

AUSTRALIA'S HEALTH TRACKER

TECHNICAL APPENDIX

2019 EDITION

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About us

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

The Australian Health Policy Collaboration is led by the Mitchell Institute at Victoria University and brings together leading health organisations and chronic disease experts to translate rigorous research into good policy. The national collaboration has developed health targets and indicators for preventable chronic diseases designed to contribute to reducing the health impacts of chronic conditions on the Australian population.

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Table of contents

Contents

About us	i
Suggested citation	i
Table of contents	ii
Contents	ii
Abbreviations.....	1
Data sources	2
Introduction	4
Indicators.....	5
Targets	6
Aboriginal and Torres Strait Islander data.....	6
International comparisons.....	6
Validation	6
Technical appendix format.....	7
Adult data.....	10
Alcohol	10
Risky drinking	10
Per capita pure alcohol consumption	12
Heavy episodic drinking	13
Emergency department (ED) presentations	14
Diabetes	16
High cholesterol.....	17
High blood pressure	19
Morbidity and mortality	21
Overweight and obesity	22
Discretionary foods.....	24
Sugar	25
Physical inactivity	26
Salt.....	28
Screening: bowel cancer	29
Screening: breast cancer.....	30
Smoking	31
Adults with a mental illness who smoke daily.....	32

Employment of people with mental illness	33
Suicide	34
Children and young people	35
Alcohol	35
Binge drinking - Heavy episodic drinking, adolescents	35
Emergency Department presentations	36
Obesity and overweight	38
Children (5-11 years)	38
Young people (12-17 years).....	40
Discretionary food	42
Sugar	43
Breastfeeding	44
Physical inactivity	45
Social inclusion for people with mental illness	46
Working group and expert advisory group members	47
References	49

Abbreviations

ABS	Australian Bureau of Statistics
AHPC	Australian Health Policy Collaboration
AHS	Australian Health Survey
AIHW	Australian Institute of Health and Welfare
ASSAD	Australian School Students Alcohol and Drug Survey
BMI	body mass index
BP	blood pressure
CVD	cardiovascular disease
DHHS	Department of Health and Human Services, Victoria
JCU	James Cook University
NAIP	National Alcohol Indicators Project
NDSHS	National Drug Strategy Household Survey
NHMRC	National Health and Medical Research Council
NHS	National Health Survey
NMHC	National Mental Health Commission
OECD	Organisation of Economic Cooperation and Development
PHIDU	Public Health Information Development Unit
SAHMRI	South Australian Health and Medical Research Institute
UWA	University of Western Australia
WHO	World Health Organization

Data sources

Australian Bureau of Statistics Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012-13.

Australian Bureau of Statistics Australian Aboriginal and Torres Strait Islander Health Survey: Updated Results, Australia, 2012-13.

Australian Bureau of Statistics, Australian and Torres Strait Islander Health Survey: Physical activity 2012-13.

Australian Bureau of Statistics, Apparent Consumption of Alcohol, Australia, 2012-13.

Australian Bureau of Statistics, Apparent Consumption of Alcohol, Australia, 2013-14.

Australian Bureau of Statistics, Apparent Consumption of Alcohol, Australia, 2017-18.

Australian Bureau of Statistics, Australian Health Survey, First Results, 2011-12.

Australian Bureau of Statistics, Causes of Death, Australia 2014.

Australian Bureau of Statistics, Causes of Death, Australia 2017.

Australian Bureau of Statistics, National Health Survey: First Results, 2014-15.

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

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

Australian Coordinating Registry & Victorian Department of Justice, Cause of Death Unit Record Files 2009-2013.

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Australian Institute of Health and Welfare, 2010 Australian national infant feeding survey.

Australian Institute of Health and Welfare, BreastScreen Australia monitoring report 2012-23.

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Australian Institute of Health and Welfare, National Bowel Cancer Screening Program: monitoring report 2013-14.

Australian Institute of Health and Welfare, National Bowel Cancer Screening Program: monitoring report 2018.

Australian Institute of Health and Welfare, National Drug Strategy Household Survey 2010.

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Australian Institute of Health and Welfare, National Drug Strategy Household Survey 2016.

Department of Health, State Government of Victoria, Victorian Health Monitor report 2011.

Guerin, N. White, V. Australian Secondary Students' Use of Tobacco, Alcohol, Over-the-counter Drugs, and Illicit Substances.

Lensvelt et al. Trends in estimated alcohol-related emergency department presentations in Australia, 2005-2006.

Introduction

This technical appendix (second edition) is a companion and reference tool for the following publications; Australia's Health Tracker Australia's Adult Health Tracker, and Australia's Children and Young People Health Tracker (hereafter collectively referred to as the report cards).

Compiled through the collaborative effort and expert guidance of leading Australian public health and chronic disease experts, the report cards have been developed by the Australian Health Policy Collaboration at the Mitchell Institute at Victoria University, Melbourne.

The report cards are the first comprehensive assessment of how Australia's population – both Aboriginal and Torres Strait Islander and non-Indigenous people, and children as well as adults – are faring when measured against health targets for 2025.

The report cards are a part of a national project for accountability for chronic disease prevention in Australia which align with the *World Health Organization's (WHO) Global Action Plan for Prevention and Control of Non-communicable Diseases* ([World Health Organization, 2013a](#)) and the *WHO Mental Health Action Plan* ([World Health Organization, 2013b](#)). Targets and indicators to measure progress for prevention and control of chronic disease (also known as non-communicable disease) were developed through a comprehensive process using seven national expert working groups in 2015. The working groups ultimately proposed targets tailored to Australia, described in full in *Targets and Indicators for Chronic Disease Prevention in Australia* ([McNamara et al., 2019](#)); summarised in table 1 on pages 6-7.

For full details on the development of the targets and indicators, see the reports *Development of Australian Chronic Disease Targets and Indicators* ([Tolhurst, 2015](#)) and the technical paper *Suitability of the WHO 25 x 25 Chronic Disease Targets and Indicators for Australia* ([Leung and Tolhurst, 2015](#)).

This technical appendix is the second edition of the technical appendix, with the first released in 2015.

Indicators

The indicators that are used in the report cards are drawn from Targets and Indicators for Chronic Disease Prevention in Australia ([McNamara et al., 2015](#)). In considering targets and indicators, the Australian Health Policy Collaboration and colleagues used Australian Institute of Health and Welfare criteria. The criteria state that chronic disease indicators must:

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

The most recent data were used for the report cards. Some of the indicator data are as recent as 2017-18, and other data are from 2011/12.

The available recent data have limitations. We do not have regular, comprehensive health surveillance in Australia that includes anthropometric, biomedical and environmental measures. The Australian Health Survey ([Australian Bureau of Statistics, 2012](#)) carried out in 2011-12 was the most comprehensive Australian survey ever undertaken in this regard. Particularly relevant to the report cards are the biomedical measures from the 2011-12 survey ([Australian Bureau of Statistics, 2013b](#)), such as cholesterol, diabetes biomarkers and salt intake. The more recent National Health Survey ([Australian Bureau of Statistics, 2015f](#)) did not involve collection of blood and urine samples so the resulting survey data does not include a comprehensive set of measures. Lack of such measures reduces the ability to track and address these health risk factors in the report cards (and elsewhere).

The Intergenerational Health and Mental Health Study will provide valuable population health data on mental health, general health, nutrition and physical activity. The Study forms part of Australia's Long Term National Health Plan to "make Australia's health system the world's number one" ([Australian Government Department of Health, 2019](#)) and will include four surveys over three years. In February 2018, [Calder et al. \(2018\)](#) discussed the urgent need for, and cost-benefits of, a comprehensive approach to population health surveillance that includes data on valuable anthropometric, biomedical and environmental measures for risk factors and preventable chronic diseases data. This policy paper also recommends that such a survey be repeated every six years thereafter, to ensure the availability of routine comprehensive health surveillance data for addressing chronic disease.

Targets

Targets and Indicators for Chronic Disease Prevention in Australia ([McNamara et al., 2015](#)) used 2025 as the target year for most chronic disease prevention targets and 2010 as the baseline year. This is consistent with the approach specified by the WHO Action Plans.

Where possible we have used 2010 data as the baseline in the report cards. This works well for some data sources (e.g., the Australian School Students Alcohol and Drugs survey, for which there is a 2010 report). But in other areas (e.g., the National Nutrition Survey, which occurred in 1995 and again in 2011-12), data are available for the years either before or after 2010.

Aboriginal and Torres Strait Islander data

Comparative data in this report is drawn from the most recent reputable source for the most appropriate age cohort. Indigenous and non-Indigenous comparisons may be measured on different timescales, for different age groups, and may involve slightly different concepts.

When comparing data on Indigenous and non-Indigenous Australians, adjusting for differences in age structure between the two populations is necessary and should be considered when interpreting the data.

International comparisons

Providing an international comparison to understand how Australian adults are faring in the global context is briefly discussed in the adult section of *Australia's Health Tracker* and further details are provided in this appendix. Where possible, the OECD country comparative figures are provided to rank Australia relative to other similar nations. WHO's annual reports to governments on progress against its *Action Plans* have also been used for international comparisons.

Internationally comparable population data for children and young people were not readily available for most indicators and hence were not included in the children and young people's section of *Australia's Health Tracker*. If possible, they will be included in the next release of the report cards.

Validation

The data included in the report cards were reviewed and validated by expert working group members. The Public Health Information Development Unit (PHIDU) at Torrens University compiled the relevant data, undertook data analysis and located data that were not readily available. PHIDU is cited where applicable. The Mitchell Institute takes responsibility for the final publication, its contents and data as reported.

Technical appendix format

This document provides information, in alphabetical order, relevant to the targets and indicators reported in *Australia's Health Tracker*. As the report cards are divided into two main sections – adults and children/young people – so too is this document.

Table 1 Targets and indicators proposed for implementation in Australia by 2025

FRAMEWORK ELEMENT	PROPOSED MEASURES TO REACH TARGETS	PROPOSED AUSTRALIAN INDICATORS
Mortality and Morbidity		
Premature mortality from noncommunicable disease	1. 25% reduction in the overall mortality from cardiovascular diseases, cancer, chronic respiratory diseases and diabetes	<ul style="list-style-type: none"> • Unconditional probability of dying between ages of 30 and 70 years from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases • Age-standardised rates of unplanned admission for patients aged between 30 and 70 years admitted to hospital with a primary diagnosis of cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases • Age-standardised rates of unplanned readmission for patients aged between 30 and 70 years admitted to hospital with an initial primary diagnosis of cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases
	a. 25% reduction in the overall mortality from cardiovascular diseases and diabetes	<ul style="list-style-type: none"> • Unconditional probability of dying between ages of 30 and 70 from cardiovascular diseases • Unconditional probability of dying between ages of 30 and 70 from diabetes • Age-standardised average blood pressure among patients with chronic kidney disease, and percent of adults aged 18 years or more with elevated blood pressure ($\geq 140/90$ mmHg)
	b. 25% reduction in the overall mortality from chronic respiratory diseases	<ul style="list-style-type: none"> • Unconditional probability of dying between ages of 30 and 70 from chronic obstructive pulmonary disease
	c. Elimination of asthma deaths in adults aged under 65 years	<ul style="list-style-type: none"> • Unconditional probability of dying between ages of 30 and 70 from asthma • Percent of patients aged 30-70 years who are readmitted within 28 days of discharge following a hospital admission related to asthma or COPD
	d. 25% reduction in the overall mortality from cancer	<ul style="list-style-type: none"> • Unconditional probability of dying between ages of 30 and 70 from cancer • One-year survival rates for individuals diagnosed with the following cancers (individual indicators): lung, breast, colorectal, cervix, melanoma and prostate
e. Reduction in the national suicide rate by 10% by 2020 ³	<ul style="list-style-type: none"> • The suicide rate as an age-standardised rate per 100,000 population 	
Behavioural risk factors		
Harmful use of alcohol	<p>2. At least 20% relative reduction in the harmful use of alcohol, with regard to:</p> <ul style="list-style-type: none"> • Per capita consumption; and • Heavy episodic drinking; and • Alcohol-related morbidity and mortality 	<ul style="list-style-type: none"> • Apparent consumption of pure alcohol per capita (aged 14+), based on excise data, import clearances and sales data from Australian produced wine. • Heavy episodic drinking: Proportion of the population (aged 15+) reporting monthly or more frequent episodes of drinking where 5 or more standard drinks were consumed in a single occasion • Heavy episodic drinking among adolescents: Proportion of the adolescent (12-17 yo) population reporting at least one drinking occasion where 5 or more standard drinks were consumed in the previous week. • Long-term risky drinking: Proportion of the population (aged 15+) reporting average alcohol consumption of more than two standard drinks per day over the past year. (gender split) • Emergency department presentations: Presentations for injury (S & T ICD-10 codes) to Australian Emergency Departments (excluding Tasmania) at any of the following times: Fridays, 22:00 to 23:59; Saturdays, 0:00 to 3:59; 22:00 to 23:59; Sundays, 0:00 to 3:59 and 18:00 to 23:59). Rate per 100,000 population. (gender and age (<30, 30+)) • Hospital admissions for alcohol use disorders: Hospital admissions with primary diagnoses of ICD-9-CM codes; 291.0-291.9, 303.0-303.9, 305.0 and ICD-10-AM codes; F10.0-F10.9. Rate per 100,000 population. (gender split) • Alcoholic liver disease deaths: Mortality rates with primary cause of alcoholic liver cirrhosis (ICD-9-CM codes: 571.0, 571.1, 571.2, 571.3 ICD-10-AM codes: K70.0, K70.1, K70.2, K70.3, K70.4 and K70.9) (gender split)

Physical inactivity	3. A 10% relative reduction in prevalence of insufficient physical activity	<ul style="list-style-type: none"> • Prevalence of insufficiently physically active children and adolescents aged 5–17 years defined as less than 60 minutes of activity daily • Prevalence of insufficiently physically active adults aged 18+ is based on a physical activity recommendation of 150 minutes from five or more sessions per week. (Updated guidelines have removed the sessions requirement and thus the baseline prevalence and WHO target will need to be updated according to estimates based on the new guidelines.)
Salt/sodium intake	4. A 30% relative reduction in mean population intake of salt/sodium	<ul style="list-style-type: none"> • Age-standardised mean population intake of sodium expressed as salt grams per day
Tobacco use	5a. Reduce smoking to 5% prevalence or less	<ul style="list-style-type: none"> • Adults: Age-standardised prevalence of daily smokers aged 14 years and older from National Drug Strategy Household Survey (NDSHS) (also group 1) • Adolescents: daily smoking prevalence (in the seven days prior to the survey) for adolescents aged 12–17 years
	5b. Reduce smoking rates of adults over 18 years with a mental illness by 30% by 2020* and 60% by 2025	<ul style="list-style-type: none"> • The proportion of the population with mental illness who report being smokers compared with the smoking rates for the population without mental illness
Biological risk factors		
Raised blood Pressure	6. A 25% relative reduction in the prevalence of raised blood pressure	<ul style="list-style-type: none"> • Age-standardised average blood pressure and percent of adults aged 18 years or more with elevated blood pressure ($\geq 140/90$ mmHg) (also group 1)
Diabetes and obesity	7. Halt the rise in obesity	<ul style="list-style-type: none"> • Age-standardised prevalence of normal weight, overweight and obesity class I, II, III in persons 18 years or older (also group 1) • Prevalence of normal weight, overweight and obesity in children and adolescents (also group 1) • Age-standardised proportion of total energy intake from discretionary foods in persons aged 18 years or older and in children (2–17 years) • Prevalence of breastfeeding and exclusive breastfeeding
	8. Halt the rise in new diabetes	<ul style="list-style-type: none"> • Age-standardised incidence and prevalence of diabetes in persons 25–65yrs
Additional indicators		
		<ul style="list-style-type: none"> • Age-standardised average total cholesterol levels for adults aged 18 years or more, and percent with total cholesterol ≥ 5.0 mmol/L
Mental ill-health	9. Improve employment rates of adults over 18 with mental illness, and participation rates of young people with mental illness in education and employment, halving the employment and education gap by 2025	<ul style="list-style-type: none"> • Participation rates by people with mental illness of working age in employment: general population • Participation rates by young people aged 16–30 with mental illness in education and employment: General population




Note: Indicators in bold were regarded as core by the mortality & morbidity working group or were nominated by multiple groups. Extracted from the Targets and indicators for chronic diseases prevention in Australia ([McNamara et al., 2019](#)).

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

Adult data

Alcohol

Risky drinking

RISK FACTORS	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 Drinking at 'risky' levels	17.1%	16.1%			20.4%

Latest Australian data: 17.1% of Australians aged 14 and over drink in a long-term 'risky' manner. *Source: National Drug Strategy Household Survey (NDSHS), [Australian Institute of Health and Welfare \(2017b\)](#).*

Technical note: 'Risky' is defined in the National Health and Medical Research Council (NHMRC) guidelines for lifetime risk as consuming, on average, more than two standard drinks per day.

Target: The 2010 baseline is 20.1% *Source: NDSHS 2010, [Australian Institute of Health and Welfare \(2011\)](#)*. The 2025 alcohol target is for a 20% reduction, to 16.1%.

Trend: Latest data suggests good progress towards the 2025 target.

- **Baseline:** 20.1% (NDSHS 2010, [Australian Institute of Health and Welfare \(2011\)](#))
- **Australia's Health Tracker 2016:** 18.2% (NDSHS 2013, [Australian Institute of Health and Welfare \(2014\)](#))
- **Australia's Health Tracker 2019:** 17.1% (NDSHS 2016, [Australian Institute of Health and Welfare \(2017b\)](#))


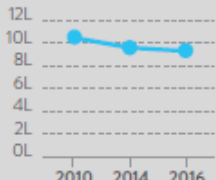

Latest Indigenous data: In 2016, 20.4% of Aboriginal and/or Torres Strait Islander people aged 14 years or older consumed alcohol at 'risky' levels. *Source: NDSHS 2016, [Australian Institute of Health and Welfare \(2017a\)](#), data tables 8.6*

Indigenous data:

- **Australia's Health Tracker 2016:** 22.7% (Australian Aboriginal and Torres Strait Islander Health Survey 2012-13, ([Australian Bureau of Statistics, 2014b](#)))
- **Australia's Health Tracker 2019:** 20.4% (NDSHS 2016, [Australian Institute of Health and Welfare \(2017a\)](#))

International: Not available.

Per capita pure alcohol consumption

RISK FACTORS	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 Per capita pure alcohol consumption	9.4 litres	8.4 litres			Not available

Latest Australian data: Total alcohol consumption is at its lowest since 1961-62. In 2016-17, apparent consumption of alcohol per person was 9.5 litres. *Source: Apparent Consumption of Alcohol 2016-17, [Australian Bureau of Statistics \(2018a\)](#)*

Technical note: A standard drink consists of 12.5 mls of pure alcohol; 9.7 litres of pure alcohol per year is equivalent to an average of 2.1 standard drinks per day. This figure overestimates the true level of alcohol consumed as beverages, as adjustments cannot be made for wastage and other factors such as for alcohol used in cooking ([Australian Bureau of Statistics, 2015c](#)). The OECD defines alcohol consumption as annual sales of pure alcohol in litres per person aged 15 years and over ([OECD, 2015](#)). This is consistent with one of the WHO alcohol measures ([World Health Organization, 2013a](#)), and matches the definition used in Targets and indicators for chronic disease prevention in Australia ([McNamara et al., 2015](#)).

Target: The 2025 alcohol consumption target is 8.4 litres – 20% under the 2010 level of 10.5 litres of pure alcohol per capita. *Source: Apparent Consumption of Alcohol 2012-13 table 7, [Australian Bureau of Statistics \(2015b\)](#).*

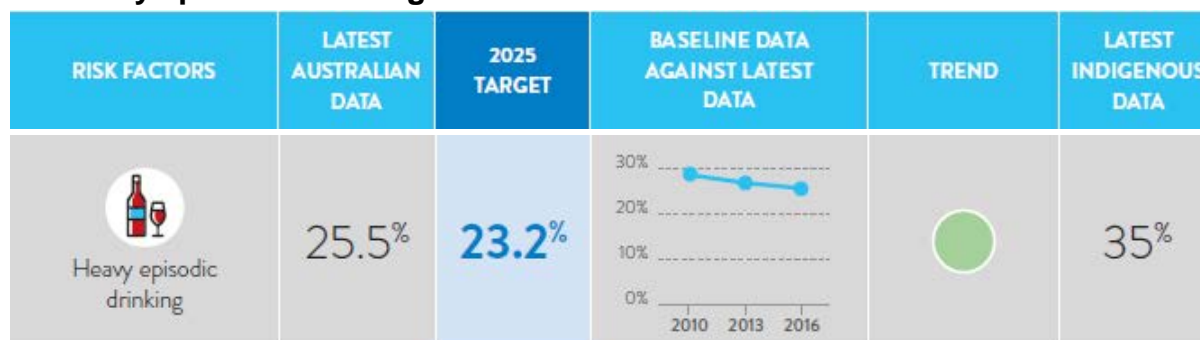
Trend: Latest data suggests no/limited progress towards the 2025 target.

- **Baseline:** 10.5L (Apparent Consumption of Alcohol 2012-13, [Australian Bureau of Statistics \(2015b\)](#))
- **2016 data:** 9.7L (Apparent Consumption of Alcohol 2013-14, [Australian Bureau of Statistics \(2015c\)](#))
- **Latest data:** 9.5L (Apparent Consumption of Alcohol 2017-18, [Australian Bureau of Statistics \(2018a\)](#))

Indigenous data: Comparable Aboriginal and Torres Strait Islander data not available.

International: Of the 35 member countries, Australia is ranked 21 for (alcohol) litres per capita consumed in a year close to the OECD average. The OECD average is 9 litres ([OECD, 2017](#)).

Heavy episodic drinking



Latest Australian data: The latest (2016) National Drug Strategy Household Survey reports more than one-quarter of people aged 14 and over (25.5% of the population) engaged in heavy episodic drinking. *Source: NDSHS 2016, [Australian Institute of Health and Welfare \(2017a\)](#).*

Technical note: Heavy episodic drinking is five or more standard drinks on a single drinking occasion at least once a month.

Target: The 2025 target is 23.2%, 20% below the 2010 baseline of 29% of Australians aged 14 and over reporting heavy episodic drinking. *Source: NDSHS 2013, [Australian Institute of Health and Welfare \(2014\)](#).*

Trend: Latest data suggests good progress towards the 2025 target.


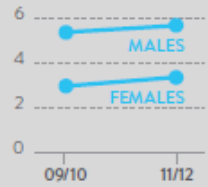
- **Baseline:** 29% (NDSHS 2010, [Australian Institute of Health and Welfare \(2011\)](#))
- **Australia's Health Tracker 2016:** 26.4% (NDSHS 2013, [Australian Institute of Health and Welfare \(2014\)](#))
- **Australia's Health Tracker 2019:** 25.5% (NDSHS 2016 table 16, [Australian Institute of Health and Welfare \(2017a\)](#))

Indigenous data:

- **Australia's Health Tracker 2016:** 37.8% (NDSHS 2013 table 8.4, [Australian Institute of Health and Welfare \(2014\)](#))
- **Australia's Health Tracker 2019:** 35% (NDSHS 2016 chapter 8, [Australian Institute of Health and Welfare \(2017a\)](#))

International: Not available.

Emergency department (ED) presentations

RISK FACTORS	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 <p>Emergency Department presentations (estimated alcohol injuries per 1,000)</p>	<p>Males 5.7[^]</p> <p>Females 3.4[^]</p>	<p>Males 4.3</p> <p>Females 2.4</p>		Inadequate data to assess trend	Not available

[^]Unable to update data as no comparable data has been collected since the 2016 report. Original data source was taken from a singular study that has not been repeated.

Latest Australian data: As reported in Australia's Health Tracker 2016, in 2011-12, estimated rates of alcohol-related injury presentations to EDs were 5.7 per 1,000 persons for males and 3.4 per 1,000 persons for females aged 14 years or older ([Lensvelt et al., 2015](#)).

Technical note: The alcohol-related ED presentation data ([Lensvelt et al., 2015](#)) includes all Australian jurisdictions except Tasmania. WA data includes ED presentations in the Perth metropolitan area only; NSW data includes ED presentations coded 'assault' or 'injury' in free-text fields only.

Target: The 2025 targets for alcohol-related injury presentations to EDs are 4.9 and 2.7 per 1,000 per annum for males and females respectively (10% reductions from the 2009-10 baseline figures which were 5.4/1,000 males and 3/1,000 females) ([Lensvelt et al., 2015](#)).

Trend: Latest data indicate slightly higher numbers and therefore, poor progress towards the 2025 target.

Males

- **Baseline:** 4.3 per 1,000 in 2009-10 ([Lensvelt et al., 2015](#))
- **Australia's Health Tracker 2016:** 5.7 per 1,000 in 2011-12 ([Lensvelt et al., 2015](#))
- **Australia's Health Tracker 2019:** no comparable data source – study has not been repeated




Females

- **Baseline:** 2.4 per 1,000 in 2009-10 ([Lensvelt et al., 2015](#))
- **Australia's Health Tracker 2016:** 3.4 per 1,000 in 2011-12 ([Lensvelt et al., 2015](#))
- **Australia's Health Tracker 2019:** no comparable data source – study has not been repeated.

Indigenous data: Comparable Aboriginal and Torres Strait Islander data not available.

International: Not available.

Diabetes

RISK FACTORS	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 Prevalence of diabetes in adults (25-64 years)	4.2%	4.1%			Not available

Latest Australian data: Latest figures estimate that 4.2% of Australians aged 25-64 years are living with diabetes. *Source: NHS 2017-18, [Australian Bureau of Statistics \(2018d\)](#).*

Technical note: We used prevalence – not incidence – to develop and report on the target. The data could not be standardised for age.

Target: Using the 2007-08 figure as a baseline, the 2025 target is 4.1%. *Source: NHS 2007-08, [Australian Bureau of Statistics \(2009\)](#)*

Trend: Latest data suggests good progress towards the 2025 target.


- **Baseline:** 4.1% (NHS 2007-08, [Australian Bureau of Statistics \(2009\)](#))
- **Australia's Health Tracker 2016:** 4.7% (National Health Survey 2014-15 extracted by PHIDU)
- **Australia's Health Tracker 2019:** 4.2% (NHS 2017-18 extracted by PHIDU). 95% Margin of Error of Proportion (\pm) 0.5%

Indigenous data: Comparable Aboriginal and Torres Strait Islander data not available.

International data: A comparison for Australia using the ABS data (years 25-64 years) against other OECD countries is not possible. However, the latest International Diabetes Federation (IDF) (2017) provides insight into Australia's position globally. According to this data, the prevalence of diabetes (20-79 years) was lower (6.5%) than New Zealand (10.1%), the United States (13%) and Canada (9.6%). Prevalence in the United Kingdom (5.9%) was lower than Australia ([International Diabetes Foundation, 2017](#)).

According to the IDF, Australia has the highest mean expenditure estimate for diabetes per person in 2017 at International Dollars (ID) 5,650 compared to Papua New Guinea with ID 172.

High cholesterol

RISK FACTORS	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 High cholesterol	32.8%^	24.6%	No new data since baseline	Inadequate data to assess trend	25%^

^Unable to update data as no comparable has been collected since the 2016 report.

Commentary: Although an explicit target was not originally nominated in *Targets and indicators for chronic disease prevention in Australia* (McNamara et al., 2015), in 2016, the working group subsequently agreed upon a target for inclusion in the report card, informed by the related target of a 25% relative reduction in the overall mortality from cardiovascular disease, common cancer, chronic respiratory diseases and diabetes.

Latest Australian data: As reported in *Australia's Health Tracker 2016*, one in three Australians aged 18 years and over (32.8%, or 5.6 million people) had abnormal or high total cholesterol levels according to their blood test results ([Australian Bureau of Statistics, 2013b](#)). However, only 10.1% of this group self-reported having high cholesterol as a current and long-term health condition. Hence, the majority of people with high cholesterol were either unaware that they had the condition or did not consider it to be a long term or current problem.

Technical note 1: High cholesterol = total cholesterol greater than or equal to 5.5 mmol/L.

Technical note 2: The 2017-18 NHS reports on high cholesterol. However, the 2016 data (32.8%) has been maintained for this second edition. The results reported in the 2017-18 survey is self-reported data compared to biomedical data from the 2011-12 AHS and is therefore not comparable. If feasible, future editions of the Australia's Health Tracker will continue to report on biomedical data (for high cholesterol).

Target: A 25% reduction from 32.8% gives a 2025 target of 24.6%. *Source: AHS 2011-12, ABS.* The 2011-12 AHS data provides the optimal baseline because it objectively measured cholesterol levels rather than relying on self-report.

Trend: Insufficient data to assess trend as no new data since baseline.

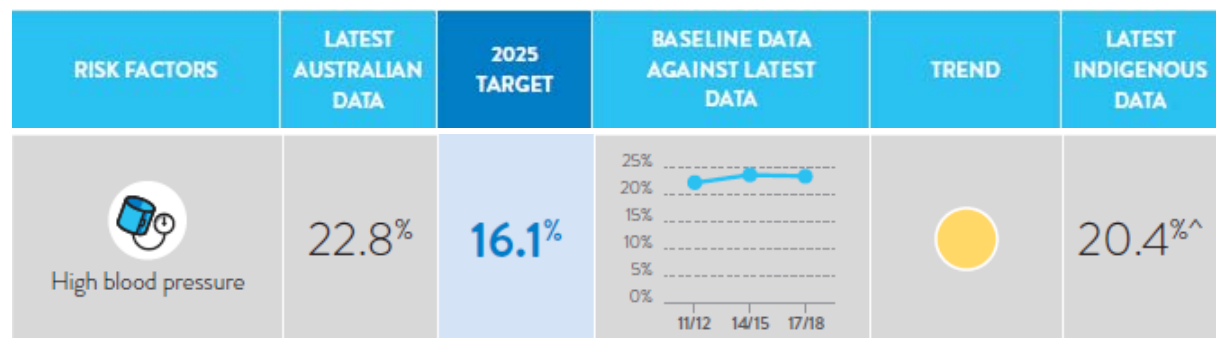
- **Baseline:** 32.8% (AHS 2011-12, [Australian Bureau of Statistics \(2013c\)](#))
- **Australia's Health Tracker 2016:** 32.8% (AHS 2011-12, [Australian Bureau of Statistics \(2013c\)](#))
- **Australia's Health Tracker 2019:** no comparable data

Indigenous data:

- **Australia's Health Tracker 2016:** In 2012-13, one in four Aboriginal and Torres Strait Islander adults (25%) had abnormal or high total cholesterol levels according to their blood test results. However, only 9.1% of this group self-reported high cholesterol as a current long-term health condition. *Source: Australian Aboriginal and Torres Strait Islander Health Survey 2012-13, ABS.*
- **Australia's Health Tracker 2019:** Comparable Aboriginal and Torres Strait Islander data not available.

International: Not available.

High blood pressure



[^]Unable to update data as no comparable has been collected since the 2016 report.

Latest Australian data: An estimated 22.8% of adults have high blood pressure. Males are more likely to have high blood pressure than women (25.4% and 20.3% respectively). This gender difference has been observed over the last few years. *Source: NHS 2017-18, [Australian Bureau of Statistics \(2018d\)](#).*

Technical note: The definitions of diagnosed hypertension and measured high blood pressure in the latest NHS (2017-18) was defined as systolic/diastolic blood pressure equal to or greater than 140/90 mmHg. *Source: [\(Australian Bureau of Statistics, 2018c\)](#).*

Target: 2011-12 was used for the baseline. In 2011-12, 21.5% of adults had measured high BP. The 2025 target therefore, is 16.1%. *Source: NHS 2014-15, [Australian Bureau of Statistics \(2015a\)](#).*

Trend: Latest data suggests no/limited progress towards the 2025 target.

- **Baseline:** 21.5% (Australian Health Survey 2011-12, [Australian Bureau of Statistics \(2013c\)](#))
- **Australia's Health Tracker 2016:** 23% (NHS 2014-15, [Australian Bureau of Statistics \(2015f\)](#))
- **Australia's Health Tracker 2019:** 22.8% (NHS 2017-18, [Australian Bureau of Statistics \(2018d\)](#)). 95% of Margin of Error of Proportion (\pm) 0.8%

Indigenous data:

- **Australia's Health Tracker 2016:** In 2012-13, one in five (20.4%) Aboriginal and Torres Strait Islander adults had measured high BP. Four in five Aboriginal and Torres Strait Islander adults with measured high BP did not report it as a long-term health condition. *Source: Australian Aboriginal and Torres Strait Islander Health Survey, [Australian Bureau of Statistics \(2014b\)](#)*
- **Australia's Health Tracker 2019:** comparable Aboriginal and Torres Strait Islander data not available.

International: A global study published in the Lancet in 2017 investigated the worldwide trends in blood pressure between 1975 and 2015. According to this study, Australia has some of the lowest rates of high blood pressure ([Zhou et al., 2017](#)). The UK, New Zealand, Canada and Singapore were also amongst the high-income countries with the lowest mean diastolic blood pressure.

Morbidity and mortality

RISK FACTORS	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)	208 deaths per 100,000	166 deaths per 100,000			Not available

Latest Australian data: Between 2011-15, 208.2 deaths per 100,000 Australians aged 30-70 years were attributed to four major chronic diseases. *Source: Refer to footnote¹*

Technical note: We cannot report on unconditional probability of dying between 30-70 years from CVD, common cancer, diabetes or chronic respiratory diseases for the current report card. Deaths per 100,000 is considered a reasonable alternative indicator. Note that the rates are age-standardised to the sum of the two years data to account for any change in the population distribution in these age groups over the two time periods. The percentage is calculated on these age-standardised rates. Common cancers ([McNamara et al., 2015](#)), were defined as lung, breast, colorectal, cervix, skin (melanoma) and prostate.

Target: In the baseline year of 2010, there were 221.5 deaths per 100,000; therefore the 2025 target (a 25% reduction) is 166 deaths/100,000. *Source: refer to footnote²*

Trend: Latest data suggests poor progress towards the 2025 target.

- **Baseline:** 221.5 deaths per 100,000 (compiled by PHIDU footnote 2)
- **Australia's Health Tracker 2016:** 207.0 deaths per 100,000 (provided by PHIDU footnote 2)
- **Australia's Health Tracker 2019:** 208.2 deaths per 100,000 (provided by PHIDU footnote 1)


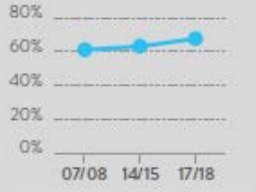


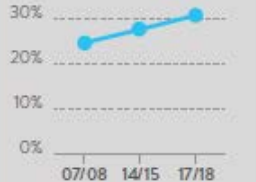

Indigenous data: Comparable Aboriginal and Torres Strait Islander data not available.

International: No comparable death rates for chronic diseases as reported in report cards are available across OECD countries. The WHO Noncommunicable Diseases Progress Monitor 2017 reports 9% risk of premature death from target NCDs (CVD, cancer, diabetes or chronic respiratory diseases) ([World Health Organization, 2017](#)).

¹ Data compiled by the PHIDU, from deaths data based on the **2011 to 2015** Cause of Death Unit Record Files supplied by the Australian Coordinating Registry and the Victorian Department of Justice, on behalf of the Registries of Births, Deaths and Marriages and the National Coronial Information System. The ICD codes used were CVD I00-I99, cancer C00-C97, diabetes E10-E14, and chronic respiratory disease J30-J98.

² Data compiled by the PHIDU, from deaths data based on the **2009 to 2013** Cause of Death Unit Record Files supplied by the Australian Coordinating Registry and the Victorian Department of Justice, on behalf of the Registries of Births, Deaths and Marriages and the National Coronial Information System. The ICD codes used were CVD I00-I99, cancer C00-C97, diabetes E10-E14, and chronic respiratory disease J30-J98.

Overweight and obesity

RISK FACTORS	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 Adults who are overweight or obese	67%	61.1%			71.4% [^]
 Adults who are obese	31.3%	24.6%			41.7% [^]

[^]Unable to update data as no comparable data has been collected since the 2016 report.

Latest Australian data: The 2017-18 National Health Survey reported on overweight and obesity. 67% of the adult population were overweight or obese, with 47% of this group (31.3%) being obese. *Source: NHS 2017-18, [Australian Bureau of Statistics \(2019\)](#)*

Technical note: Overweight is defined as a body mass index (BMI = (weight in kg) / (height in m)²) of 25 to 29.99, and obesity is defined as a BMI of 30 or more.

Target: The experts set a target to 'halt and reverse the rise in obesity'. The baseline year was 2007-08, therefore the 2025 targets are 61.1% of people overweight/obese and 24.6% classified as obese. *Source: NHS 2007-08, [Australian Bureau of Statistics \(2009\)](#).*

Trend: The latest data suggests poor progress towards the target.

Overweight and obesity

- **Baseline:** 61.1% (NHS 2007-08 table 1.3, [Australian Bureau of Statistics \(2009\)](#))
- **Australia's Health Tracker 2016:** 63.4% (NHS 2014-15, [Australian Bureau of Statistics \(2015f\)](#))
- **Australia's Health Tracker 2019:** 67% (NHS 2017-18, [Australian Bureau of Statistics \(2018d\)](#)). 95% Margin of Error of Proportion (\pm) 0.8%

Obesity


- **Baseline:** 24.6% (NHS 2007-08 table 1.3, [Australian Bureau of Statistics \(2009\)](#))
- **Australia's Health Tracker 2016:** 27.9% (NHS 2014-15, [Australian Bureau of Statistics \(2015f\)](#))
- **Australia's Health Tracker 2019:** 31.3% (NHS 2017-18, [Australian Bureau of Statistics \(2018d\)](#)). 95% Margin of Error of Proportion (\pm) 0.9%

Indigenous data:

- **Australia's Health Tracker 2016:** In 2012-13, an estimated 71.4% of Aboriginal and Torres Strait Islander adults were overweight or obese (41.7% obese). Indigenous Australians are significantly more likely to have a BMI denoting overweight or obesity than non-Indigenous Australians. After adjusting for differences in age structure between the two populations, Aboriginal and Torres Strait Islander people were 1.5 times as likely as non-Indigenous people to be obese. *Source: Aboriginal and Torres Strait Islander Health Survey 2012-13, [Australian Bureau of Statistics \(2013a\)](#)*
- **Australia's Health Tracker 2019:** comparable Aboriginal and Torres Strait Islander data not available

International: According to a 2017 OECD report, 27.9% of Australians are obese. This is compared to the OECD average of 19.4%. Australia is among the bottom five OECD countries for percentage of population with a BMI > 30 ([OECD, 2017](#)). Hungary, New Zealand, Mexico and United States make up the remainder of the bottom five.

Discretionary foods

RISK FACTORS	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 <p>Proportion of total energy intake from discretionary or 'junk foods' in adults diets</p>	34.6%^	Indicator to be monitored	-	-	40.7%^

^Unable to update data as no comparable has been collected since the 2016 report.

Latest Australian data: As reported in *Australia's Health Tracker 2016*, adults aged 19 years and over report an average of 34.6% of energy intake from discretionary foods. *Source: AHS 2011-12 table 9.1, [Australian Bureau of Statistics \(2014c\)](#).*

Technical note: Discretionary foods or "junk" food are foods considered to be of little nutritional value and which tend to be high in saturated fats, sugars, salt and/or alcohol. The ABS states that dietary surveys are "...subject to under-reporting. That is, a tendency for respondents to either change their behaviour or misrepresent their consumption (whether consciously or sub-consciously) to report a lower energy or food intake. Given the association of under-reporting with overweight/obesity and consciousness of socially acceptable/desirable dietary patterns, discretionary foods would be expected to be more likely to be under-reported than non-discretionary foods." See [Under-reporting in Nutrition Surveys \(Australian Bureau of Statistics, 2014d\)](#) for more information. This should be considered when interpreting data.

Target: Indicator to be monitored.

Latest Indigenous data: As reported in *Australia's Health Tracker 2016*, the average proportion of total daily energy from discretionary foods was higher among Aboriginal and Torres Strait Islander people than non-Indigenous people (40.7% vs. 34.6%). *Source: Australian Aboriginal and Torres Strait Islander Health Survey: Nutrition Results – Food and Nutrients 2012-13, table 9.1, [Australian Bureau of Statistics \(2015d\)](#).*

International: not available.

Sugar

RISK FACTORS	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 <p>Adults consuming too much sugar</p>	47.8%^	Indicator to be monitored	–	–	Not available

^Unable to update data as no comparable has been collected since the 2016 report.

Latest Australian data: As reported in Australia's Health Tracker 2016, 47.8% of adults did not adhere to the recommendation to limit energy from free sugars to less than 10% of dietary energy intake. *Source: AHS 2011-12, Table 3.1, [Australian Bureau of Statistics \(2016b\)](#).*


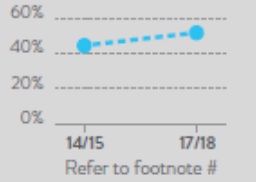
Technical note: 'Too much sugar' is defined as $\geq 10\%$ of daily energy (on a usual basis) from free sugars, based on WHO recommendations.

Target: Indicator to be monitored.

Latest Indigenous data: Comparable Aboriginal and Torres Strait Islander data not available.

International: Not available.

Physical inactivity

RISK FACTORS	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 <p>Adults not meeting physical activity recommendations</p>	52.7%	40%	 <p>60% 40% 20% 0%</p> <p>14/15 17/18 Refer to footnote #</p>		65%^

^Unable to update data as no comparable has been collected since the 2016 report.

Latest Australian data: Latest Australian data indicate a low proportion of adults meeting the national physical activity guidelines. Just over half (52.7%) engaged in the recommended 150 minutes in the last week. *Source: NHS 2017-18, [Australian Bureau of Statistics \(2019\)](#).*

Technical note: The 2017-18 National Health Survey has changed its definition of physical activity from that used in earlier surveys. The results reported in the 2017-18 survey are therefore not comparable to previous surveys.

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

Target: The 2025 target is a 10% reduction from baseline = 40%. *Source: NHS 2014-15, [Australian Bureau of Statistics \(2015f\)](#).*

Progress: The latest data suggests poor progress towards the target.

- **Baseline:** 44.5% (NHS 2014-15, [Australian Bureau of Statistics \(2015f\)](#))
- **Australia's Health Tracker 2016:** 44.5% (NHS 2014-15, [Australian Bureau of Statistics \(2015f\)](#)).
- **Australia's Health Tracker 2019:** 52.7% (NHS 2017-18, table 13.3, [Australian Bureau of Statistics \(2018d\)](#)). 95% Margin of Error of Proportion (\pm) 0.9%

Latest Indigenous data:

- **Australia's Health Tracker 2016:** Existing data are based on old guidelines for physical activity and must be revised. Prevalence of insufficient physical activity = 65%. Source: *Australian Aboriginal and Torres Strait Islander Health Survey: Physical activity, 2012-13*, [Australian Bureau of Statistics \(2014a\)](#).
- **Australia's Health Tracker 2019:** comparable Aboriginal and Torres Strait Islander data not available.

International: Not available.

Salt

RISK FACTORS	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

[^]Unable to update data as no comparable has been collected since the 2016 report.

Latest Australian data: As reported in *Australia's Health Tracker 2016*, the average daily salt intake in Victorian adults was estimated at 8.1g per day. Few data exist on salt consumption in Australia and the expert working group agreed that data from the Victorian Health Monitor should be used as a proxy for national data. This data was calculated from survey participants providing a urine sample, self-reported food frequency questionnaire, and three 24-hr dietary recalls. *Source: Victorian Health Monitor 2011, [Department of Health and Human Services Victoria \(2012\)](#).*

Technical note: *Targets and Indicators for Chronic Disease Prevention in Australia* ([McNamara et al., 2015](#)) uses a baseline figure from the Victorian Health Monitor ([Department of Health and Human Services Victoria, 2012](#)), as no national data was available at the time. The AHS, (conducted in 2011-12; ([Australian Bureau of Statistics, 2012](#)) estimated average daily intake of salt from food sources at 7.1g for men and 5.3g for women. However, the dietary survey method used by the AHS underestimates daily salt intake, as respondents tend to under-report, and the survey does not measure the amount of salt added during cooking and at the table. Therefore the data from the Victorian Health Monitor were used as a proxy for national data. It is recommended that Australian adults consume less than 4g salt daily (equivalent to 1,600mg sodium) ([National Health and Medical Research Council, 2013](#)). The latest data on average daily salt intake of 8.1g is 62% more than 3g daily and 49.5% more than 4g daily.




Target: A 30% reduction from the 2011 Victorian average salt intake of 8.1 g per day (baseline) gives a 2025 target of 5.7 g per day. *Source: Victorian Health Monitor 2011, [Department of Health and Human Services Victoria \(2012\)](#).*

Trend: Insufficient data to assess trend, no new data since baseline.

Latest Indigenous data: As reported in *Australia's Health Tracker 2016*, no salt intake data from 24-hour urine collection is available for Aboriginal and Torres Strait Islanders.

International: The method of measurement and monitoring population average daily salt intake varies across countries (for example: 24hr urine tests, spot urine tests, dietary recalls, food frequency questionnaires, weighed food records) and may include representative and non-representative sample sizes. Therefore, at the current time, comparing Australia's average population salt (or sodium) intake is not possible.

Screening: bowel cancer

RISK FACTORS	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 Bowel cancer screening (50-74 years)	41%	56.6%*			21%

*2022 target

Latest Australian data: Participation in the National Bowel Cancer Screening Program has increased each over the last few years. From January 2015 to December 2016, 41% (of the 3.2 million people invited to participate) returned a completed bowel cancer screening kit for analysis. *Source: National Bowel Cancer Screening Program (NBCSP): monitoring report 2018, [Australian Institute of Health and Welfare \(2019\)](#).*

Target: A screening target of 41% for 2019-20 was set by the Department of Health in its 2016-17 Portfolio Budget Statements which has been reached for all but the Aboriginal and Torres Strait Islander population. *Source: ([Commonwealth of Australia as represented by the Department of Health, 2016](#)).*

The Department of Health has since extended its screening targets. A target of 56.6% has been set for 2022 as listed in the recent 2019-20 Portfolio Budget Statements ([Commonwealth of Australia as represented by the Department of Health \(2019\)](#)).

The *Australia's Health Tracker 2019* has adopted this target and will report against this target in future editions.


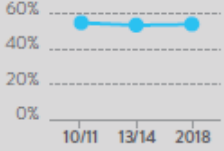

Trend: Trend in right direction. Good progress towards target. Maintain efforts.

- **Baseline:** 33.4% (NBCSP 2013-14, [Australian Institute of Health and Welfare \(2015b\)](#))
- **Australia's Health Tracker 2016:** 36% (NBCSP 2013-14, [Australian Institute of Health and Welfare \(2015b\)](#))
- **Australia's Health Tracker 2019:** 41% (NBCSP 2019, [Australian Institute of Health and Welfare \(2019\)](#))

Latest Indigenous data: In 2015-16, testing participation rate for eligible Indigenous Australians was estimated to be 21%. *Source: NBCSP 2019, [Australian Institute of Health and Welfare \(2019\)](#).*

International: Not available.

Screening: breast cancer

RISK FACTORS	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 <p>Breast cancer screening in women (50-74 years)</p>	55%	54%*		 <p>Reached the target other than for the Aboriginal and Torres Strait Islander population</p>	39%

*2022 target

Latest Australian data: In 2015-16, more than 1.7 million women aged 50–74 (55%) participated in BreastScreen Australia. *Source: Breastscreen Australia monitoring report [Australian Institute of Health and Welfare \(2018\)](#).*

Target: Screening targets of 54% were set by the Department of Health in its 2016-17 Portfolio Budget Statements which has been reached for all but the Aboriginal and Torres Strait Islander population. *Source: ([Commonwealth of Australia as represented by the Department of Health, 2016](#)), p. 78. A target of 54% has been maintained until 2022 as ongoing participation is expected to remain stable.*


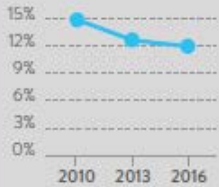

Trend: Australia has reached the 2020 target for all but the Aboriginal and Torres Strait Islander population.

- **Baseline:** 54.6% (Breastscreen Australia monitoring report 2012-13, [Australian Institute of Health and Welfare \(2015a\)](#))
- **Australia's Health Tracker 2016:** 53.7% (Breastscreen Australia monitoring report 2012-13, [Australian Institute of Health and Welfare \(2015a\)](#))
- **Australia's Health Tracker 2019:** 55% (Breastscreen Australia monitoring report 2018, [Australian Institute of Health and Welfare \(2018\)](#))

Latest Indigenous data:

- **Australia's Health Tracker 2016:** 35.5%. (Breastscreen Australia monitoring report 2012-13, [Australian Institute of Health and Welfare \(2015a\)](#))
- **Australia's Health Tracker 2019:** 39% (Breastscreen Australia monitoring report 2018, [Australian Institute of Health and Welfare \(2018\)](#))

Smoking

RISK FACTORS	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 <p>Daily smokers (aged 14 and over)</p>	12.2%	5%			27.4%

Latest Australian data: Recent estimates (2016) show 12.2% of Australians aged 14 and over smoke daily. *Source: NDSHS 2016, [Australian Institute of Health and Welfare \(2017b\)](#)*

Target: The 2025 target endorsed by Australian experts is 5%. *Source: ([McNamara et al., 2015](#)).*

Trend: The latest data suggests good progress towards the target.


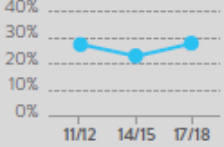

- **Baseline:** 15.1% (NDSHS 2013, [Australian Institute of Health and Welfare \(2014\)](#))
- **Australia's Health Tracker 2016:** 12.8% (NDSHS 2013, [Australian Institute of Health and Welfare \(2014\)](#))
- **Australia's Health Tracker 2019:** 12.2% (NDSHS 2016, table 3.1, [Australian Institute of Health and Welfare \(2017a\)](#))

Latest Indigenous data:

- **Australia's Health Tracker 2016:** 38.9% (National Aboriginal and Torres Strait Islander Social Survey 2014-15, [Australian Bureau of Statistics \(2016d\)](#))
- **Australia's Health Tracker 2019:** 27.4% (NDSHS 2016, [Australian Institute of Health and Welfare \(2017a\)](#))

International: Australia performs better than the OECD average for the percentage of the population who smokes daily. Note that the OECD's measure for smoking is the "proportion of daily smokers aged 15 and over who report tobacco smoking every day" as opposed to our 14 years and over who smoke daily. *Source: [OECD \(2017\)](#), p. 70.*

Adults with a mental illness who smoke daily

RISK FACTORS	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 Adults with mental illness who smoke daily	27.7%	11%			50%^

^Unable to update data as no comparable has been collected since the 2016 report.

Latest Australian data: More than one-quarter (27.7%) of adults with a mental illness smoke daily. *Source: NHS 2017-18, [Australian Bureau of Statistics \(2019\)](#).*

Technical note: The number of people who reported a mental or behavioural condition in the NHS in 2014-15 increased over earlier surveys, potentially due to the greater prominence of these conditions in the new module. The [Australian Bureau of Statistics \(2015f\)](#) states that “data on mental and behavioural conditions for 2014-15 are therefore not comparable with data in previous National Health Surveys”.

Target: A 60% reduction from the 2011-12 baseline of 27.5% makes the 2025 target 11%. *Source: AHS 2011-12, [Australian Bureau of Statistics \(2012\)](#).*

Trend: the latest data suggests poor progress towards the target.


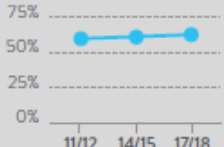

- **Baseline:** 27.5% (AHS 2011-12, [Australian Bureau of Statistics \(2013c\)](#))
- **Australia’s Health Tracker 2016:** 23.5% (NHS 2014-15, [Australian Bureau of Statistics \(2015f\)](#))
- **Australia’s Health Tracker 2019:** 27.7% (NHS 2017-18, table 5.3, [Australian Bureau of Statistics \(2018d\)](#)). 95% Margin of Error of Proportion (\pm) 2.4%

Latest Indigenous data:

- **Australia’s Health Tracker 2016:** The smoking rate for Aboriginal and Torres Strait Islanders with mood disorders was 50%. Although the Indigenous indicator is not identical to the non-Indigenous indicator, they were deemed to be comparable and hence reported on. *Source: PHIDU, using 2012/13 data. Table builder, The Australian Aboriginal and Torres Strait Islander Health Survey, [Australian Bureau of Statistics \(2014b\)](#).*
- **Australia’s Health Tracker 2019:** comparable Aboriginal and Torres Strait Islander data not available.

International: Not available.

Employment of people with mental illness

RISK FACTORS	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 Employment of people with mental illness	62.9%	70.5%			Not available

Latest Australian data: The 2017-18 NHS estimated that 62.9% of people aged 16-64 with current and long-term mental and behavioural problems are employed. Source: *NHS 2017-18 extracted from ABS Survey Table Builder by PHIDU.*

Target: Halve the employment gap. In 2011-12, 60.6% of people aged 16-64 years old with current and long-term mental and behavioural problems were employed, compared to 79.7% of people aged 16-64 years old who did not report current and long-term mental and behaviour problems. Halving the gap between these figures means the 2025 target is 70.5% Source: *AHS 2011-12, [Australian Bureau of Statistics \(2012\)](#).*




Trend: Latest data suggests no or limited progress towards 2025 target.

- **Baseline:** 60.6% (AHS 2011-12, [Australian Bureau of Statistics \(2013c\)](#))
- **Australia's Health Tracker 2016:** 61.4% (NHS 2014-15, [Australian Bureau of Statistics \(2015f\)](#))
- **Australia's Health Tracker 2019:** 62.9% (NHS 2017-18 [Australian Bureau of Statistics \(2018d\)](#)). 95% Margin of Error of Proportion (\pm) 2.5%

Latest Indigenous data: Comparable Aboriginal and Torres Strait Islander data not available.

International: Not available.

Suicide

RISK FACTORS	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 <p>Suicide rate</p>	12.6 deaths per 100,000	9.8** deaths per 100,000			25.5 per 100,000

*2020 target

Latest Australian data: In 2017, the ABS reported intentional self-harm was the leading cause of mortality in Australia. An estimated 12.6 per 100,000 cases were related to intentional self-harm. *Source: Causes of Death 2017, [Australian Bureau of Statistics \(2018b\)](#).*

Target: The baseline year for this indicator is 2013 and the target year is 2020 to be consistent with the WHO *Mental Health Action Plan* ([World Health Organization, 2013b](#)). The suicide rate was 10.9 per 100,000 in 2013; a 10% reduction means the target is 9.8 per 100,000 (reflecting ~265 fewer deaths per annum based on current population). *Source: Causes of Death 2014, [Australian Bureau of Statistics \(2016c\)](#)*

Trend: Latest data suggests no or limited progress towards the 2025 target

- **Baseline:** 10.9 per 100,000 (Causes of Death 2014, [Australian Bureau of Statistics \(2016c\)](#) table 11.6)
- **Australia's Health Tracker 2016:** 12.0 per 100,000 (Causes of Death 2014, [Australian Bureau of Statistics \(2016a\)](#))
- **Australia's Health Tracker 2019:** 12.6 per 100,000 (Causes of Death 2017, [Australian Bureau of Statistics \(2018b\)](#))

Indigenous data:

- **Australia's Health Tracker 2016:** 20.3 per 100,000 (2009-13) (Causes of Death 2013, [Australian Bureau of Statistics \(2015e\)](#), table 12.4)
- **Australia's Health Tracker 2019:** 25.5 per 100,000 (Causes of Death 2017, [Australian Bureau of Statistics \(2018b\)](#), table 12.1).

International: The latest OECD data ranks Australia 13th highest for suicide rates per 100,000 out of 35 OECD member countries. *Source: [OECD, 2019](#).*

Children and young people

Alcohol

RISK FACTORS	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 <p>Young people (12-17 years) who binge drink</p>	5%	5.1%			Not available

Binge drinking - Heavy episodic drinking, adolescents

Latest Australian data: According to the 2017 Secondary School Students Use of Alcohol and Drug (ASSAD) survey, 5% of young people (aged 12-17) consumed five or more alcohol drinks on any one occasion. *Source: ASSAD 2017, [Guerin and White \(2018\)](#).*

Technical note: Binge drinking is defined as consuming five or more alcoholic drinks on any one occasion in the past two weeks, four weeks, year, and life.

Target: A 20% reduction from the 2011 baseline makes the 2025 target 5.1%. *Source: [White and Bariola, 2012](#).*

Trend: latest data suggests good progress against the 2025 targets

- **Baseline:** 6.4% ([White and Bariola, 2012](#))
- **Australia's Health Tracker 2016:** 6.4% ([White and Bariola, 2012](#))
- **Australia's Health Tracker 2019:** 5% (ASSAD 2017, ([Guerin and White, 2018](#)))

Latest Indigenous data: As reported in *Australia's Health Tracker 2016*, comparable Aboriginal and Torres Strait Islander data is not available. However, in the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, based on alcohol consumed in the last 12 months using the 2001 NHMRC risk level guidelines, 20.3% of Indigenous young people aged 15-17 years and 18.6% of non-Indigenous young people aged 15-17 years reported risky/high risk drinking. *Source: [Australian Bureau of Statistics, 2013a](#), table 14.3.*

Emergency Department presentations

RISK FACTORS	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
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	<p>15% 12% 9% 6% 3% 0%</p> <p>09/10 11/12</p> <p>MALES FEMALES</p>	<p>Males Females</p>	Not available

[^]Unable to update data as none has been collected since the 2016 report. Original data source was taken from a singular study and has not been repeated.

Latest Australian data: As reported in *Australia's Health Tracker 2016*, in 2011-12 estimated rates of alcohol-related injury presentations to EDs by age/sex for males and females aged 15-19 years were 12.9 and 7.5 per 1,000 persons respectively. *Source:* ([Lensvelt et al., 2015](#)).

Technical note: NAIP Bulletin 14 ([Lensvelt et al., 2015](#)) includes all Australian jurisdictions except Tasmania. WA data includes ED presentations in the Perth metropolitan area only; NSW data includes ED presentations coded 'assault' or 'injury' in free-text field only.

Target: The 2009-10 baseline figures were 13.1 per 1000 for males and 6.7 per 1000 for females; a 10% reduction makes the 2025 alcohol targets 13.0 per 1,000 for males and 6.0 per 1,000 for females.

Trend: Male presentation rates have declined slightly and are nearing the target, but female rates have increased.

Males







- **Baseline:** 13.1 per 1,000 in 2009-10 ([Lensvelt et al., 2015](#))
- **Australia's Health Tracker 2016:** 12.9 per 1,000 in 2011-12 ([Lensvelt et al., 2015](#))
- **Australia's Health Tracker 2019:** no comparable data source – study has not been repeated

Females

- **Baseline:** 6.7 per 1,000 in 2009-10 ([Lensvelt et al., 2015](#))
- **Australia's Health Tracker 2016:** 7.5 per 1,000 in 2011-12 ([Lensvelt et al., 2015](#))
- **Australia's Health Tracker 2019:** no comparable data source – study has not been repeated.

Latest Indigenous data: Comparable Aboriginal and Torres Strait Islander data not available.

Obesity and overweight

RISK FACTORS	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 Children (5-11 years) who are overweight	17.6%	15%			21.2% ^{^*}
 Children (5-11 years) who are overweight or obese	26.2%	21.6%			32.8% ^{^*}
 Children (5-11 years) who are obese	8.4%	6.6%			11.8% [^]

[^]Unable to update data as none has been collected since the 2016 report.

Children (5-11 years)

Latest Australian data: In 2017-18, 26.2% of children aged 5-11 were overweight or obese; 17.6% were overweight and 8.4% were obese. *Source: NHS 2017-18 PHIDU calculation.*

Technical note: Physical measurement data including BMI from the latest (2017) NHS is comparable with the 2014-15 survey. The classification of children's BMI is different to that of adults', and takes into account individual age and sex. BMI cut-off ranges for children 2–17 years of age are included in Appendix 4 of ([Australian Bureau of Statistics, 2017](#))).

Target: The 2007-08 data were used as the baseline. Hence to halt the rise: 21.6% needs to be maintained for overweight and obese; 15% for overweight and 6.6% for obese. *Source: Provided by PHIDU from the NHS 2007-08.*

Trend: The latest data suggests poor and/or limited progress towards the target.

Overweight and obesity

- **Baseline:** 21.6% (NHS 2007-08 table 16.1, [Australian Bureau of Statistics \(2009\)](#))
- **Australia's Health Tracker 2016:** 25.6 (NHS 2014-15 provided by PHIDU)
- **Australia's Health Tracker 2019:** 26.2 (NHS 2017-18 provided by PHIDU).
Margin of Error of Proportion (\pm) 3.5%

Overweight

- **Baseline:** 15% (NHS 2007-08, [Australian Bureau of Statistics \(2009\)](#))
- **Australia's Health Tracker 2016:** 18.1% (NHS 2014-15 provided by PHIDU)
- **Australia's Health Tracker 2019:** 17.6% (NHS 2017-18 provided by PHIDU).
Margin of Error of Proportion (\pm) 3.2%

Obesity






- **Baseline:** 6.6% (NHS 2007-08, [Australian Bureau of Statistics \(2009\)](#))
- **Australia's Health Tracker 2016:** 7.8% (NHS 2014-15 provided by PHIDU)
- **Australia's Health Tracker 2019:** 8.4% (NHS 2017-18 provided by PHIDU)

Margin of Error of Proportion (\pm) 2.8%

Latest Indigenous data:

- **Australia's Health Tracker 2016:** In 2012/13, for children 5 to 14 years, an estimated 32.8% of children were overweight or obese; 21.2% overweight; 11.8% obese (Australian Aboriginal and Torres Strait Islander Health Survey 2012-13 table 24.1, [Australian Bureau of Statistics \(2014b\)](#))
- **Australia's Health Tracker 2019:** comparable Aboriginal and Torres Strait Islander data not available.

Young people (12-17 years)

RISK FACTORS	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 Young people (12-17 years) who are overweight	15.8%	19.8%			20.6% ^{^*}
 Young people (12-17 years) who are overweight or obese	23.2%	28.3%			36.3% ^{^*}
 Young people (12-17 years) who are obese	7.9%	7.5%			15.8% ^{^*}

[^]Unable to update data as none has been collected since the 2016 report.

****15-17 YEARS**

Latest Australian data: Overweight and obesity rates have increased over the last few years for young Australians. According to the 2017-18 NHS, 23.2% of young people (12-17 years) are overweight or obese; 15.8% are overweight and 7.9% are obese. *Source: NHS 2017-18 PHIDU calculation.*

Technical note: Preventing the prevalence of obesity in young people from increasing further is important, and it is encouraging to see percentages unchanged since 2007-08. Efforts need to be expanded to increase the proportion of young people within a healthy weight range. Nationally representative data collection every five years is necessary so we can track progress towards the 2025 targets. It can be difficult to capture quality data from people in this age group as they may not regularly weigh themselves or accurately report their weight. The classification of young peoples' BMI is different to that of persons aged 18 years and over, and takes into account individual age and sex. BMI cut-off ranges for children 2 to 17 years of age are included in Appendix 4 of ([Australian Bureau of Statistics, 2017](#)).

Target: 2007-08 data were used as the baseline for creating 2025 targets. Hence, to halt the rise in obesity, Target 2025 = 7.5% for obesity: 19.8% for overweight and 28.3% for overweight and obese. *Source: Provided by PHIDU from the NHS 2007-08.*

Trend: The latest data on overweight and obesity in young people suggests good progress towards the overweight and obesity targets; however, there is poor progress towards the obesity target.

Overweight and obesity

- **Baseline:** 28.3% (NHS 2007-08 table 16.1, [Australian Bureau of Statistics \(2009\)](#))
- **Australia's Health Tracker 2016:** 29.5% (NHS 2014-15 provided by PHIDU)
- **Australia's Health Tracker 2019:** 23.2% (NHS 2017-18 provided by PHIDU). Margin of Error of Proportion (\pm) 4.0%

Overweight

- **Baseline:** 19.8% (NHS 2007-08, [Australian Bureau of Statistics \(2009\)](#))
- **Australia's Health Tracker 2016:** 22.4% (NHS 2014-15 provided by PHIDU)
- **Australia's Health Tracker 2019:** 15.8% (NHS 2017-18 provided by PHIDU). Margin of Error of Proportion (\pm) 3.2%

Obesity

- **Baseline:** 7.5% (NHS 2007-08, [Australian Bureau of Statistics \(2009\)](#))
- **Australia's Health Tracker 2016:** 7.4% (NHS 2014-15 provided by PHIDU)
- **Australia's Health Tracker 2019:** 7.9% (NHS 2017-18 provided by PHIDU). Margin of Error of Proportion (\pm) 2.8%

Latest Indigenous data:

- **Australia's Health Tracker 2016:** In 2012/13, for those aged 15 to 17 years, an estimated 36.3% of young people were overweight or obese; 20.6% were overweight and 15.8% were obese. For the same age brackets in non-Indigenous people the data were: 24.2%, 16.9% and 7.4%. Source: ([Australian Bureau of Statistics, 2013a](#)), Table 9.3.
- **Australia's Health Tracker 2019:** comparable Aboriginal and Torres Strait Islander data not available.

Discretionary food

RISK FACTORS	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 <p>Proportion of total energy intake from discretionary or 'junk foods' in young people's (14-18 years) diets</p>	40.7%^	Indicator to be monitored	-	-	42.9%^

^Unable to update data as none has been collected since the 2016 report.



Latest Australian data: As reported in *Australia's Health Tracker 2016*, children's (9-13 years) diets, on average, include 39.4% of energy intake from discretionary foods and in young people's (14-18 years), 40.7% of energy intake is from discretionary foods. The 14-18 year-olds had the highest proportion of energy from discretionary foods of all age groups. *Source: AHS 2011-12 table 9.1, [Australian Bureau of Statistics \(2014c\)](#).*

Technical note: Discretionary foods or 'junk' foods are foods considered to be of little nutritional value and which tend to be high in saturated fats, sugars, salt and/or alcohol. The ABS notes that dietary surveys are "...subject to under-reporting. That is, a tendency for respondents to either change their behaviour or misrepresent their consumption (whether consciously or sub-consciously) to report a lower energy or food intake. Given the association of under-reporting with overweight/obesity and consciousness of socially acceptable/desirable dietary patterns, discretionary foods would be expected to be more likely to be under-reported than non-discretionary foods" (see [Under-reporting in Nutrition Surveys \(Australian Bureau of Statistics, 2014d\)](#)). This should be considered when interpreting data.

Target: Indicator to be monitored.

Latest Indigenous data: As include reported in *Australia's Health Tracker 2016*, children's (9-13 years) diets, on average, include 41% of energy intake from discretionary food and in young people's (14-18) diets, 42.9% of energy intake is from discretionary foods. *Source: National Aboriginal and Torres Strait Islander Health Survey: Nutrition Results - Food and Nutrients 2012-13 table 9.1, [Australian Bureau of Statistics \(2015d\)](#).*

Sugar

RISK FACTORS	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 <p>Children (9-13 years) consuming too much sugar</p>	70.3%^	Indicator to be monitored	-	-	Not available
 <p>Young people (14-18) consuming too much sugar</p>	73.1%^	Indicator to be monitored	-	-	Not available

^Unable to update data as none has been collected since the 2016 report.

Latest Australian data: As reported in *Australia's Health Tracker 2016*, in 2011-12, almost three-quarters of children (70.3%) and young people (73.1%) exceeded the recommended maximum intake of dietary energy from free sugars of 10%. *Source: AHS 2011-12 table 3.1, [Australian Bureau of Statistics \(2014c\)](#).*

Technical note: Too much sugar is defined as $\geq 10\%$ of daily energy (on a usual basis) from free sugar.

Target: Indicator to be monitored.

Latest Indigenous data: Comparable Aboriginal and Torres Strait Islander data not available.

Breastfeeding

RISK FACTORS	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 <p>Proportion of infants exclusively breastfed to six months of age</p>	28.9%	Indicator to be monitored	–	–	Not available

Latest Australian data: The last national data suggest 28.9% of children are exclusively breastfed to 6 months. *Source: NHS 2017-18, table 31.1, [Australian Bureau of Statistics \(2018d\)](#).* These figures have remained consistent since 2014-15.

Technical note 1: Any breastfeeding and prolonged breastfeeding are associated with significantly reduced risk of obesity later in life. Exclusive breastfeeding means the child receives only breast milk (including expressed milk) and no other fluids or food (with the exception of vitamins, minerals and medicines where necessary). This indicator includes the proportion of infants *exclusively* breastfed to six months of age, because this is consistent with WHO 2025 Global Nutrition targets ([World Health Organization, 2014](#)), and the NHMRC Guidelines. Although the NHMRC guidelines recommend exclusive breastfeeding until six months, many families introduce solids at around four months of age. The 2010 Australian National Infant Feeding Survey is the most reputable source for reporting on this information and no equivalent study has occurred since.

Technical note 2: The *Australia's Health Tracker 2019* has reported on breastfeeding data from the NHS 2017-18 as it provides the most accurate representation of the current situation in Australia. This updated data source is not directly comparable with the original data source (Australian Infant Survey 2010, [Australian Institute of Health and Welfare \(2010\)](#)), therefore, we will not be reporting trend over time for this indicator.



Target: Indicator to be monitored.

Progress:

- **Australia's Health Tracker 2016:** 2.1% (Australian Infant Feeding Survey 2010, [Australian Institute of Health and Welfare \(2010\)](#) table 2.2.)
- **Australia's Health Tracker 2019:** 28.9% (NHS 2017-18, table 31.1, [Australian Bureau of Statistics \(2018d\)](#))

Indigenous data: not available.

Physical inactivity

RISK FACTORS	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 since baseline	-	40.5%^
 Young people (12-17 years) not meeting physical activity recommendations	91.5%^	82.6%	No new data since baseline	Inadequate data to assess trend	65.2%^

^Unable to update data as none has been collected since the 2016 report.

**add Tracker graphic*

Latest Australian data: As reported in *Australia's Health Tracker 2016*, 70.8% of 5-11 year-olds and 91.5% of 12-17 year-olds were not meeting physical activity guidelines. Data were not collected for children in 2014-15. Source: *AHS 2011-12 table 2*, [Australian Bureau of Statistics \(2012\)](#).


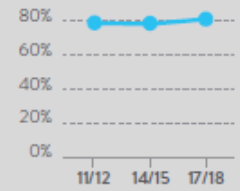

Technical note: Australia's updated Physical Activity and Sedentary Behaviour Guidelines highlight the importance of limiting sedentary behavior ([Australian Government Department of Health, 2017](#)). Children (5-11 years) and young people (13-17 years) should be physically active every day and accumulate at least 60 minutes of vigorous intensity physical, limiting sedentary behavior.

Target: A 10% reduction from the baseline (2011-12) is 63.7% for children and 82.6% for young people as the 2025 target. Source: *AHS 2011-12*, [Australian Bureau of Statistics \(2012\)](#).

Trend: Insufficient data to assess trend as no new data since baseline.

Indigenous data: As reported in *Australia's Health Tracker 2016*, 40.5% of 5-11 year-olds and 65.2% of 12-17 year-olds are not meeting physical activity guidelines. Source: *National Aboriginal & Torres Strait Islander Health Survey: Physical Activity 2012-13 table 9.1*, [Australian Bureau of Statistics \(2014a\)](#).

Social inclusion for people with mental illness

RISK FACTORS	LATEST AUSTRALIAN DATA	2025 TARGET	BASELINE DATA AGAINST LATEST DATA	TREND	LATEST INDIGENOUS DATA
 <p>Young people (16-30 years) with mental illness in education or employment</p>	81.5%	84.5%			Not available

Latest Australian data: Around one in eight (81.5%) young people aged 16-30 years with current and long-term mental and behavioural problems are either studying or employed. *Source: NHS 2017-18 data extracted from ABS Survey Table Builder by PHIDU.*

Target: Halve the participation gap. According to the 2011-12 AHS, 79% of 16-30 year-olds with current and long term mental and behavioural problems were either studying or employed, vs. 90.2% of 16-30 year-olds who did not report such problems. Hence the target of people aged 16-30 years with current and long-term mental and behavioural problems either studying or employed is 84.5%. *Source: NHS 2011-12 data extracted from ABS Survey Table Builder by PHIDU.*

Trend: Latest data suggests good progress towards 2025 target.

- **Baseline:** 79% (NHS 2014-15, [Australian Bureau of Statistics \(2015f\)](#))
- **Australia's Health Tracker 2016:** 78.4% (NHS 2014-15, [Australian Bureau of Statistics \(2015f\)](#)).
- **Australia's Health Tracker 2019:** 81.5% (NHS 2017-18, [Australian Bureau of Statistics \(2018d\)](#))

Indigenous data: Comparable Aboriginal and Torres Strait Islander data not available.

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