

2016

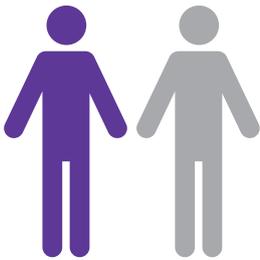
GETTING AUSTRALIA'S HEALTH ON TRACK

Priority policy actions for a healthier Australia

Getting Australia's Health on Track 2016 is the subsequent policy report to the chronic disease report card Australia's Health Tracker 2016. Both were compiled by a national collaboration of Australia's leading chronic disease experts.



AUSTRALIAN
HEALTH POLICY
COLLABORATION

 <p>1 in 2 Australians have a chronic disease.</p>	<p>Chronic diseases, like CARDIOVASCULAR DISEASE CANCER and DIABETES are the leading cause of illness, disability and death in Australia.</p> 	 <p>Almost ONE THIRD could be prevented by removing exposure to risk factors such as smoking, high body mass, alcohol use, physical inactivity and high blood pressure.</p>	<p>Despite the need...</p> <p>ONLY 1.5%</p> <p>of health spending is dedicated to prevention.</p>
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Measures for achievement by 2025 relevant to this policy report

 <p>Halt the rise in obesity</p>	 <p>Halt the rise in diabetes</p>	 <p>Reduce smoking to 5%</p>	 <p>10% reduction in physical inactivity</p>
 <p>20% reduction in harmful use of alcohol</p>	 <p>Halve the employment gap for people with mental illness</p>	 <p>30% reduction in average salt intake</p>	 <p>25% reduction in high blood pressure</p>

TABLE KEY

 <p>Trend in right direction. Good progress towards target. Maintain efforts.</p>	 <p>Trend indicates no/limited progress towards target.</p>	 <p>Trend in wrong direction. Poor progress against target.</p>
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ACKNOWLEDGEMENTS:

The Australian Health Policy Collaboration (AHPC) at Victoria University developed this report in collaboration with working group members and strategic advisory members (listed on p.27). Members committed their own time and expertise to this work, and came together to provide national leadership addressing the growing impact of chronic diseases. This work was led by Dr Rebecca Lindberg, Hazel Fetherston and Rosemary Calder of AHPC. Designed by Fenton Communications.

FOREWORD

Getting Australia's Health on Track outlines 10 priority policy actions for a healthier Australia by 2025.

A national collaboration of Australia's leading chronic disease experts and organisations has produced targets for 2025 for the prevention and reduction of chronic diseases in our population, in line with the global agenda set by the World Health Organization.

Getting Australia's Health on Track follows the recently published report card *Australia's Health Tracker*. The report card shows where progress has been made towards those targets for prevention of and reduction in cancers, mental illness, diabetes, cardiovascular disease and respiratory disease, as well as other chronic conditions. *Australia's Health Tracker* also shows where Australia is failing to adequately address chronic disease risk factors such as poor diet, physical inactivity, risky alcohol intake and smoking.

Getting Australia's Health on Track presents 10 priority policy actions that, together, will help get Australia on track to reach the 2025 targets and significantly reduce preventable illness and disability in the population. The priority policy actions have been developed by expert working groups of Australia's leading chronic disease scientists, researchers and clinicians. The actions complement existing national and state and territory policy measures aimed at reducing chronic disease incidence and prevalence.

Immediate implementation of the 10 actions – that are proven to be effective, and can be executed affordably – will build a systematic approach to reducing the national health, social and economic impact of chronic diseases.

Actions include support for taxation measures to reduce consumption of unhealthy products and investment in public interventions to improve the health of children and vulnerable population groups and people with specific health risks.

Without a systematic, whole-of-population strategy aimed at prevention and early risk management, the ongoing rise in chronic disease will harm more individuals and adversely impact on health expenditure and the broader economy.

Long-term systematic investment in improved road safety has drastically reduced the incidence of road trauma (as a proportion of population) experienced in Australia since the early 1970s. Had that not been achieved, Australia's health services would be overwhelmed by road injury and mortality, and the health budget would be dominated by the costs of premature mortality and long-term disability.

A similar systematic approach is needed to reduce the diseases that now affect one in every two Australians.

The priority policy actions, and this work more generally, were informed by the *Blueprint for Preventative Action* published by AHPC in 2015. The actions aim to facilitate healthier diets, further reduce smoking, increase physical activity, decrease harm from alcohol, improve mental health, intervene early to decrease biomedical risk factors and reduce the growing disparities in health status. Overall, they will improve the national capacity to prevent and reduce chronic diseases in our population.

The priority policy actions are:

- > implement a health levy on sugar-sweetened beverages;
- > protect children and young people from unhealthy food and beverage marketing;
- > enhance media campaigns to reduce smoking;
- > reduce health and mortality disparities in disadvantaged populations caused by smoking;
- > invest in active travel initiatives to and from school to kickstart a national physical activity plan;
- > consistently implement volumetric tax on all alcohol products and increase the current taxation rate;
- > scale up supported vocational programs across Australia for people with a mental illness;
- > reduce salt content in processed foods and meals to decrease the risks of high blood pressure;
- > scale up primary care capacity in primary and secondary prevention of cardiovascular risks; and
- > invest in comprehensive national measurement and monitoring of chronic diseases and their risk factors in the population over time.

Australians need a healthier future. We can, and we must, do better.

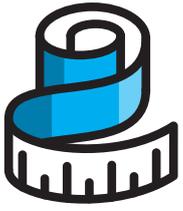
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TEN PRIORITY POLICY ACTIONS TO PREVENT AND REDUCE CHRONIC DISEASES IN AUSTRALIA

This complementary suite of priority policy actions will help get Australia on track to reach the 2025 targets and significantly reduce preventable illness and disability in the population. The priority policy actions were developed by Australia's leading chronic disease scientists, researchers and clinicians. Designed to tackle shared risk factors for chronic disease, these actions will drive change where it is needed most.





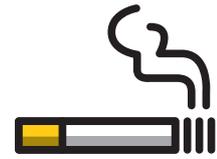
Monitor the health of all



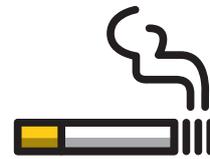
Health levy



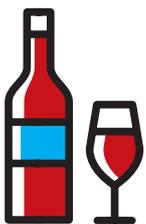
Restrict unhealthy food marketing



Mass media campaigns



Reduce health disparities



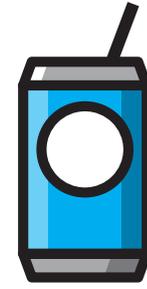
Responsible taxation



Active travel

A HEALTHIER AUSTRALIA BY 2025

HEALTHIER DIETS



HEALTH LEVY

Half of Australia's adults and more than 70% of children and young people are consuming too much sugar. In particular, teenage males consume an average of 23 teaspoons of sugar each day – equivalent to 2.5 cups of sugar per week.

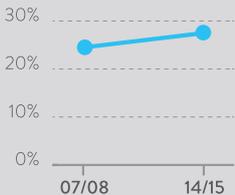
A 20% flat-rate tax as a health levy on sugar-sweetened beverages will reduce average sugar and calorie intake. It has been estimated that it will decrease the number of new type 2 diabetes cases by approximately 800 per year and reduce mean body mass index, particularly in younger age groups. In addition, it could generate \$400 million in tax revenue annually.

THE PROBLEM

Australia's Health Tracker reports that half of Australia's adults and more than 70% of children and young people are consuming too much sugar. *Australia's Health Tracker* also shows that 27.9% of adults are obese and 4.7% of 25–65-year-olds have diabetes. Australia is not on track to reach the 2025 targets for obesity and diabetes.

A high-sugar diet can increase the likelihood of becoming overweight or obese, developing type 2 diabetes and other chronic diseases. Diabetes is the fastest-growing chronic disease in Australia and increasingly younger people are being affected.

The estimated total annual cost of overweight and obesity in Australia is \$58.2 billion¹. The cost of healthcare attributed to diabetes is estimated to increase by 436% by 2033 – mostly attributed to the rise in spending for type 2 diabetes².

	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 Adults who are obese	27.9%	24.6%			41.7%
 Prevalence of diabetes in adults (25-65 years)	4.7%	4.1%			Not available

2025 TARGET

HALT

the rise in obesity
and new diabetes

Sugar-sweetened beverages – like soft drink, cordial and sports drinks – account for a substantial proportion of sugar intake in our diet. Although many factors and food choices influence health, research has consistently shown a significant association, and demonstrated a direct dose-response relationship, between sugary drink consumption and long-term weight gain and risk of type 2 diabetes³.

THE EVIDENCE

A health levy will save lives. A levy on sugar-sweetened beverages can be realised through a 20% increase in the cost of these beverages. A flat-rate (valoric) tax results in a percentage increase in price, as opposed to an excise (volumetric) tax that varies with the content of the product. A 20% flat-rate tax to increase the cost of carbonated soft drinks and flavoured mineral waters is estimated to reduce consumption by 12.6% and decrease obesity rates by 2.7% for men and 1.2% for women. Furthermore, there would be a sustained reduction in the incidence of chronic diseases over time, including the prevention of 16,000 cases of type 2 diabetes, 4,400 heart attacks and 1,100 strokes⁴.

Other nations are taking action. The governments of France, Mexico, South Africa, the United Kingdom, Ireland and others have implemented or committed to implement taxation strategies to lower consumption of sugary drinks.

A health levy is cost-effective. The savings to the health-care system from a 20% levy on carbonated soft drinks and flavoured mineral waters alone have been estimated at \$609 million over 25 years, stabilising at around \$29 million per year⁴. This levy would generate \$400 million annually which could be spent on health and nutrition education and information programs (similar to QUIT initiatives).

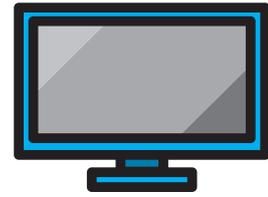
Public health organisations and leaders in Australia and internationally endorse this approach. A 2015 consumer survey found that 85% of people supported the application of revenue from a tax on sugary drinks to reduce childhood obesity, and 84% supported funding for initiatives to encourage children to play sport⁵. The success of this type of approach has been well demonstrated in tobacco control and reductions in smoking-related harm.

Action is within reach. A health levy could be implemented by amending Australia's existing tax framework. The attributes of well-designed tax policy include simple administration and compliance mechanisms and efficient, practicable and equitable application. A levy would be designed to ensure the consumer absorbed the tax at the retail stage. A levy will benefit the whole Australian population but will have the greatest benefit on those of lower socioeconomic status⁶.

PRIORITY POLICY ACTION

Introduce a 20% health levy (flat-rate valoric tax) on sugar-sweetened beverages.

HEALTHIER DIETS



PROTECTION FROM UNHEALTHY MARKETING

Many Australian children and adolescents exhibit risk factors for chronic diseases that manifest in adulthood, including the consumption of unhealthy foods. Healthy habits are formed in the early years; giving every person the opportunity to have a healthy childhood and adolescence is an investment in the future of the nation.

Restricting children and young people's exposure to television advertisements of unhealthy food and drink has been shown to significantly reduce the consumption of unhealthy products and hence reduce rates of obesity.

TV advertising restrictions have a wide reach, are cost-effective and are endorsed by the community and peak health organisations.

THE PROBLEM

Australia's Health Tracker reports that 25.6% of children and 29.5% of young people are overweight or obese, with even higher prevalence reported in Aboriginal and Torres Strait Islander communities. Over-consumption of discretionary or junk foods contributes to Australia's inability to halt the rise of diabetes and obesity.

Australia's Health Tracker also reports that junk foods contribute, on average, to approximately 40% of children and young people's daily energy needs. These foods and drinks tend to have low levels of essential nutrients and can take the place of other, more nutritious foods. They are associated with increased risk of obesity and chronic disease such as heart disease, stroke, type 2 diabetes, and some forms of cancer. Obesity during adolescence is a risk factor for chronic disease later in life and can seriously hinder children's and young people's physical and mental development.

	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 Children (5-11 years) who are overweight or obese	25.6%	21.6%			32.8% [^]
 Young people (12-17 years) who are overweight or obese	29.5%	28.3%			36.3% ^{^^}

[^] Aged 5-14 years, ^{^^} Aged 15-17 years

2025 TARGET

HALT

the rise in obesity
and new diabetes

The evidence consistently finds that children are particularly amenable to marketing and the greater the exposure to advertising, the greater the consumption of the advertised product. Australian children and young people are highly exposed to unhealthy products. TV advertising is the dominant form of food marketing to children, and an estimated 63% of the products promoted during children's popular viewing times are unhealthy products⁷.

The World Health Organization concluded that government-led regulation (rather than self-regulation) is the most appropriate method for managing the promotion of unhealthy products. This has been widely endorsed by Australia's leading medical and health organisations. However, in Australia a mix of statutory regulations and co-regulatory and self-regulatory codes has created a complex system which inhibits the protection of those aged under 18 from unhealthy product advertising.

THE EVIDENCE

Protecting children from unhealthy product advertising is gaining momentum across the globe. Ireland, Norway, the United Kingdom, Canada, France and the United States have employed policies to tackle 'junk food' advertising aimed at children.

Restricting TV advertising is cost-effective. The restriction of TV marketing of unhealthy food was the most cost-effective of 13 population interventions analysed in the ACE-Obesity project⁸. The modelling revealed low implementation cost, profound population reach for those aged 5–14 years and impressive health benefits (savings of 37,000 disability-adjusted life years (DALYs)).

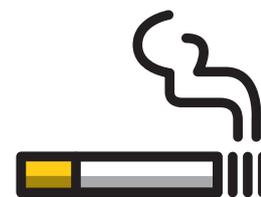
Australians want action to make children and young people healthier. The VicHealth Citizens Jury on Obesity concluded that banning unhealthy food/beverage advertising was necessary.

Independent and less complex regulation is required. Legislation will be required to implement restrictions on exposure of those under 16 years of age to unhealthy food and drink marketing on free-to-air television up to 9pm. In addition, a review and reformulation of broadcasting codes is recommended. Commonwealth-led regulation is appropriate for changes to television advertising in Australia and has been identified as the preferred policy environment to monitor and regulate advertising⁹.

PRIORITY POLICY ACTION

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.

REDUCE SMOKING



MASS MEDIA CAMPAIGNS

Approximately 15,000 Australians die each year as a result of tobacco use. The costs to the economy were estimated to be in excess of \$35 billion in 2008, and are likely to be higher in 2015.

Increased funding for mass media campaigns, as part of a comprehensive approach to tobacco control, has the potential to save tens of thousands of lives over the next decade.

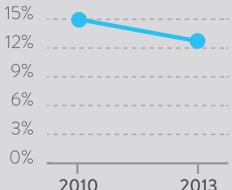
THE PROBLEM

Smoking is the leading cause of preventable death and disease in Australia; two out of three regular smokers are likely to die because of their smoking, and most smokers will require treatment for preventable diseases such as cancers, heart disease, stroke and respiratory conditions. *Australia's Health Tracker* reports 12.8% of people aged 14 and over smoked daily in 2013; the 2025 target is to reduce this to 5%.

The physical, financial and social tolls of smoking are considerable, and these tolls are heaviest on disadvantaged groups that have disproportionately high smoking rates, such as people with socioeconomic disadvantage, Aboriginal and Torres Strait Islander peoples, and people with mental illness.

Mass media campaigns that highlight the dangers of smoking are an essential element of any comprehensive tobacco control program. Mass media campaigns have been proven to reduce the number of young people who start smoking, increase the number of smokers attempting to quit, and motivate and support former smokers to remain tobacco-free. These components underpin reductions in smoking prevalence in youth and adults.

There is a well-established threshold of intensity that makes mass media campaigns highly effective in reducing prevalence. When the threshold has been reached, changes in the underlying components of smoking prevalence occur relatively quickly. However, when campaign intensity decreases, smoking prevalence reductions can reverse, particularly in youth from disadvantaged groups¹⁰.

	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 Daily smokers (aged 14 and over)	12.8%	5%			38.9%

2025 TARGET

5%

smoking prevalence
by 2025

At the national level, campaign funding over the years has been sporadic and insufficient to achieve the intensity required. There is considerable variability across Australia with respect to delivering this highly effective and proven strategy to prevent death and disease. Ensuring a consistent national approach to providing sufficient funding to reach the threshold should be addressed urgently.

THE EVIDENCE

Mass media campaigns are effective. Mass media messages have a direct influence on young people and adults. They can contribute to efforts to de-normalise smoking by influencing family and peer discussions about smoking and therefore social norms and attitudes towards smoking¹¹. Importantly, they complement and support the implementation of other tobacco control policies, such as tobacco tax increases, plain packaging and efforts to reduce smoking among disadvantaged groups. The evidence that public education campaigns are effective at reducing tobacco use is extensive and has been recognised in major reports, including those from the US Surgeon General.

Mass media campaigns are cost-effective. Large numbers of individuals can be reached by campaign messages. Numerous studies have demonstrated that returns on investment exceed the costs of the campaigns¹².

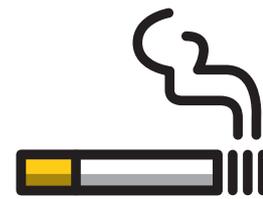
Achieving adequate campaign intensity is critical to success. Intensity is an important factor for all mass media campaigns, especially those that seek to influence smokers with socioeconomic disadvantage. There is evidence of a threshold effect for effectiveness: exposure to an average of at least 1,200 Target Audience Ratings Points (TARPs) per quarter is necessary to reduce smoking prevalence.

Although people may recall advertising for a long period after a media campaign ends, recent media exposure is required to achieve behaviour change. Campaigns that do not have adequate funding to achieve the TARPs threshold level are unlikely to reduce smoking prevalence to the required extent, and sporadic exposure to campaigns does not drive the continuing changes in behaviour required to reduce smoking prevalence¹¹.

PRIORITY POLICY ACTIONS

1.	Mass media campaigns should be funded to achieve a population reach and frequency proven to reduce smoking prevalence across Australia.
2.	Some campaigns should be designed specifically to provide culturally relevant messages for Aboriginal and Torres Strait Islander communities.
3.	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 in public opinion polls.

REDUCE SMOKING



REDUCE HEALTH DISPARITIES

The prevalence of smoking among highly disadvantaged groups remains disproportionately high. To reduce health disparities and reach the 2025 target, a particular focus on Aboriginal and Torres Strait Islander people and people with mental illness is needed.

THE PROBLEM

Smoking prevalence is disproportionately high among disadvantaged groups in Australia. *Australia's Health Tracker* reports daily smoking prevalence of 38.9% among Aboriginal and Torres Strait Islander people and 23.5% among people with mental illness. Prevalence can be even higher in some sub-groups – for example, an estimated 66% among people with psychosis and 84% among prisoners¹³.

Smoking is a major contributor to the life expectancy gaps for both Aboriginal and Torres Strait Islander people (10 years) and people with mental illness (more than 14 years). Smoking also compounds existing social inequalities and poverty by reducing funds available for essentials such as food and accommodation, and has been shown to increase the risk of intergenerational poverty. Reducing smoking among disadvantaged groups is not only healthy for individuals, but reduces health, social and financial inequities.

Proven strategies to deter adolescents from starting to smoke and to motivate and support smokers to quit – that also work for people from disadvantaged groups – include increases in tobacco price, mass media campaigns, smoke-free legislation and related policy initiatives such as plain packaging. Disadvantaged groups, however, are not receiving the full effect of this comprehensive approach.

	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 Daily smokers (aged 14 and over)	12.8%	5%			38.9%

2025 TARGET

5%

smoking prevalence
by 2025

THE EVIDENCE

There has been progress in reducing the equity gap for smoking. Smoking rates in Indigenous communities have declined in recent years¹⁴ although they remain disturbingly high. From 2005–2011, the prevalence of regular smoking in Victoria declined most rapidly among adults living in the most disadvantaged areas, reversing previous trends¹⁵. This decline coincided with a period of strong tobacco control activity (including substantial tax increases, well-funded mass media campaigns, and other policy initiatives).

Funding for evidence-based mass media campaigns that influence disadvantaged smokers has decreased across Australia in recent years. The high prevalence of smoking among disadvantaged families, social groups and communities acts to reinforce pro-smoking norms, and the mass media campaign levels required to change these norms are not being reached. Mass media campaigns motivate quit attempts and support those trying to quit or to stay quit, and deter children from initiating smoking. There is evidence to show that when campaign intensity drops below a certain level, smoking prevalence in disadvantaged communities increases¹⁰.

Smoke-free public places. Although smoke-free legislation is extensive in Australia, many disadvantaged groups do not have physical environments that support quit attempts and smoking cessation, either through failure to implement or to comply with smoke-free legislation in some health services, residential care settings and workplaces¹³.

Smokers from disadvantaged groups are less likely to access proven interventions. Behavioural support (e.g. Quitlines) and pharmacotherapies are underutilised, even when subsidised medication is available. These interventions have been shown to be effective for all disadvantaged groups, including people with severe mental illness and substance use disorders¹⁶.

The recently published draft Fifth National Mental Health Plan notes that building smoking cessation and supportive environments into routine care for people with mental illness would be consistent with the recommended emphasis on the physical health of people with mental illness in general. It is vital that this is seen as a high priority aspect of care for people with mental illness, with appropriate programs and reporting.

Approaches to address policies and practices that undermine smoke-free legislation, and promoting smoking cessation as routine care for all people accessing health or other services¹³, will further reduce smoking among disadvantaged groups and reduce the many inequities caused by tobacco use.

PRIORITY POLICY ACTIONS

Future efforts to accelerate reductions in smoking prevalence among disadvantaged groups in Australia should focus on implementation of proven population-based tobacco control approaches, including:

- | | |
|----|--|
| 1. | increasing funding for mass media campaigns to ensure they can effectively reach and influence people from disadvantaged groups. |
| 2. | incorporating smoking cessation into routine care. |
| 3. | ensuring smoke-free legislation is well implemented. |
| 4. | where appropriate, incorporating smoking cessation targets in government funding agreements. |

INCREASE PHYSICAL ACTIVITY



ACTIVE TRAVEL

Despite Australia's image as a sporting, outdoor and leisure-loving nation, almost three million children and young people are not doing enough physical activity.

Physical inactivity is a significant risk factor for chronic diseases such as mental illness, cardiovascular disease and cancer. Furthermore, the estimated total economic cost of physical inactivity in Australia is over \$800 million each year.

National initiatives that promote active travel to and from school are cost-efficient and provide opportunities for carers and the 3.7 million children in schools to get active every day.

Getting all children active is the first step towards a national physical activity strategy.

THE PROBLEM

Australia's Health Tracker reports that approximately 45% of adults, 71% of children and 92% of young people do not meet the recommended guidelines for physical activity in Australia. Australia would benefit from a national physical activity plan to promote and facilitate opportunities for physical activity for everyone, every day. The target is for a 10% reduction in the number of people who are not sufficiently active by 2025.

Whilst the federal government's recent \$100 million investment in the Sporting Schools initiative is welcome, Australian children are still missing out on crucial (and free) incidental exercise due to being among the most 'chauffeured' in the world: two-thirds of 5-6-year-olds and over half of 9-10-year-olds are driven to school every day¹⁷.

	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 Children (5-11 years) not meeting physical activity recommendations	70.8%	63.7%	No new data	Inadequate data to assess trend	40.5%
 Young people (12-17 years) not meeting physical activity recommendations	91.5%	82.6%	No new data	Inadequate data to assess trend	65.2%

2025 TARGET

10%

reduction in
insufficient physical
activity

Recent data suggest that 63% of children aged 5–10 years and 50% of 12–17 year-olds do not walk – and 91% of 12–17 year-olds do not cycle – to or from school, and levels of active transport are declining¹⁷. The evidence demonstrates the necessity of comprehensive school-based physical activity initiatives rather than unilateral interventions¹⁸.

Physical activity is associated with a reduction in cardiovascular risk factors such as high blood pressure, cholesterol, overweight and obesity, and improvement in psychological and cognitive indicators such as lower depression and better academic performance¹⁹. The estimated economic costs of physical inactivity in Australia are \$640 million in direct healthcare expenditure and \$165 million in lost productivity²⁰.

Physical activity contributes to the general good health and development of children, including fundamental motor skills such as hand and eye coordination. The development of these skills is often a prerequisite for participation in organised and non-organised physical activity throughout childhood and later in life²¹.

Leading public health organisations, including the World Health Organization, endorse active travel interventions within comprehensive active school schemes which typically include physical education, staff development and support, and community involvement.

THE EVIDENCE

Active travel to and from school is effective. School walking, scooter and cycling programs, provision of secure bike racks, collaboration with local council and business, dedicated support staff and the creation of safe routes all help to provide a setting that enables active travel²². The Brisbane School Travel Program resulted in a 24.8% decrease in car trips, 19.1% increase in walking and 3%

increase in cycling²³. In addition, parents reported an increase in their child's road safety awareness.

Safety matters. Danger posed by other road users is a major deterrent to children cycling to and from school¹⁷. Reorienting current funding and government mechanisms for Road Safety and Black Spots programs will support safe walking and cycling for children and young people, with flow-on benefits to other members of the community.

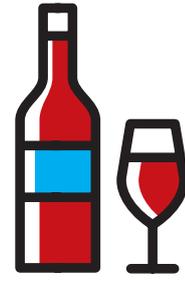
Australian parents want active children. The 2016 Australian Child Health Poll found 88% of parents supported compulsory daily physical activity in primary schools, ranking it as the top priority for child health interventions.

Active travel programs are cost-saving. The Australian active travel campaign, TravelSmart, has been recognised as a cost-effective intervention as part of a package of physical activity programs²⁴. An evaluation of the Western Australian TravelSmart workplace program found every \$1 spent returned \$4.50 in community benefit, with net annual benefits of \$2.4 million²⁵.

PRIORITY POLICY ACTIONS

1.	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.
2.	This framework should include support for safe walking, scootering and cycling to and from school through current Road Safety and Black Spots programs.

REDUCE HARM FROM ALCOHOL



RESPONSIBLE TAXATION

Approximately 5,500 deaths and 157,000 hospital admissions are attributed to alcohol consumption in Australia each year. Alcohol misuse has a heavy toll on the individuals and families it affects; the estimated economic cost to society of alcohol-related harms is over \$14 billion per annum.

Australia's alcohol taxation system should be consistent, coherent and based on harm reduction principles. Therefore, a 10% increase in the current excise for all alcohol is recommended, and volumetric excises should apply to wine, cider and other fruit-based alcohol products (which have previously been exempt from volumetric tax).

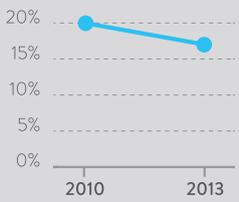
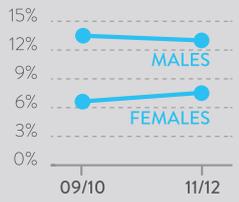
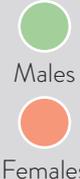
This is the most effective way of significantly reducing alcohol related harm.

THE PROBLEM

Australia's Health Tracker reports that recent trends in alcohol consumption indicate progress towards the target of a national 20% reduction in the harmful use of alcohol by the year 2025. However, whilst average consumption appears to be reducing, alcohol-related harm has remained stable or worsened.

Australia's Health Tracker reports that 18% of Australians, approximately four million people, still drink at risky levels. The proportion of young women presenting in emergency departments for alcohol-related injuries (7.5 per 1,000) is on the rise, and the proportion of young men – although improving slightly – remains too high (12.9 per 1,000).

Worldwide, approximately 8% of breast cancer and hypertensive deaths, 7% of ischaemic heart disease deaths, 11% of haemorrhagic stroke deaths and 22% of suicide deaths are attributable to alcohol consumption ²⁶.

	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 Drinking at risky levels (aged 14 and over)	18.2%	16.1%			22.7%
Emergency Department presentations (estimated alcohol injuries) per 1,000 young people (15-19 years)	Males 12.9 Females 7.5	Males 10 Females 5.4		 Males Females	Not available

2025 TARGET

20%

reduction in harmful use of alcohol

On our roads, in homes and at parties, the misuse of alcohol can have devastating social and health consequences: approximately 5,500 deaths and 157,000 hospital admissions are attributed to alcohol consumption ²⁷.

The economic costs to society of alcohol-related problems in 2010 were estimated to be \$14.4 billion. Of this, approximately \$3 billion related to the criminal justice system, \$1.7 billion to the health care system, \$6 billion to productivity and \$3.7 billion to traffic accidents ²⁸. These costs substantially exceed the tax revenue generated from the sale of alcohol.

THE EVIDENCE

Increasing the price of alcohol reduces harm and adverse health outcomes. Taxation which increases the price of alcohol is the most effective population prevention intervention to reduce adverse health outcomes associated with alcohol ²⁴. The impact of alcohol taxation is most strongly felt by heavy drinkers and hence can trigger behaviour change where it is most needed ²⁹.

Volumetric taxes are cost-effective. Modelling suggests the application of a volumetric tax to products currently susceptible to the wine equalisation tax – even at a conservative rate equal to the current tax rate applicable to low-strength beer sold offsite – could save the health system \$820 million over the lifetime of the population and increase taxation revenue by \$1.3 billion per year ³⁰. When combined with an overall 10% increase in the current excise, the benefits would be profound.

Consistent and coherent taxation is needed. The current policy allows for wine to be sold for less than \$0.30 per standard drink, so cask wine and other cheap wines and drinks have become the beverages of choice of the heaviest drinkers ³¹. The Henry Review and numerous health and

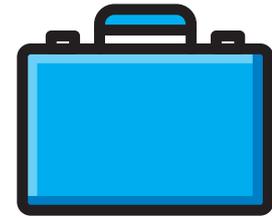
medical organisations' investigations of the Australian taxation system concluded that health and social harm have not been adequately considered.

Re-investing in prevention. Revenue generated by increased alcohol taxation can be used for a range of interventions aimed at supporting healthy behaviours and reducing risk factors for chronic disease across the life course, as well as alcohol treatment and rehabilitation programs. Increases in tax that are explicitly used to pay for health, education and treatment costs related to alcohol are supported by 43.8% of Australians ³².

PRIORITY POLICY ACTIONS

1.	Increase the current excise for all alcohol by 10%.
2.	Apply consistent volumetric tax pricing – including on wine, cider and other fruit-based alcohol products – at a rate for wine halfway between the 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.

IMPROVE MENTAL HEALTH



VOCATIONAL PROGRAMS

People with a mental illness are over-represented in national unemployment statistics. Unemployment and the associated financial duress exert a significant toll on the mental and physical health and wellbeing of Australians with a mental illness, and cost an estimated \$2.5 billion due to lost productivity each year.

Supported vocational programs have positive employment outcomes for people with moderate and severe persistent mental illness. Scaling up and better integrating these programs is an urgent priority.

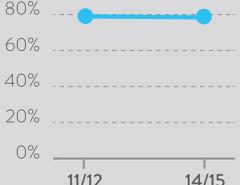
THE PROBLEM

Australia's Health Tracker reports 61% of working-aged people with current and long-term mental and behavioural problems were employed in 2014-15, compared to 79% of people without mental and behavioural problems. Recent

trends indicate limited progress towards the target of halving the employment gap by 2025. The gap is greatest for people with severe rather than mild or moderate mental illness.

Despite people with mental illness having the desire and capacity to undertake work, unemployment and financial distress have been reported as among their most significant challenges³³. Unemployment often leads to social security dependency, unstable housing, social exclusion and financial insecurity, and elevates the risk of suicide. On the other hand, employment increases a person's financial stability and is associated with reductions in outpatient psychiatric treatment and improved self-esteem³⁴.

The value of forgone production due to psychotic illness in Australia is estimated at \$2.62 billion per annum, overwhelmingly due to reduced employment among people with psychosis (\$2.5 billion). From a government perspective, \$1.49 billion is being forfeited in income tax and psychosis-related transfer payments such as the disability support pension³⁵.

	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 Employment of people with mental illness	61.4%	70.5%			Not available
 Young people (16-30 years) with mental illness in education or employment	78.4%	84.5%			Not available

2025 TARGET

HALVE

the employment
gap for people with
mental illness

In this report, vocational programs are identified as a priority policy action to complement suicide prevention and other vital policies and services that aim to improve mental health.

THE EVIDENCE

Supported vocational programs are highly effective.

Considerable evidence (including from randomised controlled trials) on individual placement and support programs has been generated over the past 20 years. Focused on rapid job placement in positions matched to individual preferences with ongoing job support, the goal is competitive mainstream employment for people with mental illness³⁶. One of the 8 key principles of the program, that is not often implemented in Australia, is that employment services are integrated with mental health treatment services.

Maintaining and not just gaining work. Studies show three main factors impact job tenure: interesting work and duties commensurate with experience; support from colleagues and supervisors; and work, recovery and wellness are integrated³⁷. Vocational services must ensure workplaces address these factors and performance measurements need to monitor tenure as well as job entry.

Supported vocational programs are cost-effective.

Analysis of data from European countries found individual placement and support programs were more cost-effective than standard vocational training interventions³⁸. In the UK for every £1 spent on programs, the Treasury received £1.04 as a result of increased tax and reduced benefit payments³⁹.

There are well-established service barriers to gaining and maintaining work.

Disability employment services are seriously underutilised and yet are the most appropriate services for people with mental illness⁴⁰. Financial disincentives, such as unintended interruptions to social security payments, are known barriers to entering work.

National Disability Insurance Scheme measurements do not currently recognise the impact of psychiatric disability on employment; specific measures need to be developed to enable the scheme to deliver on its intended outcomes³³.

Preparing young people with mental illness for work.

Interventions to actively improve educational outcomes for people living with moderate and severe persistent mental illness are underdeveloped. Supported education consists of programs and courses designed to provide pathways and supports for reengagement in education. Further research is needed to build evidence of effectiveness. Completion of high school is a strong indicator of likely employment in adulthood⁴⁰ and support for students with a mental illness is therefore vital throughout schooling.

PRIORITY POLICY ACTIONS

1.	Implement adequate and sustainable individual placement and support programs nationally for people with moderate and severe persistent mental illness.
2.	Provide incentives to increase program fidelity to existing evidence and the eight key program principles.
3.	Address service and policy barriers that inhibit employment and constrain the implementation of supported vocational programs.
4.	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.

REDUCE BIOMEDICAL RISK FACTORS



REDUCE SALT

More than four million Australians have high blood pressure – a major risk factor for cardiovascular disease (CVD).

Product reformulation to reduce salt can lower consumption across the entire population and trigger reductions in blood pressure and disease prevalence.

Reducing population salt intake by 30% by 2025 has the potential to save 3,500 lives a year through reductions in the incidences of heart disease, stroke and kidney disease. It is one of the most cost-effective population interventions available.

THE PROBLEM

Australia's Health Tracker reports 23% of Australian adults have high blood pressure, which is the most important modifiable risk factor for CVD. Excess consumption of salt substantially increases blood pressure. Average adult daily consumption in Australia is estimated to be 8.1 g – despite the currently recommended maximum of 5 g daily.

Cardiovascular disease is both the leading cause of death and the second-largest contributor to Australia's disease burden⁴¹. CVD remains the most expensive disease group in Australia, costing about \$7.47 billion in 2008–09⁴². Vascular dementia and kidney disease have also been linked with high blood pressure. Therefore, a diet high in salt is implicated in a range of adverse health outcomes.

Reducing population salt intake through food reformulation reduces the risk of CVD and other diseases. It lowers blood pressure at 1–2% of the cost of clinical hypertension programs, and a 30% reduction in population salt intake would save the Australian healthcare system an estimated \$200 million dollars⁴³.

	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 Adults consuming too much salt	8.1g	5.7g	No new data	Inadequate data to assess trend	Not available

2025 TARGET

30%

reduction in average salt intake

THE EVIDENCE

Food reformulation can reduce salt intake. Around 75% of the salt Australians eat comes from processed foods and pre-prepared meals. Therefore, reducing the average level of salt in the food supply can measurably reduce Australia's high salt intake. Population salt reduction is recommended by the World Health Organization as a 'best buy' for tackling non-communicable diseases; it is highly cost-effective, very cheap and highly feasible.

A government-led approach is effective for population health outcomes. In 2009, the Australian Government established the Food and Health Dialogue and worked with the food industry to voluntarily reduce salt levels in a selected range of processed foods. Consequently, the average sodium (a component of salt) content of bread, breakfast cereals and processed meats fell by 9%, 25% and 8% respectively⁴⁴, as well as in selected fast food products⁴⁵.

Food reformulation is cost-effective. Limiting the amount of salt permitted in both staple foods and highly processed foods which contribute significantly to average salt intake could reduce Australian health expenditure by \$4.8 billion. This would be the most cost-effective strategy for the primary prevention of CVD in Australia, saving more money than drug therapy or lifestyle programs targeting behaviour change⁴⁶. There are also indirect savings associated with economic productivity and reduced disability⁴⁷.

Actionable. The Healthy Food Partnership established in 2015 comprises government, industry and preventative health agencies and works on "strategies to educate consumers on consuming fresh produce and accelerate efforts to reformulate foods to make it healthier".

Consistent salt reduction targets in specific food categories provide a level playing field for industry action. The Healthy Food Partnership complements the Health Star Ratings system and facilitates government and industry collaboration on progressively reducing salt levels in a broad range of food categories.

PRIORITY POLICY ACTIONS

The Healthy Food Partnership should:	
1.	adopt previous Food and Health Dialogue targets for selected product categories;
2.	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;
3.	support independent monitoring of industry progress towards reaching these targets;
4.	ensure that the national Health Star Rating scheme has appropriate criteria for salt;
5.	publish reports to highlight progress on salt reduction; and
6.	promote product reformulation for salt reduction in the Quick Service Restaurants sector.

REDUCE BIOMEDICAL RISK FACTORS



HEART HEALTH

One Australian dies every 12 minutes from cardiovascular disease (CVD); it is a leading cause of death and disease burden in Australia. CVD is also the most expensive disease nationally, costing about \$7.5 billion each year, with more than half spent on patients admitted to hospital ⁴².

The evidence strongly supports a dual approach to effective reduction in risks for poor cardiovascular health and preventable premature mortality through:

- > **primary prevention:** targeted screening for absolute risk of CVD in the adult population; and
- > **secondary prevention:** treatment and management for individuals who have already had a relevant incident (eg. heart attack or stroke).

Implementing a dual approach to cardiovascular health will benefit tens of thousands of Australians each year.

THE PROBLEM

Australia's Health Tracker indicates good progress towards the national 2025 target to reduce premature mortality from chronic diseases such as cancer, CVD, diabetes and respiratory diseases. CVD shares several risk factors with other chronic diseases: it is common, increasingly prevalent and costly. Nevertheless, available infrastructure could be used efficiently to reduce CVD incidence, and we have good evidence about how to deliver effective prevention and management strategies.

Modifiable risk factors for CVD include blood pressure, cholesterol, smoking and physical activity. Considerable and rising numbers of Australian adults have high blood pressure (23%), high cholesterol (32.8%) and are overweight/obese (63.4%). Without a strong focus on these risk factors, progress towards the 2025 health targets for Australia is unlikely.

Adults living in the lowest socioeconomic areas in Australia are 2.2 times more likely to have coronary heart disease than adults living in the highest socioeconomic areas ⁴⁸. Migrants, people living in regional and remote communities, and Aboriginal and Torres Strait Islanders all have higher prevalences of CVD.

	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 High blood pressure	23%	16.1%			20.4%

2025 TARGET

25%

reduction in
high blood pressure

THE EVIDENCE

Most people at high risk of CVD do not know it.

Australian Bureau of Statistics data show that almost three-quarters of people with high blood pressure do not know they have it and only 10% of the one in three Australians that have high cholesterol are aware of it^{49, 50}. Absolute risk assessments identify these significant risk factors for CVD, together with other risk factors, and enable the introduction of medication, lifestyle change or both for the individuals at risk.

Many high-risk people are not receiving optimal care.

An estimated 970,000 Australians (13% of 45–74-year-olds) at high risk of a CVD event within the next five years are not receiving evidence-based optimal care⁵¹. These (often disadvantaged) individuals need to have care plans reviewed and to be managed medically. Practice nurse-led education and support is a critical resource.

Comprehensive CVD care requires investment in service infrastructure. Primary and secondary prevention for CVD is well supported by evidence and consistent with national clinical guidelines. Care coordination, quality improvement, disease registers, strategic funding and IT infrastructure to monitor performance data are required to deliver comprehensive care. Primary health care services are well placed to implement prevention. Primary Health Networks could support, monitor and provide incentives for improved performance.

Primary and secondary prevention for CVD will have benefits for health equity. Adequately funded primary care has been shown to improve coronary heart disease outcomes in low socioeconomic populations. Other interventions, such as community health workers, also show promising results in helping ensure disadvantaged communities at highest risk can access the necessary care.

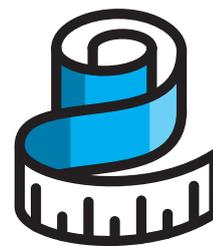
Primary and secondary prevention for CVD is cost-effective.

Significant cost-efficiencies and benefits for health (>100,000 DALYs prevented) could occur if absolute risk assessments, rather than individual risk factor thresholds, were performed nationally and if the most cost-effective generic drugs were prescribed²⁴.

PRIORITY POLICY ACTIONS

1.	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, may be required (primary prevention).
2.	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).
3.	Invest in service infrastructure, including disease registers and care coordination, to support comprehensive and effective primary and secondary prevention.

BETTER DATA FOR BETTER CHOICES



MONITOR THE HEALTH OF ALL

Accurate monitoring of chronic diseases and related risk factors requires a national commitment to regular and comprehensive collection of health data, including anthropometric, biomedical and environmental measures.

The 2011/12 Australian Health Survey (AHS) provided a baseline for more comprehensive health surveillance than has previously been available nationally, and routinely undertaking this survey at five-yearly intervals is a priority.

THE PROBLEM

The data systems needed to mitigate known health risks in the population, to plan for health needs for current and future generations, and to effectively fund and service chronic disease management and prevention are sub-standard in Australia.

The AHS collected information on physical activity and nutrition behaviours, anthropometric and biomedical measures of nutrition status and chronic disease risk in the general and Aboriginal and Torres Strait Islander populations. From 2014 the AHS reverted to its traditional form, that is, the three-yearly National Health Survey and National Aboriginal and Torres Strait Islander Health Survey. These surveys are largely based on less reliable self-reported information.

The AHS was the first survey since 1995 – almost a 20 year gap – to gather information about nutritional status. It also independently measured the prevalence of high cholesterol, a risk factor that is regularly under-reported when collected by other means.

There is very limited value in counting the number of public hospital beds or hospital performance against waiting time targets if there is no comprehensive monitoring of whether

we are achieving success in reducing the incidence of chronic disease.

Australia's obligation to report against the World Health Organization's Global Action Plan for the Prevention and Control of Non-Communicable Diseases 2013-2020 offers an important opportunity to commit to more comprehensive health surveillance.

THE EVIDENCE

Improved data collection about risk factors would assist in assessment of progress towards the 2025 targets and is vital to chronic disease prevention and reduction.

Collection of alcohol sales data, for example, is mandatory in Western Australia and the Northern Territory. National collection of this data would substantially improve surveillance and the capacity to assess effects of policy changes.

Further development of indicators, improved regular data collection and data linkage is also needed. For example, the collection and reporting of employment, education and health disparities experienced by people with a mental illness is vital. Another example is salt/sodium consumption, for which data collection could be improved through regular surveys using 24-hour urine collection samples.

The AHS contains the minimum consistent data needed over time. It is critical to planning and ensuring the adequacy of Australia's health services into the future.

PRIORITY POLICY ACTION

Establish the comprehensive Australian Health Survey involving biomedical, nutritional and physical activity measures, as a permanent, routine survey conducted every five years.

TEN PRIORITY POLICY ACTIONS FOR A HEALTHIER AUSTRALIA BY 2025



Implement a health levy on sugar-sweetened beverages.



Protect children and young people from unhealthy food and beverage marketing.



Enhance media campaigns to reduce smoking.



Reduce health and mortality disparities in disadvantaged populations caused by smoking.



Invest in active travel initiatives to and from school to kickstart a national physical activity plan.



Consistently implement volumetric tax on all alcohol products and increase the current taxation rate.



Scale up supported vocational programs across Australia for people with a mental illness.



Reduce salt content in processed foods and meals to decrease the risks of high blood pressure.



Scale up primary care capacity in primary and secondary prevention of cardiovascular risks.



Invest in comprehensive national measurement and monitoring of chronic diseases and their risk factors in the population over time.

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Working Group 4 – Salt: Chair – Dr Bruce Bolam, Executive Manager, WHO Collaborating Centre for Excellence in Health Promotion, VicHealth. Rapporteur – Dr Carley Grimes, Postdoctoral Research Fellow, Deakin University. Rapporteur – Ms Sonya Stanley, Principal Program Officer, VicHealth. Prof. Bruce Neal, Senior Director, The George Institute, University of Sydney; Prof. Caryl Nowson, Chair of Nutrition and Ageing, Centre for Physical Activity and Nutrition Research Deakin University; Dr Jacqui Webster, Centre Director, WHO Collaborating Centre for Population Salt Reduction, The George Institute for Global Health; Dr Sue Forest, Director of Cardiovascular Programs, National Heart Foundation of Australia; Mr Scott Stirling, Advocacy Manager National Stroke Foundation; Alexandra Jones, The George Institute for Global Health.

Working Group 5 – Tobacco: Chair – Prof Mike Daube AO, Professor of Health Policy, Curtin University. Rapporteur – Dr Michelle Gooley. Mr Todd Harper, CEO, Cancer Council Victoria; Dr Sarah White, Director, QUIT Victoria, Cancer Council Victoria; Ms Kate Purcell, Director, Purcell Consulting NSW.

Working group 6 – Obesity and diabetes: Chair – Prof. Stephen Colagiuri, Boden Institute, University of Sydney. Co-chair – Prof. Anna Peeters, School of Health & Social Development, Deakin University. Rapporteur – Dr Sharleen O'Reilly, NHMRC TRIP Fellow, Institute of Physical Activity and Nutrition, Deakin University. Prof. Boyd Swinburn, Alfred Deakin Professor, Deakin University and School of Population Health, University of Auckland; Prof. David Crawford, Institute for Physical Activity and Nutrition, Deakin University; Prof. Helena Teede, Monash Partners Academic Health Sciences Centre, Monash University; Ms Jane Martin, Executive Manager, Obesity Policy Coalition, Cancer Council Victoria; Dr Julie Brimblecombe, Nutrition Program Lead Menzies School of Health Research, Darwin; Prof. Louise Baur AM, Professor of Paediatrics & Child Health, Associate Dean and Head, The Children's Hospital at Westmead Clinical School, University of Sydney and The Children's Hospital, Westmead; Prof. Stephen Simpson AC, Director, Charles Perkins Institute, University of Sydney and Obesity Australia; Prof. Steve Allender, Co-Director WHO Collaborating Centre for Obesity Prevention, Deakin University; Prof. Timothy Gill, Research Programs Director, Boden Institute, University of Sydney.

Working group 7 – Mental Health: Chair – Dr Philip Batterham, Fellow in Mental Health Research, Centre for Mental Health Research, Australian National University. Prof. Carol Harvey, University of Melbourne, Director, Psychosocial Research Centre/ Northwestern Mental Health; Prof. Helen Herrman, Director Research, Orygen and Director, WHO Collaborating Centre for Mental Health; Prof. Jane Pirkis, Director, Centre for Mental Health, School of Population and Global Health, University of Melbourne; Prof. Philip Burgess, Professor of Mental Health Services Research, School of Public Health, University of Queensland; Dr Tim Coombs, Director of Nursing, Mental Health, Illawarra Shoalhaven Local Health District.



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