Submission from Australia to WHO on Non-Communicable Diseases monitoring framework and global targets – 1st Discussion Paper 29 February 2012

Introduction

This submission outlines Australia's views on the WHO global monitoring framework (the Framework) on targets and indicators for non-communicable diseases (NCDs) provided in the Discussion Paper of 21 December 2011 titled *A comprehensive global monitoring framework and voluntary global targets for the prevention and control of NCDs*.

The submission incorporates the views of the Australian Government Department of Health and Ageing (DoHA), and the Australian Agency for International Development (AusAID) in the Department of Foreign Affairs and Trade – thus providing both a domestic and international perspective.

This submission firstly raises some broad issues around the framework, summarises Australia's views on the targets and indicators and then raises some questions around measurement and data collection issues and seeks clarification of these from the WHO. The Submission includes more information on the framework in Attachment 1.

The Australian Government has met with the Australian branch of the Non-Communicable Diseases Alliance. This group has provided a submission on its response to the discussion paper and Australia has attached it in full for consideration by the WHO (**Attachment 2**).

Overarching views

The political declaration agreed at the United Nations General Assembly High Level Meeting on NCDs in September 2011 in New York recognised the large burden of disease imposed by four diseases: cancer, diabetes, cardiovascular diseases and chronic respiratory diseases, and associated risk factors including tobacco use, harmful use of alcohol, an unhealthy diet, and lack of physical activity. Australia is supportive of the international focus on these diseases and risk factors and the effort to assist in making health gains around them.

The Framework has the potential to be a powerful political tool to galvanise action on NCDs prevention and control, and health systems strengthening. To do this, the targets need to be achievable, and useful as policy levers. There needs to be consideration of the costs and resources required to achieve these targets – many countries will not have finances available to implement programs that would achieve such substantial improvements or appropriate data collection arrangements in place to assess their baseline position or measure progress. The importance of strong country ownership and commitment cannot be overstated, thus in-depth and meaningful consultation will be needed. There is a need for careful assessment of what is realistically possible to monitor. These will be important factors in the success of the Framework and voluntary global targets.

More guidance is required by the WHO on how the global targets and indicators will be adapted to a country context. The targets do not recognise differences in the disease burden and prevalence of risk factors across various countries. The position of some developing countries, where NCDs are increasing, is very different from many developed countries, which have seen high rates of NCDs for a sustained period. If the targets are not realistic and measurable for developing countries, we risk undermining the NCDs response. The targets should recognise that in many developing countries a double burden of both communicable and non-communicable diseases exists. The indicators should also be disaggregated using relevant stratifiers such as gender and age.

The Framework would be strengthened if there were a more balanced mix of disease burden measures, measures of the policy environment / political commitment and health systems measures. The WHO Global Status Report on NCDs represented a good starting point for the Framework. The report lists the three major components of NCD surveillance as being: a) monitoring exposures (risk factors); b) monitoring outcomes (morbidity and disease-specific mortality); and c) assessing health system capacity and response, which also includes national capacity to prevent NCDs.

Table 1 summarises Australia's view on the proposed targets and indicators and more information is provided at **Attachment 1**.

Table 1: Australia's views on targets and indicators

Target[1]	**Target Feasibility**[2]	**Indicator validity**[3]	**Approach Feasibility**[4]	**Measurement**[5]
Mortality from NCDs	Possible, but very challenging due to progress already achieved	No concerns	No concerns	Many challenges with mortality data
Diabetes	Possible, but challenging due to trends in diabetes prevalence	May have concerns	Some concerns – limited success with these approaches to date	Some concerns assuming self reported data on diagnosis prevalence.
Tobacco	Likely	No concerns	No concerns	No concerns assuming self-reported data

[1] As described on p.11 of discussion paper dated 21 Dec 2011.
[2] Likelihood of the target being met by Australia.
[3] The degree to which the indicator may be suitable.
[4] Ability of mechanisms to achieve the target.
[5] Whether technique of measurement exists.

Alcohol	Unlikely – Australia's current APC is relatively stable and is not expected to significantly decline	Significant concerns – APC does not reflect risk of NCDs. A measure of long term harmful use of alcohol is preferred.	Significant concerns – support from jurisdictions, public, industry and other stakeholders will take time.	Significant concerns – APC can be misleading and difficult to compare over time or between members
Salt	Unlikely	No concerns	Some concerns – progress has been made in voluntary reformulation but public awareness campaigns are less successful	Significant concerns with collection of 24 hour urinary sodium data from a representative sample
Hyper-tension	Possible	No concerns	Some concerns – medication and lifestyle interventions can be effective, however, persistence with these measures by individuals is poor world-wide.	Some concerns – Australia has only recently begun collecting measured data for this indicator.
Obesity	Possible	No concerns	Significant concerns – agree that evidence for effective interventions is limited	No concerns
Prevention CVD events	Possible	Some concerns due to complexity	Some concerns due to expense and poor rates of persistence with medication management.	Some concerns due to the lack of data for this indicator
Cervical Screening	Likely	No concerns	No concerns	No concerns

Trans-fats	Unlikely	Some concerns due to approach.	Some concerns, elimination requires legislation, it would be more feasible to replace 'elimination' with 'reduction'.	No concerns
Physical Activity	Recommend consideration of inclusion of a new target/indicator			

The positions noted in the table are subject to confirming some issues (outlined below) on the WHO's methodology.

Measurement questions
Australia has a number of questions and observations about how the targets will be measured.

In particular, it is not clear if the WHO intends that the targets will apply to all participating countries or if they will be measured as an aggregated average of the performance of participating countries. The discussion paper indicates that targets would be adapted to meet country-specific issues and needs for indicators and targets (page 4). Australia seeks clarification on these issues.

Target feasibility and selection
There would appear to be a level of inconsistency within the targets in that some are likely to be achievable in many countries, some appear very ambitious and some may be unattainable.

Further discussion may be warranted around whether it is intended that some target areas are prioritised over others. Further, if it is intended, then it would be helpful to examine which targets should be prioritised. If this is not intended, consideration should be given to targets which are similarly attainable or ambitious.

In setting targets, recognition needs to be given to the different approaches to public health and the prioritisation of issues that can occur within countries. Gains are usually more achievable when there is targeted effort on specific health concerns rather than addressing multiple issues at the same time.

The rationale for several of the targets draws on the experiences of countries in the 5^{th} or 10^{th} percentile. It may not be feasible for those countries to continue to make gains at the levels sought, as these countries are now targeting their efforts to those populations that continue to experience poor health outcomes for the target diseases and risk factors, that is, populations which have more intractable health behaviours or risk factors. It may also

be difficult for countries with less developed health systems to achieve the targets set by the highest performers.

Physical Activity Indicator
Australia strongly supports consideration of the inclusion of a target or indicator on physical activity, given its impact on health outcomes.

Attachment 1

Detailed comments on proposed targets and indicators

1. Mortality from NCDs

Outcome target: 25% relative reduction in overall mortality from cardiovascular disease, cancer, diabetes, or chronic disease.
Indicator: Unconditional probability of dying between ages 30–70 from, cardiovascular disease, cancer, diabetes, or chronic respiratory disease.

Current picture:
It is feasible to measure premature deaths from these 4 disease categories.

Comments on proposed indicator/target: It may be possible for developed countries, like Australia, to meet this target, particularly in relation to CVD and cancer. This is especially the case given the focus on reducing preventable and premature death through strong action on smoking and falling smoking and blood pressure levels etc. Mitigating against this is the unfavourable trends in physical activity, obesity and diabetes prevalence with little change in cholesterol levels nationally.

There may be difficulties in gathering accurate and timely data on cause of death that is specific enough to support measurement.

It is noted that the desired target will be expected to be met over a fifteen year period, whereas the reductions in mortality from NCDs occurred over thirty years. We note WHO's comment that the reduced time period has been considered in determining an achievable target.

As developing countries are also likely to lack the necessary mechanisms for ensuring accurate and detailed reporting and monitoring of relevant mortality data, it is possible that the upper percentile of countries will again have to realise significant mortality reductions to make the target achievable globally. This may be possible, given the current emphasis on preventive approaches to addressing NCDs and their primary causes, but it would detract from the achievement if the 25% target were realised without marked improvement occurring in less developed regions.

Under the National Indigenous Reform Agreement[6] (NIRA), Australian governments committed (2008) to six ambitious targets aimed at overcoming Indigenous disadvantage; two of which are relevant to the WHO targets:

- Close the gap in life expectancy within a generation (by 2031); and
- Halve the gap in mortality rates for Indigenous children under five within a decade (by 2018).

These 'Closing the Gap' targets are deliberately ambitious.

[6] This is an agreement between Commonwealth and State and Territory Governments in Australia describing funding arrangements and policy priorities relating to Aboriginal and Torres Strait Islander People in Australia.

2. Diabetes
Outcome target: 10% relative reduction in prevalence of diabetes (where diabetes is defined as fasting plasma glucose ≥ 7.0mmol/L (126 g/dl) or on treatment for diabetes) (baseline year is 2010 and target year is 2025)
Indicator: Age-standardised prevalence of diabetes among persons aged 25+ years

Current picture
Based on estimates from the Australian Diabetes, and Lifestyle (AusDiab) study in 1999-2000, using measured data, the prevalence of diabetes was 7.5% among those aged 25 years and over.
Source: Dunstan D, Zimmet P, Wellborn T et al 2001. Diabesity and associated disorders in Australia 2000. International Diabetes Institute: Melbourne.

Comments on proposed indicator/target:
There may be difficulties in meeting this target world-wide, with many countries experiencing rapidly rising rates of diabetes due to a range of factors, including increasing rates of obesity. While preventive measures have been in place over decades nationally and internationally, we have not yet begun to reverse the trend in diabetes prevalence.

Australia has a performance benchmark in its National Healthcare Agreement[7] to reduce the aged-adjusted prevalence rate for Type 2 diabetes to 2000 levels (equivalent to a national prevalence rate of 7.1%) by 2023.

Issues around measurement of this Australian target are still being resolved. The closest data collection to the baseline year is the 2011-13 Australian Health Survey. If a baseline measurement is required before 2010, the nearest data would be 1999-2000. Plans for future biomedical surveys are not yet in place. There may be similar issues in measuring the WHO global target.

3. Tobacco smoking
Exposure target: 40% relative reduction in prevalence of current tobacco smoking (baseline year is 2010 and target year is 2025)
Indicator: Age-standardised prevalence of current tobacco smoking among persons aged 15+ years

Current picture
The 2007-08 National Drug Strategy Household Survey (conducted in 2007-08) estimates that 18% of people in Australia aged 14 years or older were current smokers, comprising: 15.1% daily smokers, 1.5% weekly smokers and 1.4% less than weekly smokers.

[7] This is an agreement between Commonwealth and State and Territory Governments in Australia describing funding arrangements and policy priorities.

Comments on proposed indicator/target:
The WHO Framework Convention on Tobacco Control (FCTC) is an enabler that has contributed to Australia's approach in developing and implementing tobacco control measures, using strategies to reduce both demand and supply of tobacco.

Australia has a performance benchmark in its National Healthcare Agreement to reduce the national smoking rate to 10% of the adult population and halve the Indigenous smoking rate by 2018 compared with 2009. A reduction to 10% of the adult population would represent a 33% reduction from 2007-08.

The definition of current tobacco smoking is appropriate as it encompasses the population at risk of tobacco smoking. The current national indicators (in the Healthcare Agreement) focus on daily smoking and this does not include all tobacco smokers, such as weekly and infrequent smokers.

There are two potential data sources for Australia: the National Drug Strategy Household Survey and the National Health Survey (2011-13 Australian Health Survey). Both surveys differ in response rates and collection methodology and a decision would need to be made on which data source would be used for this indicator to ensure appropriate analysis of change over time.

4. Alcohol
Exposure target: 10% relative reduction in persons aged 15+ alcohol per capita consumption (APC) (baseline year is 2010 and target year is 2025)
Indicator: Per capita consumption of pure litres of alcohol among persons aged 15+ years

Current picture
On a per capita basis, there were 10.4 litres of pure alcohol available for consumption per person in 2009–10, the same as in 2008–09. As a standard drink consists of 12.5 mls of pure alcohol, this is equivalent to an average of 2.3 standard drinks per day per person aged 15 years and over. The per capita consumption of pure alcohol has been around 10 litres since 2005.

Comments on proposed indicator/target:
The APC is not a targeted measure that focuses on the primary area of concern with alcohol, namely, long term harm. Reducing alcohol consumption associated with long term harm may be more easily achieved than a reduction in consumption of alcohol per capita.

APC would appear to be a crude measure of alcohol consumption as it merely estimates consumption by dividing the quantity of alcohol available for consumption by the estimated resident population of persons aged 15 years and over each year in Australia.

In addition, no adjustments are made for:

- retail or wholesale storage;
- duty-free alcohol imported by individual overseas travellers; or
- for alcohol that has been stored or cellared, used in the preparation of food or discarded as waste.

Thus, the data source is not entirely reliable.

5. Dietary salt intake

Exposure target: Mean population intake of salt less than 5 grams per day (baseline year is 2010 and target year is 2025)

Indicator: Age-standardised mean population intake of salt per day (where salt refers to sodium chloride and 5 grams of salt is approximately 2 g of sodium)

Current picture

Results from Food Standards Australia and New Zealand (FSANZ) analysis of sodium intake data from the 1995 National Nutrition Survey estimate that the mean sodium intake for Australians aged two years and above was 2.15g per day.

Source: Boorman J, Cunningham J and McKerras D for FSANZ. Salt intake from processed food and discretionary use in Australia. Poster presentation. Canberra: FSANZ. This is the most recent sodium intake data available in Australia at this time.

Comments on proposed indicator/target:

Australia considers the salt target to be ambitious and would not support this target as it would be difficult to achieve and measure. It is difficult at this stage to commit to a target in the absence of current data on consumption of salt.

The Nutrient Reference Values for Australia and New Zealand currently recommends an upper limit of 2300mg of sodium intake per person per day, which equates to 6g of salt. This level has been set on the basis of population studies showing low levels of hypertension (less than 2%) and no other observed adverse effects in communities with intakes below this level. Thus, Australia would like to further understand the rationale for the target level of 5g per day was set.

The monitoring of this target in Australia is a significant issue. The most recent data on salt consumption for adults is from the 1995 National Nutrition Survey. The Australian government is currently conducting the Australian Health Survey, with collection of both dietary intake data, and biochemical parameters (including spot sample urine collection) with results available from May 2012. At this stage there is no commitment to conduct further surveys.

Most of the salt consumption in the Australian diet is in processed foods and meals prepared outside the home. The Australian government is working with the food industry to reduce the salt content of some food products through a voluntary reformulation program. The sodium reduction targets are specific to each category - for example, a 15 per cent reduction for ready-to-eat breakfast cereals that exceed 400mg of sodium per

100g by the end of 2014. To date, individual sodium reformulation targets have been set for Bread, Breakfast Cereals, Simmer Sauces, Processed Meats and Soups.

6. Blood pressure/Hypertension
Exposure target: 25% relative reduction in prevalence of raised blood pressure (where raised blood pressure is defined as systolic blood pressure ≥ 140 and/or diastolic blood pressure ≥ 90) (baseline year is 2010 and target year is 2025)
Indicator: Age-standardised prevalence or raised blood pressure among persons aged 25+ years

Current picture
Based on estimates from the Australian Diabetes, Obesity and Lifestyle (AusDiab) study in 1999-2000, using measured data, the prevalence of high blood pressure was 29% of people aged 25 years and over.
Source: Dunstan D, Zimmet P, Wellborn T et al 2001. Diabesity and associated disorders in Australia 2000. International Diabetes Institute: Melbourne.

Comments on proposed indicator:
The capacity for countries to achieve this target appears reliant on health promotion and preventive health activities to facilitate lifestyle change and access to effective, affordable antihypertensive medication. It is likely that many countries (particularly developing ones) lack the capacity to implement the broad scale awareness campaigns required. Antihypertensive medications are highly effective depending on their availability and population compliance once prescribed.

The closest data collection to the baseline year is the 2011-13 Australian Health Survey. If a baseline measurement is required before 2010, the nearest data would be 1999-2000. There is no collection planned for the target year 2025.

In addition, despite the effectiveness of anti-hypertensive medication, persistence with medication has been found to be poor, with as few as 15% of patients persisting with treatment after three years.[8]

7. Obesity
Exposure target: No increase in obesity prevalence (where obesity is defined as a Body Mass Index (BMI) ≥ 30kg/m^2, baseline year is 2010 and target year is 2025)
Indicator: Age-standardised prevalence of obesity among persons aged 25+ years

Current picture
In 2007-08, based on measured data collected in the National Health Survey 25% of Australians aged 18 years and over were obese.

[8] Hasford J, Schroder-Bernhardi D, Rottenkolber M et al (2007). *Persistence with antihypertensive treatments: results of a 3-year follow-up cohort study.* European Journal of Clinical Pharmacology, 63(11):1055-1061.

Comments on proposed indicator/target
The inclusion of obesity as an indicator is supported, however, it is suggested that 'no increase in overweight prevalence' is included as a target.

This would be a more achievable target than 'no increase in obesity prevalence' as the interventions to prevent overweight present a lower risk to the individual and require less involvement of the health system.

The interventions for the obese can be costly and high risk, and would be difficult for most countries to support. For example, for individuals who are obese, intensive weight management interventions such as very low energy diets, weight loss medication and bariatric surgery are recommended.

In Australia, the Federal, State and Territory governments have funded initiatives to increase healthy eating and physical activity as a strategy to prevent overweight and obesity. This is supported by evidence that lifestyle intervention (healthy eating plan, increased physical activity and behavioural modification) has been shown to have some effect in addressing obesity. These initiatives also bring a range of health benefits beyond weight loss.

Australia has a performance benchmark in its National Healthcare Agreement to increase by 5 percentage points the proportion of Australian adults and Australian children at a healthy body weight by 2017 compared with 2009.

The National Partnership Agreement on Preventive Health[9] (NPAPH) includes a performance benchmark of any increase in proportion of adults at unhealthy weight held at less than five per cent from baseline for each state by 2013: proportion of adults at healthy weight returned to baseline level by 2015. The NPAPH performance benchmark is acknowledged as ambitious. An analysis of the unhealthy weight benchmark indicates that to meet this target the rate of 5-year weight gain in Australia would need to be 75% less than it was between 2000 and 2005.

The definition of obesity is consistent with national standards. The closest data collection to the baseline year is the 2011-13 Australian Health Survey. If a baseline measurement is required before 2010, the nearest data would be 2007-08 National Health Survey. As yet there is no collection planned for the target year 2025.

8. Prevention of heart attack and stroke
Exposure target: 80% coverage of multidrug therapy (including glycaemic control) for people aged 30+ years with a 10 year risk of heart attack or stroke ≥ or existing cardiovascular disease
Indicator: Percentage of estimated people aged 30 years+ with a 10 year risk of heart attack or stroke ≥ 30%, or existing cardiovascular disease who are currently on multiple drug therapy (including glycaemic control)

[9] This is an agreement between Commonwealth and State and Territory Governments in Australia describing funding arrangements and policy priorities on preventive health.

Current picture
There are no data available at present in Australia on this target.

Comments on proposed indicator/target
Australia notes that if this target were met, it would be a very cost effective mechanism in treating NCDs. However, it also notes that there may be some difficulties posed in gathering the data to measure the target. In addition, persistence with relevant medications has been found to be sub-optimal.[10]

9. Cervical cancer screening
Exposure target: 80% of women between ages 30-49 screened for cervical cancer at least once (baseline year is 2010 and target year is 2025)
Indicator: Prevalence of women between ages 30-49 screened for cervical cancer at least once

Current picture
Approximately 84% of women between the ages of 20 and 69 years have screened once between 2005 and 2009. Australia currently recommends cervical screening once every two years for women between 18 and 69 years of age. In 2008-09, 3,802,203 Australian women had Pap smears. Of these 3,638,941 (95.7%) were in the target age group 20–69 years. This represents age-standardised rates of 58.2% for all women and 58.6% for women aged 20–69 years meeting these recommendations.

Comments on proposed indicator/target
While this target is supported, a key component of a screening program is the ability for abnormal test results to be followed up and treated appropriately. If access to follow-up is not achievable in some countries, the target will not impact on mortality rates.

10. Elimination of industry produced trans-fats from the food supply
Exposure target: Elimination of industrially produced trans-fats (PHVO) from the food supply
Indicator: Adoption of national policies that eliminate partially hydrogenated vegetable oils (PHVO) in food supply

Current picture
There has been a decline in PHVOs in Australia from manufactured sources by around 25-45% since 2007.

A review of the Australian food supply conducted in 2009 by Food Standards Australia New Zealand found that contributions of trans fatty acids to energy intake in Australia averages 0.5%, which is well below the intake goal of 1% proposed by the World Health Organisation.

[10] AIHW (2007). *Medicines for cardiovascular health: are they used appropriately?*, page 27-30.

Comments on proposed indicator/target
Australia would not be able to support this target as it would require legislation to eliminate trans-fatty acids levels in foods containing partially hydrogenated vegetable oils. As noted in the NCDs paper, Australia has already made substantial reductions through food labelling initiatives, which were voluntary changes in industry practice facilitated by Australia and New Zealand Food Regulation Ministerial Council (ANZFRMC).

Current Australian policy endorsed by ANZFRMC in 2009, following two reviews of the Australian food supply in 2006 and 2009, is to continue with the current non-regulatory approaches to reducing levels of trans fatty acids in the food supply.

It may be more feasible to change the trans fatty acids target and indicator to reduction rather than elimination.

Physical Activity Indicator
Australia would support the inclusion of a target and indicator on physical inactivity in the global monitoring framework for NCDs and notes that physical inactivity meets the five criteria used in the selection of the global indicators.

There is currently no internationally agreed measure for monitoring physical activity that could be used, although two self-report measures, the International Physical Activity Questionnaire (IPAQ) and the Global Physical Activity Questionnaire (GPAQ), have been developed and used in over 130 countries.

Nations, including Australia, would be able to measure against their own internal baseline data relating to physical activity. The Australian Health Survey (2011-13) includes a National Nutrition and Physical Activity Survey (NNPAS). The NNPAS will allow Australia to monitor and report against the Australian physical activity guidelines and recommendations.

Under the National Partnership Agreement on Preventive Health (NPAPH), the Commonwealth, the States and Territories have agreed to the following performance benchmarks relating to adult physical activity:

- increase in proportion of adults participating in at least 30 minutes of moderate physical activity on five or more days of the week of 5% from baseline for each state by 2013; 15 percent from baseline by 2015.