Submission from Australia to WHO on Non-Communicable Diseases global monitoring framework and targets – 2nd Discussion Paper 19 April 2012

Introduction

Australia recognises the progress being made by WHO to move forward the development of the global monitoring framework, including indicators and voluntary targets, post the United Nations General Assembly High Level Meeting (UNGA HLM) on non-communicable diseases (NCDs) in September 2011.

Australia provided comments on the first discussion paper of 22 December 2011. We are pleased to provide our views on the second Discussion Paper of 21 March 2012 titled *A comprehensive global monitoring framework including indicators and a set of voluntary global targets for the prevention and control of noncommunicable diseases*.

This second submission incorporates the views of the Australian Government Department of Health and Ageing, the Australian Agency for International Development (AusAID) in the Department of Foreign Affairs and Trade and the Australian National Preventive Health Agency.

Overarching views

The Australian Government broadly supports the framework presented in the second discussion paper as the targets are focused on the highest priorities.

Australia also notes that the timeframe for these targets is very long – from a baseline set in 2010 through to targets to be reached by 2025. This is much longer than the Millennium Development Goals (MDGs) or any other global targets. It will be important for the framework to be integrated with the post-2015 MDG agenda. Given this framework is the first ever set of targets and indicators for global monitoring of NCDs, and much more complex than MDGs or other reporting frameworks, Australia requests consideration be given to providing some capacity to review the framework after a first round of measurement. All countries will need to prioritise expenditure and initiatives.

In setting the targets and indicators, there is a need to strike a balance between aspiration and achievability, especially if the key indicators and targets within the global monitoring framework are to act as a real impetus for action by Member States. However, we are concerned that some of the targets will be very difficult to meet and that some of the targets/indicators may be difficult to measure.

Australia agrees with the inclusion of new targets and indicators, such as physical inactivity and access to palliative care.

Australia also supports the continued consultative process being undertaken by the WHO on the framework. This process will help to ensure that Member States have the opportunity to understand, engage and influence, any options that are developed and that the framework will have strong support from Member States.

Measurement questions

Australia also notes that there is a need to ensure that the agreed set of indicators and targets are meaningful and measurable. We are concerned that some of the targets and indicators will be difficult to measure as appropriate data sources have not been

developed or data are not available as regularly as outlined in the submission. Capturing biometric data (salt intake) is expensive and may not be a cost effective use of health funding. It is unclear that systems are in place to support accurate and consistent measurement and reporting of data over time and across countries under the proposed framework.

Australia also seeks clarity on whether 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 although there is little detail on this point.

Target/Indicator selection and feasibility

Physical Activity Target

Australia and other nations strongly supported the inclusion of a target on physical inactivity given its impact on health outcomes. We support such a target being included.

Palliative Care Indicator

Australia supports a palliative care indicator being included in the suite of indicators as access to such care clearly improves the quality of end-of-life.

Number of indicators

The discussion paper lists 20 indicators. Countries may find reporting against this large number of indicators difficult. Consideration might be given by WHO to lessons learned previously in implementing indicators if there are a large number of indicators and they are difficult to report against.

Feasibility

As previously advised, Australia is concerned that some of the targets will be very difficult to meet. In particular, Australia has concerns with the rationale that bases forward-looking targets on achievements made in the high-income countries' context. Further, there appears to still exist an inconsistency within the targets in that some are highly ambitious while others seem to be much more attainable.

Attachment 1 outlines Australia's views on the specific targets and indicators.

Capacity strengthening for health systems

This discussion paper recognises that strengthening the capacity for health systems to monitor NCDs is vital. Australia supports wider health system strengthening efforts within the NCD response. Considering that fetal and childhood under-nutrition is identified as a major long-term risk factor for developing adult chronic disease, efforts to support better maternal and child health outcomes are critical. Consideration might be given by WHO to the possible adverse consequences of implementing the Framework, particularly in developing countries, such as the redirection of funding away from life-saving programs to prevent communicable diseases and reduce maternal mortality. Australia also supports equity as one of the general principles of the global monitoring framework, with progress against the framework importantly monitored against key social determinants.

The discussion paper highlights the need for an integrated approach to NCD surveillance and the importance of alignment with existing efforts, such as the Framework Convention on Tobacco Control. Australia supports this approach, which is particularly critical for achieving sustainability in developing countries and works to avoid vertical programming. Australia also considers that the harmonisation of strategies and health policies at the regional level is critical for effective NCD prevention and control.

Looking forward

If we are to achieve the global goal of reducing poverty, the burden of NCDs on the poor must be considered in the post-2015 Millennium Development Goal (MDG) agenda. The global monitoring framework represents an opportunity to highlight the need for re-orientation and strengthening of health systems to better prevent, detect and manage chronic disease. Given that the framework goes to 2025, it will be important for it to be integrated with the post-2015 MDG agenda.

Australia encourages the WHO to seek out the views of developing countries to ensure that by the end of 2012 there is global consensus around the feasibility of the monitoring framework. This is particularly crucial in the Asian region where countries are undergoing rapid demographic transition. Countries in the region may only have a single generation to plan for and prepare their health and social systems for an ageing population.

Attachment 1

Key indicators and targets

Mortality from NCDs

25% relative reduction in overall mortality from cardiovascular, disease, cancer, diabetes, and chronic respiratory disease

Australia reiterates the comments it provided in its first submission around this target. In particular, 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. It should also be noted that there may be difficulties in gathering accurate and timely data on cause of death that is specific enough to support measurement.

Blood pressure/Hypertension

25% relative reduction in prevalence of raised blood pressure

This target may be unachievable for Australia. While lifestyle and medication interventions to address hypertension are effective, compliance with these measures has been found to be poor.

Tobacco smoking

30% relative reduction in prevalence of raised blood pressure

The discussion paper proposes a target of a 30 per cent reduction in prevalence of tobacco smoking by 2025. The baseline year would be 2010. Progress against the target would by measured using the aged-standardised prevalence of current tobacco smoking among persons aged 15 and over.

In Australia, we note that if the baseline is taken from the Australian 2010 National Drug Strategy Household Survey, which found that 15.1 per cent of persons aged over 14 smoked daily, Australia's target would be a daily smoking rate of 10.6 per cent by 2025.

From Australia's perspective, the proposed WHO global target is supported, noting that it would be less ambitious than the Australian National Health Agreement performance benchmark for the states and territories which aimed at reducing Australia's national smoking rate to 10 per cent by 2018.

Dietary salt intake

30% relative reduction in mean adult (aged 18+) population of intake of salt, with aim of achieving recommended level of less than 5 grams per day

The Australian Government considers the salt target to be very ambitious, and difficult to achieve and measure. While acknowledging that the targets are intended to encourage Member States to do more than the status quo, this target for Australia will prove to be more difficult than most of the other targets identified. The ambitiousness of targets appears to be inconsistent for the Australian context.

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.

The WHO discussion paper on targets advocates for salt reduction interventions which include mass media campaigns. Campaigns require significant investment. To fund this initiative, the WHO discussion paper on effective approaches proposes strategies for raising funds that are inconsistent with current Australian policy, such as taxation on high sodium foods, and regulating to reduce sodium in processed foods.

Measuring salt intake through biometric testing is expensive. The WHO may wish to give consideration to whether such testing is a cost effective use of health funding.

The summary of feedback from member states on the first discussion paper shows that the Australian government is not alone in expressing concern regarding this target's achievability and measurement. There was only a modest level of support for this target.

Physical inactivity

10% relative reduction in prevalence of insufficient physical activity in adults aged 18+ years

Australia supports the inclusion of physical inactivity as one of five indicators, with a voluntary target for 2025, under the global monitoring framework for NCDs. The data collection tool used to measure Australian physical activity participation, both in the past and currently, does not directly align with the tools recommended in the discussion paper (WHO STEPS and GPAQ). The frequency of the collection of Australian physical activity data is at this stage undetermined and may not meet the 3-5 year frequency recommended, or align with the progress assessment interim target points set for 2015 and 2020.

The rationale for the development of the physical inactivity target outlines that existing international examples demonstrate that change in the order of 1% per year can be achieved through national action.

Under a partnership agreement between the Federal and State and Territory Government, the agreed performance benchmark relating to adult physical activity is:

- 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 per cent from baseline by 2015.

Other core indicators

Overweight/obesity

Under a partnership agreement between the Federal and State and Territory Government, the agreed performance benchmark relating to adult obesity is:

- 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.

In the discussion paper, the core indicator for NCD surveillance for obesity (age-standardized prevalence of overweight and obesity in adults – defined as body mass index greater then 25 kg/m^2 for overweight or 30 kg/m^2 for obesity) is consistent with

the parameters in the Australian National Health and Medical Research Council Clinical Guideline and could be reported on through the NHS.

Trans fats
The elimination of industrially produced trans-fatty acids from the food supply has been changed from a target to an indicator. This is a reasonable approach for this indicator. This change is consistent with the comments provided by Australia on the first discussion paper dated December 2011.

Low fruit and vegetable intake
Low fruit and vegetable intake has become a new indicator without a target. This is a reasonable approach, and is consistent with current Australian government policy. A partnership agreement between the Federal and State and Territory Governments in Australia (2008-2015) has two benchmarks on fruit and vegetable consumption, for children and adults. The benchmarks aim to increase the mean number of fruits and vegetables consumed by at least 0.2 for fruits and 0.5 for vegetables from baseline for each state or territory by 2013, and 0.6 for fruits and 1.5 for vegetables by 2015.

Access to palliative care
Australia supports the inclusion of palliative care as one of the core indicators without a target. Australia has been a strong supporter and active promoter of adequate access to palliative care medications in the Asia-Pacific region and at the international fora such as the United Nations Commission on Narcotic Drugs.