indigenous Australians aged 15-17 years. That survey found that 4.8% were meeting the physical activity guidelines (that is, an estimated 95.2% were not).

Physically inactive children

Latest Australian data: In 2011-12, 70.8% of children aged 5-11 years were not meeting the physical activity guidelines of at least 60 minutes or more physical activity per day on each three days prior to \interview (19).

Target: A 10% reduction in insufficient physical activity is based on 2011-12 AHS data, making the target that 63.7% of children are insufficiently active by 2025. (14).

Trend: There is insufficient data to assess the trend towards the target.

Latest Indigenous data: The 2012-13 AATSIHS reported that 40.5% of 5-12 years old were not meeting physical activity guidelines of at least 60 minutes or more physical activity per day on each three days prior to interview (8).

Mental ill-health

People living with mental illnesses are over-represented in national unemployment and out of school statistics. In 2018, 62.9% of people aged 16-64 living with current and long-term mental and behavioural conditions were employed, compared to 80.5% of people without a mental health condition (3). This is despite people with mental illnesses expressing the desire and having capacity to undertake work (163). Education is a powerful intervention to stay connected or to reconnect and prepare for work, protecting individuals with mental ill-health against future unemployment (20). PPAs to increase engagement in education and employment are proposed.

An additional policy initiative to redress the poorer physical health of people living with mental illness proposes that physical health assessments be included as a component of all mental health care plans. Currently, there are no relevant Australian targets in relation to people living with long-term mental health conditions and physical health assessments or physical health checks.

	LATEST AUSTRALIAN DATA	2025 TARGET	2016 DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
Employment of people with mental illness (aged 16-64)	62.9%	70.5%	2011-12: 60.6% 2014-15: 61.4% 2017-18: 62.9%		Not available
Young people (16-30 years) with mental illness in education or employment	81.5%	84.5%	2011-12: 79% 2014-15: 78.4% 2017-18 81.5%		Not available

Employment of people with mental illness

Latest Australian data: The 2017-18 NHS estimated that 62.9% of people living with long-term mental and behavioral problems aged 16-64 were engaged in employment (3). Compared to 80.5% of people living without mental health conditions.

Target: Halve employment gap. In the baseline year, 2011-12, an estimated 60.6% people aged 16-64 living with long-term mental and behavioral problems were employed, compared

to 79.7% of their peers living without similar problems (21). Halving the gap means a target of 70.5% employed (22).

Trend: The data suggest little or no progress towards the 2025 target.

Latest Indigenous data: No data available.

Young people with mental illness in education or employment

Latest Australian data: The 2017-18 NHS survey reported that 79% of young people (16-30 years) living with mental health condition were involved in education or employment.

Target: The target for 2025 is to halve the participation gap, which is 84.5%. The NHS 2011-12 survey reported that 79% of 16-30 year-old living with current and long term mental and behavioral problems were involved in education or employment, compared to 90.2% of their peers not reporting those conditions.

Trend: The data shows positive progress towards the target.

Latest Indigenous data: No data available.

Reduce biomedical risk factors

Cardiovascular disease screening

Cardiovascular diseases are the largest contributors to premature deaths, that is, potentially avoidable deaths between the ages of 30 and 70, in Australia (4). Premature deaths from chronic diseases in Australia have been declining for several decades, making it likely that the target for reduction in these deaths in the national population, which has been endorsed for Australia by the AHPC, will be met. However, residents of the lowest socio-economic communities in Australia have mortality rates almost 50% higher than those in more affluent areas; premature mortality rates are higher for people living in rural and remote areas than for those living in major cities; and socioeconomic and geographic inequalities in premature mortality are widening (23).

Reduction of biomedical risk factors such as cardiovascular risks and high blood pressure through systematic screening, together with high rates of screening for common cancers particularly breast, bowel and cervical cancer, are essential to achieve further reduction in premature death rates, particularly among communities with lower socio-economic status and other priority population groups.

	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
Death rates from CVD, stroke, common cancers or chronic respiratory disease (30-70)	210 deaths per 100,000 in 2014-18	166 deaths per 100,000	2009-13: 221.5 2011-15: 208.2 2014-18: 210		No data available
Adults with high blood pressure (aged 18 years and over)	22.8%	16.1%	2011-12: 21.5% 2014-15: 23% 2017-18: 22.8%		31%^

^ aged 25 years and over

Premature mortality

Latest Australian data: The five leading underlying causes of premature mortality in Australia in 2018 were coronary heart disease, dementia (including Alzheimer's disease) cerebrovascular disease, lung cancer and chronic obstructive pulmonary disease (24). For the period 2014-2018, 210 deaths per 100,000 population from major chronic diseases

(CVD, stroke, common cancers or chronic respiratory disease) among people aged 30-70 were reported (PHIDU).

Premature mortality data was compiled by PHIDU and is based on the 2014 to 2018 Cause of Death Unit Record Files supplied by the Australian Coordinating Registry and the Victorian Department of Justice, on behalf of the Registries of Births, Deaths and Marriages and the National Coronial Information System.

2025 target: The AHPC agreed on a 25% reduction in premature deaths by 2025. In the baseline year of 2010, there were 221.5 premature deaths per 100,000 population, which translates to a target of 166 premature deaths per 100,000.

Trend: The latest data suggest limited progress towards the target.

Latest indigenous data: No data available.

High blood pressure

Latest Australian data: The 2017-18 NHS (3) reported a high blood pressure prevalence rate of 22.8% among adults aged 18 years and over. High blood pressure was defined as a systolic/diastolic pressure equal to or greater than 140/90 mmHg. The survey collected both measured blood pressure and self-reported blood pressure data.

2025 target: In the baseline year 2011-12, the AHS survey reported that 21.5% of Australian adults had high blood pressure (21). The 2014-15 and 2017-18 NHS estimated a high blood pressure prevalence rate of 23% and 22.8%.

Trend: The data suggest no progress towards the target.

Latest indigenous data: The 2018-19 NATSIHS (7) estimated that 31% of Aboriginal and Torres Strait Islander adults aged 25 years and over had high blood pressure (140/90 mmHg or higher). The survey collected both measured blood pressure and self-reported blood pressure data.

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