



Draft National Alcohol Strategy 2018-2026: Australian Health Policy Collaboration Submission

The Australian Health Policy Collaboration (AHPC) is pleased to have the opportunity to lodge a submission in response to the draft National Alcohol Strategy 2018-2026.

The AHPC at Victoria University works with and supports a collaborative national network of organisations and chronic disease experts, bringing together Australia's leading chronic disease experts, scientists and clinicians to translate rigorous research into good policy. The national collaboration has developed health targets and indicators for 2025 that, together, can reduce preventable chronic diseases and reduce the health impacts of chronic conditions in the Australian population. These targets and indicators are aligned with the *World Health Organisation (WHO) Global Action Plan for the Prevention of and Control of Non-Communicable Diseases 2013 – 2020*, with the additional target area of mental health, and were tailored to the Australian context.

The targets and the performance of Australia against those targets is presented in [Australia's Health Tracker 2016](#). This includes a target of a 20% reduction in the harmful use of alcohol, agreed on by the national expert working group (refer Appendix I).

The AHPC therefore urges that the National Alcohol Strategy 2018 – 2026 should include an increased target, to 20%, for reduction in harmful use of alcohol. Currently, the draft National Strategy target is set at 10%, and we would respectfully propose that this is inadequate to address the significant contribution of alcohol-related harms to the physical and mental health of Australians. The unanimous agreement of Australia's leading experts and health organisations on the importance of a 20% reduction target by 2025 is a strong endorsement of the significance of this measure for improved health outcomes in at risk populations.

Australia's Health Tracker targets include three other measures that are also included in the draft National Alcohol Strategy:

- Lifetime Risk – presented in *Australia's Health Tracker* as Drinking at risky levels
- Emergency Department presentations
- Total alcohol consumption per capita

The *Tracker* includes a target reduction from 26.4% to 23.2% in Heavy Episodic Drinking, in line with the WHO targets. We note that this measure is described as "Single Occasion Risk" in the Draft Strategy. The national collaboration experts gave considerable attention to the description as well as the selection of targets and indicators relevant to the Australian context. It may be of considerable benefit to ensure that Indicators in the Strategy are described in terms that are clear and unambiguous to the lay and public audience to strengthen the potential for the Strategy to have an impact on public awareness.

Key recommendation:

1. Adopt the 20% reduction in the harmful use of alcohol endorsed by leading alcohol experts in *Australia's Health Tracker 2016*

We thank you for considering the submission from the AHPC and on behalf of the leading chronic disease experts, scientists, clinicians and researchers of Australia.



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About the Australian Health Policy Collaboration

The Australian Health Policy Collaboration (AHPC) at Victoria University works with and supports a collaborative network of organisations and leading chronic disease experts, bringing together Australia's leading thinkers to translate rigorous research into good policy. The AHPC is leading a national collaboration of more than 50 high-profile organisations and 70 chronic disease scientists, researchers and clinicians. The national collaboration has developed health targets and indicators for 2025 that together, will reduce preventable chronic diseases and reduce the health impacts of chronic conditions.

The AHPC has developed two integrated and interdependent programs of work:

- a national Health and Public Policy Strategy to prevent and reduce the impact of chronic diseases in the Australian population; and,
- the *Growing Brimbank* program, a unique place-based initiative between the AHPC, Victoria University and the Brimbank City Council in the western suburbs of Melbourne that has established a long-term translational research program to lift health, development, wellbeing and education outcomes in Brimbank. The *Australian Health Tracker* targets will be used to guide health and other interventions in this program.



Targets and Indicators for Chronic Disease Prevention

Australia is part to the World Health Organization's (WHO) *Global Action Plan for the Prevention and Control of Noncommunicable Diseases (NCD) 2013-2020*. The WHO states that all countries need to set national NCD targets; develop and implement policies attain them; and establish a monitoring framework to track progress. In **2015**, the collaboration drew on the agenda set by the WHO Global Action Plan and the Mental Health Action Plan 2013-2020, to develop a set of targets and indicators for achievement by the year 2025. The AHPC supported project established seven working groups to review the suitability of the WHO targets and proposed targets and indicators for their subject in the [targets and indicators for chronic disease prevention in Australia report](#). A summary of the WHO targets and AHPC working groups are listed in Table 1.

AREA	TARGET	WORKING GROUP
	Mortality and Morbidity	
Mortality & morbidity; high risk populations	1. A 25% relative reduction in the overall mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases	Group 1 plus high risk aspects of targets 6, 7, and 8 (hypertension; high risk of diabetes; drug therapy and counselling for myocardial infarction and stroke)
	Behavioural risk factors	
Alcohol	2. At least 10% relative reduction in the harmful use of alcohol, as appropriate, within the national context	Group 2
Physical inactivity	3. A 10% relative reduction in prevalence of insufficient physical activity	Group 3
Salt	4. A 30% relative reduction in mean population intake of salt/sodium	Group 4
Tobacco	5. A 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years	Group 5
	Biological risk factors	
Hypertension	6. A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure, according to national circumstances	No specific group (group 1 for high risk considered)
Diabetes and obesity	7. Halt the rise in diabetes & obesity	Group 6
	National system response	
National systems/ equity	8. At least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes	No specific group (relevant groups to consider)
	9. An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major NCDs in both public and private facilities	No specific group (relevant groups to consider)
	Mental health	
Mental health	10. An appropriate target, preferably linked to WHO targets for mental health within the Mental Health Action Plan 2013-2020	Group 7
	11. Other possible targets	All groups

Table 1 WHO targets and AHPC working groups

The Alcohol Expert Working Group

The AHPC alcohol working group is one of seven expert working groups that form part of the targets and indicators project. This group is comprised of leading academics, implementers and policymakers. Refer to Appendix I for full membership.

The WHO target for alcohol is, *"at least 10% relative reduction in the harmful use of alcohol, as appropriate, within the national context"*. Upon review of the WHO target within the Australian context, the alcohol working group argued the need for a more ambitious target. Below is an excerpt



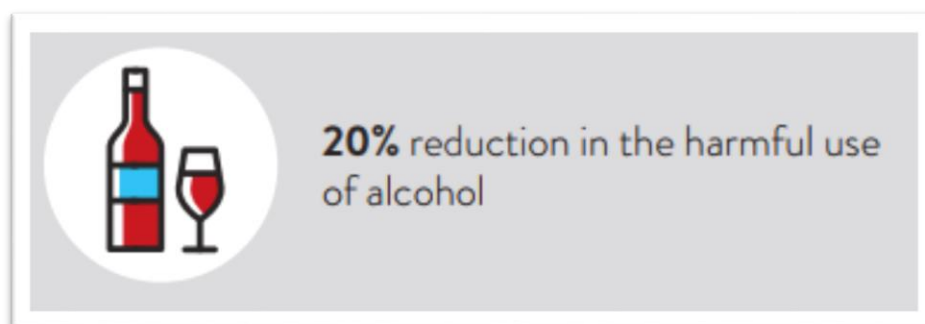
taken from the Alcohol chapter in [Targets and indicators for chronic disease prevention in Australia](#) (refer to Appendix II for the full alcohol chapter).

“A 10% reduction in each of these indicators between 2010 and 2025 is not ambitious enough given the extent of alcohol-related harm in Australia, and evidence for effective countermeasures. The consumption indicators are already trending towards these targets, but there is no guarantee that these trends will continue without appropriate policy support. Concerted effort by federal and state governments will be necessary to ensure that reductions in alcohol-related morbidity and mortality are achieved. A future target of a 20% reduction in the indicators is supported by the working group.”

In 2016, the AHPC together with the national collaboration produced Australia’s first comprehensive national report card on preventable chronic diseases. [Australia’s Health Tracker](#) builds on work undertaken by the expert working groups that produced health targets to support, guide and track progress towards a substantial change in the health of our nation. This national report card graphically highlights where preventative health policy efforts have been successful in tackling risk factors for chronic disease in Australia. It also shows where Australia is lagging behind world standards and failing to prevent chronic diseases.

The original report cards were revised in October 2016 and changes were made to the alcohol targets. Based on the lack of precision in estimation of alcohol consumption and harm, and given the feasibility of achieve more than 10% change over a period of 10 years if the evidence is applied to policy, the alcohol working group endorses a more ambitious 20% target reduction in the harmful use of alcohol by 2025 for Australia.

Therefore, the alcohol working group support a 20% reduction in the harmful use of alcohol.



Reconvening the expert working groups

This year, the AHPC will reconvene the original targets and indicators working groups. 2018 marks almost three years since the development of the proposed chronic disease targets and indicators for Australia. At the conclusion of the agreed health targets and indicators for Australia, working group members agree that the revision of the targets and indicators should be considered in two years and potentially every two years in the foreseeable future. This process is currently underway.

The seven working groups will reconvene to either **affirm** or **review** the proposed targets and indicators in 2015 in light of recent changes since the original targets and indicators were developed, including the WHO's Consultation on the 13th General Programme of World Global Work Plan and the Draft Australian National Alcohol Strategy. The revision process of the targets and indicators will form part of an updated *Australia's Health Tracker 2018* national report card; a tool to hold governments, and others, to account for chronic diseases in Australia.

Australia's Health Tracker 2018 is expected to be launched mid-2018 (refer to Appendix III).

Complementary submissions

Organisations and experts that have contributed to the *Australia's Health Tracker* targets and indicators include the Foundation for Alcohol Research & Education (FARE) and Professor Robin Room, Centre for Alcohol Policy, La Trobe University.

The joint submission from the National Alliance for Action on Alcohol and FARE states:

1. That the National Alcohol Strategy 2018-2026 include an overarching target that aligns with the Australian Health Policy Collaboration Health Tracker 2025 target of a **20 per cent reduction in harmful use of alcohol** with regard to:
 - Per capita consumption
 - Heavy episodic drinking
 - Alcohol-related morbidity and mortality (refer to Figure 1).

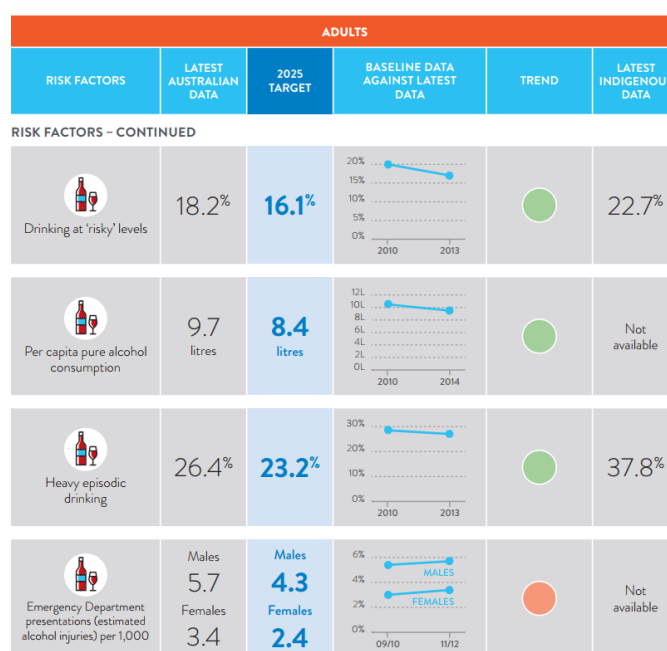


Figure 1 Alcohol targets and indicators from Australia's Health Tracker 2016

The submission from Professor Robin Room also reinforces the need for a more ambitious goal supporting the *Australia's Health Tracker's* target of a **20% reduction** in each of the several main indicators for harmful drinking.



Oral Health and Alcohol

The AHPC, together with the Australian Dental Association (ADA), will launch *Australia's Oral Health Tracker* on Tuesday March 20 2018. *Australia's Oral Health Tracker* is the latest 'Tracker' report as part of the [Australia's Health Tracker](#) suite and is an international first of its kind.

Alcohol is a major risk factor for oral disease and, in particular, for oral cancers, as alcohol introduces carcinogenic material into the mouth. Evidence confirms the association between long-term alcohol consumption and oral cancers^{1,2,3,4}. The risk is in the long-term consumption rather than the amount consumed at each event as even light drinking (defined as 1 drink/day) was associated with oral cancers. A population-level reduction in harmful use of alcohol is recognised as one of the most effective and cost-effective strategies to improve incidence of oral cancers^{5,6}.

Leading oral health experts have developed a set of health targets and indicators for the year 2025 and have adopted several targets and indicators from *Australia's Health Tracker* including the alcohol target of a *20% reduction in harmful use of alcohol*. Oral health experts propose monitoring a single indicator for *Australia's Oral Health Tracker* – long term risky drinking.

In light of new publicly available data since the launch of *Australia's Health Tracker 2016*, a new baseline data point has been set for the long term risky drinking indicator. The latest Australian data estimates 17.1% of Australians (aged 14+) are engaging in long term risky drinking (source: National Drug Household Survey 2016). This is the same baseline as per the draft National Alcohol Strategy.

Therefore, a new target of 13.7% by 2025 - a 20% reduction in harmful use of alcohol- is supported by both the *Australia's Health Tracker* alcohol working group **and** the oral health working group.

¹ Bagnardi V, Rota M, Botteri E, Tramacere I, Islami F, Fedirko V, et al. Alcohol consumption and site-specific cancer risk: a comprehensive dose-response meta-analysis. *British Journal of Cancer*. 2015;112(3):580-93

² Bagnardi V, Rota M, Botteri E, Tramacere I, Islami F, Fedirko V, et al. Light alcohol drinking and cancer: a meta-analysis. *Annals of Oncology*. 2013;24(2):301-8.

³ Reidy J, McHugh E, Stassen LFA. A review of the relationship between alcohol and oral cancer. *The Surgeon*. 2011;9:278-83.

⁴ Turati F, Garavello W, Tramacere I, Bagnardi V, Rota M, Scotti L, et al. Review: A meta-analysis of alcohol drinking and oral and pharyngeal cancers. Part 2: Results by subsites. *Oral Oncology*. 2010;46:720-6.

⁵ Moynihan P, Kelly S. Effect on caries of restricting sugars intake: systematic review to inform WHO guidelines. *Journal of Dental Research*. 2014;93(1):8-18.

⁶ Schwendicke F, Thomson WM, Broadbent JM, Stolpe M. Effects of Taxing Sugar-Sweetened Beverages on Caries and Treatment Costs. *Journal of Dental Research*. 2016;95(12):1327-32.



Appendix I: Members of the Targets and Indicators Alcohol Working Group

Chair Professor Kypros Kypri, Senior Brawn Fellow, School of Medicine and Public Health, Newcastle University

Rapporteur Dr Michael Livingston, NHMRC Early Career Research Fellow, National Drug and Alcohol Research Centre, UNSW

Associate Professor Kerry O'Brien, School of Social Sciences, Monash University

Professor Maree Teesson, Director, NHMRC Centre of Research Excellence in Mental Health and Substance Use (CREMS National Drug & Alcohol Research Centre, UNSW)

Mr Michael Thorn, CEO, Foundation for Alcohol Research and Education, Canberra

Associate Professor Peter Millar, Principal Research Fellow, School of Psychology, Deakin University

Professor Robin Room, Centre for Alcohol Policy Research, La Trobe University

Professor Steve Allsop, Director, National Drug Research Institute, Curtin University

Professor Tanya Chikritzhs, National Drug Research Institute, Curtin University

Appendix II: Alcohol Chapter – Targets and indicators report

3. Alcohol

Michael Livingston and Kypros Kypri

The WHO target and indicators relevant to harmful use of alcohol are provided in Table 3.1.

TABLE 3.1: WHO alcohol target and indicators

TARGET	INDICATORS	FRAMEWORK ELEMENT
Harmful use of alcohol	At least a 10% reduction in the harmful use of alcohol nationally by 2025 (from 2011 levels)	<ul style="list-style-type: none"> • Total (recorded and unrecorded) alcohol per capita (aged 15+ years old) consumption within a calendar year in litres of pure alcohol, as appropriate, within the national context • Age-standardised prevalence of heavy episodic drinking among adolescents and adults, as appropriate, within the national context • Alcohol-related morbidity and mortality among adolescents and adults, as appropriate, within the national context

3.1 Key findings

- Per capita alcohol consumption and the prevalence of risky drinking in Australia have declined, but rates of harms remain high and appear to be increasing in some population groups.
- The WHO indicators need to be expanded and made more specific to ensure that Australia can comprehensively monitor trends in alcohol consumption and related harms.
- The WHO targets of a 10% relative reduction in per capita alcohol consumption, the prevalence of heavy episodic drinking, and rates of morbidity and mortality are achievable within a comprehensive public-health-oriented policy framework.
- Policies focusing on the price, physical availability and promotion of alcohol have the strongest evidence base for reducing population levels of harmful alcohol consumption. Australian governments need to act decisively to ensure Australia reaches the WHO targets.

3.2 Introduction

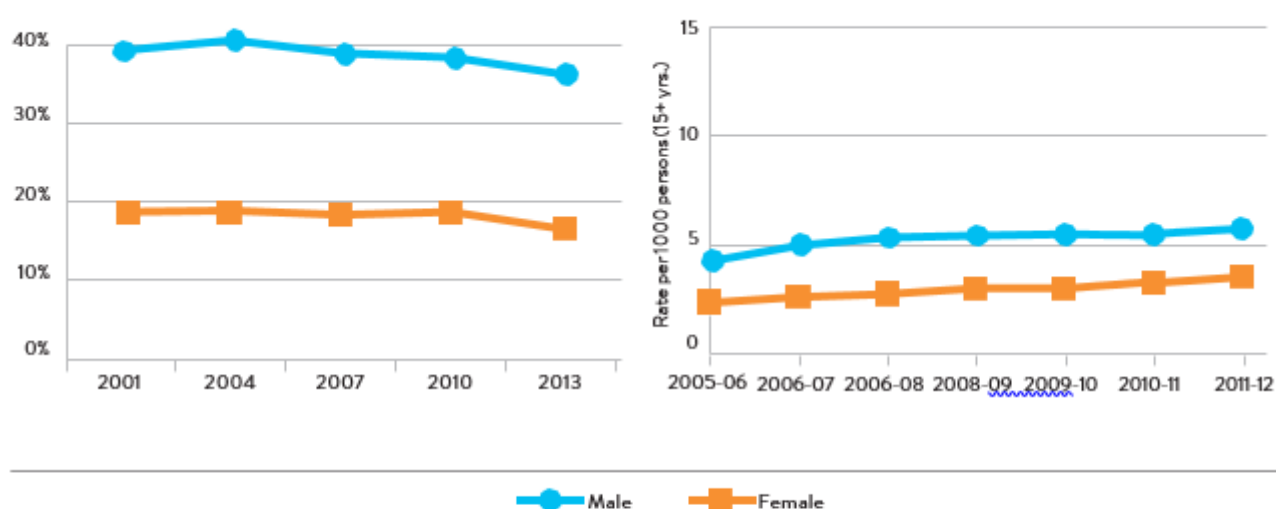
The recent Global Burden of Disease study ranked alcohol consumption as the sixth leading risk factor for death and disability globally (GBD 2013 Risk Factors Collaborators 2015). Some conditions, such as alcoholic liver disease are, by definition, wholly attributable to alcohol consumption. However, alcohol is a cross-cutting risk factor, causally implicated in more than 200 medical conditions (WHO 2014). Accordingly, one of the challenges in monitoring alcohol-related morbidity and mortality is the large number and variety of conditions partly attributable to alcohol consumption. For example, recent estimates suggest that globally, 8% of breast cancer and hypertensive deaths, 7% of ischaemic heart disease deaths, 11% of haemorrhagic stroke deaths and 22% of suicide deaths are attributable to alcohol consumption (WHO 2014).

Divergent trends

The most recent study examining alcohol's contribution to the burden of disease in Australia estimated that, in 2010, 5,554 deaths and 157,132 hospital admissions were attributable to alcohol consumption (Gao et al. 2014).

Per capita consumption in Australia has averaged around 10 litres of pure alcohol per person since the early 1990s. It steadily increased between 2000 and 2008, but declined from 10.8 litres in 2008 to 9.7 litres in 2014 (ABS 2015). Similarly, survey-based estimates of both long-term and short-term risky drinking have declined recently (see Figure 3.1a), with particularly sharp declines among young people (AIHW 2014). In contrast, trends in most indicators of alcohol-related harm have been stable or increasing (Lensvelt et al 2015, Liang et al 2011, Pascal et al. 2013) (see Figure 3.1b). There is evidence that harms in young women are increasing faster than they are in young men, but men still account for most of the harm burden (Lensvelt et al. 2015).

FIGURE 3.1 A: Prevalence of monthly risky episodic drinking among Australians aged 15 years and over by gender, 2001-2013 & **FIGURE 3.1B:** Alcohol-related Emergency Department presentations per 1,000 persons, aged 15 years and older, by gender, 2005-06 – 2011-12 (all states excluding Tasmania)



Sources: (a) National Drug Strategy Household Survey and (b) *National Alcohol Indicators Project Bulletin 14* (2015). Trends in estimated alcohol-related emergency department presentations in Australia 2005-06 to 2011-12

Policy and economic conditions

While in recent years state and federal governments have developed alcohol strategies and policy frameworks (MCDS 2006, MCDS 2010, Ministerial Taskforce on Alcohol and Public Safety 2008, NSW Health 2007), there have been only a few major policy initiatives underpinned by strong evidence and these have been limited in scope or scale. On the supply side, an increase in taxation on pre-mixed spirits (or ‘alcopops’) in 2008 was followed by a sharp fall in their consumption, which was only partly offset by substitution to other beverage types (Chikritzhs et al. 2009). In general, though, alcohol has become more affordable in the last decade (Carragher & Chalmers 2012). Similarly, restricting late trading in particular precincts has produced sharp declines in assaults in those precincts (Kypri et al. 2014b, Menéndez et al. 2015), but the national trend has been toward greater alcohol availability (Manton et al. 2014). On the demand side, there has been no movement away from ineffective industry ‘self-regulation’ of broadcast advertising, nor any restrictions on alcohol industry sponsorship of sport, despite mounting evidence that exposure to such promotion increases the risk of hazardous drinking (O’Brien & Kypri 2008, O’Brien et al. 2011). The decline in consumption since 2008 may be related to the impact of the global financial crisis and slowing down of the mining boom. Increasing rates of harm may have been driven by policies that encourage alcohol consumption in high-risk settings or by high-risk drinkers via expanded availability, particularly late at night (Chikritzhs & Stockwell 2007, Livingston 2011a).

Data sources

Various sources of population survey and official data are potential indicators of harmful alcohol consumption in Australia. A full summary of alcohol’s contribution to disease and injury is beyond the scope of this document, but it is important to note two things. First, acute episodes matter for NCD in terms of their contribution to the cumulative consumption level and also because of risks they confer for injury (included here under the umbrella of NCD) via elevated blood alcohol concentration. Second, for many of the outcomes in question, alcohol interacts with other causal factors. For example, trends in incidence and mortality from colorectal cancer (of which 10% is estimated to be attributable to alcohol) are also influenced by changes in diet and obesity. For these reasons, we require indicators that (1) capture both the acute and chronic risks of alcohol consumption and (2) have high alcohol-attributable fractions (for the morbidity and mortality indicators) to ensure that changes over time are likely to have been driven by changes in alcohol consumption.

3.3 Relevance of WHO targets

The WHO targets of 10% reductions in per-capita consumption, heavy episodic drinking and alcohol-related morbidity and mortality are appropriate but they lack the necessary specificity for surveillance. The targets are presented as a set of alternatives in the WHO documents, but we argue that Australia should aim to achieve all three: reducing overall consumption, risky drinking and rates of alcohol-related harm.

3.4 The case for reforming Australian healthcare funding

We provide a set of indicators for measuring alcohol consumption and related harm in Table 3.2. In addition to the complexity of alcohol’s action on the body and as an agent in the aetiology of injury and other acute harms, the recent disjunction in trends (illustrated in Figures 3.1a and 3.1b) highlights the need for a suite of indicators to reduce the risk of invalid inferences about trends.

A 10% reduction in each of these indicators between 2010 and 2025 is not ambitious enough given the extent of alcohol-related harm in Australia, and evidence for effective countermeasures. The consumption indicators are already trending towards these targets, but there is no guarantee that these trends will continue without

appropriate policy support. Concerted effort by federal and state governments will be necessary to ensure that reductions in alcohol-related morbidity and mortality are achieved. A future target of a 20% reduction in the indicators is supported by the working group.

TABLE 3.2: Indicators for monitoring Australia's progress in reducing the harmful use of alcohol

INDICATOR	DESCRIPTION	SUB-GROUPS	SOURCE*
Per capita consumption	Consumption of pure alcohol per person aged >15 years, based on excise data, import clearances and sales of Australian-produced wine.	NA	ABS
Heavy episodic drinking	Proportion of the population aged >15 years reporting monthly or more frequent episodes where >5 drinks were consumed	Gender	NDSHS
Heavy episodic drinking, adolescents	Proportion of 12–17 years olds reporting at least one drinking occasion in the previous week where >5 drinks were consumed.	Gender	ASSAD
Long-term risky drinking	Proportion of the population aged >15 years reporting average alcohol consumption of more than 14 standard drinks per week	Gender	NDSHS
Emergency department	Presentations for injury to Australian Emergency Departments on Friday, Saturday and Sunday nights	Gender and age (<30, >30 years)	NAIP
Hospital admissions for alcohol use	Hospital admissions for Alcohol Use Disorder	Gender	NAIP
Alcoholic liver disease deaths	Mortality rates with primary cause of alcoholic liver cirrhosis	Gender	ABS

*ABS: Australian Bureau of Statistics; NDSHS: National Drug Strategy Household Survey; ASSAD: Australian School Students Alcohol and Drug Survey; NAIP: National Alcohol Indicators Project

3.5 Discussion

There is a well-established evidence base identifying policy actions likely to reduce alcohol consumption and related harms (Babor et al. 2010). The three key policy approaches relate to pricing, physical availability and promotion.

Pricing

There is robust research evidence from many countries, including Australia, that increasing the price of alcohol reduces alcohol consumption and related harms (Wagenaar et al. 2009, Wagenaar et al. 2010). Modifying the price of the cheapest beverages is likely to produce the largest health gains (Gruenewald et al. 2006). This can be achieved both through modifying the tax rates applied to alcohol and via a mandated minimum unit price (Purshouse et al. 2010, Stockwell et al. 2013). The current policy allows for wine to be sold for less than \$0.30 per standard drink (The Australia Institute 2015) such that wine has become the beverage of choice of our heaviest drinkers (Gray et al. 1999).

Physical availability

Restricting the physical availability of alcohol, either via limiting the number of outlets in proximity to people's homes or the times of day at which alcohol can be sold, are effective means of reducing alcohol-related harm (Babor et al. 2010). In Australia, there is particularly strong evidence that liberalising pub trading hours increases alcohol-related harm (Chikritzhs & Stockwell 2002, Chikritzhs & Stockwell 2006) and that restrictions on late-night trading by pubs and bars reduces harm (Kypri et al. 2014b, Menéndez et al. 2015). There is growing evidence that expansion of the packaged liquor market has had negative impacts on population health, eg. via increased rates of chronic disease and family violence (Livingston 2011a, Livingston 2011b). In relation to harms among young adults, there is evidence that increasing the minimum legal purchase age to 20 or 21 years is an effective policy (Dejong & Blanchette 2014, Kypri et al. 2014a).

Promotion

Exposure to alcohol advertising among children and adolescents is associated with early initiation to drinking and with the volume consumed (Anderson et al. 2009). Alcohol is widely promoted in Australia, with children and adolescents exposed to intensive advertising via traditional media outlets (Carr et al. 2015, O'Brien et al. 2015, Pettigrew et al. 2012) and the internet (Carah et al. 2015). Furthermore, the current 'self-regulation' of alcohol advertising content in Australia is ineffective (Alcohol Advertising Review Board 2015, Jones et al. 2008). Government regulation of the volume, timing, context (eg., sport), and medium of advertising, is necessary to reduce harmful alcohol consumption.

Population groups of concern

Some population groups (eg., young people, people in remote communities, dependent drinkers) are at particularly high risk of alcohol-related harm. It is important to note that the strategies outlined above are effective at reducing harm among these groups as well as in the population as a whole. For example, there is increasing evidence that sales restrictions in remote and regional communities reduce rates of injury (Margolis et al. 2011, Western Australian Drug and Alcohol Office 2015) and that price policies are effective at reducing consumption among heavy drinkers and young people (Grossman et al. 1994, Wagenaar et al. 2009).

Treatment for alcohol use disorder

The treatment system should be adequately resourced to provide high-quality care for patients with alcohol use disorder. Given the relatively small number of people seeking treatment and the wide distribution of harm from alcohol consumption, treatment should not be relied upon to address this problem. The emphasis on policy

must be on the price, physical availability and promotion of alcohol for population level improvements to occur.

Better data

A noteworthy outcome of the Working Group's deliberations was recognition of the need for commitment by the Commonwealth and State governments to improve the quality of data used for outcome and risk factor surveillance in relation to alcohol. Mandated alcohol sales data at the outlet level is achievable (eg., it is collected in WA and NT) and would substantially improve surveillance and the capacity to estimate the effects of policy changes.

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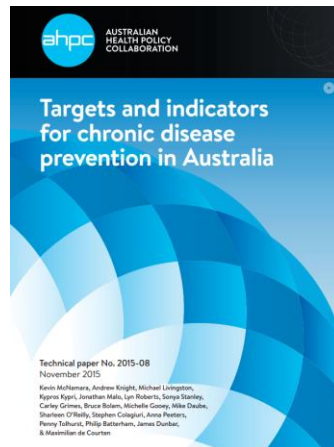
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Appendix III: Timeline of the AHPC national collaboration work

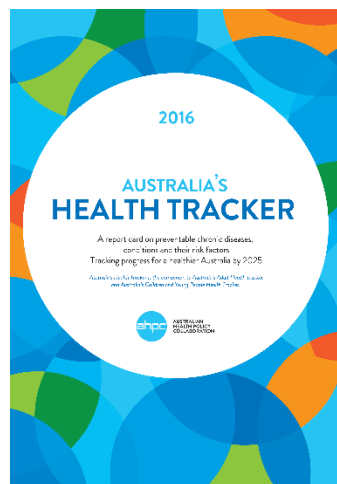
November 2015

Launch of the *Targets and indicators for chronic disease prevention in Australia* report



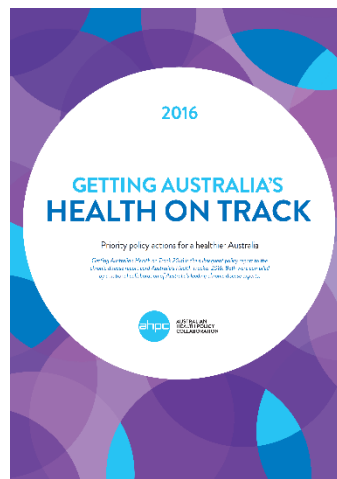
July 2016

Launch of the *Australia's Health Tracker 2016* national report cards



November 2016

Launch of policy roadmap, *Getting Australia's Health on Track 2016*



2017

Launch of 2x national implementation strategies from *Getting Australia's Health on Track*



2018

- Reconvening the targets and indicators working groups
- Launch of *Australia's Oral Health Tracker 2018*