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Dietitians Australia acknowledges all traditional custodians of the lands, waters and seas that we work and live on across Australia. We pay our respect to Elders past, present and future and thank them for their continuing custodianship.

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About Dietitians Australia

Dietitians Australia is the national association of the dietetic profession with over 9000 members, and branches in each state and territory. Dietitians Australia is the leading voice in nutrition and dietetics and advocates for the profession and the people and communities we serve.

Dietitians Australia's credentialing program, the Accredited Practising Dietitian program, provides an assurance of safety and quality and is the foundation of self-regulation of the dietetic profession in Australia. Accredited Practising Dietitians have an important role in the health and wellbeing of all Australians.

This submission was prepared by Dietitians Australia staff in consultation with members, following the Conflict of Interest Management Policy and processes approved by the Board of Dietitians Australia. Contributors include Dietitians Australia members with wide ranging expertise in areas including clinical nutrition, early childhood, disability, food services, public health, food systems and academia.

Recommendations

Medicare Benefits Schedule

Recommendation 1: Implement recommendation 12 of The State of Diabetes Mellitus in Australia in 2024, including increasing the number and length of dedicated dietetic consultations for people living with diabetes.

Recommendation 2: Increase allied health service limits for Medicare's Chronic Disease Management (CDM) program to include a minimum of 12 dedicated services with Accredited Practising Dietitians per year.

Recommendation 3: Support quality of care and communication in the multidisciplinary team by creating and funding Medicare items for allied health professionals to prepare reports for the referring practitioner.

Recommendation 4: Create Medicare Benefit Scheme items relating to dietetic services for people experiencing depression, other mood disorders and severe mental illness, including standard and extended individual consultations, group sessions and telehealth.

Recommendation 5: Create unique 820** Medicare Benefits Schedule item numbers for children with autism, pervasive developmental disorder and disability to see an Accredited Practising Dietitian for dietary assessment, diagnosis and treatment, and create the associated multidisciplinary case conferencing item numbers.

Early Childhood

Recommendation 6: Strengthen food and nutrition regulations, standards and practical guidance for Early Childhood Education and Care (ECEC) services to improve national health outcomes from an early age.

Recommendation 7: Fund on-the-ground food environment support from Accredited Practising Dietitians for ECEC services in all jurisdictions through an initial on-site visit and six-monthly follow-up visits.

National Disability Insurance Scheme (NDIS) Pricing

Recommendation 8: Increase prices for NDIS therapy supports, including dietetic supports, in line with wage increases of 3.19%.

Preventive health

Recommendation 9: Invest in national food and nutrition actions to reduce the exposure and intake of unhealthy foods, support healthy eating and protect all Australians from the risk of diet-related disease.

Recommendation 10: Fund ongoing nutrition monitoring

Discussion

Medicare Benefits Schedule

RECOMMENDATION 1

Implement recommendation 12 of The State of Diabetes Mellitus in Australia in 2024, including:

a. Access to **longer appointments** with a health care provider, including Accredited Practising Dietitians, through Medicare for those people diagnosed with diabetes

COST - $400 million per annum – estimated based on items attracting double the current Medicare benefit

b. **Increase in the number** of Medicare Item numbers for allied health consultations for Australians with diabetes to access diabetes educators, dietitians and other allied health providers.

COST - $150 million per annum, estimated based on publicly available MBS usage data.

RECOMMENDATION 2

Increase allied health service limits for Medicare's Chronic Disease Management (CDM) program to include a **minimum of 12 dedicated services with Accredited Practising Dietitians** per year.

COST- **$310 million per annum** (includes 1(b) above), estimated based on Medicare data from 2023/24 FY (Table 1).

RECOMMENDATION 3

Support quality of care and communication in the multidisciplinary team by creating and funding Medicare items for allied health professionals **to prepare reports** for the referring practitioner.

COST - $60.35 per report (equivalent to benefit of 20-minute consultation.

RECOMMENDATION 4

Create Medicare Benefit Scheme items relating to **dietetic services** for people experiencing **depression, other mood disorders and severe mental illness**, including standard and extended individual consultations, group sessions and telehealth.

COST - $25 million, estimated based on up to 7 sessions per individual, referral rates to Accredited Practising Dietitians through Chronic Disease Management Plans and prevalence of depressive disorders.

RECOMMENDATION 5

Create unique 820** Medicare Benefits Schedule item numbers for **children with autism, pervasive developmental disorder and disability** to see an Accredited Practising Dietitian for dietary assessment, diagnosis and treatment, and create the associated multidisciplinary case conferencing item numbers.

COST - Scoping required.

BENEFITS OF RECOMMENDATIONS 1-5

- Increased utilisation of early-intervention and preventive allied health care to reduce future and ongoing health costs[2]
- Reduced preventable disability and deaths attributable to diet-related disease
- Better continuity and quality of care for consumers with complex needs, who require ongoing consultations and support to enable long-term changes[3]
- Improved cost-effectiveness of treatment,[4, 5] reduced cost to the economy[6-9] and reduced burden on the hospital system[10, 11]
- Improved health outcomes and quality of life for all Australians
- Increased social and economic participation of people with disability[12]
- Supported communication in the multidisciplinary team
- Support achievement of targets in focus area 2 of the National Preventive Health Strategy,[13] ambitions 2 and 3 of the National Obesity Strategy,[14] streams 2 and 3 of the Primary Health Care 10 Year Plan[15] and goals 3, 5 and 6 of the National Diabetes Strategy[16]
- Address desired outcomes of the National Roadmap for Improving the Health of People with Intellectual Disability
- Adopt the Medicare Benefits Schedule Review Taskforce's recommendation to update the M10 items to include dietitians in the list of eligible professionals

BACKGROUND

Chronic disease

- 15.4 million (61%) Australians of all ages were living with at least one chronic health condition in 2022. This rate increases with age - 28% of 0–14 year olds to 94% of people 85 and over.
- The Australian Government spends $1.18 billion dollars every year addressing dietary risk factors that contribute to chronic disease burden.
- $320 million is spent each year on avoidable hospitalisations of people with heart disease, asthma, diabetes and other chronic diseases.
- Currently only 5 sessions per year shared between 13 allied health professions are available through the Medicare Chronic Disease Management program.
- Current Medicare Chronic Disease Management program does not meet best practice standards for dietetic care. It does not allow enough consultations for Australians.

- The Department of Veterans' Affairs recognises the need for longer consultations with a higher benefit for extended initial and subsequent consultations.

Outcomes for Australians with chronic health conditions, including diabetes, can be improved by better access to Accredited Practising Dietitians,[2] to support self-management under the Medicare Chronic Disease Management items (10954, 93000, 93013), the Eating Disorder Treatment items (82350, 93074, 93108) and Aboriginal and Torres Strait Islander allied health follow-up items (81320, 93048, 93061). This can be achieved by increasing the number of dedicated consultations for Accredited Practising Dietitians attracting Medicare benefits, and introducing new items for longer consultations.[3]

Under the current system, patients with a Chronic Disease Management plan may access up to 5 sessions from their whole allied health team, including their dietitian.[17] This is 5 services each year, split across 13 allied health professions. Five sessions or fewer does not meet best practice guidelines for dietetic care,[18, 19] does not support building rapport and trust with clients,[20] and is insufficient to support sustainable long-term health behaviour changes necessary to improve health outcomes.[3, 21]

Previous changes in 2006 recognised that the allowance of 5 services across 12 allied health professions was insufficient to provide support and enable health behaviour change for patients requiring mental health services, and the Better Access Initiative was established.[22] Further, the 2019 implementation of the Treatment Cycle Initiative under the Department of Veteran Affairs allowed 12 consultations per allied health profession per year for eligible veterans.[23] Similar initiatives to support dietetics services for chronic disease management and prevention under Medicare should be implemented.

Increasing the limit to a minimum of 12 dietetic consultations per year will enable patients to access the care and support needed to manage diabetes and other chronic health conditions, and prevent further complications and costs associated with ill health.[3, 24]

Dietetics in the ambulatory and community setting is largely a counselling-type therapy, backed by evidence. Effective counselling in a patient-centred approach requires time to build rapport[20] and develop an individualised nutrition care plan.[25] An Australian longitudinal study of 20 dietitians and 176 consultations under the Medicare Chronic Disease Management program found that the mean time spent on an initial consultation was 55 minutes and for a review, 36 minutes.[26] Other counselling professions (eg, psychologists, social workers, occupational therapists) have item numbers for consultations of 50 minutes or longer to reflect the time that is needed to support patients. The Department of Veterans' Affairs also recognises the need for longer consultations with a higher benefit for extended initial and subsequent consultations.[27] Increasing the benefit for longer consultations will help ensure that providers are able to undertake an effective assessment of the patient and provide a high-quality service.[3, 21, 28]

Effective multidisciplinary collaboration that leads to optimal outcomes for Australians must be underpinned by strong communication and appropriate resources.[29] With increasing rates of diabetes and other chronic diseases in Australia and a greater demand for more complex care, it is imperative to support multidisciplinary health care teams to continue to deliver comprehensive, quality services through adequate remuneration for collaboration, including report writing. The Department of Veterans' Affairs recognises this and offers a benefit for reporting.[30] Renumerating dietitians for this time will promote strong communication across the multidisciplinary team and support a better health care experience for consumers.

Table 1. Benefits paid for chronic disease management services by dietitians between July 2021 to June 2024

Service type	Item numbers	Benefits paid per financial year		
		2021/22	2022/23	2023/24
In-person	10954			
No.services		350,041	360,114	357,133
Benefit		$19,699,973	$20,699,951	$21,451,158
Telehealth	93000 93013			
No.services		99,136	60,860	56,511
Benefit		$5,813,871	$3,695,125	$3,767,750
	Total no. services	449,177	420,974	413,644
	Total benefit	$25,513,844	$24,395,076	$25,218,908
	Average uptake over 3 years			427,931
	Cost of 12 dedicated APD services (in-person and telehealth) based on current benefit and average rate of uptake			**$309,907,630**

Data sourced from Services Australia's online reporting tool at www.medicarestatistics.humanservices.gov.au

Mental Health

Half of all Australians will experience some form of mental illness in their lifetime.[31] Mental illness is a collective term that describes a wide array of conditions such as mood, anxiety, personality, psychotic, substance use and eating disorders.[32] Mental illness impacts all society and is associated with significant economic costs. The healthcare costs for individuals living with mental illness increases by at least 45% when they also have a long-term physical illness. These costs are largely avoidable.[7-9]

Dietary factors including poor dietary intake, poor hydration status, difficulty regulating food intake and food insecurity are all commonly associated with mental illness, yet nutrition is not part of mental health care plans. Poor diet quality, often characterised by foods high in energy and salt, can contribute to physical illness and is prevalent in people across the spectrum of mental illness.[33] There is growing evidence of the direct impact that nutrients, food, dietary patterns and behaviours have on mental health showing they help support healthy brain structure and function in many ways. Factors that adversely affect physical health such as inflammation, glucose intolerance, impaired cerebral blood flow and oxidative stress, also impact on mental health.[34, 35] Further, several antipsychotic and other psychotropic medications used to manage mental health conditions have known metabolic side effects, such as affecting a person's weight.[36]

Early dietary intervention with referral to an Accredited Practising Dietitian provides people with the opportunity to make dietary changes that can help prevent, treat and/or manage both their mental and physical health, and manage the metabolic side effects of psychotropic medications. Evidence

shows that individuals with depression attending 7 consultations with an Accredited Practising Dietitian and following a Mediterranean-style dietary intervention experience significant reduction in symptoms and over 30% remission rate.[37]

Early intervention, together with collaborative care, will mitigate costs to the economy, reduce the burden of disease and minimise the impact of physical illnesses.[6]

Disability

The prevalence of disability in Australia is estimated to be around 18% (4.4 million people) across all age groups, and 7.6% in children between 0 to 14 years of age.[38] Population studies show that people with disability have poorer self-reported general health and higher prevalence of modifiable risk factors, compared to people without disability. Modifiable risk factors include insufficient fruit and vegetable intake, higher consumption of sugar sweetened beverages, high blood pressure, insufficient physical activity, high Body Mass Index and high waist circumference.[38] The presence of these risk factors may contribute to the higher risk of diet-related health conditions, such as cardiometabolic disease, diabetes and cancer among people with disability, compared to people without disability.[39-41]

Disability may lead to unique food, fluid and nutrition requirements, further placing individuals at higher risk of nutritional problems.[42] For instance, children with disability are often at higher risk of growth alterations such as failure to thrive or obesity, metabolic disorders, poor feeding skills, drug-nutrient interactions and sometimes partial or total dependence on enteral or parenteral nutrition.

Accredited Practising Dietitians are the health professionals appropriately trained, qualified and credentialled to address nutrition problems in children with disability. Early dietetic intervention can improve the nutrition and food intake of children, leading to improved physical and mental health, and social outcomes of children with disability and their families.

However, there is a lack of investment in supported access to community based or outpatient dietetic services for people with disability. Standard Medicare allied health funding for chronic disease is insufficient to meet the needs of people with a disability for the same reasons as for all Australians indicated above.

Currently seven other allied health professions have access to M10 unique 820** numbers.[43] Expanding this to include Accredited Practising Dietitians will ensure people with disability can access affordable, preventive dietetic care and provide dietitians with parity to the other allied health professionals already included.[12]

The National Roadmap for Improving the Health of People with Intellectual Disability outlines key activities and outcomes to improve the lives of people with disability. Better use of MBS items is a key goal including “More comprehensive health plans for people with intellectual disability developed that include action on health promotion, disease prevention, and chronic disease detection”. One way to improve health outcomes and plans for children with disability is to fund the inclusion of dietitians in teams for children with autism, developmental delay and disability.

The Medicare Benefits Schedule Review Taskforce recommended updating the M10 items to include dietitians in the list of eligible professionals.[44]

Early Childhood Education and Care (ECEC)

RECOMMENDATION 6

Strengthen food and nutrition regulations, standards and practical guidance for ECEC services to improve national health outcomes from an early age.

RECOMMENDATION 7

Fund on-the-ground food environment support from Accredited Practising Dietitians for ECEC services in all jurisdictions.

COST - $32.5 million per annum ($35.86 per centre-based child/per annum) for on-the-ground Accredited Practising Dietitian support.

BENEFITS OF RECOMMENDATIONS 6-7

- Strengthened regulations, standards and on-the-ground support from Accredited Practising Dietitians will enable ECEC services to create best-practice food environments, protect children from nutritional vulnerability and strengthen preventive health outcomes for children attending ECEC services.

BACKGROUND

- Currently, only 3 states (NSW, TAS, VIC) provide nutrition support to ECEC services, creating inequitable access and compromising food environment quality across jurisdictions.
- A nationally coordinated program would provide high-standard support, prioritising the most disadvantaged areas first.

A healthy food environment within ECEC settings plays a critical role in shaping children's early food preferences, eating habits, and nutritional intakes, which can have long-term impacts on their health, development, and relationship with food. The existing National Quality Framework provides limited guidance for food and nutrition, leading to varied interpretations across jurisdictions. Strengthened regulations and standards for food and nutrition will help ECEC services to understand their obligations, allow assessment criteria to remain consistent across states and territories, and strengthen preventive health outcomes for children in early childhood settings.

All children have the right to a standard of food, nutrition and nutritional care that supports growth, development, health and wellbeing. It is therefore imperative that governments have systems and supports in place to realise this right, including in ECEC programs, where a high percentage of young children in care receive most of their daily meals and snacks while in care. We therefore call on the federal government to introduce funding that allows ECEC services to access nutrition support from Accredited Practising Dietitians to realise the food and nutrition rights of children in ECEC programs.

National Disability Insurance Scheme (NDIS) Pricing

RECOMMENDATION 8

Increase **prices for NDIS therapy supports**, including dietetic supports, in line with wage increases of 3.19%.

COST - **A pricing increase of 3.19%**

BENEFITS OF RECOMMENDATION 8

- Enhanced outcomes by ensuring people with disability have access to high quality dietetic supports that build their function and independence
- Improved service equity by enabling the continued provision of dietetic therapy supports in rural, regional and remote areas
- Stabilised workforce through attracting and retaining skilled dietitians
- Maximised functional outcomes through dietetic support, reducing long-term healthcare and NDIS costs.

BACKGROUND

Dietitians play a pivotal role in supporting people with disability within the National Disability Insurance Scheme (NDIS). They address the unique and often complex dietary needs of people with disability, contributing to their overall health, wellbeing, independence, and quality of life.[87]

Recent evidence shows that dietitians and other allied health professionals delivering services under the NDIS are increasingly withdrawing from the scheme due to unsustainable pricing structures. This trend poses a serious risk to the ongoing availability of high-quality, essential services for NDIS participants, including those in rural and remote areas or those experiencing intersecting disadvantage.

A recent survey of 180 Dietitians Australia members who provide NDIS services found that 24% of dietitians plan to reduce or cease their services to NDIS participants. 25% reported that the changes will disproportionately impact people in regional or remote areas, where access to specialised services is already limited.

The NDIA's current pricing does not reflect the true cost of delivering therapy supports, especially dietetic services,[88] which have seen significant increases in operational costs. Over the past year, dietitians report rising costs attributed to inflation, higher wages, insurance, rent, and travel expenses. Furthermore, growing administrative burdens related to NDIS compliance and increased workloads have further driven costs, making it financially unsustainable for many businesses to continue delivering services at current rates.

In particular, the NDIA's failure to adjust prices in line with wage increases is threatening the financial viability of therapy practices, including dietetics. With workforce challenges exacerbated by recruitment and retention issues, many providers are unable to meet the rising costs of service delivery, jeopardising access to care for people with disability.

To ensure equitable access to high-quality therapy supports and prevent further workforce attrition, it is crucial that the NDIA adjusts pricing for therapy supports, including dietetics, in line with wage increases of 3.19%. This adjustment will help sustain the delivery of essential services and ensure that all NDIS participants, regardless of location, can access the care they need.

Preventive Health

RECOMMENDATION 9

Invest in national food and nutrition actions to reduce the exposure and intake of unhealthy foods, support healthy eating and protect all Australians from the risk of diet-related disease.

COST - 5% total health spending*

*A target of 5% of total health spending dedicated to investments in preventive health, achieved by 2031 as stipulated in the National Preventive Health Strategy.[45]

BENEFITS OF RECOMMENDATION 9

Progress to achieve the targets of the National Preventive Health Strategy and National Obesity Strategy:[45, 46]

- Adults and children (≥9 years) maintain or increase their fruit consumption to an average 2 serves per day and increase their vegetable consumption to an average 5 serves per day by 2030
- Reduce the proportion of children and adults' total energy intake from discretionary foods from >30% to <20% by 2030
- Reduce the average population sodium intake by at least 30% by 2030
- Increase the proportion of adults and children who are not exceeding the recommended intake of free sugars by 2030
- At least 50% of babies are exclusively breastfed until around 6 months of age by 2025

Cost saving and revenue generating:

- Reduce deaths, hospitalisations and burden of diet-related disease
- Reduce workplace absenteeism and increase workplace productivity and profitability
- Revenue generating policies

BACKGROUND

Diet-related disease, including malnutrition in all its forms is a leading cause of ill health and death. A nutritious diet is one of the most influential factors contributing to our overall health and well-being, as well as economic prosperity.[47, 48]

Australians are consuming a diet with a low intake of fruits, vegetables, wholegrains, nuts and seeds, and a high intake of salt, unhealthy fats and sugar.[48] Diet-related diseases, namely, cardiovascular disease, type 2 diabetes and cancer are leading causes of hospital expenditure and death in Australia.[49] Of the leading factors that have been identified as contributing to the health gap between Aboriginal and Torres Strait Islander people and non-Indigenous Australians, 5 of the 7 are related to poor dietary intake: low fruit and vegetable intake, obesity, alcohol consumption, high blood cholesterol and high blood pressure.[50]

Effective preventive health measures have the potential to have the greatest impact on the health of Australians, the health care system and the economy by preventing disease in the first place.

ACTIONS

An up-to-date National Nutrition Strategy is needed and would align with the National Preventive Health Strategy[8] where the need for food and nutrition action guided by a specific policy document is acknowledged. It would also be an essential component of the National Obesity Strategy[9] and the National Breastfeeding Strategy[10] and would deliver multiple complementary benefits in terms of health, the economy, equity and environmental sustainability.

A coordinated, multi-strategy approach to improve nutrition is needed to have the greatest impact on health.[51] There are multiple policy options available to improve nutrition in Australia. For example, they can impact on the way food is made, sold, labelled and advertised.

The World Health Organization recommends several food and nutrition policies which are evidence-based, cost-effective and practical. Many of these actions have been endorsed and adopted by the National Preventive Health Strategy and National Obesity Strategy. Below outlines several of these actions that can help to improve the nutritional health of Australians as part of a coordinated, multi-strategy approach.

Reformulation – government-led mandatory reformulation targets that set criteria for the maximum limits for sodium, saturated fats and sugars in pre-packaged/processed/manufactured foods. Reformulation is an effective way to reduce population intake of salt, fats and sugar. It creates a marketplace that preferences healthy food options regardless of where people shop or how much they understand (or have access to) information on labels. This type of policy requires no consumer action.

Front-of-pack labelling - government-led mandatory Health Star Labels. Front-of-pack labelling contributes to increasing consumer awareness and enables consumers to make healthier choices, change purchasing intentions and provide the food and beverage industry with incentive to reformulate and produce healthier products.[52, 53]

Policies to protect children from the impact of food marketing on diet - marketing impacts food preferences, purchase requests and consumption patterns. Implementing marketing restrictions limits exposure to unhealthy foods high in salt, fats and sugars, decreases demand and provides the food and beverage industry incentive to reformulate and market healthier products.[54-56]

Fiscal policies – a minimum 20% health levy on sugar sweetened beverages is publicly accepted,[57, 58] and will generate immediate revenue to subsidise healthy foods such as fruit and vegetables. Studies of levies on sugar-sweetened beverages have demonstrated both reductions in sugar-sweetened beverage purchases and reductions in healthcare costs for consumers over their lifetime.[59] Sugar-sweetened beverages are suitable for a health levy for several reasons:

- the product category is well-defined
- they provide minimal to no nutritional benefit
- consumption has been associated with chronic diseases, including dental decay leading to dental caries – conditions that are highly prevalent in Australia.[60-62]

Over one third of Australian adults and almost half of children consume sugar-sweetened beverages at least once a week. Adolescents and young adults are the highest consumers of sugar-sweetened beverages.[63]

In 2021, the Australian Medical Association estimated that the rise in annual revenue from levies on sugary beverages could be between $749 million to $814 million[64]

Education – investing in strong public health education campaigns has the potential for far-reaching impacts, including changing attitudes and behaviours across the community, reducing the incidence of disease and saving lives.[65, 66]

When the updated Australian Dietary Guidelines (ADGs) are released, comprehensive, well-considered public education campaigns will be needed to maximise their usefulness and uptake. While the ADGs review is underway, and to compliment it, there are other guidelines that also need to be updated to benefit high risk populations.

For example, the Australian Government's Get Up and Grow collection of resources for parents and early childhood educators need to be updated. The Get Up and Grow resources [67] are now between 12 and 15 years old. Our understanding of the effect of different food environments on children's health has evolved significantly in that time.[68] Early childhood is a critical stage of development and an important time to ensure quality nutrition is accessible for all children.[69,70]

Nutrition during the early years is critical for development and for shaping lifelong nutrition, health outcomes and disease prevention. Poor nutrition and related outcomes are known to track from infancy through to childhood and adulthood.[71-73]

With two-thirds of children aged 1-4 years accessing childcare in some form in Australia, childcare settings rely on current, evidence-based food and nutrition guidance, including from the Up and Grow collection of resources, to ensure the nutrition needs of infants and young children are adequately met for growth, development, health and wellbeing[24]. [68]

RECOMMENDATION 10

Fund ongoing nutrition monitoring

COST - Scoping needed

BENEFITS

- Regular food and nutrition monitoring will provide information on dietary behaviours and nutrition measures over time, which is critical to both informing effective policy and program development and evaluating their implementation
- Monitoring will support development of policy to protect public health and improve the health and wellbeing of Australians
- Implementing a food and nutrition monitoring and surveillance program would contribute towards achieving United Nations' Sustainable Development Goal 3: Good Health and Wellbeing. It is also an essential component of the wellbeing budget as it will support 'measuring what matters'.

BACKGROUND

Dietitians Australia calls on the Australian Government to fund a food and nutrition monitoring and surveillance program. This is in line with calls from other groups including the Public Health Association of Australia[74]

There have been previous food and nutrition surveys in Australia, and the National Nutrition and Physical Activity Study is a component of the Intergenerational Health and Mental Health Study. These surveys have not been conducted regularly and there is yet to be a clear ongoing commitment to a regular and comprehensive food and nutrition monitoring program in Australia.[75] Many other OECD nations have established programs for nutrition monitoring, and there is a need for Australia to become a world leader in implementing a food and nutrition monitoring and surveillance program.

According to the Australian Institute of Health and Welfare (AIHW), unhealthy eating was the third leading risk factor, contributing to 4.8% of the total disease burden in Australia in 2024. This was closely followed by high blood pressure for which unhealthy eating is a significant risk factor.[76] The AIHW reports that dietary risk factors contributed to:

- coronary heart disease
- lung and oesophageal cancer
- Type 2 Diabetes
- stroke[77]

Australia is a food secure nation with enough food for its population, but many people do not have enough food and regularly rely on emergency food relief.[78] In 2011-2012, 4.0% of people lived in households that had run out of food in the previous 12 months and could not afford to buy more.[79] Food insecurity disproportionately affects Aboriginal or Torres Strait Islander people, with more than one in five (22%) reporting food insecurity at the same time.[80]

A comprehensive food and nutrition monitoring and surveillance program in Australia is critical for monitoring the healthiness of diets and access to, and affordability and availability of healthy foods in all communities and service settings across the country. Food and nutrition monitoring is imperative to inform the development of effective public health policy and programs, and regulation. It is also essential for monitoring the implementation of these policies, programs and regulations, including existing national health strategies.

There is a current commitment to develop a National Nutrition Policy framework, and work is underway to develop revised Australian Dietary Guidelines. To support the development and implementation of these, a commitment to an ongoing national food and nutrition monitoring and surveillance program is a priority.

Such a monitoring and surveillance program needs to measure more than just dietary intake. It should include at minimum a continual, comprehensive, population-based dietary survey program that measures trends over time including all measures outlined under the subheadings below:

Biometrics

- relevant anthropometry
- physical activity
- appropriate biological measures of nutritional status

Food supply

- food supply monitoring (including composition of contemporary Australian foods, soil quality, and biodiversity)
- food purchasing/acquisition (eg, food expenditure, food type, price and quantity of food purchased, place of food purchase)
- physical and online food environments (eg, availability, affordability, accessibility, advertising and promotion of healthy and discretionary foods)

Food literacy

- food literacy knowledge, skills and behaviours including planning and management, selection (eg, use and understanding of food labelling and promotion), preparation (eg, frequency and types of meals prepared, skills, distribution of work in households), and eating (eg, commensality, shared eating occasions, settings for eating)

Food consumption patterns

- food and nutrient intake behaviours including breastfeeding (eg, 24-hour recall and short questionnaire)[74, 81]
- food security (eg, using a validated screening tool such as the United States Department of Agriculture 18-item Household Food Security Survey Module (HFSSM)).[82]

Coverage

- Nutrition monitoring should be conducted for the entire population and also target different settings, such as early childhood education services, schools, aged care.

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