2021

SECOND EDITION

GETTING AUSTRALIA'S HEALTH ON TRACK

Priority policy actions for a healthier Australia

Getting Australia's Health on Track 2021 presents a suite of priority policy actions to support measurable improvements in the health of Australians by 2025.

This report updates and expands Getting Australia's Health on Track 2016. The policy recommendations have been agreed by a national collaboration of Australia's leading experts in chronic disease prevention, the Australian Health Policy Collaboration, as the initiatives Australia needs to reduce preventable chronic disease in our population.

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1 in 2
Australians have a chronic disease and

1 in 3
live with two or more chronic diseases[1].

CARDIOVASCULAR DISEASE
CANCER
and
MUSCULOSKELETAL CONDITIONS
are the leading causes of illness, disability and death in Australia

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, physical inactivity, and high blood pressure[2].

Despite this,
ONLY
1.34%
of national health expenditure is dedicated to prevention[3].

2025 targets relevant to this policy report

- Halt the rise in obesity
- 30% reduction in average salt intake
- 20% reduction in harmful use of alcohol
- Reduce smoking to 5%
- 10% reduction in physical inactivity
- Halve the employment gap for people with mental illness
- 25% reduction in high blood pressure
- Reduce premature mortality rate to 166 per 100,000 people

TABLE KEY

Trend in right direction. **Good progress** towards target. Maintain efforts.	Trend indicates **no/limited progress** towards target.	Trend in wrong direction. **Poor progress** against target.

ACKNOWLEDGEMENTS OF CONTRIBUTORS

The Australian Health Policy Collaboration (AHPC) is a national collaboration of chronic disease and population health experts and organisations that is supported by the Mitchell Institute for Education and Health Policy, Victoria University. AHPC collaborating organisations and individuals have contributed their time and expertise to this work and have worked together for more than six years to provide national consensus and leadership on how Australian policy-makers can best reduce the growing impact of chronic diseases on our society and economy. Contributing experts to this report are listed at page 24.

This report is designed by Fenton Communications.

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. The Traditional Custodians of lands throughout Australia on which the contributors to this report live and work are acknowledged and honoured.

SUGGESTED CITATION

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INTRODUCTION

The Australian Health Policy Collaboration (AHPC), led by the Mitchell Institute for Education and Health Policy, is a national collaboration of Australia's leading chronic disease experts and organisations that works together to drive progress in preventing and reducing chronic diseases in Australia. Over one third of the burden of chronic disease in the Australian population is considered to be preventable by reducing exposure to modifiable risk factors such as tobacco use, overweight and obesity, dietary risk and physical inactivity[2].

The AHPC has established targets for improvements in the health of our population that will reduce preventable disease and poor health. The targets include prevention and reduction in cancers, cardiovascular disease, diabetes and mental illness and in the contributing risk factors to these conditions particularly diet, physical activity, smoking and risky alcohol consumption. They align with the 2025 global targets for prevention and reduction of chronic diseases set by the World Health Organization (WHO).

Australia's Health Tracker 2019 reports on progress towards the AHPC targets and Chronic Diseases in Australia: Blueprint for Preventive Action published in 2015, sets out a consensus based framework of principles, strategic priorities and action areas for improved population health in Australia.

Getting Australia's Health on Track is a set of policy initiatives that are particularly relevant to governments, industry and to health, education and employment services and professions and that will be effective in helping Australia to improve the health of the nation. The recommendations include those in the 2016 policy proposals that have not been implemented through policy actions, or that require further work to achieve effective implementation and have real effect on the health of people in our population.

The Australian Government commitment to implementation of a National Preventive Health Strategy in 2021-22 is an initial step on a long-overdue path to action on health improvement and prevention at the federal level. Australia is lagging in its investment in preventive health when compared to like countries[3].

People in low socioeconomic communities have higher rates of illness and chronic disease[5], as well as higher risk of early deaths than those in higher socioeconomic communities and groups[4]. Inequalities in health by socioeconomic status are widening in Australia, with premature mortality rates up to twice as high among the most socioeconomically disadvantaged individuals and communities compared to the most advantaged population[4]. Strategies to reduce risk factors for poor health and preventable chronic disease need to reach, engage and be effective in supporting disadvantaged population groups and communities to have lower rates of preventable illness and disease[6,7].

The priority policy actions recommended in this report are focussed on healthier diets, healthier living and reducing biomedical risk factors.

The priority policy actions are to:

1.	introduce a 20% health levy on sugar-sweetened beverages;
2.	protect children and young people from unhealthy food and beverage marketing through comprehensive and consistent regulation;
3.	reduce salt content in processed foods and promote potassium as a sodium substitute;
4.	implement consistent volumetric tax on all alcohol products and increase the current taxation rate;
5.	restrict late supply and concentrated supply of alcohol by preventing alcohol sales after 3am and restrict alcohol delivery between 10am and 10pm;
6.	invest in development and evaluation of evidence-based school-based alcohol prevention programs;
7.	re-invest in mass media information and expand smoking cessation supports to maintain and further reduce smoking rates, particularly among priority population groups and communities with continuing high rates of smoking;
8.	implement a national physical activity plan, invest in active travel and walking infrastructure for all ages and abilities and enhance access for all through a voucher scheme;
9.	include physical health checks as core components of all mental health care plans;
10.	establish sustainable vocational individual placement and support programs nationally for people with moderate and severe persistent mental illness;
11.	establish systematic screening for biomedical risk factors.

Australia should have a healthy population. We can and must invest now and substantially to protect and improve the health of all.

PRIORITY POLICY ACTIONS TO PREVENT AND REDUCE CHRONIC DISEASE IN AUSTRALIA

This complementary suite of priority policy actions will get Australia on track to reach 2025 targets and significantly reduce preventable illness and health disabilities in the population. The priority policy actions complement and expand ten policy priority actions identified in *Getting Australia's Health on Track 2016*.

Regular measurement of population health risks and status and comprehensive use of available data for improved preventive health care together with a community-based approach within priority population communities in particular are essential, in addition to these measures, to achieve sustained change in the health of all Australians.

DATA AND MEASUREMENT

Data collection and progress measurement are essential foundations to the priority policy actions. One of the 2016 policy priorities called for accurate and regular monitoring of chronic diseases and related risk factors. Australia has a number of health related surveys but has lagged behind most other advanced countries in the health information it regularly collects and uses in health policy and planning. In 2018, the AHPC recommended investment in a second Australian Health Survey in the year 2021, and every six years thereafter[8]. The Intergenerational Health and Mental Health Survey (IHMHS), to be undertaken through 2021-2023, has been commissioned by the Australian Government Department of Health and expands on the Australian Health Survey 2011-2013 that provided, for the first time, a baseline for comprehensive health surveillance. The AHPC commends the investment in the IHMHS and urges that the ABS be resourced to conduct these surveys recurrently at six-year intervals.

The forthcoming National Obesity Strategy provides the opportunity for systematic and rigorous evaluation and impact measurement of the healthiness of food environments including at community level and particularly among priority population groups.

The strategy is a 10-year plan for action to reduce overweight and obesity and is to address five key areas through community and expert consultation: healthier food and drinks, price of food and drinks, reducing unhealthy food and drinks advertising, creating day-to-day settings that encourage healthy living, and creating infrastructure and urban design that promotes physically active lifestyles[9]. The AHPC urges the importance of a detailed implementation and evaluation of progress and outcomes of the National Obesity Strategy.

PLACE-BASED AND COMMUNITY DRIVEN

Place-based and community-led approaches have emerged as a means to address complex problems known to have multiple, interacting causes[9]. Community based approaches to health promotion have been shown to facilitate social and structural change[10], in particular among priority populations[11]. The National Preventive Health Strategy and state and territory strategies should provide for significant commitment to collaborative place-based approaches for communities with higher rates of risk factors for, and levels of, preventable chronic disease.

Getting Australia's Health on Track 2021 and the 2016 edition have been developed by expert working groups of Australia's leading chronic disease scientists, researchers and clinicians. The 2016 recommended policy actions still stand and with the 2021 suite of actions provide a comprehensive national approach that complements and strengthens national, state and territory existing policy measures aimed at reducing chronic diseases.

Areas for health improvement are the focus of these policy priorities: healthier diets; healthier living; and reducing biomedical health risk factors.

HEALTHIER DIETS

HEALTHIER LIVING

REDUCING BIOMEDICAL RISKS

HEALTHIER DIETS

Health levy: reduce sugary drinks consumption

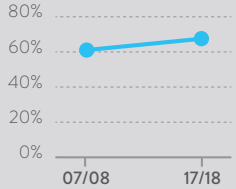
Excess consumption of 'free sugars'* contributes to health risks including overweight and obesity, type 2 diabetes, dental caries, metabolic syndrome, heart disease and cancer[12]. A large proportion of Australians across all population groups exceed the WHO recommended intake of 'free sugars', with sugar-sweetened beverages (SSBs) as the main contributor of total free sugar intake[13].

Internationally, tiered taxation on SSBs has been effective in reducing the sugar content of beverages and reducing consumer purchases of SSBs[14]. In 2018, an Australian poll found that the majority of all major-party voters support a sugar tax[15,16]. A 2015 consumer survey found that 85% of people supported the application of revenue from a tax on sugary drinks to fund efforts to reduce childhood obesity[17]. A tax on SSBs, tiered based on sugar content, is considered to be a feasible and effective strategy for reducing the consumption of SSBs and thus total free sugar intake and is long overdue in Australia.

THE PROBLEM

Unhealthy diets and excess body weight are leading contributors to poor health and the burden of disease in Australia[2]. Based on 2019-20 figures, the total annual economic burden (direct and indirect costs) of obesity and overweight is estimated at $14.9 billion, of which $8.6 billion is incurred in direct healthcare costs[16].

Consumption of SSBs has been shown to increase the risk of developing type 2 diabetes, CVD, dental caries, excess body weight and obesity-related diseases[18,19]. In 2017-18, 9.1% of adults (aged 18 and over) and 7.1% of children (12-17 years) consumed SSBs daily[20]. In the same period, three in five adults 19-30 years, two in three children, 4-8 years and seven in ten children, 9-18 years exceeded the recommended proportion of daily energy intake of 10% from free sugar[13]. The contribution of free sugar to total energy intake decreases slightly in older age groups, but remains high with ranges between 35% and 50%[13]. SSBs is the main contributor, in varying proportions, in all age groups.

	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
Adults living with overweight or obesity	67%	61.1%			71%

* *'Free sugars' are sugars added to foods by manufacturers or consumers, and those naturally present in honey, syrups and fruit juices, excluding 100% pure fruit juices.*

2025 TARGET

HALT

the rise in obesity

SSBs significantly contribute to total free sugar intake without adding nutritional value[12]. The high availability, affordability and promotion of SSBs contributes to Australia's 'obesogenic environment'[16].

THE EVIDENCE

International evidence supports taxation on SSBs to improve diets. Australian and international evidence shows that an increase in prices through taxation reduces sugary drink consumption[14,18]. Lower-income consumers, who tend to consume more sugary drinks than others in the population, are likely to benefit the most (in terms of health gain and healthcare savings) from sugar based taxation as they are more sensitive to price signals and more likely to reduce their consumption[12,21]. Increasing the price of sugar sweetened beverages through taxes is recommended by the World Bank and the WHO and in Australia by the Australian Medical Association as a priority component of a comprehensive approach to prevent and manage obesity rates and related chronic diseases[12,16].

A healthy levy is cost-effective. In the Australian context, modelling indicates that a 20% SSB tax can be expected to deliver an average decline of 20% in SSB purchases[22]. The annual government revenue is estimated at around $800 million[16], which could be spent on preventive health initiatives.

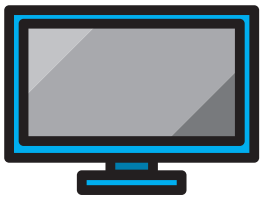
Tiered taxation is most effective. Since 2001, over 45 international jurisdictions have implemented taxes on SSBs in different tax forms[14]. A tiered taxation structure, with tax rates based on sugar content, is likely to have the most impact because it has been shown, internationally, to reduce consumer purchases whilst incentivising beverage manufacturers to reduce the sugar content of their products[14]. In the Australian context, the recommendation is for a tax rate of $0.40/100g sugar per unit of product, which will result in an increase in the SSB retail price of around 20%[16].

PRIORITY POLICY ACTION

Introduce a 20% health levy (tiered based on sugar content) on sugar-sweetened beverages.

HEALTHIER DIETS

Protect children from marketing of unhealthy food & drinks



Unhealthy diets are a major public health issue in Australia. Less than 7% of people in Australia consume a healthy diet (consistent with the Australian Dietary Guidelines)[23]. Discretionary food (for brevity this includes drinks) intake is highest in children and young people with up to 40% of children's and young people's energy intake coming from discretionary food[24]. These foods are not needed for health and are often high in added sugar, saturated fat and/or sodium.

Exposure of children and adolescents to marketing of unhealthy food has a harmful impact on their diets[25,26].

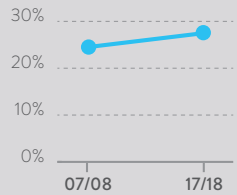
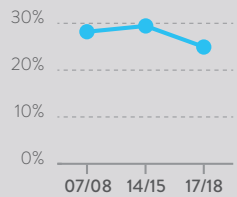
Comprehensive restrictions on the marketing of unhealthy foods have been shown to be a highly cost-effective strategy that improves children's diets. Restrictions on marketing of unhealthy foods and drinks are endorsed by community and peak health organisations and seven out of ten Australian adults want the government to protect children from unhealthy food and beverage marketing[27].

THE PROBLEM

Along with obesity, unhealthy diets are leading contributors to poor health in Australia and have a high cost to the economy[2]. Young people have the highest energy intake from discretionary foods at 40.7%[24], and consume 6 to 8 serves of discretionary food per day, well above the recommended 0 to 3 servings[13].

Persuasive marketing techniques influence children's food preferences from a young age and normalise unhealthy food consumption[28]. Substantial international evidence shows that exposure of children and young people to marketing of unhealthy foods and drinks (and associated brands) is harmful to their diets[29,30] and contributes to childhood obesity[31].

Children exposed to marketing of unhealthy food significantly increase their intake of unhealthy food during

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

^ Aged 2-14 years

2025 TARGET

HALT

the rise in obesity

or shortly after exposure to advertisements[32,33] and children and adolescents develop a longer-term preference for energy-dense, low-nutrient food after exposure to marketing of unhealthy food[33].

Children and adolescents are exposed to unhealthy food and drinks marketing in numerous settings. In Australia, an estimated 63% of the products promoted on free-to-air television to children and young people are unhealthy foods and drinks[34]. In children's peak viewing time, 5-8 year olds are exposed to 41 sec/hr of unhealthy food marketing compared to 19 sec/hr of healthy foods[35]. Eighty minutes of television watching per day exposes children to 827 unhealthy food advertisements every year[35]. Through social media, Australian children (13-17 years) are exposed to nearly 100 unhealthy food promotions per week[28]. Outdoor advertising including at train stations, on buses and bus shelters[36], sports sponsorship[37], product packaging [38] and in store marketing further exposes children to unhealthy food marketing[39].

Despite the evidence of adverse health outcomes from consumption of excess levels of discretionary foods, children and adolescents remain 'overbranded and under-protected' across settings[40].

THE EVIDENCE

Marketing restrictions on unhealthy food are successful. Protection of children and young people from exposure to unhealthy food marketing is gaining global momentum[41,42]. In 2016, Chile implemented comprehensive regulations to restrict marketing of unhealthy products to children under 14 years old[43] with promising results from a public health perspective[42,43]. In 2021, the UK government endorsed a policy to eliminate junk food marketing at any time of the day on digital platforms and up until 9pm on television[44]. In-store marketing restrictions trialled within twenty retail stores in remote Indigenous Australian communities reduced SSBs sales by 13.2%[39] with evidence of both public health and business gains.

Marketing restrictions are cost-effective. Modelling in Australia has demonstrated that regulations that restrict television advertising of unhealthy foods are likely to be cost-effective due to the large population reach and low intervention implementation costs[22] and have positive impacts on equity of health outcomes[22].

Independent and less complex regulation is required. Australia's mix of statutory regulations, co-regulatory and self-regulatory codes has created a complex system which has proven ineffective in protecting those aged under 18 from exposure to unhealthy food marketing. Nationally consistent, comprehensive regulation is required[45,46] and, given the wide scope of unhealthy food marketing platforms and settings, must be extended beyond television to include all marketing channels[28].

PRIORITY POLICY ACTION

Implement comprehensive 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.

HEALTHIER DIETS

Reduce salt

High salt intake is one of the main contributors to high blood pressure, which increases the risks of heart disease, chronic kidney disease and stroke[47].

Reduction of sodium (a component of salt) consumption is recognised as a cost-effective strategy for preventing chronic diseases[48]. Australian modelling has shown that a mandatory reduction program of salt intake of up to 1 gram per day (g/day) would lead to an estimated $154 million in reduced costs to health per year[48]. The reduction of costs includes yearly healthcare cost savings ($87.1m), workforce participation savings ($15.8m), absenteeism savings ($6.9m) and presenteeism savings (5.6m)[48].

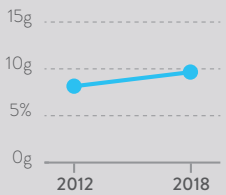
A combined strategy of mandatory food reformulation to reduce salt in processed food and a strategy to promote replacement of sodium by potassium in discretionary salt (used at table or during cooking) would promote healthy nutrition and reduce the risk of diet-related chronic diseases.

THE PROBLEM

Current average salt consumption in Australia is 9.6 g/day[49], much higher than the target recommended by AHPC experts of 5.7 g/day[50], or one teaspoon of salt.

The causal relationship between dietary salt intake and high blood pressure is well documented[47,51]. In 2017-18, one in five Australians aged 18 years and over reported high blood pressure[52] which is the leading modifiable risk factor for stroke and coronary heart disease In 2019, stroke and other cardiovascular diseases were the third leading cause of death in Australia[53].

Up to 75% of salt that Australians consume is added to processed foods including breads, cereals and condiments during the manufacturing process[48]. Current initiatives in Australia include voluntary industry reformulation, the national Healthy Food Partnership and Health Star Rating scheme. These have helped reduce salt in the food supply but salt levels in processed foods remain high. While reformulation policies are generally accepted and supported in Australia[54], progress towards their implementation is considered slow.

	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 Adults consuming too much salt	9.6g	**5.7g**		Inadequate data to assess trend	Not available

The use of discretionary salt in Australian homes is common. Discretionary salt intake among Australian adults is estimated at 16.9% of the total salt intake, which is similar to Austria, Canada, Denmark, New Zealand and United Kingdom[55]. The use of salt at home starts young. Among Australian children (5-13 years), two-thirds of parents reported added salt during cooking and half of the children reported adding salt at the table[56].

THE EVIDENCE

Food reformulation improves nutrient composition. Food reformulation is a promising strategy to tackle poor nutrition[57]. Food reformulation aims to improve nutrient composition of food while minimising changes in other product characteristics such as taste, convenience or affordability[58]. Reformulation can be implemented incrementally[58]. Supermarket chain Coles recently significantly reduced added salt to over forty of its bakery products[59].

Mandatory reformulation programs are most effective. Modelling estimates show that mandatory reformulation is twice as cost-effective and prevents twice as much of the burden of disease compared to voluntary programs[48]. Mandatory programs also lead to the highest decrease in salt consumption[58] with a reduction of up to 1.45g/day, compared to voluntary reformulation (-0.8g/day), school interventions (-0.7g/day) and short term dietary advice (-0.6g/day)[60]. An Australian study provided modelled estimates that a population wide reduction of one gram of salt per day would result in 2,526 fewer heart attacks and 2,626 fewer strokes each year[48]. The study estimated that, for each dollar invested in a voluntary program, $5.70 is returned to society, leading to an estimated $120 million in savings annually. In the mandatory program, in which manufacturers of processed foods comply with maximum salt targets, for each dollar invested, the return on investment is $10 and an estimated $154 million would be saved per year[48]. The savings in both scenarios include healthcare costs, productivity costs, and costs to informal carers.

Mandatory food reformulation programs have been successful in other countries. Reformulation programs in salt have been successful in other countries[61]. A United Kingdom based study identified key components of successful reformulation policies to be: strong incentives, tight implementation strategy, a focus on overall nutritional quality, and effective monitoring and evaluation[58].

Replacing sodium with potassium chloride reduces high blood pressure. Potassium chloride is a common mineral replacement of sodium chloride in salt and can replace sodium in discretionary salt and manufactured food. The population-wide replacement of sodium with potassium-enriched substitutes (which are low in sodium) has the potential to reduce blood pressure[62,63] while keeping potassium intake within the recommended range for the healthy population[64,65].

Replacing sodium with potassium chloride is an effective public health strategy. While the economic return on investment is yet to be modelled, the growing base of empirical evidence shows that the replacement of sodium with potassium in salt lowers high blood pressure[66]. The evidence indicates the promotion of potassium as a sodium substitute (in regular salt and in salt used by manufacturers in processed food) has potential as a large-scale public health strategy in Australia and that this should be accompanied by efforts to safeguard at risk populations and to invest in empirical research to assess the population-wide impact[66].

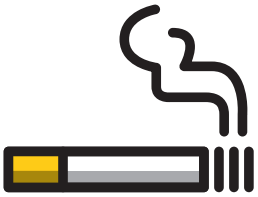
Multi-level policy strategies are effective. While the biggest population-wide reductions in salt consumption can be achieved through 'upstream' interventions such as mandatory food reformulation and sodium replacements for salt, comprehensive multi-level strategies, including downstream community level interventions such as dietary counselling, targeted media campaigns[60], have broader impact. Community based approaches to health promotion and healthy eating have been shown to facilitate social and structural change[10].

PRIORITY POLICY ACTIONS

1.	**National legislation is required to achieve effective and immediate reduction of sodium intake through mandatory large-scale reformulation of processed foods.**
2.	**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 at risk populations and be funded to evaluate population-wide impact of these measures.**

HEALTHIER LIVING

Maintain and further reduce smoking rates



A comprehensive suite of national policy initiatives has driven a significant reduction in tobacco smoking in Australia over the past several decades, with another significant decrease between 2016 (12.2%) and 2019 (11%)[67]. However, smoking continues to be the leading risk factor for preventable disease and death in Australia[2]. In 2015-16, the total costs of tobacco in Australia were estimated at $136.9 billion[68].

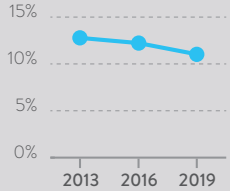
Smoking rates among priority population groups remain well above the national average[69–71]. The evidence of health risks associated with smoking is compelling[72,73]. Investment in national and inclusive mass media campaigns, including a focus on the harmful effects of cigarette filters, and cessation support in routine care are proposed as priority policy actions to reduce population wide smoking rates with a focus on priority populations.

THE PROBLEM

In 2015, daily tobacco use was responsible for 9.3% of the total burden of disease and injury and contributed to 13% of deaths in Australia (equivalent to 20,933 deaths)[2].

The social and economic burden of tobacco use is also costly. Tangible costs, such as reduced economic productivity, healthcare costs and cost of informal care by family and friends were estimated to be $19.2 billion in 2015-16[68]. Intangible costs, such as value of life lost, pain and suffering from premature mortality and lost quality of life, were estimated to be much higher in the same year at $117.7 billion[68].

Tobacco smoking rates are particularly high ranging from 25% to over 90% in priority populations[69], including Aboriginal and Torres Strait Islander peoples[70], people living with mental illnesses[74] and those living in institutional settings, such as prisons[71]. Individuals in these high smoking prevalence groups generally experience one or more forms of discrimination and life circumstances that are

	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
Daily smokers (aged 14 and over)	11%	5%			40.2%^

^ Adults aged 15 and over

associated with increased tobacco use. The combination of disadvantages is often referred to as intersectionality and is known to increase initiation of smoking and to make quitting more challenging[75]. Despite higher smoking rates, priority populations commonly report keen interest and motivation in quitting smoking[69,76] but have some of the lowest cessation rates suggesting that there is significant opportunity for change[77,78].

Mass media campaigns have been one of the tools contributing to decreased smoking rates and have been shown to be cost-effective[69]. However for nearly 10 years, the national expenditure on anti-smoking television campaigns has been inadequate to achieve the levels of campaign reach and frequency required to reduce smoking prevalence[79].

Few people receive advice and assistance to quit and even fewer people use effective tobacco-dependence treatment[80]. For example, in Victoria, only 11% of smokers and recent quitters have been advised by their GP to call Quitline, 8% received a prescription for pharmacotherapy and 5.7% were provided with a combination of behavioral intervention and pharmacotherapy[81].

Success in reducing uptake of smoking by young people and adults is being threatened by e-cigarette use; with the highest rates of e-cigarette use in Australia in young adults (18-24 years) and adolescents (14-17 years)[82]. Reports indicate that e-cigarette use increases the risk of smoking uptake by threefold in non-smokers[72].

Over the decades, the design and engineering of cigarettes including features such as filters and the ingredients used in manufacturing combine to make cigarettes more attractive and addictive to smokers[83]. Research has shown that filters are a major environmental harm[84] and contribute to higher risks of lung cancer as smokers inhale more deeply, causing harm through pulling harmful chemicals more deeply into lung tissue[83,85].

Australian research shows that approximately one in two smokers believes filters reduce harm and improve palatability[86].

THE EVIDENCE

Mass media campaigns are effective for reaching national smoking prevalence targets. Mass media campaigns are a powerful way to keep shaping and building non-smoking social norms and support for tobacco control measures across Australia[69]. Campaigns discourage uptake, promote cessation, and help former smokers to resist relaps[87]. Mass media campaigns are cost-effective as they reach a wide audience, and can be designed to ensure they are inclusive of and effectively engage priority populations[69,88].

Smoking cessation in routine healthcare is effective. Brief advice, provided through health care interactions, to promote cessation and facilitate use of tobacco-dependence treatment (behavioural intervention, provided by Quitlines in Australia, and pharmacotherapy) has been shown to be an effective population-level approach to increasing cessation[89,90]. Investment in Quitlines has also been shown to be cost-effective given the low cost of the intervention and the significant economic gains from increased smoking cessation[91]. The highly successful Tackling Indigenous Smoking program has engaged Aboriginal and Torres Strait Islander people who smoke with Aboriginal community-controlled health organisations and Aboriginal Quitline and encourages the use of pharmacotherapy and behavioural intervention, as part of a population health approach[92].

Routine healthcare has the potential to reduce inequalities. The Federal Government has announced that a Medicare Item Number for cessation treatment in primary care will be introduced[93]. Priority population groups are in frequent contact with primary care services and are likely to benefit from additional encouragement and support to quit[94].

Embedding smoking cessation care as routine treatment with capacity to adapt the intensity of health intervention to levels of need and/or disadvantage could improve smoking cessation among priority population groups[94].

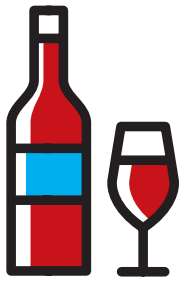
Social prescribing supports behavior change. Social prescribing enables referral to funded non-clinical support services that can address the social determinants of health. It has been shown to be effective in promoting and support behavioural change for improved health, particularly among disadvantaged communities and populations[95]. Social prescribing funding arrangements through primary care, tailored to the needs and circumstances of priority populations, could provide for access to individualised smoking cessation support[96].

Mass media campaigns inform people on the harmful effects of filters. Australian research has argued that the enhanced product appeal through filters in cigarettes undermines plain packaging legislation, aimed to reduce appeal to youth and 'minimise misconceptions about the relative harms of different tobacco products[86]. Building on the proven success of mass media campaigns in informing the public about harmful effects of tobacco smoking[88], the campaigns are suggested to include public health warnings on the harmful effects of cigarette filters.

PRIORITY POLICY ACTIONS

1.	**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 effectively engage priority populations. This is fundamental to ensuring Australia meets its national smoking prevalence target and prevents avoidable illness and premature deaths.**
2.	**Smoking cessation treatment must be embedded in all routine healthcare with adequate resourcing, including funding 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.**
3.	**Mass media campaigns should include public health information about the harmful impact of cigarette filters, in order to support the objectives of plaing packagin legislation and to further reduce uptake of smoking and minimise misconceptions about the relative harms of different tobacco products.**

Responsible alcohol taxation, restricted supply and school-based prevention programs



Australia's Health Tracker 2019 reports positive progress towards the target of 20% reduction in risky drinking by 2025[97] and the Australian Institute for Health and Welfare reports more Australians are giving up alcohol and more Australians are taking action to reduce their drinking[22]. However, harmful use of alcohol continues to cause health related harm and is the leading contributing burden of disease in the ages 15-44[2].

Social costs of alcohol related problems are high and include both health care related costs and other costs (such as traffic accidents and criminal justice costs)[98].

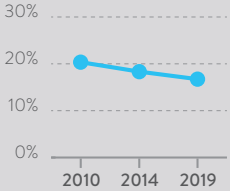
Australia's alcohol policies should be focused on the most effective way to significantly reduce alcohol related harm. Differentiated volumetric tax has been shown to reduce harmful drinking. Established strategies known to reduce harmful drinking are restrictions on late hours supply and concentration of supply outlets and school-based education.

THE PROBLEM

Globally, alcohol consumption is ranked as the sixth leading risk factor for death and disability[2]. In 2015, alcohol use was estimated to be responsible for 40% of liver cancer and 28% of the chronic liver disease burden in Australia[2]. In 2019, 16.8% of Australians aged 15 years and over exceeded the lifetime risk guidelines (two standard drinks per day on average. A new guideline component recommending no more than ten standard drinks per week was added in 2020)[99].

The annual social cost to society of alcohol related problems have been estimated to be at least $7.1b[98]. Estimates of annual health care costs attributable to alcohol range from $1.9b to $2.6b. Additional costs from traffic accidents (estimated to cost at least $2.9b annually) and the criminal justice system (at least $1.2b annually) outweigh the healthcare costs[98].

These include health care costs ($1.9b to $2.6b) and additional costs from alcohol-related traffic accidents (estimated to cost at least $2.9b) and criminal justice system costs (estimated to cost at least $1.2b).

	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
Risky drinking (more than 2 standard drinks per day on average)	16.8%	16.1%			20%

In Australia, wine and cider are currently taxed under the wine equalisation tax (WET) and is based on price not alcohol content, encouraging the production and sale of cheap wine, which incurs less tax. In contrast, other alcohol is taxed on the basis of alcohol content, which removes this incentive[101].

In Australia over the past 40 years, there has been a trend towards increasing number of outlets selling alcohol and to minimal or no restrictions on trading hours[102]. Late-night supply of alcohol has been linked to assaults and violence in public[114]. More recently, the expansion of the home delivery alcohol market further raises public health concerns, with initial evidence suggesting fast delivery services in particular are linked with heavy drinking[103,104]. Recently, public opinion about late and concentrated supply has changed and Australian governments have started to respond with stronger alcohol licensing controls[102].

Harmful use of alcohol is the leading contributing burden of disease among young people[2]. Educational settings are ideal for the delivery of prevention programs to young people[105]. Schools have the potential to deliver universal prevention programs that are aimed at all students regardless of their level of risk for alcohol misuse and, through their large scale for delivery, have 'the potential to reduce substance use and harm in a greater audience'[106]. While Australian school-based programs for prevention of harmful use of alcohol are available and have proven effective in reducing harm caused by alcohol, the uptake and development of evidence based programs is lacking[107].

THE EVIDENCE

Price increase through taxation reduces overall alcohol consumption. Strong evidence shows that increases to the price of alcohol reduce consumption and related morbidity and mortality[108,109]. Increasing the price of the cheapest alcohol is likely to have the most significant effect, as it is disproportionately consumed by the 40% of consumers with the highest consumption rates[110,111]. An international review found that price increase through taxation was the strategy with the most consistent evidence for large meaningful impact[105]. Modelling work has shown repeatedly that a differentiated volumetric tax applied to all alcohol would result in health gains, including through restrictions in alcohol-related harm and rates of overweight and obesity[112,113,179]. Replacing the WET applied to wine and cider by a differentiated volumetric tax is among the most cost-effective options available to government to reduce alcohol-related harm[112].

Restricted availability can reduce harm from alcohol. There is strong evidence that reducing the availability of alcohol late at night can reduce some of the acute harms associated with intoxication (e.g., violence)[102,114]. Other restrictions on availability (such as the number and density of outlets) are likely to be effective, but specific evidence of effective policy options remains lacking and appropriate availability levels are likely to vary between places[115].

School-based alcohol prevention programs have been proven effective. While existing school-based programs are scarce and need further evaluation, specific interventions have been shown to be effective in achieving reduction in alcohol consumption among young people relative to control conditions post implementation in the Australian context[106]. One Australian program (Climate Schools) is evaluated to high standard and shown to have positive effects on alcohol outcomes[107,116]. Another Australian program (School Health and Alcohol Harm Reduction Project) has shown some evidence of positive effects on alcohol outcomes[116].

PRIORITY POLICY ACTIONS

1.	**Ensure wine and cider are taxed in the same way as beer and spirits, by replacing the wine equalisation tax with a differentiated volumetric tax.**
2.	**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.**
3.	**Invest in development and evaluation of evidence-based school-based alcohol prevention programs.**

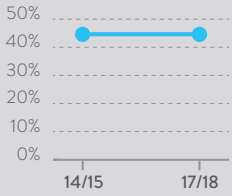
National physical activity plan

In light of COVID-19 and subsequent lockdown conditions worldwide, the importance of physical activity for physical and mental wellbeing and for building resilience in populations has been emphasised in social and political discussions.

Getting Australia's Health on Track 2016 recommended a National Physical Activity Plan. In addition to the continuing need for a National Physical Activity Plan, three additional strategies are recommended to reduce physical inactivity in the Australian population: walking strategies and infrastructure that are appropriate for all ages and abilities; a national voucher scheme to promote participation in sport and physical activity in children living in low socioeconomic areas; and standardised national surveillance for physical activity.

THE PROBLEM

Regular physical activity is associated with considerable health-related benefits such as reduced risk of cardiovascular disease, type 2 diabetes, various forms of cancer and reduced mortality[117]. Physical activity is also a protective factor, directly benefiting health in

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

^ 13-17 years, ^^ 5-12 years

ways beyond simply its impact on other risk factors[118]. In addition, physical activity is associated with improvements in musculoskeletal health and functional capacity, and in psychological and cognitive indicators such as reduced depression, reduced risk for dementia and better academic performance[119–121].

The benefits of physical activity were recognised widely during the COVID-19 pandemic[122], with exercise being an essential reason that people could leave their homes during lockdown conditions in Australia. Physical inactivity is now recognised as a risk factor for COVID-19 severity along with obesity and tobacco smoking[123]. The estimated total cost of physical inactivity in Australia is $805 million, comprising $640 million in estimated direct costs and $165 million in productivity losses[125]. Despite this, physical activity rates are low across life stages[124] and Australia still lacks a national plan or policy specific to physical activity[126,127].

Australians are interested in active travel[128] and support governments investing more road funding into walking, cycling and public transport[129]. Participation is reduced by concerns about infrastructure and safety such as parental concerns for child safety when commuting unsupervised[130]; adults only feeling comfortable to cycle in protected lanes or off-road paths[128]; and older adults reporting issues with pedestrian and public transport infrastructure[131].

The costs of sport participation is a significant barrier for low-income families with children and adolescents in low-income communities more likely to experience prohibitive costs associated with sports registration, uniforms and equipment and have poorer access to sporting and leisure facilities[132]. Children from low-income families participate much less in organised physical activity outside school (58%) than children from high income families (84%)[133].

In Australia, physical activity surveillance is neither consistent nor comprehensive[134]. Lack of standardisation limits capacity to monitor progress towards the WHO target. For over 30 years there have been calls to standardise physical activity measures[135] but changes and inconsistencies in survey questions over time still occur, leading to varying estimates of physical inactivity in different jurisdictions[135].

THE EVIDENCE

National policy on physical activity is required. Achievement of consistent and comprehensive policies to support physical activity by all population groups and communities requires a comprehensive national strategy and action plan to support the development and implementation of local-level policies, initiatives, and interventions[126,136]. A national plan should adopt a systems-based approach as recommended by the WHO and the International Society for Physical Activity and Health[136–138] and provide a range of strategies such as active urban design and active travel.

A national active urban design framework to promote population physical activity. People-friendly urban designs that shift transport away from motor vehicles to public transport and more active forms of transport are important for physical activity and improved community environments[139] and add between 45 and 90 minutes of walking per week[20].

Active travel and starting young. School walking, scooter and cycling programs, provision of secure bike racks, collaboration with local councils and businesses, dedicated support staff and the creation of safe routes can enable active travel, especially for children[140]. For example, the Brisbane School Travel program resulted in a 24.8% decrease in car trips, 19.1% increase in walking and 3.1%

increase in cycling[141]. In addition, parents reported an increase in their child's road safety awareness[141].

Walking strategies and infrastructure for all ages and abilities. Several state governments in Australia have now committed to the development of walking initiatives. These strategies recognise the differential needs of individuals when it comes to walking[142]. Particular attention and resources should be directed to meet the needs of older people and those with disabilities[143]. When changes in the built environment are combined with public education campaigns and community programs, they can play an important role in the promotion of walking and increasing physical activity levels[130].

Vouchers reduce financial barriers to sport participation. A number of state and territories have provided sports vouchers schemes aimed at reducing financial barriers to organised sport participation among children and adolescents (2011-2018)[144]. The Victorian program, *Get Active Kids*, launched in March 2021 provides $200 vouchers for sports equipment, uniforms and memberships for children (4-18 years) supported by the Carer Health Care Card. Evidence from earlier programs indicates that, despite population gains from these programs, there were discrepancies in parental awareness and engagement across socioeconomic groups[145]. In one program, parents and carers who were most disadvantaged were twice as likely to have never heard of the program, or to have heard of the program but not registered, and more than twice as likely to have registered for but not redeemed a voucher compared to the least disadvantaged parents and carers[145].

Monitoring and evaluation strengthen action and outcomes. Implementation of a national physical activity plan will require effective monitoring and evaluation, including measures of physical activity, tied to the national or subnational physical activity policy and including a range of indicators to monitor the implementation, goals and targets specified in that policy[146]. To ensure national comparability, Australia needs a coordinated approach across jurisdictions to ensure consistent measurement and reporting towards the 2025 physical activity targets[146], for both adults[135] and children and adolescents[147]. Beyond measuring physical activity alone, a comprehensive surveillance system could monitor policy implementation, sector engagement and other elements of the societal 'system' that generates physical activity[146].

PRIORITY POLICY ACTIONS

1.	**Develop and implement a national physical activity plan and invest in the following actions.**
2.	**Local implementation of active travel initiatives to and from school for all school-age groups.**
3.	**Local implementation of walking strategies (infrastructure and education) for all ages and abilities.**
4.	**Use of existing infrastructure to implement a national voucher system to remove financial barriers to participation in sport and physical activity for children.**
5.	**Implement a national standardised monitoring and surveillance system to track implementation of the plan and physical activity outcomes for all population groups across jurisdictions.**

HEALTHIER LIVING

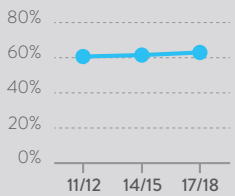
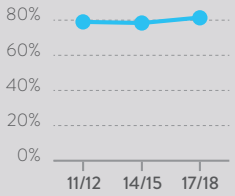
Improve mental health: physical health checks and individual placement programs for education and empoyment support

In 2017-18, 20% of the Australian population, or 4.8 million people, reported living with a mental or behavioural condition[148]. Mental illness is the second largest contributor to years lived in ill-health[2].

Mental health status especially for priority populations is related to social determinants of health including economic and social inequities, discrimination on the basis of gender, race, ethnicity and other features[149]. The COVID-19 pandemic and 2019-20 bushfire crises may have increased depression or anxiety symptoms, particularly among priority populations[150,151]. Exposure to other adversities, such as family violence or living in fear of violence[150], can have a substantial negative impact on the mental health of the victims and other family members who witness it[152].

The Productivity Commission estimated that reform of the mental health system would benefit the economy by $18 billion annually with an additional benefit of up to $1.3 billion through increased economic participation[151].

Mental and physical co-morbidities are common and costly with the yearly cost of premature death from other chronic diseases in people with serious mental illness estimated at $15 billion[153]. Policy initiatives to improve physical health checks and to provide equitable access to vocational programs and support for people living with mental illness are urgent priorities.

	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
Employment of people with mental illness (16-64 years)	62.9%	**70.5%**			Not available
Young people (16-30 years) with mental illness in education or employment	81.5%	**84.5%**			Not available

THE PROBLEM

Risk factors associated with poorer mental health include having a co-existing physical health condition, job insecurity or unemployment and limited educational attainment[154–156]. Nearly 3.6 million Australians are living with a long term mental and behavioural condition in combination with a chronic physical health condition[157]. Life expectancy among people living with serious mental health conditions is 10-15 years shorter than the average Australian and earlier deaths are mostly associated with chronic physical ill-health[158,159]. While mortality rates have decreased in recent decades in the general population, the outcomes for people with severe mental illness have worsened[159].

Australians who use mental health services visit GPs more often than the general population[160]. Despite this, and the high mortality rates from chronic physical conditions, people with mental and physical co-morbidity may be 50% less likely to receive treatment for their physical condition(s) than people without mental ill-health[161]. This trend has not changed and may suggest that people with mental illnesses are less likely to be offered standard physical health checks and diagnostic tests[162].

Alongside poorer physical health, people living with mental illnesses are over-represented in national unemployment[52] and out of school statistics[164], with the latter derailing long term employment opportunities. This is despite people with mental illness expressing the desire and having capacity to undertake work[163].

THE EVIDENCE

Mental health support requires comprehensive care. Comprehensive care based on holistic, person-centred, and cross-portfolio approaches would be responsive to individual and contextual differences for people with mental illnesses[165,166]. Care for mental health conditions should address individual's basic needs such as housing and social connectedness[151], and should be focused on supporting individuals to live active lives within their community[151,167]. Holistic care is in line with the National Mental Health Commission's Vision 2030[168] and the Productivity Commission Mental Health Inquiry 2020 report to prioritise 'prevention, early intervention and recovery'[151].

Integrated physical and mental health care improves overall health. Mental and physical health problems commonly co-exist[52]. There is a growing consensus that mental and physical health treatment should be integrated systematically[165]. Australian and international research has demonstrated the success of treating mental and physical co-morbidities[169]. NSW Health recently published a guideline, Physical Health Care for People Living with Mental Health Issues, to support public hospital and health services in improving physical health services for this population group[166]. Despite existing evidence, there are considerable implementation gaps and more evidence of effective care models is needed[169].

Individual Placement and Support (IPS) programs are highly effective. IPS is an evidence-based approach to vocational rehabilitation and support and is an integrated element of mental health treatment[164]. IPS programs have been proven effective in the Australian context with 46.3% of people living with serious mental illness achieving employment compared to 23.5% with referral to external employment services[170].

Supported education programs are successful. The median age of onset of mental illnesses in Australia is 23 years with the distribution of age of onset leading to an often significant impact on an individual's ability to complete secondary or post-secondary studies[154]. Education is a powerful intervention to stay connected or to reconnect and prepare for work, protecting individuals with mental ill-health against future unemployment[164]. Supported education programs have been successfully used to create pathways for young people to stay in or get back into education[164].

PRIORITY POLICY ACTIONS

1.	**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.**
2.	**Implement sustainable IPS programs nationally for people with moderate and severe persistent mental illness.**
3.	**Invest in school completion/back into school programs through educational support programs for young people living with mental illness.**

REDUCING BIOMEDICAL RISK FACTORS

Systematic screening and care for cardiovascular health

Cardiovascular disease is one of the largest contributors to premature mortality in Australia[2]. The two main risk factors for cardiovascular disease are dietary risks and high blood pressure, contributing 40.2% and 38% respectively to the burden of cardiovascular disease in the population[2].

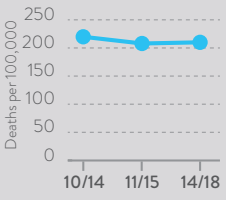
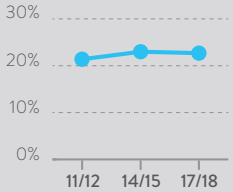
Premature mortality from chronic diseases in Australia has been declining for several decades, however rates are higher for people living in rural and remote areas than for those living in major cities and socioeconomic and geographic inequalities in premature mortality are widening[4].

Early diagnoses and preventative care play an important role in meeting the targets. Systematic implementation of primary care capacity to engage priority population groups and provide preventive care and treatment will save lives and improve the health of thousands of Australians every year.

THE PROBLEM

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[158]. Premature mortality is not equally distributed among the population in Australia and is highest among communities with the lowest socioeconomic status and remote communities[4,171,172]. There is a recognised large gap in life expectancy between Indigenous and non-Indigenous Australians[171].

In 2017-18, just over one in five Australians aged 18 years and over reported high blood pressure[52] which is the leading modifiable risk factor for coronary heart disease and stroke. In 2019, stroke and other cerebrovascular diseases were the third leading cause of death in

	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 years)	210 deaths per 100,000 in 2014-18	**166** deaths per 100,000			Not available
Adults with high blood pressure	22.8%	**16.1%**			31%

Australia[53]. Cardiovascular disease is a leading cause of illness and premature death for women with evidence that a substantial proportion of women may not be receiving necessary treatment, including screening for high blood pressure[173]. There is under-diagnosis of cardiovascular risk in the community and a nationally recognised and available screening approach to Absolute Cardiovascular Risk (aCVR) assessment is not systematically implemented.

Lack of regular, national disease surveillance data monitoring population health trends is a major barrier to systematic screening and risk assessment, and to effective intervention and treatment strategies[50]. The current Intergenerational Health and Mental Health Survey (2021-2023) will provide population estimates of biomedical risk factors for chronic disease and on nutrition for the first time in 10 years. This partially meets the 2016 Getting Australia's Health on Track recommendation that a comprehensive Australian Health Survey incorporating biomedical, nutritional and physical activity measures be established as a permanent, routine survey conducted every six years[174].

THE EVIDENCE

Screening for cardiovascular risk will save lives. There is strong evidence that aCVR assessment, contributes to prevention of heart attack, stroke and dementia[175]. The introduction in 2019 of a medical benefits subsidy for clinical aCVR assessment for eligible adults provides the basis for development of a national strategy to achieve comprehensive population aCVR assessment. Primary care provides the platform through which to achieve effective population-wide aCVR assessments[175].

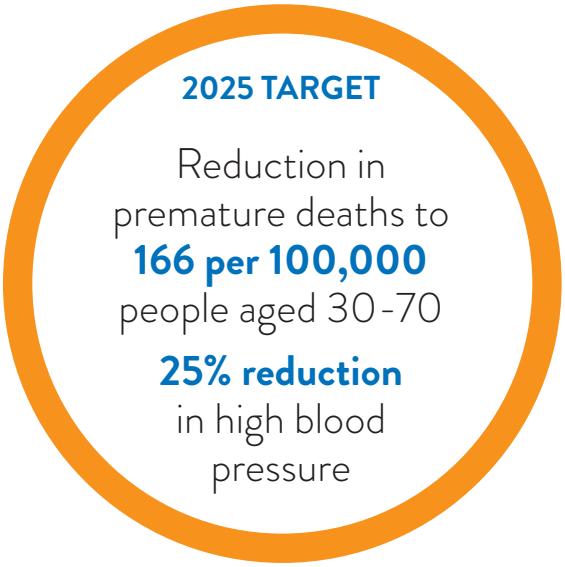
Preventive health care needs to be comprehensive and systematic. Primary and secondary prevention needs to reach, engage and provide evidence based treatment to all at risk age groups and priority populations[175]. National health strategies have endorsed a life-course approach to prevention and the National Strategic Action Plan for Heart Disease and Stroke prioritises strategies to reduce the impact of heart disease and stroke in the population[176]. Broader Medicare funded Health Assessments for priority populations, linked to evidence-based preventive health treatments, would support comprehensive primary care provision of 'the right care for the right person at the right time'. The health effects of COVID-19 (cardiac and pulmonary health in particular) and long-term unintended effects on health services and on the health of individuals need to be addressed, including reduced capacity for preventive health care generally[177] and stress impacts on mental health and wellbeing[150].

National service infrastructure to improve performance. Provision and reporting of reliable high-quality data about access, utilisation and outcomes of primary health care services will contribute to improved health outcomes[178].

A national service infrastructure program, including disease registers, decision support and care coordination, would provide support for comprehensive, equitable and effective primary and secondary prevention. Primary Health Networks should provide public reporting on primary care participation in screening for cancers and cardiovascular risk for eligible and priority populations[175].

PRIORITY POLICY ACTIONS

1.	**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.**
2.	**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.**
3.	**Expand financial support and the use of care plans for optimal management of individuals at high risk of predictable CVD events.**
4.	**Invest in a national service infrastructure program including disease registers, decision support and care coordination, to support comprehensive and effective primary and secondary prevention.**



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Working Group 7 – Mortality, Morbidity and Priority Populations: Chair – Prof Mark Morgan, Associate Dean, Faculty of Health Sciences & Medicine, Bond University. Rapporteur – A/Prof Kevin Mc Namara, Deputy Director Research, Deakin Rural Health, School of Medicine, Faculty of Health, Deakin University. Ms Karen Booth, President, Australian Primary Health Care Nurses Association; Dr Stephen Bunker, Adjunct Senior Lecturer, School of Public Health and Preventive Medicine, Faculty of Medicine, Nursing and Health Sciences, Monash University, Australia; Dr Rob Grenfell, Health Director, CSIRO; Prof Sabina Knight, Director, Murtupuni Centre for Rural and Remote Health, James Cook University; Dr Natalie Lumsden, Honorary Research Fellow, Western Health and University of Melbourne.

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TECHNICAL NOTE

Technical details for the statistics presented in this report are available in Getting Australia's Health on Track: Technical Appendix at vu.edu.au/Mitchell-Institute.

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