



**Wesfarmers
Health**

Wesfarmers Health: Australia's Health Index 2026

Australia's quiet emergency: The case for investing
in cardiometabolic disease prevention

A snapshot of Australia's overall health, focusing on cardiometabolic risk factors
at a national, state and territory level, and a bold vision for prevention.

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Executive summary



The state of Australia's cardiometabolic health

Australia is recognised as having one of the leading health systems in the world.¹ Yet a closer look at the nation's underlying health in 2026 tells a more urgent story, one with eye-opening statistics that warrant immediate action.

As Australia's population ages, chronic conditions become more common and government budgets are under growing pressure. The health system must shift its focus towards prevention and the technologies that can support it. Continuing to treat chronic disease after it emerges, rather than preventing it, is not a sustainable path for Australia's health system or for the people who rely on it.

The *Wesfarmers Health: Australia's Health Index 2026* (the Index) provides a real-world, current view of the cardiometabolic risk factors affecting Australians. Now in its third year, the Index tracks four key risk factors – obesity, high blood pressure, daily smoking and diabetes – with the Australian type 2 diabetes risk assessment tool (AUSDRISK) and daily vaping captured to provide additional insight.

From 1 July 2025 to 30 June 2026, 397,227 Australians completed 585,576 health checks through SiSU Health Stations, the largest number of health checks undertaken since 2018. Of these participants, 278,428 had a value recorded for all four risk factors that underpin the Index.

The results show signs of progress. Australia's cardiometabolic health continues to improve, with an Index score of 104, increasing by four points from last year. This is an improvement from 87 in 2022 and the first time since COVID-19 that the Index score has been above the baseline.

However, significant risks remain. One in 10 Australians live with multiple cardiometabolic risk factors. More than one in four have obesity. Three in four Australians with a high blood pressure reading were unaware of it, while 10.1 per cent of Australians smoke daily.

The findings also reveal important differences across the population. Women have lower rates of every major risk factor than men, but this health advantage narrows in midlife. Australians living in the most disadvantaged areas are 2.5 times as likely to have multiple risk factors as those in the least disadvantaged areas. Distance matters, with outer regional Australians 1.4 times as likely to have multiple risk factors as those in major cities.

Together, the findings reinforce the importance of prevention and early intervention, and the opportunity to use real and current population health data to better understand emerging risks and where action can have the greatest impact.

Modifiable risk factors account for more than one third of Australia's disease burden, yet prevention receives approximately 3 per cent of government health spending.²

Key findings 2026 at a glance

Despite making health gains, more than

1 in 10

(10.5%) Australians live with **multiple cardiometabolic risk factors**
(one in eight men compared to one in 11 women)

More than

1 in 4

(26.7%) Australians **have obesity**
(BMI ≥ 30)

3 in 4

(77%) Australian adults with a high blood pressure reading **were unaware of it**

10.1%

of Australians smoke daily, **almost double recent national estimates**



Women have lower rates of every major risk factor than men, but their **health advantage narrows in midlife**

Australians living in the **most disadvantaged areas are**

2.5 times

as likely to have **multiple cardiometabolic risk factors** as those in the least disadvantaged areas

Distance matters, with **outer regional Australians**

1.4 times

as likely to have **multiple cardiometabolic risk factors** as those in major cities

585,576

SiSU Health checks, a **record number** since 2018

Welcome to the Wesfarmers Health: Australia's Health Index 2026



Emily Amos
Managing Director
Wesfarmers Health

As I sit down to write this foreword each year, it gets harder, not because we lack evidence, but because the evidence continues to reveal an uncomfortable truth. Three in four Australians with a high blood pressure reading were unaware of it. Behind that statistic are real Australians who may have no symptoms, no reason to suspect anything is wrong, and no idea that a simple health check could help them take action earlier.

Cardiometabolic disease remains a quiet, yet significant threat to the health of the nation and to the system built to care for us. Modifiable risk factors now account for more than one third of Australia's disease burden and excess weight has overtaken tobacco use as the leading risk factor for ill health and early death.³

Now in its third year, the *Wesfarmers Health: Australia's Health Index* (the Index) does bring some encouraging news. Australia's overall cardiometabolic health is improving, with the Index score rising from 100 to 104. Yet underlying risk factors persist, and more than one in 10 Australians are living with multiple cardiometabolic risk factors.

Seven key findings in this year's Index reinforce what we have long believed at Wesfarmers Health: Australia must give prevention greater national priority. What that means is accessible services, better health literacy and a health system that helps Australians identify and address risks before disease develops.

It is encouraging to see growing momentum behind this ambition. The Australian Government's new *National Health Literacy Framework*, the refreshed *National Strategic Framework for Chronic Conditions 2026-35*, and the latest *2026 Intergenerational Report* all signal a broader recognition of the importance of prevention to Australia's health and long-term prosperity.⁴

For our business, this commitment is reflected in our investment in SiSU Health. Founded in 2014 and fully acquired by Wesfarmers Health in 2024, SiSU Health was built on a simple idea: make preventive health checks free, convenient and accessible in places Australians already visit. Our network of more than 500 SiSU Health Stations, many within Priceline Pharmacies across the country, has delivered more than 5.3 million health checks. Over 900,000 Australians have been prompted to see a General Practitioner (GP) since it was launched.

This year alone, 585,576 checks were undertaken by 397,227 Australians nationwide, contributing to the country's largest, real-time, unified dataset on cardiometabolic health.

Drawing on de-identified data collected in everyday community settings, such as Priceline Pharmacies, the Index offers a valuable complement to Australia's established national health surveys.

This scale demonstrates that SiSU Health is an established part of Australia's digitally-enabled preventive health infrastructure. Its technology allows us to continually refine the Index, expand the risks we measure and respond to emerging priorities, ensuring the insights remain relevant as Australia's health needs change.

By meeting people where they live, shop and work, SiSU Health checks provide an evolving picture of cardiometabolic health, helping identify emerging risks and where preventive efforts are needed most.

It is this combination of scale, accessibility and insight that makes the 2026 Index an important step forward. Alongside the findings we present four recommendations including, prevention, access and equity, women's health and productivity.

Women's health is particularly important for Wesfarmers Health. The findings show that while women generally have lower cardiometabolic risk than men, that advantage narrows in midlife. Through our Sisterhood Foundation, we support organisations working to improve women's health awareness and address the unique challenges facing Australian women and girls, including during menopause and midlife.

These recommendations reflect our belief that meaningful progress requires collaboration across government, healthcare, business and communities.

By working together to expand access to preventive health services, we have an opportunity to reach more Australians, address persistent health inequities and support better long-term health outcomes.

At Wesfarmers Health, our mission is to make health, beauty and wellness simpler, more affordable and easier to access. We remain committed to expanding the reach and impact of SiSU Health, alongside our broader network of community pharmacies and digital health services, and working with others who share our ambition for a healthier Australia.

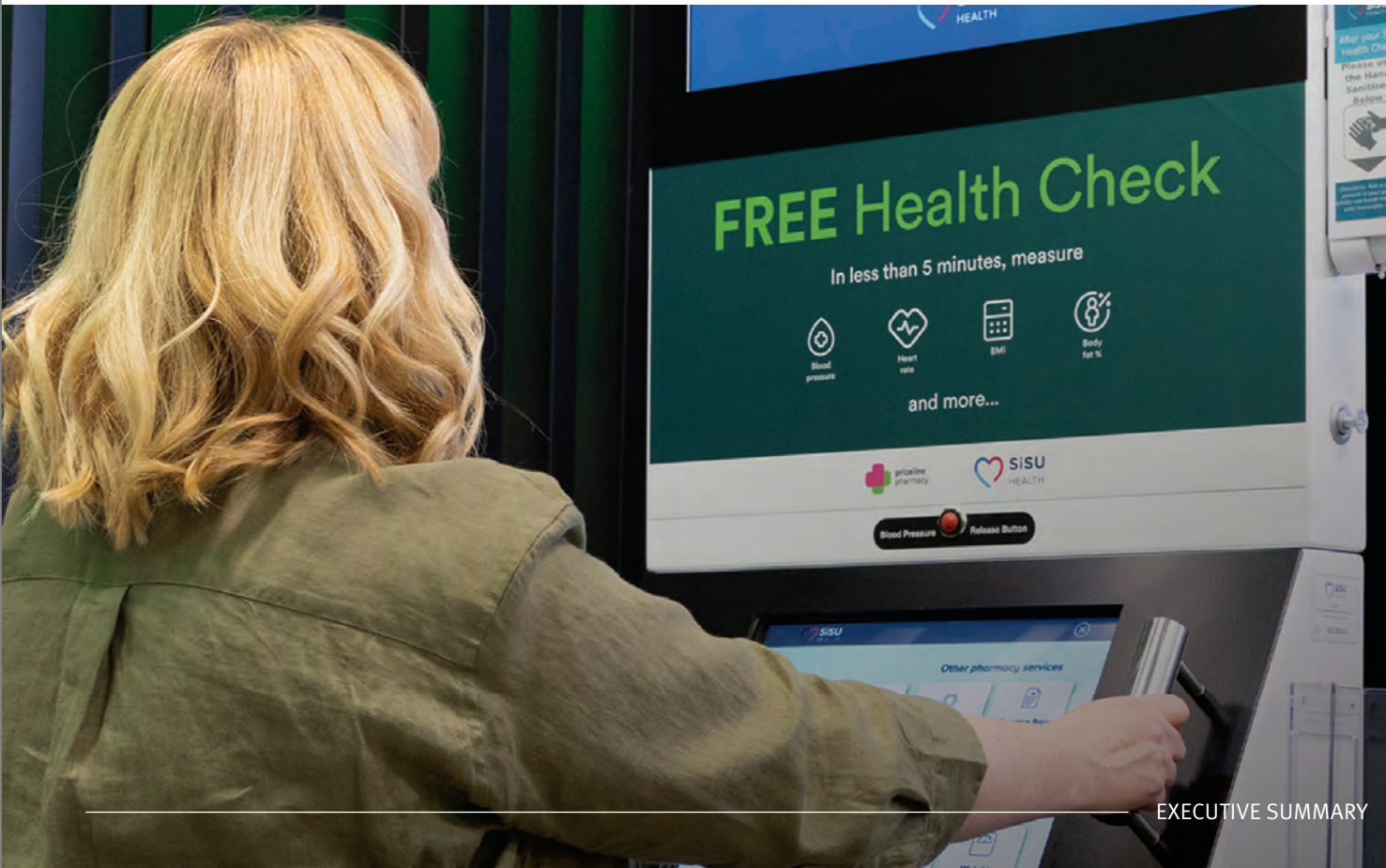
The evidence in this year's Index shows that there is more to do, but also much to be gained by acting now.

For every Australian, the single most important message is: don't wait for a symptom to tell you what a five-minute check could tell you today.

We hope the insights and recommendations that follow support turning growing national recognition of prevention into meaningful action.

With that vision in mind, I welcome you to the *Wesfarmers Health: Australia's Health Index 2026*.

Emily Amos



Recommendations

Prevention



1. Embed prevention and health literacy across every life stage. Help every Australian understand, track and act on their cardiometabolic risk throughout their lives.

Prevention and health literacy are currently treated as discretionary rather than core components of the health system, despite clear evidence that early detection and sustained engagement reduce long-term disease burden and costs. Embedding both as permanent, funded priorities is essential to shifting the system from acute care to prevention.

Women's health



3. Improve the detection, diagnosis and treatment of women's cardiometabolic disease. Address gaps in data, funding and diagnosis, with a particular focus on midlife risk.

Australia's clinical tools, research base and specialist workforce for cardiometabolic disease have historically been developed around men, leaving women's distinct risk patterns under-recognised and under-treated, particularly in midlife. Addressing this gap requires deliberate reform, not incidental improvement.

Access and equity



2. Build a more accessible, digitally-enabled health system. Expand free, technology-enabled health services including screening and access to telehealth to overcome barriers of distance, cost and workforce shortages, while strengthening national health data.

Access to preventive health services remains uneven across Australia, shaped by distance, disadvantage and workforce availability alike. Expanding free, technology-enabled services, such as SiSU Health Stations, can help address these barriers by making preventive health services more accessible and scalable, without requiring an already-stretched health workforce or constrained health budget to grow at the same pace.

Productivity



4. Scale workplace prevention as a national priority. Invest in proven workplace cardiometabolic prevention initiatives as national productivity infrastructure.

An ageing population and rising chronic conditions will place pressure on workforce participation and productivity. Scaling a proven, low-cost preventive health model, such as SiSU Health Stations, into workplaces and the broader community offers a direct, cost-effective lever to protect both health outcomes and national economic performance.

About Wesfarmers Health and the Index



SiSU Health at a glance

5.3M+

free health checks*

2.2M+

unique Australians who have conducted free health checks*

900,000+

Australians prompted to see a GP*

500+

SiSU Health Stations across Australia

5 mins

(approximately)

to complete a free SiSU Health check

*Between 2014 and 30 June 2026



Wesfarmers Health

Building better lives through better health

Established in March 2022 as a division within Wesfarmers, Wesfarmers Health has grown into one of Australia's leading health, beauty and wellness companies, spanning retail, pharmaceutical wholesale, medical aesthetics and digital health. It employs approximately 3,000 team members across Australia, delivering services to millions of Australians every year.

As Australians' expectations of healthcare continue to shift, Wesfarmers Health is focused on identifying opportunities that make services more affordable, more connected and easier to access. The portfolio spans well-known consumer, digital and business-to-business brands.

Refer to **Appendix 1: Wesfarmers Health businesses** for further information.

Wesfarmers Health is on a mission to make health, beauty and wellness simpler, more affordable and easier to access.

The Sisterhood Foundation is the official charity partner of all Wesfarmers Health businesses. Its purpose is to hear, acknowledge and address the unique issues impacting Australian women and girls.

Wesfarmers Health portfolio:



SiSU Health

Helping Australians understand, track and improve their health through free health checks

Founded in 2014, SiSU Health developed the SiSU Health Station, which provides fast, free cardiometabolic health screening. These Stations are a Class IIa Medical Device and registered on the Australian Register of Therapeutic Goods (ARTG 317543) and remain unique to the Australian market.

Wesfarmers Health fully acquired SiSU Health in 2024, recognising the opportunity to invest in crucial prevention screening, to raise awareness and to expand access to cardiometabolic health checks.

SiSU Health Station

There are currently more than 500 Stations available across the network in Australia, predominantly at Priceline Pharmacies, workplaces and other community settings.

The Stations enable Australians to complete a free, self-service health check in as little as five minutes, measuring key health metrics:

- Blood pressure
- Heart rate
- Body mass index (BMI)
- Body fat percentage
- Height
- Weight
- Diabetes risk, using the AUSDRISK assessment tool
- Smoking and vaping status

Results are shown on the Station screen and are also available in the SiSU Health app, which can send results directly to a healthcare professional. These checks are designed to support health awareness and literacy, not to diagnose or treat any condition.

Anyone identified as having an elevated risk is encouraged to follow up with a qualified healthcare professional, including to interpret results or to receive a formal diagnosis.



Since SiSU Health launched, more than 5.3 million health checks have been provided to more than 2.2 million Australians.

Refer to **Appendix 2: SiSU Health Stations** for further information.

The Index

The country's largest, real-time, unified dataset on cardiometabolic health, captured from over 500 SiSU Health Stations nationally

First launched in 2024, the Index uses de-identified data collected through SiSU Health Stations to provide a comprehensive view of cardiometabolic risk factors across Australia. Since SiSU Health launched, the Stations have delivered more than 5.3 million health checks to more than 2.2 million Australians.

The likelihood of cardiometabolic disease increases with each of these four key risk factors – obesity, high blood pressure, diabetes and daily smoking – as defined in Figure 2.

At its core, the Index tracks the share of Australians carrying two or more of the four risk factors. Where more than one risk factor is present, the probability of developing more serious clinical conditions rises.

The Index score converts this into the odds of carrying one or fewer risk factors, relative to the FY2018 baseline of 100. A higher score reflects better population health.

For FY2026, estimates are drawn from Station health checks undertaken between 1 July 2025 and 30 June 2026 and weighted to the Australian population by postcode, sex and age band against the 2021 Census.

What the Index data adds

National health surveys remain the benchmark for population-level estimates, including probability samples carrying design weights that a Station does not have. What SiSU Health Stations add is frequency, scale and reach into places where a survey sample may be thin.

The growing network of Stations also creates the opportunity to capture population health data in real time and observe changes over time. The number of SiSU Health Stations increased to 523 in FY2026, with further opportunity to expand the capture of real-time population health data (Figure 1).

Figure 1
Health Stations deployed throughout Australia

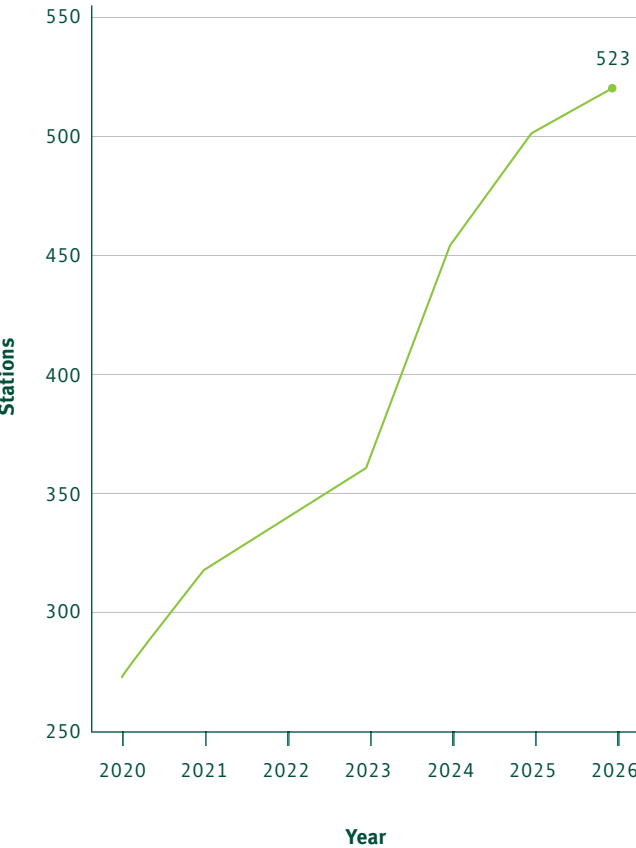


Figure 2
Key cardiometabolic risk factors and associated definitions

These four key risk factors form the Index score

Obesity

Body mass index (BMI) greater than or equal to 30 kg/m², derived from height and weight measured on the Station.⁵

High blood pressure

A measured reading at or above 140/90 mmHg (systolic blood pressure ≥ 140 mmHg, or diastolic blood pressure ≥ 90 mmHg).⁸

This is not a diagnosis of hypertension. Consistently high blood pressure is the basis for a diagnosis of hypertension.⁹

Diabetes

Self-reported diagnosis of diabetes (type 1 or type 2). The estimates draw no distinction between the two types.

No blood is taken on the Station.

Diabetes is a chronic condition marked by high levels of glucose in the blood.⁶

Daily smoking

Self-reported smoking tobacco cigarettes at least once per day.¹⁰

These risk factors are captured, but do not form part of the Index score

Australian type 2 diabetes risk assessment tool (AUSDRISK)

The official tool estimating an individual's five-year risk of developing type 2 diabetes, endorsed by the Australian Department of Health, Disability and Ageing.⁷

Daily vaping

Self-reported use of vapes or e-cigarettes at least once per day.¹¹

17 ABOUT

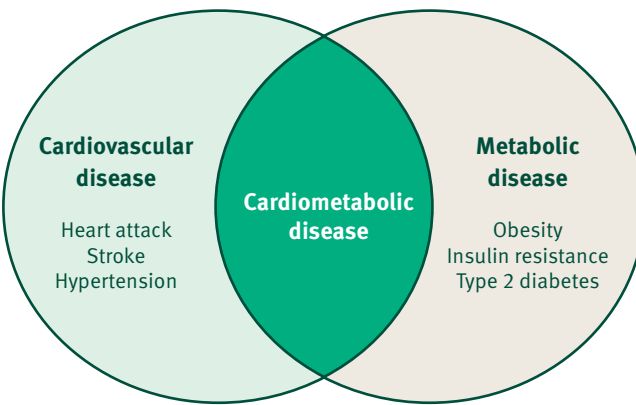
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Cardiometabolic disease

Cardiometabolic disease is a significant global challenge and a leading cause of death – and Australia is not immune.¹²

This Index focuses on cardiometabolic risk factors in recognition of the importance of prevention, not just treatment. Cardiometabolic disease comprises two closely related groups of conditions that are both common and often preventable (Figure 3).¹³

Figure 3
What is cardiometabolic disease?



This approach reflects a 2023 presidential advisory from the American Heart Association, which called for cardiovascular, metabolic and kidney health to be addressed as a single, interconnected system rather than as separate conditions.¹⁴ The Australian Heart Foundation has also recently adopted this approach.¹⁵

The Index adapts the American Heart Association’s five stages through which cardiometabolic disease typically progresses, from no risk to established heart disease (Figure 4).¹⁶ Understanding these stages reinforces why early intervention, well before a diagnosable cardiac event, is so important.

That is why Wesfarmers Health has invested in prevention, recognising that reducing cardiometabolic risk today prevents more serious health conditions from developing.

Figure 4
Cardiometabolic disease stages



Health experts

Wesfarmers Health extends its thanks to its health experts who have supported bringing this Index to life.



Prof. Alta Schutte

SHARP Professor of Cardiovascular Medicine, UNSW Sydney; Global Co-Director of the Cardiovascular Program, The George Institute; Co-Chair, National Hypertension Taskforce

Alta Schutte is a SHARP Professor and Theme Lead for Cardiac, Vascular and Metabolic Medicine at UNSW Sydney; and Professorial Fellow at The George Institute Australia. Alta is a leading researcher with extensive experience in clinical trials and population-based studies in the field of blood pressure, hypertension and cardiovascular health. She is the Past President of the International Society of Hypertension, Deputy President of the Australian Cardiovascular Alliance and Co-Chair of the Australian National Hypertension Taskforce.



Dr Sarah Cavanagh

Chief Medical Officer, Wesfarmers Health

Dr Sarah Cavanagh is Chief Medical Officer at Wesfarmers Health, where she provides clinical leadership across the organisation's digital businesses, including InstantScripts and SiSU Health. A Fellow of the Royal Australian College of General Practitioners (RACGP) with more than two decades of clinical experience, Sarah leads the development of clinical strategy, governance and innovation to ensure digital healthcare is safe, evidence-based and patient-centred.



Mel Gannon

Chief Pharmacist, Wesfarmers Health

Mel Gannon, Chief Pharmacist at Wesfarmers Health, has more than 30 years' experience in regional and metropolitan pharmacy. She leads clinical governance and professional education across a national community pharmacy network supporting over 1,000 Priceline pharmacists. Her work has a strong focus on preventive health and women's health, including partnering with Jean Hailes for Women's Health to develop pharmacist capability programs that support confident counselling and referral for people experiencing menopause and perimenopause.

Key findings



2026 key findings

- 1** Despite making health gains, more than **one in 10** (10.5%) Australians live with **multiple cardiometabolic risk factors** (one in eight men and one in 11 women).
- 2** More than **one in four** (26.7%) Australians **have obesity** (BMI ≥ 30).
- 3** **Three in four** (77%) Australian adults with a high blood pressure reading **were unaware of it**.
- 4** 10.1% of Australians smoke daily, **almost double recent national estimates**.
- 5** **Women** have lower rates of every major risk factor than men, but their **health advantage narrows in midlife**.
- 6** Australians living in the **most disadvantaged areas** are **2.5 times** as likely to have **multiple cardiometabolic risk factors** as those in the least disadvantaged areas.
- 7** Distance matters, with **outer regional Australians** **1.4 times** as likely to have **multiple cardiometabolic risk factors** as those in major cities.

Key findings: national

Australia's 2026 Index score: 104

Australia has passed its pre-COVID benchmark.

The Index (Figure 5) tracks four risk factors: high blood pressure, obesity, diabetes and daily smoking. These risk factors, particularly in combination, raise the risk of serious cardiometabolic disease. The Index tracks the likelihood of having more than one of these risk factors against an FY2018 pre-COVID benchmark of 100.

Higher scores are better, with Index scores above 100 indicating Australians are less likely to have multiple risk factors than in FY2018. Australians became more likely to have multiple risk factors in the wake of COVID-19, reaching an Index low of 87 in FY2022. The current score of 104 is the first since COVID-19 to exceed the benchmark.

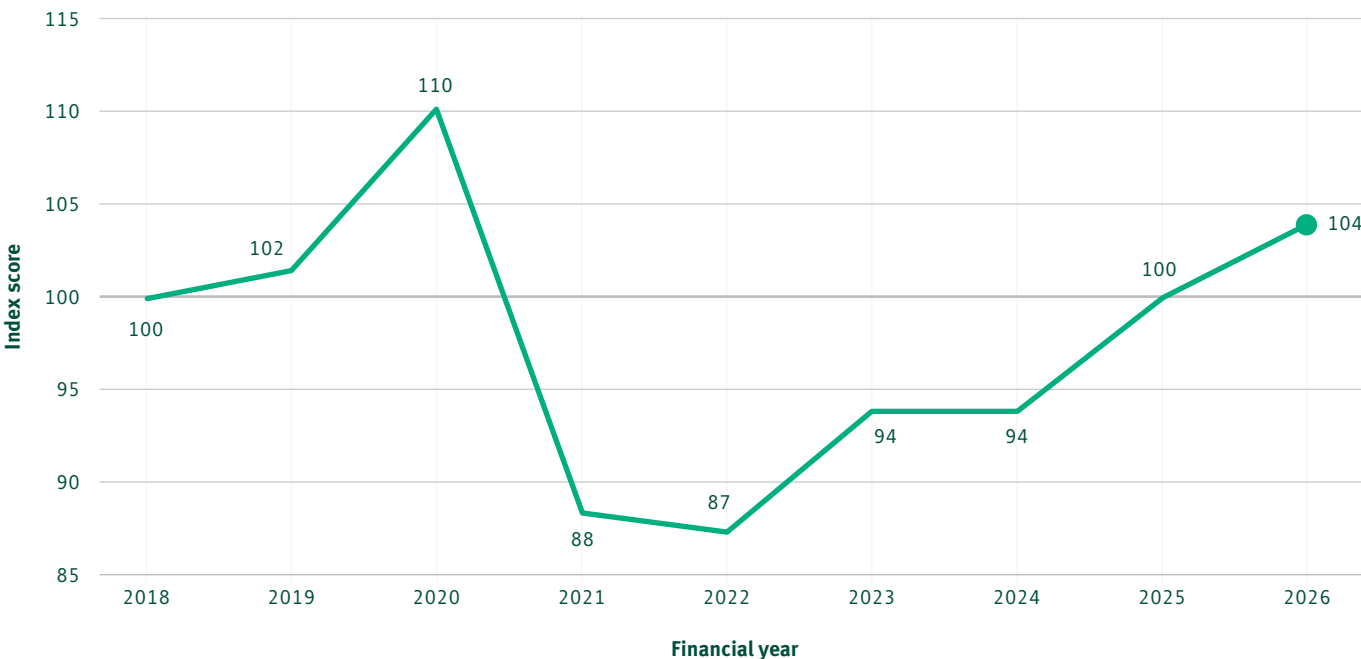
This is a positive sign that Australia's cardiometabolic health is improving, though this is not a time for complacency.

How the Index has changed

SiSU Health continues to improve how risks are measured and assessed to reflect current best practice and clinical guidance. Improvements to blood pressure and smoking assessments mean estimates made today differ from those made in prior years. The Index score is adjusted for these improvements to ensure scores remain comparable from year to year.

The derivation of the Index score and these adjustments are detailed in **Appendix 3: Methodology**.

Figure 5
Australia's Index score over time



Key findings: national

Participants

SiSU Health Stations were used by 397,227 Australians in FY2026, completing 585,576 health checks.

This is the largest number of health checks undertaken since 2018. There has also been a steady increase in the number of people using these Stations each year (except for COVID-19) (Figure 7). In FY2026, 278,428 Australians were assessed on all four risk factors as part of the Index.

Wesfarmers Health continues to deploy SiSU Health Stations in strategic, critical areas including Priceline Pharmacies and other sites to support preventive health initiatives and capture significant population health data. During the year, the number of Stations increased by 20 to 523. There is opportunity to further deploy Stations throughout Australia to improve health, health literacy and the capturing of real-time population health data.

Who is using SiSU Health Stations?

SiSU Health Station users tend to be younger than the Australian population (Figure 8). For example, 25.7 per cent of users were aged 25-34 compared to 17.4 per cent of the population. Users aged 45 and older sit under the population share, which highlights that fewer older people use the Station. This is an important finding which provides an opportunity to raise awareness and health literacy among younger Australians of their cardiometabolic risk factors.

Where are SiSU Health Stations being used?

Every state and the Australian Capital Territory (ACT) carry enough users to estimate the prevalence of health risks, with New South Wales (NSW) and Victoria (VIC) accounting for 59.9 per cent of users. Broadly, the user mix reflected the Australian population, while also highlighting where SiSU Health Stations could be deployed in the future to improve representation, such as in Western Australia (WA).

There was some movement in the state mix, as the number of users in the estimates rose 55 per cent in South Australia (SA) and 15 per cent in Queensland (QLD), and fell 13.7 per cent in NSW. These shifts likely reflect changes in the size and geographic distribution of the broader SiSU Health Station network.

Figure 6
2026 prevalence of health risk factors in Australians aged 15 and over*

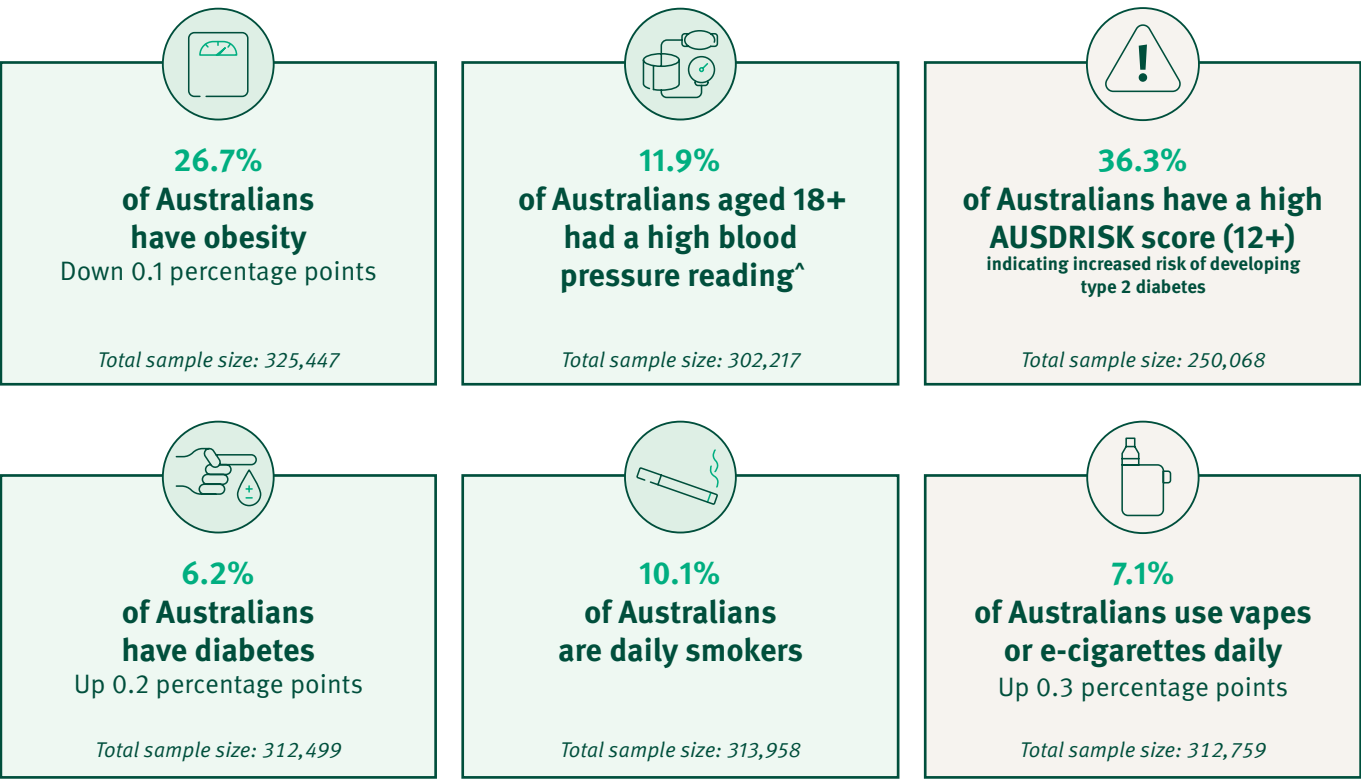


Figure 7
Station users and users assessed on all four risk factors

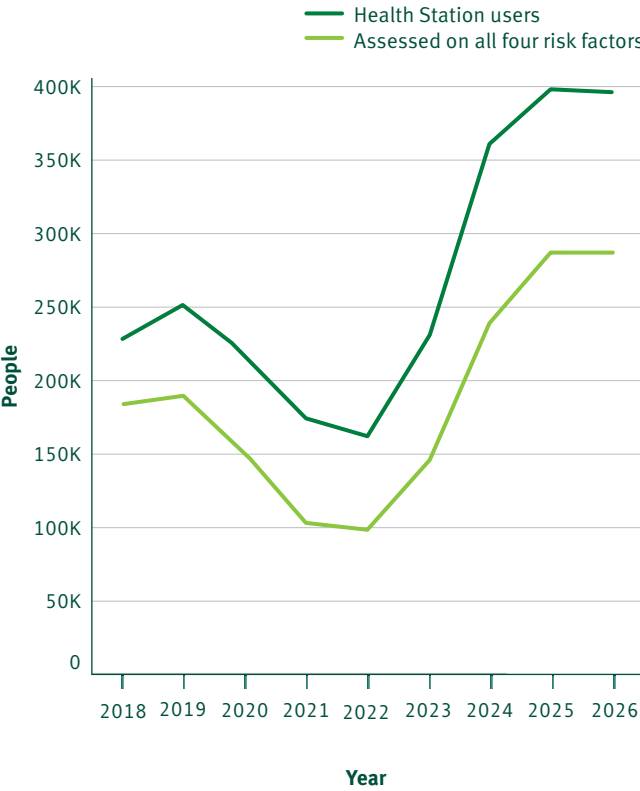
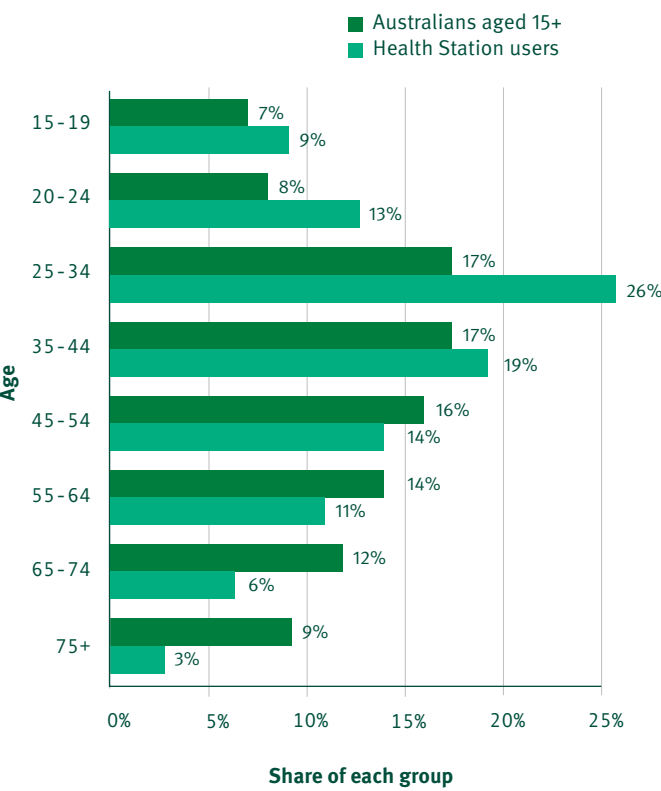


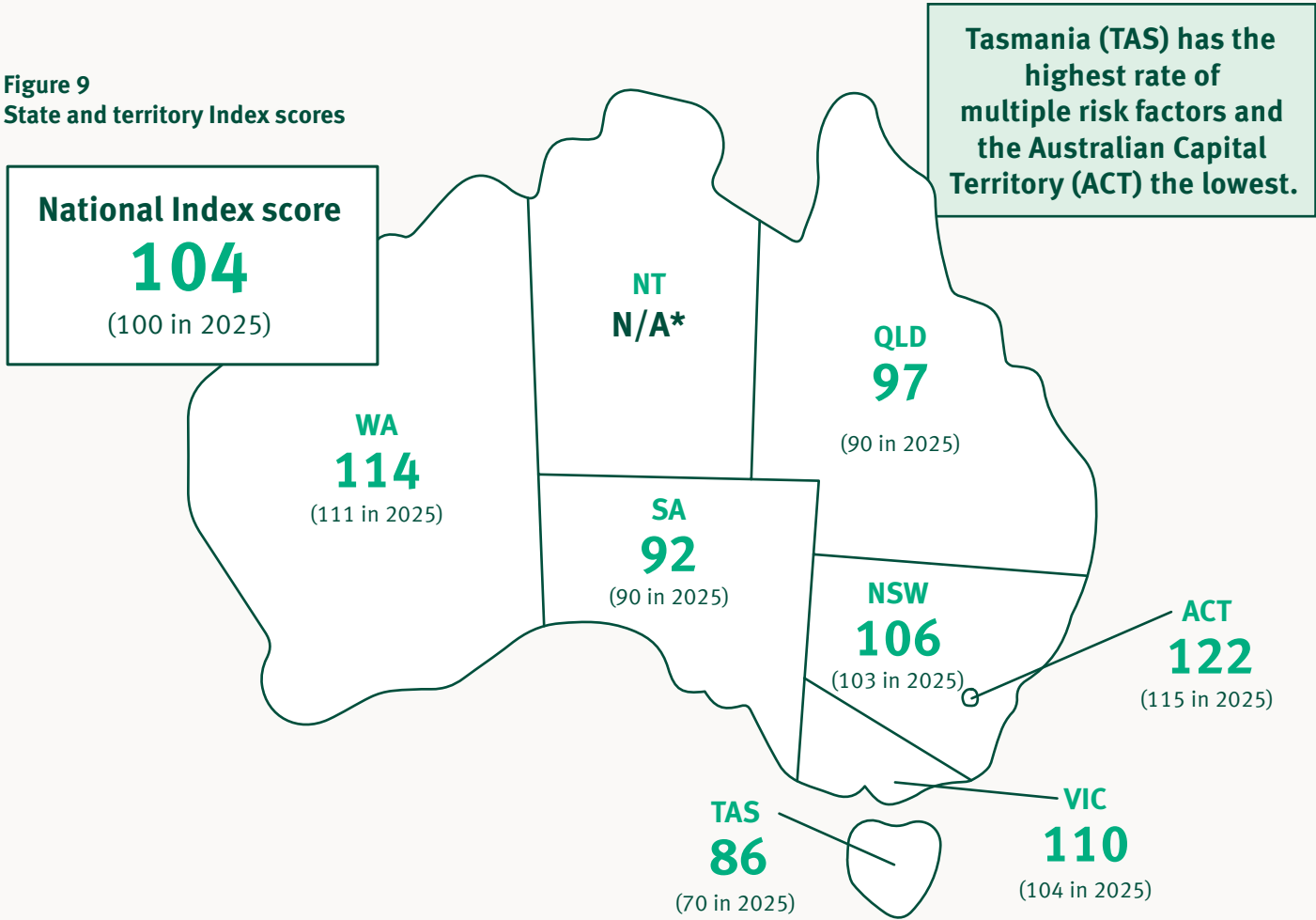
Figure 8
Age of Station users vs Australian population FY2026



*All figures are based on the user's last check on a SiSU Health Station and reflect Australians aged 15+, except high blood pressure, which is Australians aged 18+.
^Improved measurement methodology, not directly comparable with previous years. Refer to **Appendix 3: Methodology**.

Key findings: state and territory

Figure 9
State and territory Index scores



Risk factors vary across Australia

Every state and territory improved its Index score in 2026, with QLD moving ahead of SA after the two were level on 90 in 2025. However, the prevalence of individual risk factors continues to differ across the country (Figure 10).

The ACT again recorded the lowest rate for three of the four risk factors, while TAS recorded the highest rate for two. The largest difference was in obesity, ranging from 24.2 per cent in the ACT to 30.4 per cent in TAS (6.2 percentage point spread).

Diabetes had the smallest difference between states and territories, at 1.2 percentage points.

The risk factor map is also shifting

WA recorded the highest daily vaping rate, at 8.1 per cent compared to 7.1 per cent nationally, just ahead of QLD at 7.9 per cent. QLD recorded the country's highest daily smoking rate.

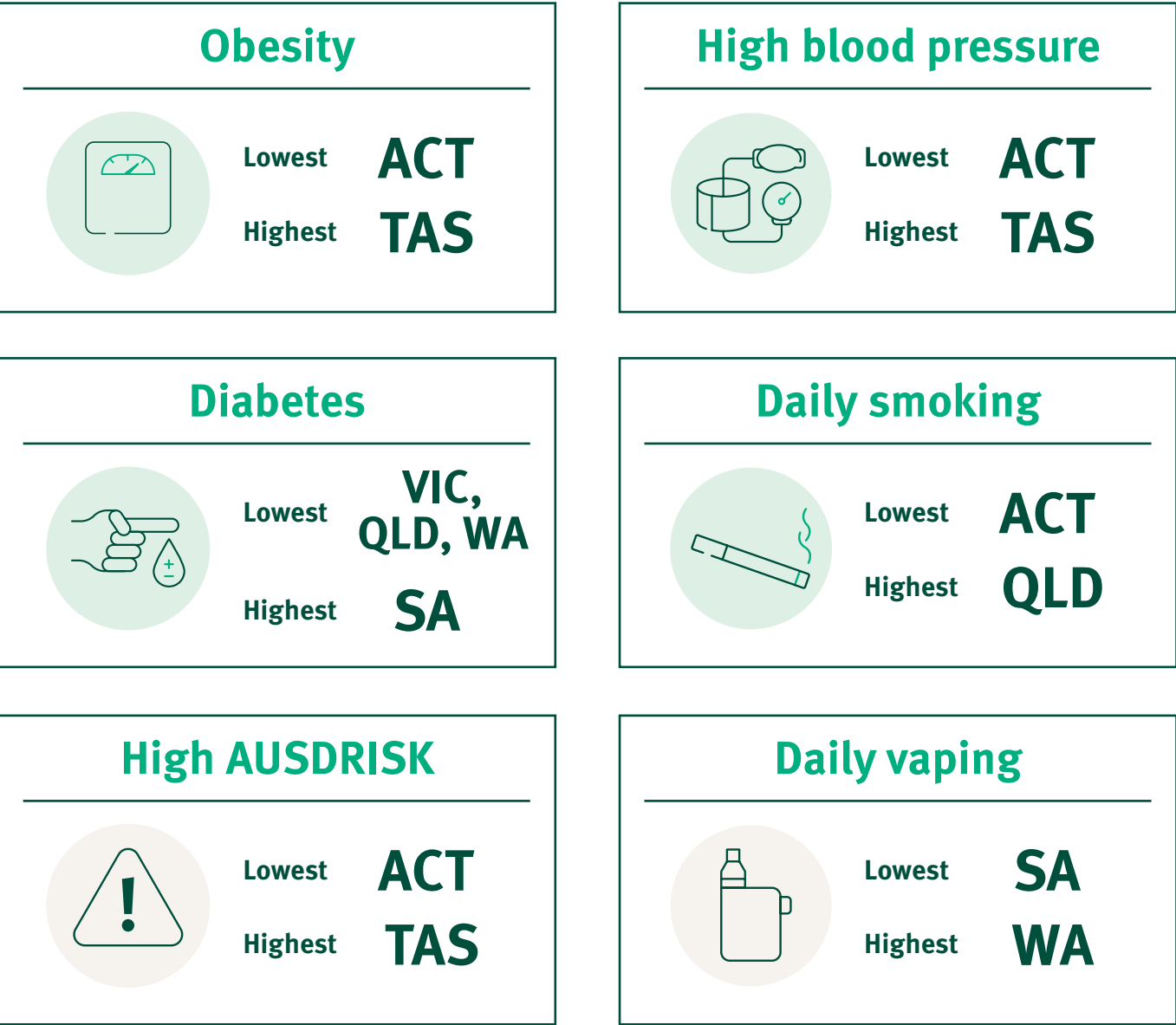
SA recorded the highest diabetes rate at 7.1 per cent, compared to 6.2 per cent nationally, overtaking NSW from FY2025.

*The Northern Territory (NT) is excluded from this Index due to insufficient and non-representative data. With a limited number of SiSU Health Stations in the region, the data collected does not accurately reflect the health outcomes of the broader NT population.

Figure 10
Prevalence of health risk factors among Australians FY2026*

Health risk factor	AU	NSW	VIC	QLD	WA	SA	TAS	ACT
Obesity	26.7%	25.8%	25.2%	29.0%	26.4%	29.6%	30.4%	24.2%
High blood pressure	11.9%	12.0%	11.8%	12.1%	11.5%	12.2%	14.5%	10.5%
Diabetes	6.2%	6.6%	5.9%	5.9%	5.9%	7.1%	6.2%	6.3%
Daily smoking	10.1%	10.2%	9.1%	11.4%	9.9%	9.3%	11.0%	7.7%
2+ risk factors	10.5%	10.6%	9.7%	11.2%	9.7%	11.4%	12.3%	9.2%
High AUSDRISK (12+) [†]	36.3%	37.5%	34.8%	36.2%	35.1%	38.7%	38.8%	33.9%
Daily vaping [‡]	7.1%	7.5%	6.4%	7.9%	8.1%	5.6%	6.0%	5.8%

■ Lowest ■ Highest



*Figures are based on de-identified, aggregated SiSU Health Station checks completed between 1 July 2025 and 30 June 2026, reweighted to match the age, sex and geographical distribution of Australians aged 15 years and over (or 18 years and over for high blood pressure). Health Station users are not a random sample and non-physical measures are self-reported, so results may not represent all Australians. The SiSU Health Station continues to improve how users are measured. Adjusting for methodological changes means prior-year figures may differ from those previously published.
[†]High AUSDRISK and daily vaping are captured but do not form part of the Index score.

Where cardiometabolic risk is highest and lowest

The most and least at-risk electorates across each of the four health risk factors in each state and territory

While Australia’s cardiometabolic health improved overall, there remain differences across the country, which provide insight into where targeted action can be taken (Figure 11).

Find your local electorate at whi.wesfarmershealth.com.au/explorer/.

Recognising the areas with lower risks and those requiring more focused attention gives a clear understanding of the diverse health landscape across the country, helping to identify where targeted interventions could be most beneficial.



Figure 11
The health of federal electorates



* Created by the Australian Bureau of Statistics (ABS), the Socio-Economic Indexes for Areas (SEIFA) combine Census data to summarise an area's socioeconomic characteristics. Each area receives a SEIFA score from 1 (most disadvantaged) to 10 (least disadvantaged), indicating how relatively advantaged or disadvantaged it is.

Cardiometabolic risk factors

1

Despite making health gains, more than one in 10 (10.5%) Australians live with multiple cardiometabolic risk factors (one in eight men and one in 11 women)

When more than one risk factor is present, the probability of developing serious chronic disease rises.¹⁸ This year, 278,428 users were assessed on all four risk factors.

Concerningly, 10.5 per cent carry two or more of the four risk factors (Figure 13). That is, one in eight men (12.2 per cent) compared to one in 11 women (8.8 per cent). Positively, 59.2 per cent carry none and 30.4 per cent carry exactly one, while 1.4 per cent carry three or four. It is clear the number of risk factors increases with age.

Risk factors often occur together

Australians may have more than one of the four risk factors. Obesity is the most common of the four and the one most often experienced alone. It affects 26.7 per cent of Australians, while 34 per cent of those affected have at least one of the other risk factors (Figure 12).

Obesity is also a major risk factor for a number of cardiometabolic conditions, including high blood pressure and type 2 diabetes.¹⁹ Diabetes and high blood pressure are comparatively more likely to occur alongside other risk factors. Among Australians with two or more risk factors, 86 per cent have obesity.

Metabolic health carries cardiovascular risk with it

A high blood pressure reading affected 18.2 per cent of Australians with a BMI of 30 or above, compared with 7.7 per cent of those with a BMI below 30. Diagnosed diabetes showed a similar pattern, affecting 10.5 per cent compared with 4.3 per cent.

Interestingly, the prevalence of multiple risk factors diverges with age (Figure 14); metabolic risk improves among younger Australians and worsens among older Australians. The two measures turn at different ages, obesity at 55 and diagnosed diabetes at 35. This highlights where efforts should be focused on tackling these specific risk factors.

Obesity increases with age and is highest for those aged 55-64 at 35.9 per cent, then falls. Meanwhile, diagnosed diabetes increases across the age spectrum, and is highest for those aged 75 and over at 15 per cent. AUSDRISK follows the same trend as diabetes (Figure 14).

Figure 12
Combinations of the four risk factors FY2026

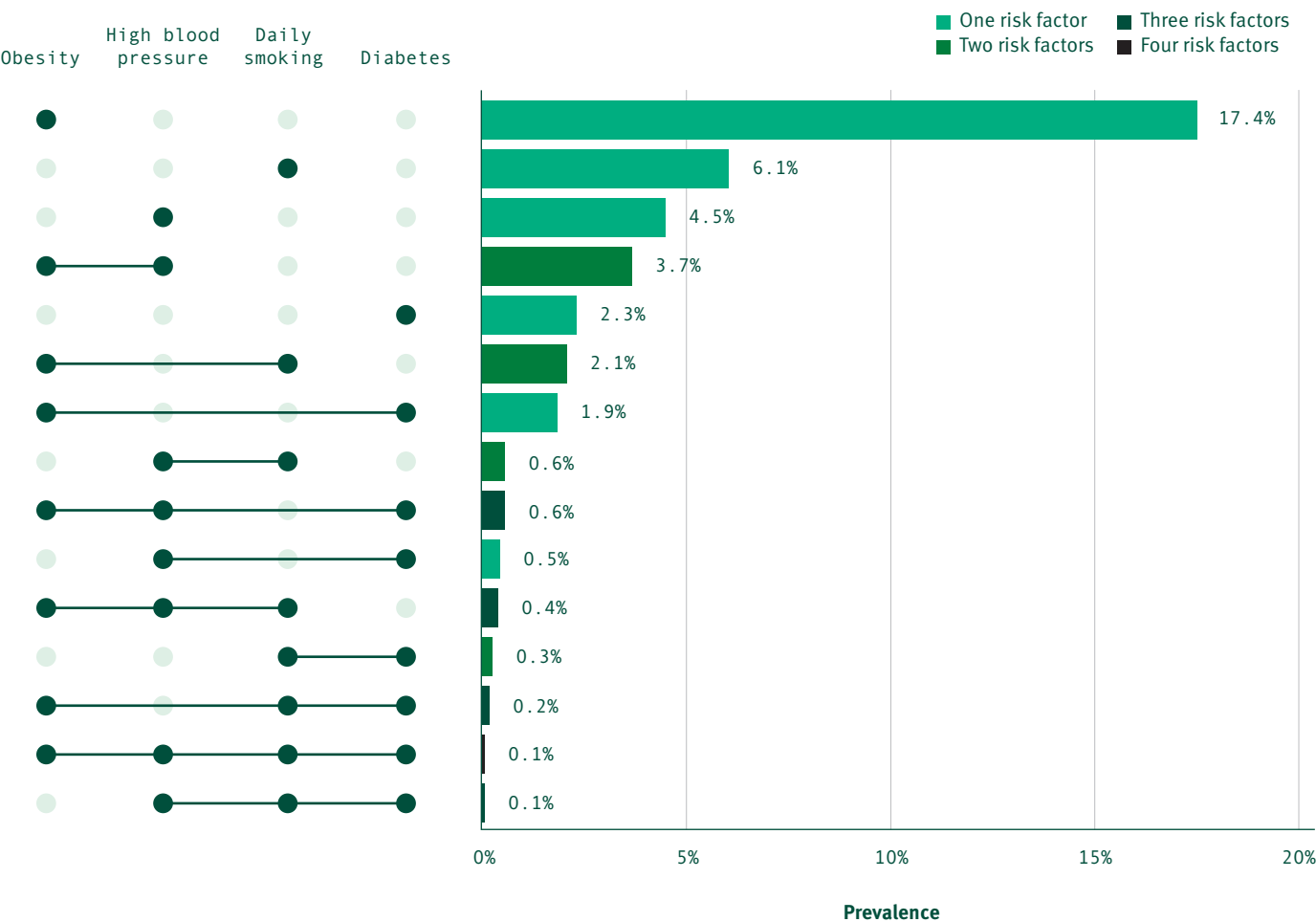


Figure 13
Number of the four risk factors Australians carry FY2026

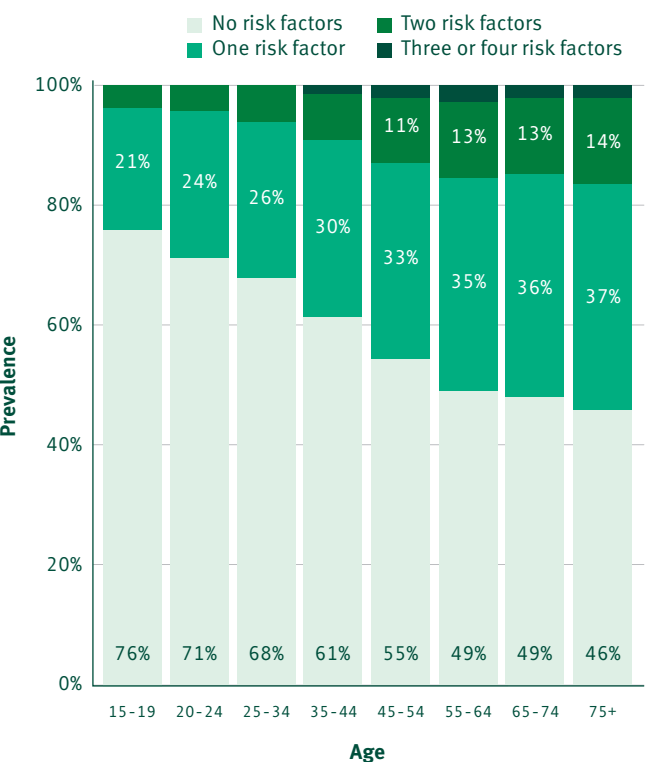
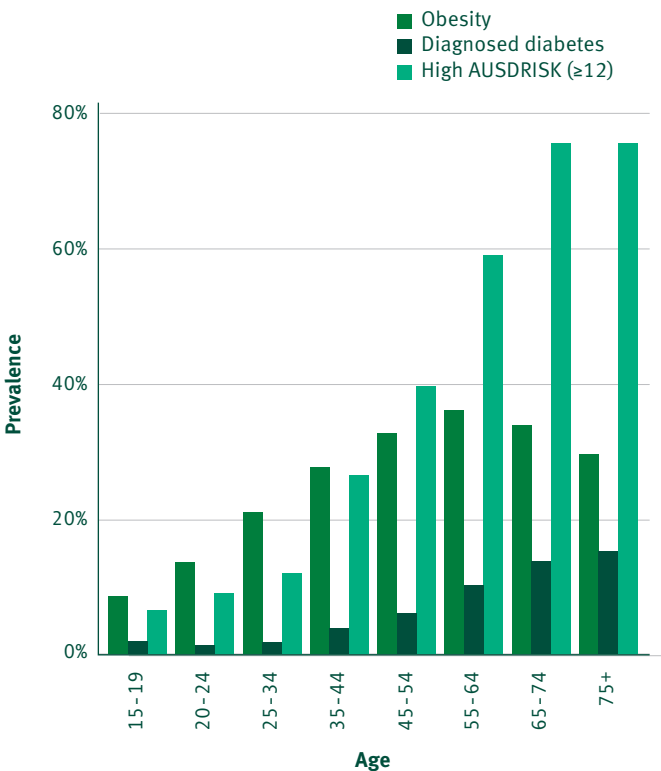


Figure 14
Obesity, diagnosed diabetes and high AUSDRISK by age FY2026



Obesity

2

More than one in four (26.7%) Australians have obesity (BMI ≥ 30)

Obesity is a chronic, relapsing disease shaped by genetics, neurobiology, eating behaviours, access to healthy foods, market forces and the wider environment.²⁰

Overweight and obesity refer to excess body weight and are risk factors for many chronic conditions.²¹ They affect mental and physical health, are linked to higher death rates and increase the likelihood of type 2 diabetes, high blood pressure and cardiovascular disease.²²

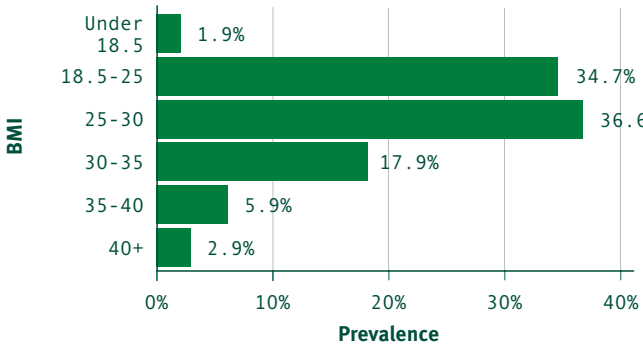
The Index estimates obesity prevalence based on Australians who recorded a BMI of 30 or above. Obesity rates have remained steady since 2025, with 26.7 per cent of Australians having obesity. This is more than one in four Australians. Obesity fell among Australians aged under 55.

Almost two in three Australians are above a healthy body mass index

Obesity is measured using the body mass index (BMI), with only 34.7 per cent of Australians at a healthy weight, while 63.3 per cent have a BMI above 25 (Figure 15).

Individuals are considered overweight with a BMI 25.0 to 29.9 kg/m², to have obesity with a BMI 30 kg/m² or higher, and to have severe obesity with a BMI 35 kg/m² or higher.

Figure 15
Australians by BMI FY2026



Cardiometabolic disease stages



Diabetes and high AUSDRISK

More than one in three Australians are at high risk of developing type 2 diabetes.

Diabetes slightly rose with 6.2 per cent of Australians diagnosed and living with the condition.

Diabetes is a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces, causing high glucose levels (hyperglycaemia).²³ There are several types of diabetes including type 1, type 2, and gestational diabetes.

Diabetes is a serious, chronic condition that can be managed, but if left untreated can lead to serious health complications, including heart disease, stroke, kidney failure, blindness and lower limb amputation.²⁴

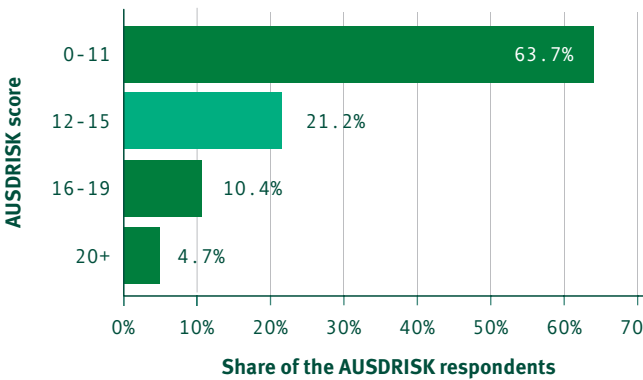
Diabetes slightly rose, up 0.2 percentage points from FY2025. This is a similar finding to the *National Health Measures Survey* which takes blood tests and found 6.6 per cent of adults had diabetes, as well as the AIHW's prevalence estimate of 6.5 per cent.²⁵

The prevalence of diabetes generally increased with age, from 1.7 per cent among Australians aged 25-34 to 13.8 per cent among those aged 65-74. It was higher again among those aged 75 and over.

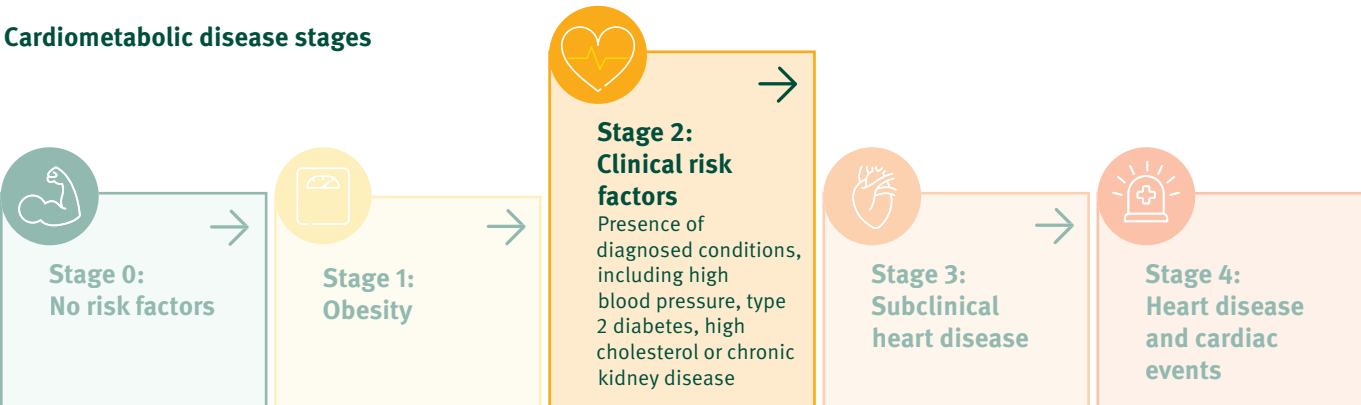
Compared with the previous year, prevalence fell among Australians under 35 but increased among those aged 35 and over.

The Australian Government's AUSDRISK questionnaire scores an individual's risk of developing type 2 diabetes over the next five years and is completed by Station users who do not have diabetes.²⁶ Approximately 36.3 per cent of these users scored 12 or more, which is denoted high risk (Figure 16). For scores of 12-15, approximately one person in every 14 will develop diabetes.²⁷

Figure 16
Distribution of Australians' AUSDRISK scores FY2026



Cardiometabolic disease stages



High blood pressure

3 Three in four (77%) Australian adults with a high blood pressure reading were unaware of it

Australians are considered to have high blood pressure when they record 140/90 mmHg or higher.²⁸ It is expressed as two numbers, systolic and diastolic pressure.

High blood pressure is a common condition that can cause serious health problems, yet is often without any noticeable symptoms.²⁹

Consistently high blood pressure is diagnosed as hypertension, and is by far the leading risk factor for preventable deaths in Australia, contributing to over 25,000 deaths annually.³⁰

Hypertension is a major risk factor for serious chronic conditions, including heart failure, heart attack, stroke, kidney disease and dementia.³¹ Each year high blood pressure is left untreated, increases the risk of cardiovascular disease.³²

An estimated 11.9 per cent of Australian adults have high blood pressure, from Health Station readings weighted by age, sex and location. Adding people whose medication keeps their blood pressure below 140/90 mmHg, as national estimates of hypertension do, gives 24.9 per cent.

High blood pressure rises sharply with age

A blood pressure reading is considered high at 140/90 mmHg or above. In FY2026, 302,217 users aged 18 and over had their blood pressure checked on a SiSU Health Station.

SiSU Health Stations measure and report blood pressure readings but do not diagnose hypertension. Over the past two years, SiSU Health has refined its measurement process (outlined in **Appendix 3: Methodology**). The Station now prompts a user whose first reading is high to measure again in the same session. This is because an initial reading can often be higher than subsequent readings.

High blood pressure rises steeply with age, from 3.8 per cent among those aged 18–24 years to 28.6 per cent among those aged 75 and over (Figure 17). Counting those taking blood pressure medication as well, the figure at 75 and over is 65.7 per cent.

Cardiometabolic disease stages

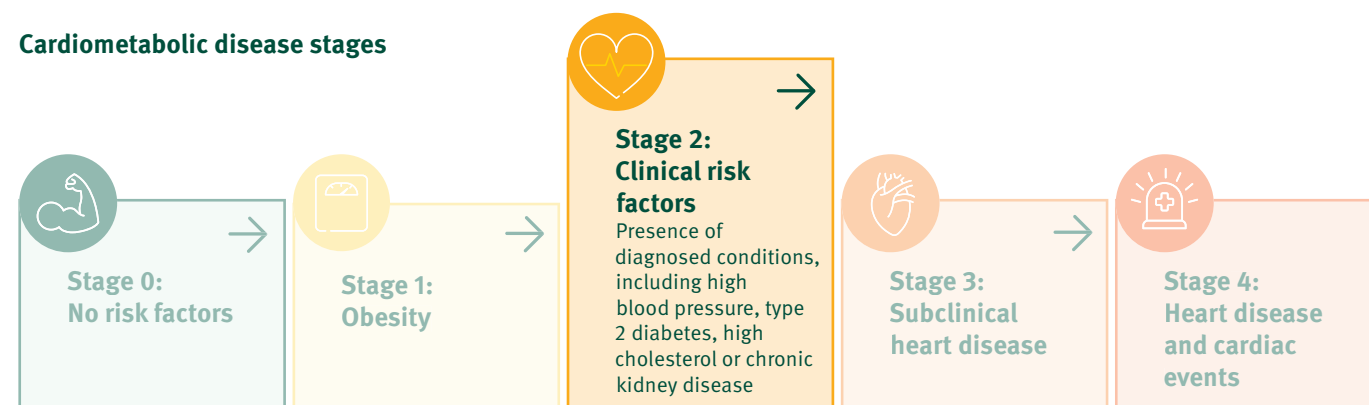
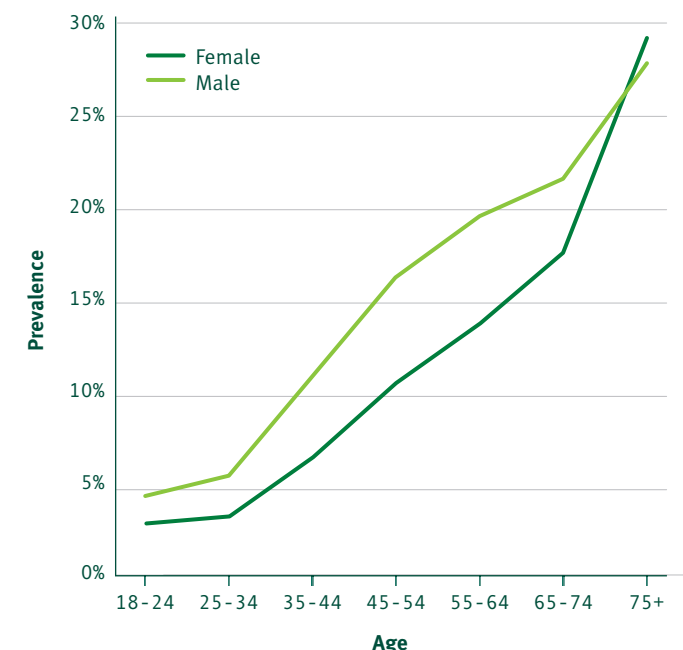


Figure 17
High blood pressure by age and sex FY2026



Most Australians with a high blood pressure reading were unaware of it

While 11.9 per cent of Australian adults are estimated to have high blood pressure, the more concerning issue is that 77.2 per cent of these Australians were unaware of it (Figure 18). Of adults with high blood pressure, 39.3 per cent had not had a blood pressure check in the past 12 months, while 37.9 per cent had been checked but understood the result was not high. Only 22.8 per cent were aware their blood pressure was high.

The reason Australians do not know changes with age. For younger Australians with high blood pressure, most are not aware because they have not had their blood pressure checked in the past 12 months. Older Australians have likely been checked but understood their previous result was not high.

Blood pressure treatment and control

The National Hypertension Taskforce has set a goal of 70 per cent blood pressure control by 2030.³³ Among Australian adults with high blood pressure or taking medication for it, the hypertension control rate is an estimated 52.1 per cent (Figure 19), 18 points short of that goal. The Taskforce's own most recent national estimate is 39.6 per cent, for 2022–23; one reason the Station's figure is higher is that it prompts a second reading when the first is high (Figure 19).³⁴

The 52.1 per cent breaks down as:

- 24.9 per cent of Australian adults either measured at or above 140/90 mmHg or reported taking medication for blood pressure;
- 69.7 per cent of them are on medication; and
- 74.8 per cent of those on medication measured below the threshold.

Figure 18
What adults with measured high blood pressure knew about their own blood pressure by age FY2026

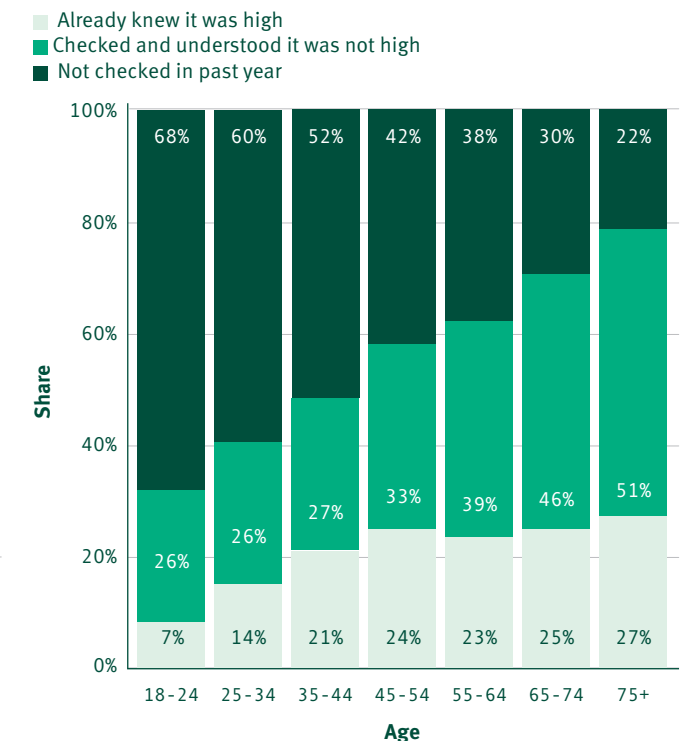
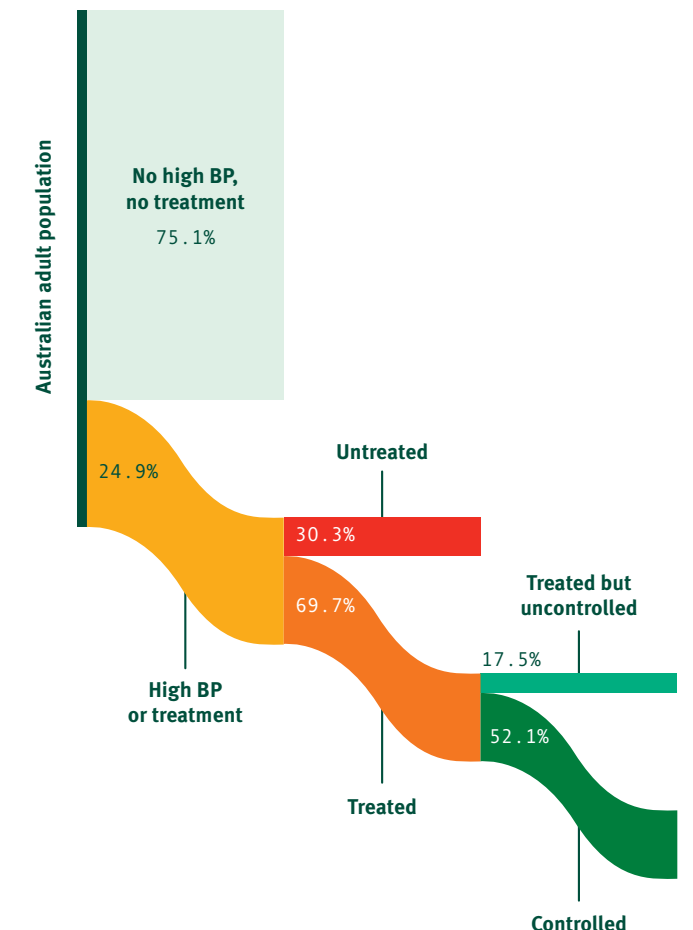


Figure 19
Blood pressure and its treatment in Australia FY2026



Smoking and vaping

4

10.1% of Australians smoke daily, almost double recent national estimates

Smoking tobacco carries substantial economic and health costs.³⁵ It increases the risk of many conditions, including cancer, respiratory conditions, heart disease, stroke and diabetes.³⁶

In recent years, e-cigarettes and vapes have become far more prominent. Vapes typically contain nicotine.³⁷ There is a growing body of research that identifies the impacts vaping can have on individuals.³⁸

The Index found 10.1 per cent of Australians smoke daily, almost double the recent AIHW estimate of 5.6 per cent.³⁹ Overall, 14.5 per cent of Australians reported smoking, while vaping was 7.1 per cent, which includes daily or less frequently (Figure 21).

The Station’s smoking and vaping measures are self-reported, recording whether an individual smokes or vapes and how often.

Vaping overtakes smoking among young Australians

Broadly, smoking and vaping decrease with age (Figure 20). Daily vaping is above daily smoking for Australians aged 15-19 at 16.8 per cent compared to 14.3 per cent. However, the two are equal for those aged 20-24 and daily smoking is higher in every age group from 25 years.

Figure 20
Daily smoking and vaping by age FY2026

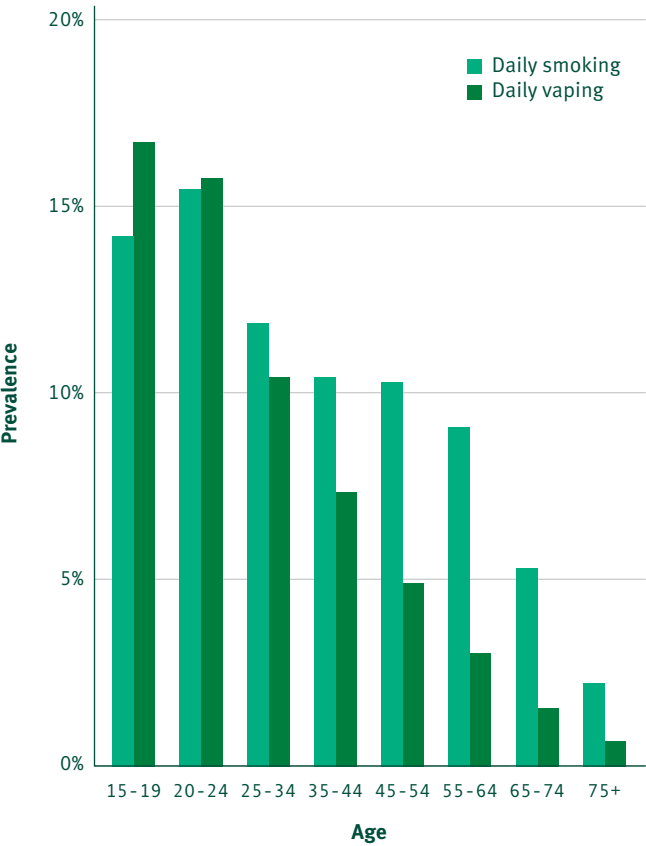
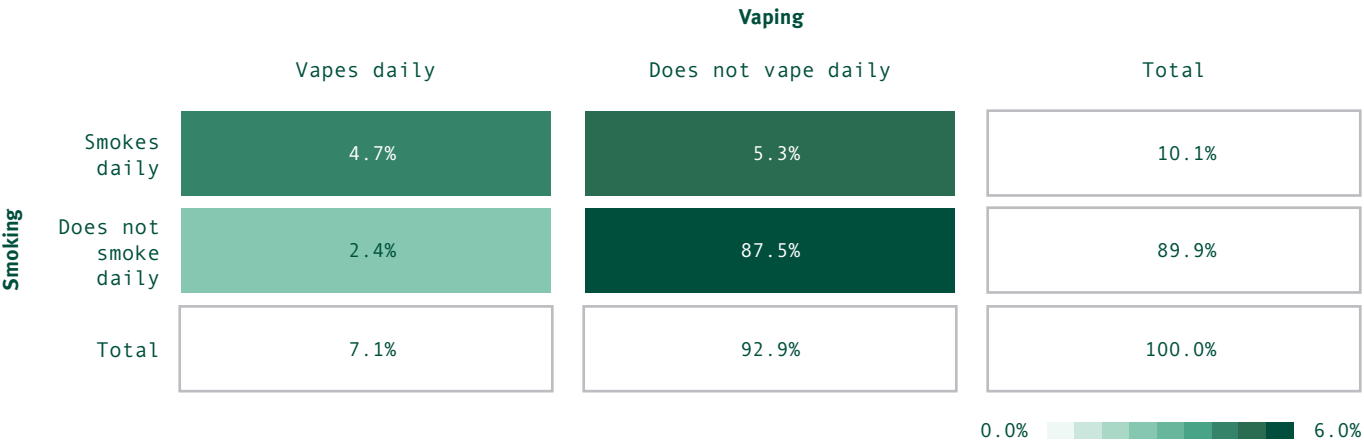


Figure 21
Daily smoking and vaping FY2026



Young daily smokers are more likely to also vape daily than older smokers

Among daily smokers aged 15-19, 87 per cent also vape daily, compared to 22 per cent for those aged 55-64.

Daily smoking showed no significant change; the movement was in vaping. Daily vaping increased by 0.3 percentage points, the proportion who reported never having vaped decreased by 0.6 percentage points and the proportion who had vaped but since stopped increased by 0.3 percentage points.

Among Australians aged 15 and over, 60.4 per cent reported never having smoked, 79.5 per cent reported never using a vape and 18.5 per cent are ex-smokers on the 100-cigarette definition.⁴⁰

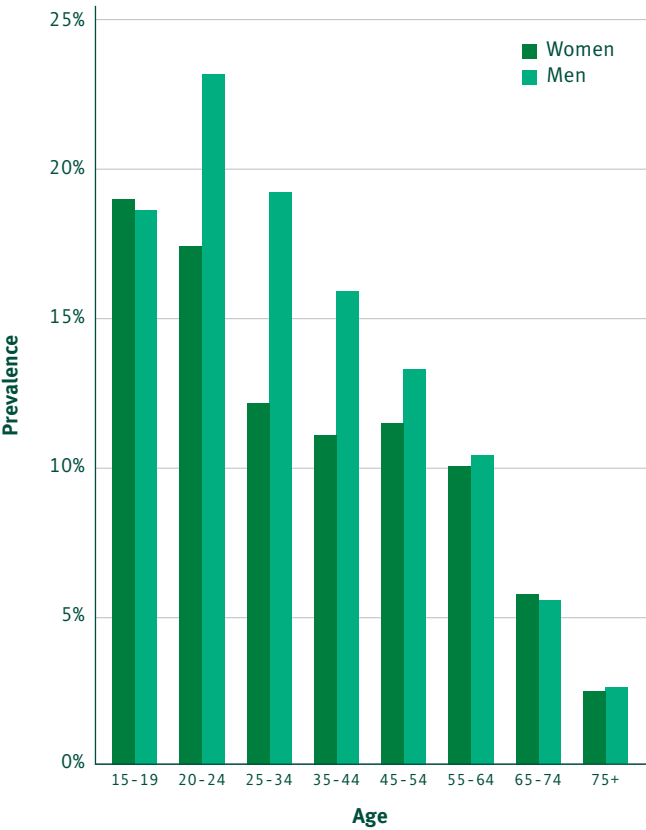
Men and women use nicotine at similar rates in their teens and in older age, but a gap widens toward greater male use in their twenties and thirties. Among those aged 15–19, 14.0 per cent of women smoked daily and 17.5 per cent vaped daily, compared with 14.5 per cent and 16.1 per cent of men, respectively (Figure 22).

However, this shifts among those aged 20-64, where men are more likely than women to smoke and vape daily. The gap between the sexes closes again and is relatively similar for those aged 65 and over.

87%

of teenage (15-19) daily smokers also vape daily

Figure 22
Daily smoking, vaping or both by age and sex FY2026



Women's health

5

Women have lower rates of every major risk factor than men, but their health advantage narrows in midlife

Wesfarmers Health recognises the importance of tailored health and care advice during major life stages such as pregnancy, perimenopause and menopause.

This year, women made up 49.9 per cent of SiSU Health Station users compared to 51.1 per cent of the Australian population aged 15 and over. Women’s participation was lowest in midlife, comprising 45.8 per cent of users aged 35-44, before rising to 53.2 per cent among those aged 65-74.

Women carry fewer cardiometabolic risk factors overall

Men have largely carried more risk factors. This year 8.8 per cent of women compared to 12.2 per cent of men carry two or more of the four risk factors.

For example, 24.1 per cent of women have obesity compared to 29.4 per cent of men; that is, around one in four women have obesity compared to three in ten men (Figure 23).

The health gap changes with life stage

The sex gap does not close uniformly across the age range, with differences in obesity and high blood pressure greatest in midlife before converging thereafter.

For example, the prevalence of high blood pressure is similar in women aged 65 and over, with 22.9 per cent recording a reading of 140/90mmHg or above compared to 24.2 per cent of men. Diabetes is more common in men, with 11.3 per cent of women aged 65 and over reporting a diagnosis compared to 18.0 per cent of men.

Obesity is less common in women but more severe

This difference is present in every age band, particularly among those aged 35–44, where 17.1 per cent of women with obesity have a BMI of 40 and above. This is compared to 8.9 per cent of men with obesity – one in six against one in ten (Figure 25).

When women have a BMI greater than 30, they are more likely than men with obesity to fall into the higher BMI categories. Since FY2018, this pattern has been consistent across every age group from 20 to 74, with women more likely to record a BMI of 35 or more, and 40 or more.

Men have higher blood pressure readings until later in life

Men were more likely than women to record a high blood pressure reading across all age groups under 75. In FY2026, 13.6 per cent of men recorded a high blood pressure reading, compared with 10.4 per cent of women (Figure 24).

However, women who recorded a high blood pressure reading were more likely than men to be aware their blood pressure was high (24.6 per cent compared with 21.4 per cent). Women were also less likely to report not having had their blood pressure checked in the past 12 months (37.0 per cent compared with 41.2 per cent of men).

Nearly three in 10 women offered menopause support want further help

Since September 2025, SiSU Health Stations have offered women the opportunity to access perimenopause and menopause support.

Of the 33,141 women asked whether they wanted to speak with someone about support, 9,545 (28.8 per cent) said yes. This rose to 35.9 per cent among women aged 45–54, compared with 16.5 per cent among those aged 55–64.

Figure 24
High blood pressure by age and sex FY2026

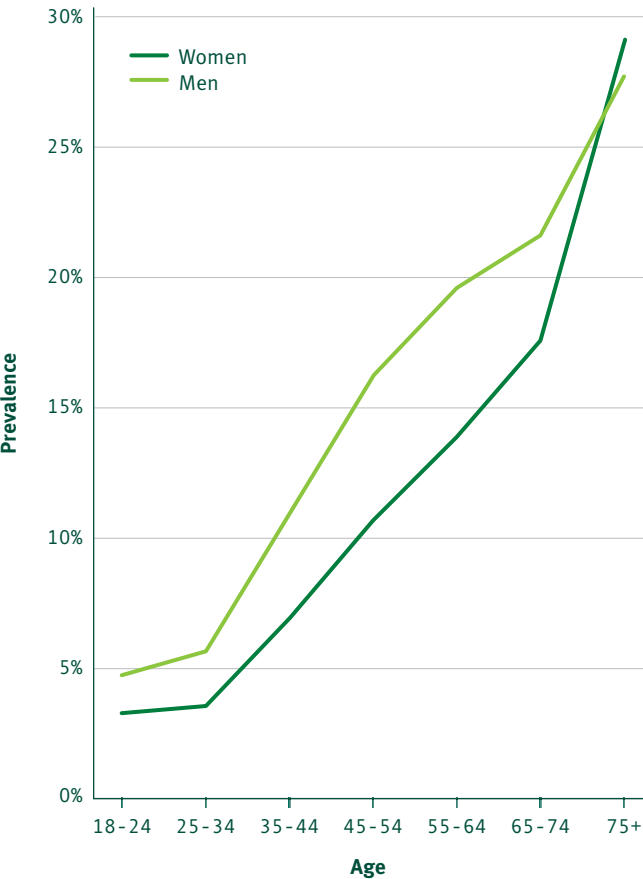


Figure 23
The four risk factors by sex FY2026

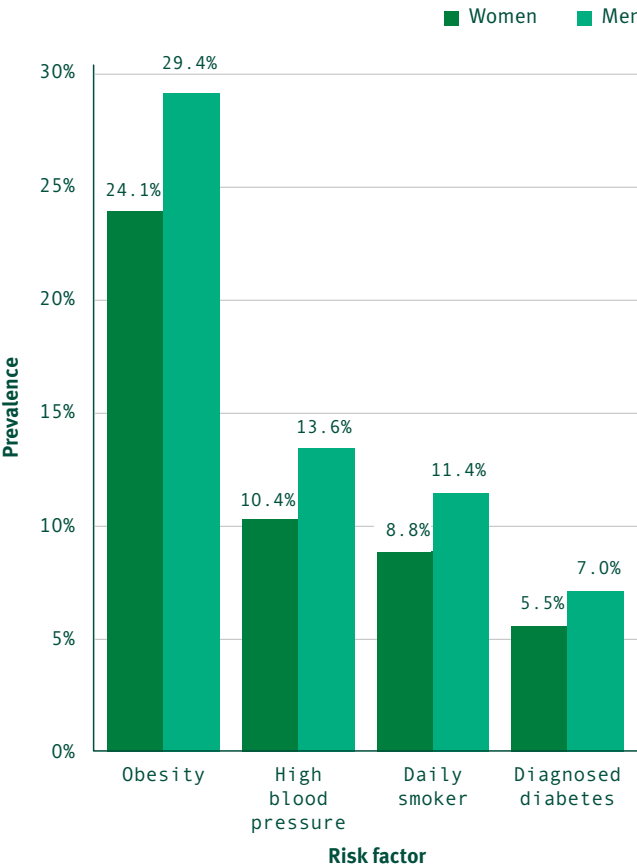
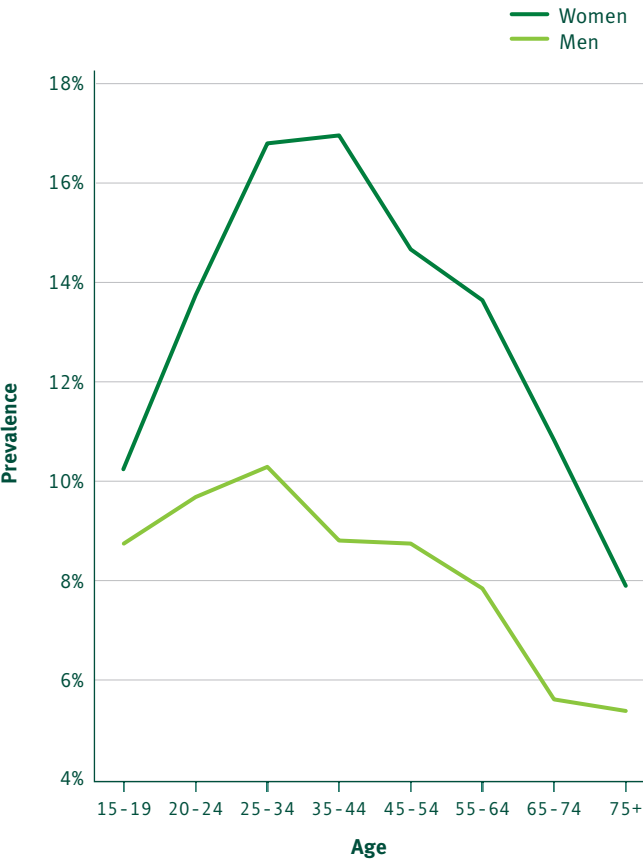


Figure 25
Share of Australians with obesity who have a BMI ≥ 40 by age and sex FY2026



Disadvantage

6 Australians living in the most disadvantaged areas are 2.5 times as likely to have multiple cardiometabolic risk factors as those in the least disadvantaged areas

Cardiometabolic risk factors become more common as disadvantage increases

Areas are divided into five equal groups (quintiles) by level of disadvantage, from quintile 1 (most disadvantaged) to quintile 5 (least disadvantaged). Australians living in the most disadvantaged areas are 2.5 times as likely to carry two or more cardiometabolic risk factors as those in the least disadvantaged areas, at 16.0 per cent compared to 6.4 per cent (Figure 26). The gradient is evident across individual risk factors. Daily smoking is 2.4 times as common in the most disadvantaged areas, diabetes 2.0 times as common, obesity 1.8 times as common and high blood pressure 1.4 times as common.

Smoking shows one of the strongest gradients by disadvantage

Daily smoking falls from 15.0 per cent in the most disadvantaged quintile to 6.2 per cent in the least disadvantaged (Figure 27). Daily vaping also increases with disadvantage, with a ratio of 1.7 between the most and least disadvantaged areas.

Smoking cessation follows the same gradient. Among Australians who have ever smoked, 47.6 per cent in the most disadvantaged quintile have stopped compared to 62.9 per cent in the least disadvantaged. High blood pressure also increases with disadvantage, from 9.8 per cent in the least disadvantaged areas to 14.2 per cent in the most disadvantaged (Figure 28). However, awareness remains consistently low, with between 76.0 per cent and 77.7 per cent of those with a high reading unaware of it across all quintiles.

The obesity gap by disadvantage is particularly pronounced for women

Obesity declines as disadvantage decreases for both sexes, but the gradient is steeper for women (Figure 30). Among women, obesity is 2.1 times as common in the most disadvantaged areas as in the least disadvantaged, compared to 1.6 times among men. The disparity begins early. Among women aged 20-24, obesity prevalence is 20.9 per cent in the most disadvantaged areas compared to 6.3 per cent in the least disadvantaged. By age 45-54, it reaches 38.3 per cent in the most disadvantaged areas, higher than the rate recorded among women in the least disadvantaged areas at any age.

Severity also differs. Among women with obesity in the most disadvantaged areas, 18.4 per cent record a BMI of 40 or above, compared to 10.9 per cent of men with obesity.

Figure 26
Prevalence ratio: most vs least disadvantaged areas

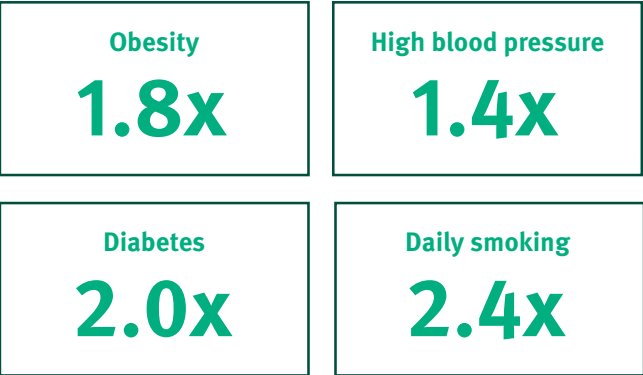


Figure 27
Daily nicotine use by type and IRSD quintile FY2026

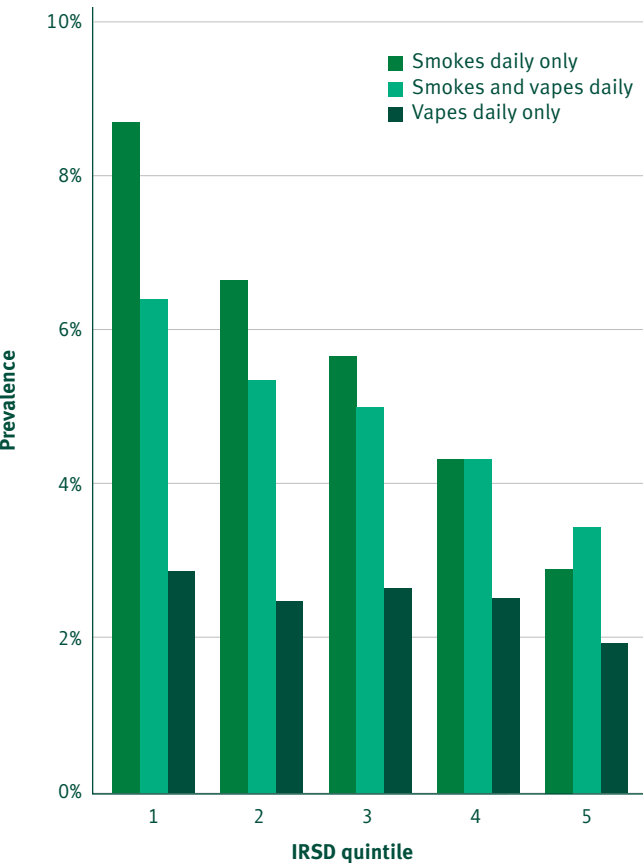


Figure 29
Metabolic risk by IRSD quintile FY2026

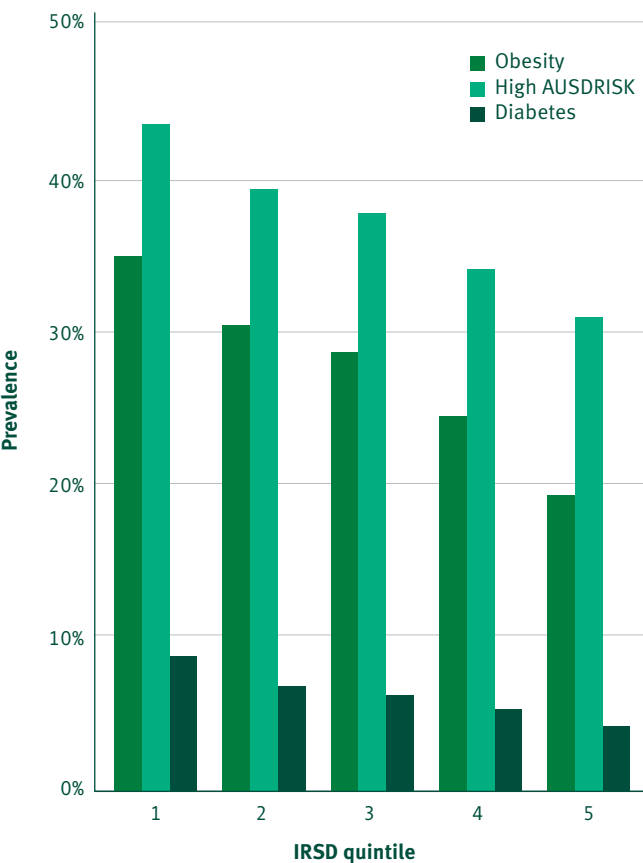


Figure 28
High blood pressure treatment by IRSD quintile FY2026

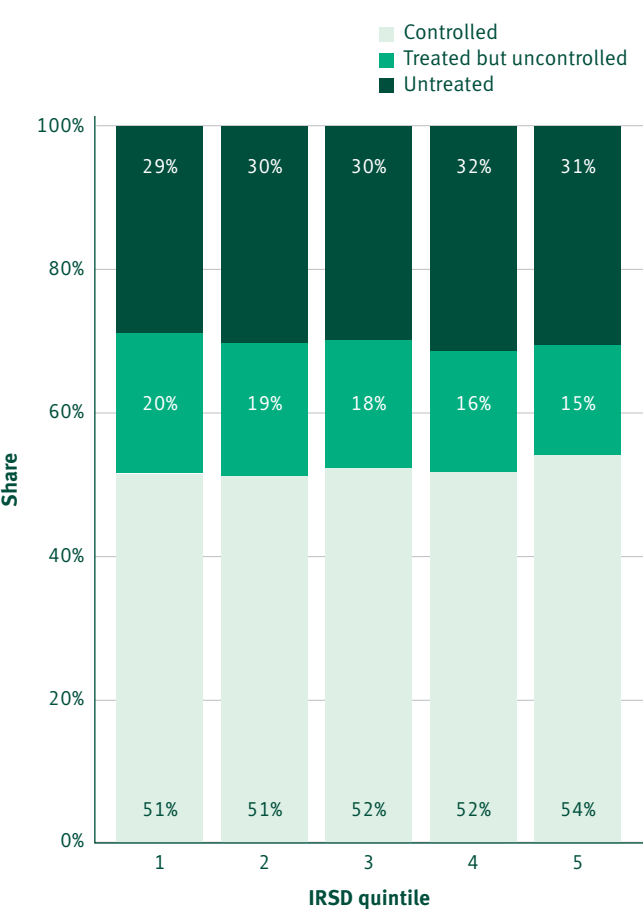
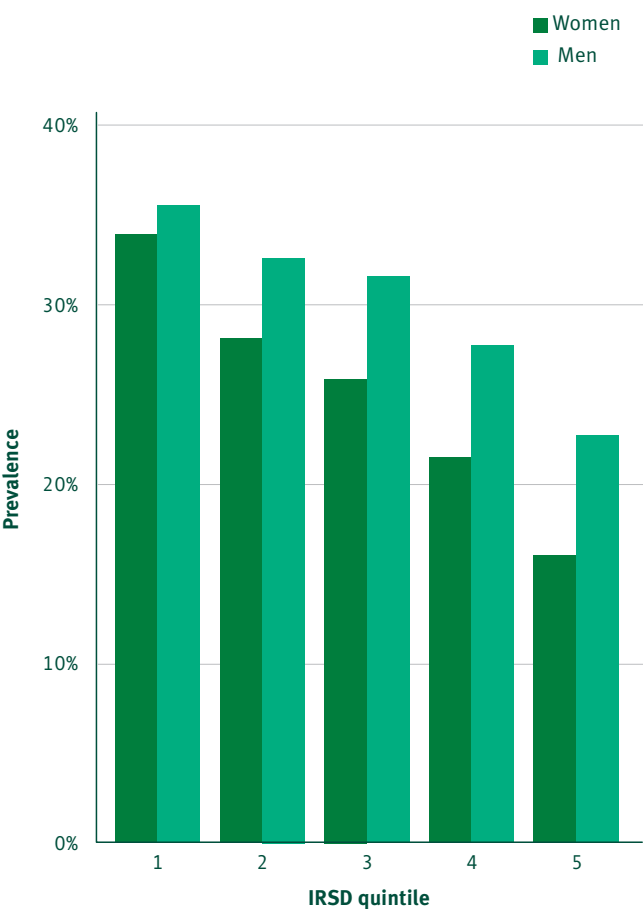


Figure 30
Obesity by sex and IRSD quintile FY2026



Regional, rural and remote health

7 Distance matters, with outer regional Australians 1.4 times as likely to have multiple cardiometabolic risk factors as those in major cities

SiSU Health Station users were more concentrated in major cities than the broader Australian population, with 78 per cent of users living in major cities compared with 69.2 per cent of Australians aged 15 and over, according to Census data (Figure 31).

People living outside the major cities are under-represented: 16.3 per cent of users live in inner regional Australia, compared to 21.6 per cent of Australians and 5.7 per cent in outer regional Australia, compared to 9.2 per cent.

Cardiometabolic risk increases with remoteness

In outer regional Australia, 13.4 per cent of Australians have two or more of the four risk factors compared to 9.4 per cent in major cities, making multiple risk factors 1.4 times as common.

Daily smoking is 1.4 times as common in outer regional Australia as in major cities, obesity 1.3 times as common, and high blood pressure 1.3 times as common.

Outer regional Australians more likely to have had their blood pressure checked

Contact with care is where the pattern reverses, with 40.3 per cent in major cities having had a blood pressure check in the previous 12 months compared to 45.6 per cent in outer regional Australia (Figure 32). This is one measure where remoteness separates Australians further than disadvantage does.

Obesity affects almost one in three outer regional Australians

Obesity rates are 32.3 per cent in outer regional Australia compared to 24.4 per cent in major cities.

Daily smoking increases with remoteness while vaping does not

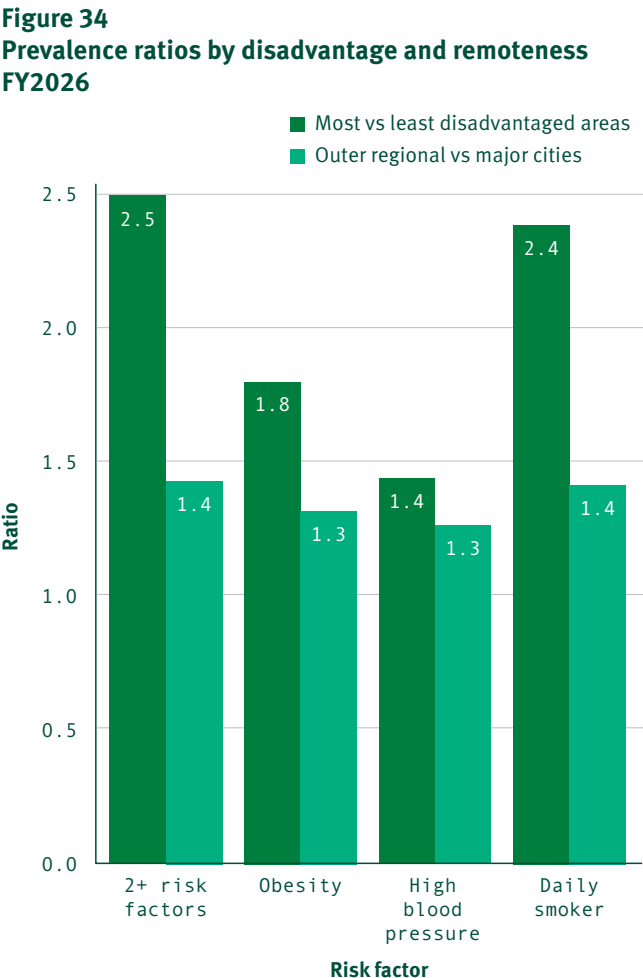
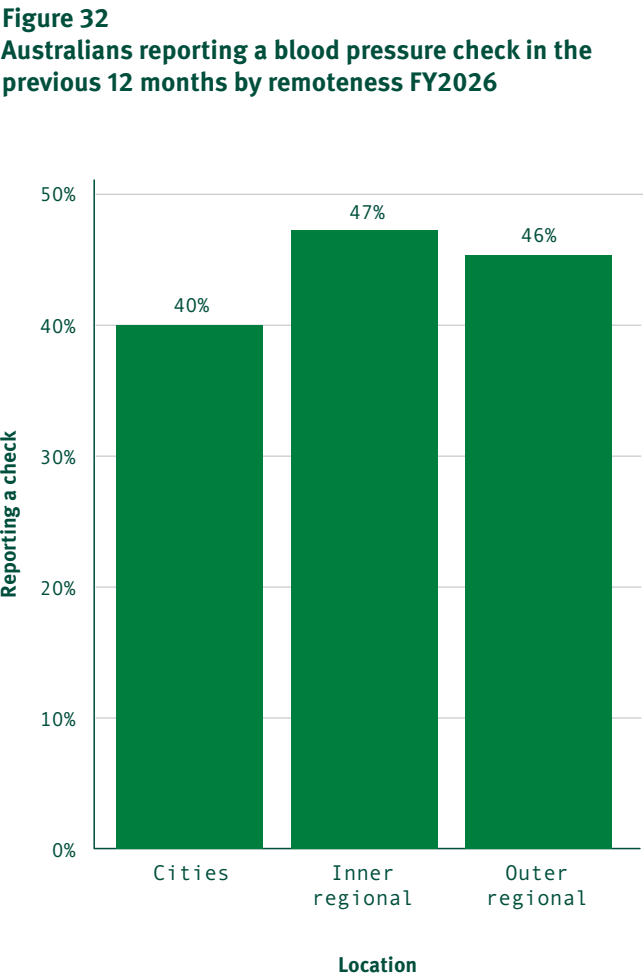
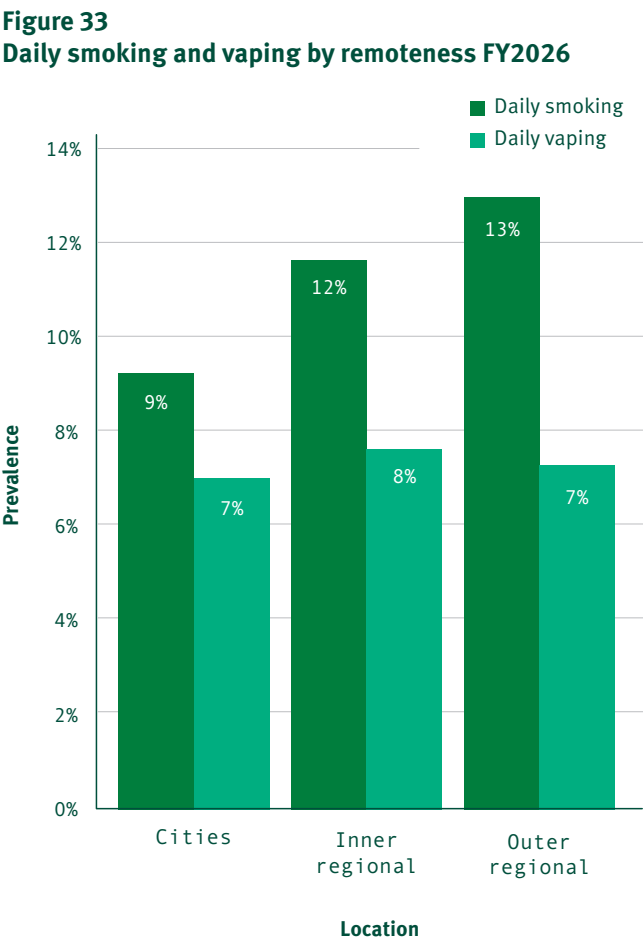
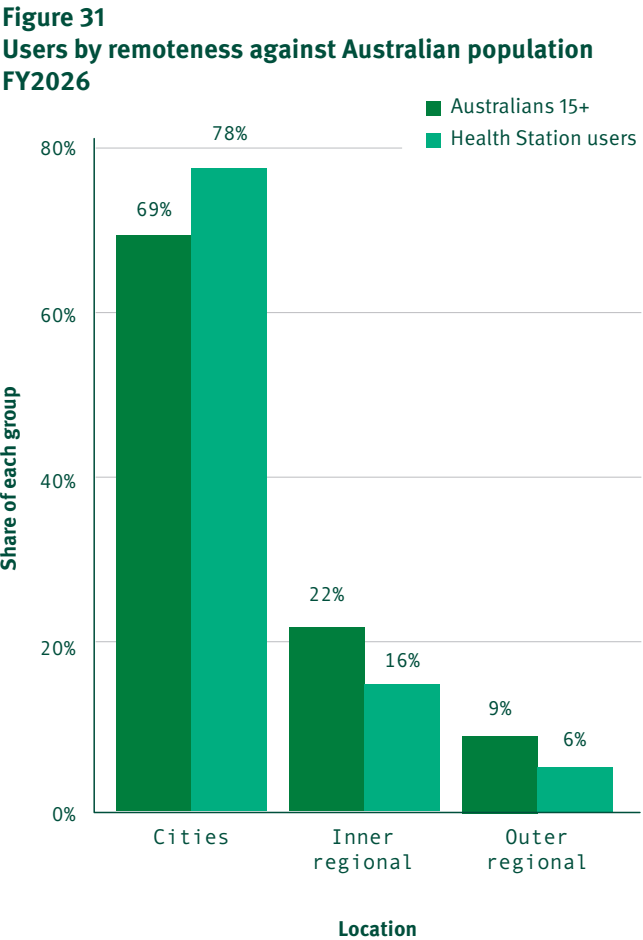
Like other findings, the rate of daily smoking increases with remoteness: 9.1 per cent in major cities, 11.7 per cent in inner regional and 13.0 per cent in outer regional (Figure 33).

In comparison, vaping does not increase with remoteness: 6.9 per cent in major cities, 7.6 per cent in inner regional and 7.3 per cent in outer regional.

Smoking without vaping is 1.8 times as common in outer regional Australia as in major cities, while vaping without smoking is 2.4 per cent in both.

Importantly, the population in regional Australia is older than in major cities, with 42 per cent aged 55 and over compared to 33 per cent in major cities.

However, age does not explain the difference: daily smoking is higher outside major cities in every age band. Smoking rates decrease with age across remoteness areas.



Australia on the global stage

The challenge of living healthier, longer



Australia on the global stage



Australia’s health system performs strongly by global standards, with the Commonwealth Fund and Organisation for Economic Co-operation and Development (OECD) reporting strong performance across many measures (Figures 35 and 36).⁴⁵

However, preventable chronic conditions continue to affect quality of life and place pressure on the health system. Cardiometabolic risk factors including overweight and obesity, high blood pressure, diabetes and smoking contribute to premature death, disability and years lived in poor health worldwide.⁴⁶

For Australia, the challenge is not simply helping people live longer, but helping them spend more of those years in good health.

Australia’s health system ranked first among 10 comparable countries in the Commonwealth Fund’s *Mirror, Mirror 2024* report, while recording the lowest health spending as a share of GDP among the countries compared, at 9.8 per cent.⁴⁷

Despite this strong performance, Australia recorded weaker results for access to care and care processes, including affordability, availability, prevention and coordination of care.⁴⁸

Australia also performs comparatively well on cardiovascular mortality. The age-standardised mortality rate for ischaemic heart disease is 62 deaths per 100,000 people compared to the OECD average of 112, while cerebrovascular disease mortality is 34 deaths per 100,000 compared to 54.⁴⁹

Living longer but not always healthier

Globally, life expectancy has increased faster than healthy life expectancy. A 2026 analysis of the Global Burden of Diseases, Injuries and Risk Factors Study 2023 (GBD) found the gap increased in 203 of 204 countries between 1990 and 2023.⁵⁰ Australia recorded one of the largest gaps, at 13.9 years in 2023, widening by 2.9 years over the period.⁵¹

High fasting plasma glucose and high BMI were among the leading contributors to this global morbidity gap.⁵² A 2025 *New England Journal of Medicine* study found that the absence of five classic cardiovascular risk factors at age 50 was associated with more than a decade greater life expectancy than having all five: hypertension, hyperlipidaemia, abnormal weight, diabetes and smoking.⁵³

The Index provides further insight into these risks in Australia. In FY2026, 63.3 per cent of Australians aged 15 and over assessed through SiSU Health Stations were overweight or had obesity, while approximately one in 10 had multiple cardiometabolic risk factors.

Cardiometabolic risk remains a global challenge

Non-communicable diseases remain a leading cause of death and disability worldwide. The GBD Study 2023 identified high blood pressure and smoking among the three leading risk factors for early death and disability globally.⁵⁴ While the burden associated with most leading risk factors declined between 2010 and 2023, the burden attributable to high blood sugar and high BMI increased.

Figure 35
Global health care system performance rankings

	AUS	CAN	FRA	GER	NETH	NZ	SWE	SWIZ	UK	US
Overall ranking	1	7	5	9	2	4	6	8	3	10
Access to care	9	7	6	3	1	5	4	8	2	10
Care process	5	4	7	9	3	1	10	6	8	2
Administrative efficiency	2	5	4	8	6	3	7	10	1	9
Equity	1	7	6	2	3	8	–	4	5	9
Health outcomes	1	4	5	9	7	3	6	2	8	10

Source: *Mirror, Mirror 2024*

Australia has one of the higher obesity rates among OECD countries, ranking fourth at 25.4 per cent on self-reported data.⁵⁵ Globally, the economic impact of obesity is predicted to reach US\$3 trillion annually by 2030 and more than US\$18 trillion by 2060.⁵⁶

Diabetes prevalence in Australia remains slightly below the OECD average, although its upward trend is associated with rising obesity, declining physical activity and an ageing population.⁵⁷

Australia’s daily smoking rate is considerably below the OECD average. However, regular vaping among Australians aged 15 and over increased from 0.9 per cent to 5.7 per cent over the measured period, approaching the OECD average of 6.1 per cent.⁵⁸

While Australia has reduced premature mortality, rising obesity, diabetes and other cardiometabolic risks remain a challenge. Better measurement, earlier identification and prevention will be central to helping Australians live healthier, longer lives.

Figure 36
How Australia compares with OECD countries on cardiometabolic risk factors

Source: *OECD, Health at a Glance 2025* (November 2025)

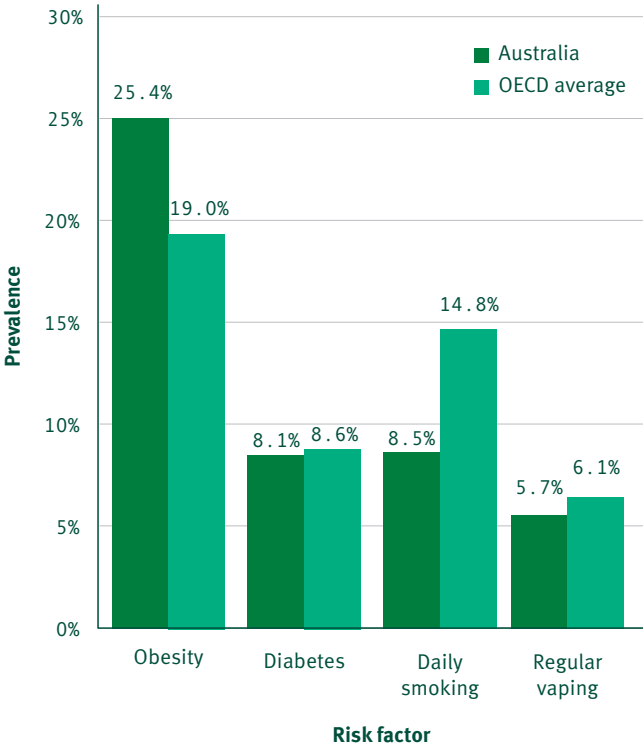
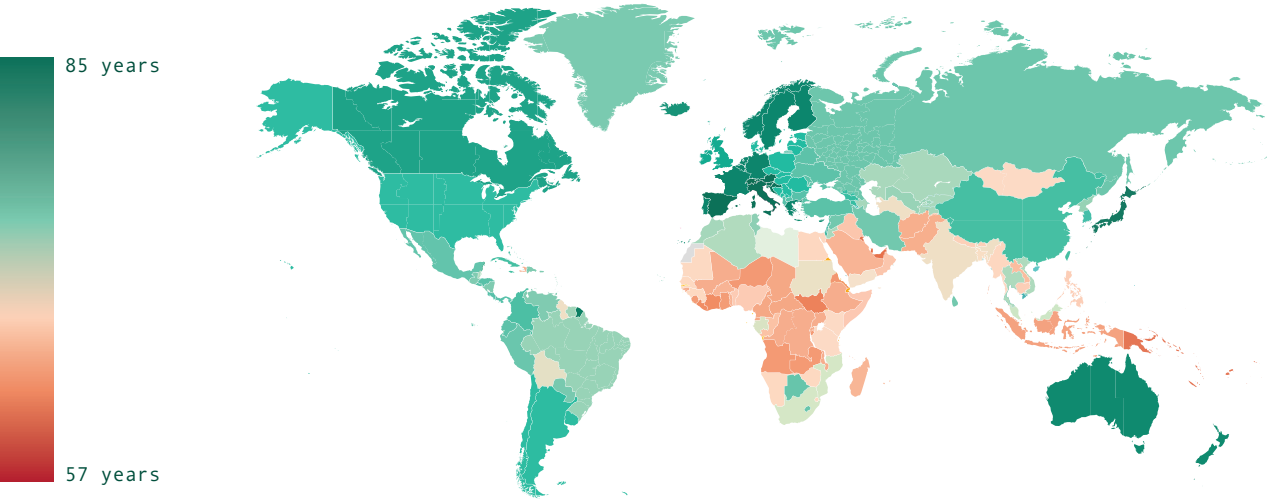


Figure 37
Mean age of death from cardiovascular diseases 2023

Source: *Global Burden of Disease Study 2023*



Local performance

Why prevention cannot wait



Local performance

Domestic data reveals that the growing chronic disease burden is placing increasing pressure on Australia’s health system and economy.

With an ageing population, rising healthcare costs and persistent cardiometabolic risk factors, the case for investing in prevention and earlier intervention is becoming increasingly urgent.

The Index adds to this evidence through large-scale, real-time data collected via SiSU Health Stations. It provides a timely snapshot of cardiometabolic risks among users, complementing established Australian population health research.

Health-adjusted life expectancy

Australians are living longer and spending more years in full health. However, the years lived in ill health are also increasing, meaning the proportion of life spent in full health has remained largely unchanged.⁵⁹

According to the AIHW, Australians lost 5.8 million years of healthy life in 2024, with more than one-third of Australia’s total disease burden attributable to modifiable risk (Figure 38).⁶⁰

Overweight and obesity, tobacco use, dietary risk, high blood pressure and high blood plasma glucose were among the leading contributors to this preventable burden.⁶¹

In 2024, men born in Australia could expect to spend an average of 71.7 years of their 81.6-year life expectancy in full health, while women could expect 73.8 years of their 85.5-year life expectancy in full health.⁶² This equates to approximately 88 per cent and 86 per cent of their lives in full health respectively.⁶³

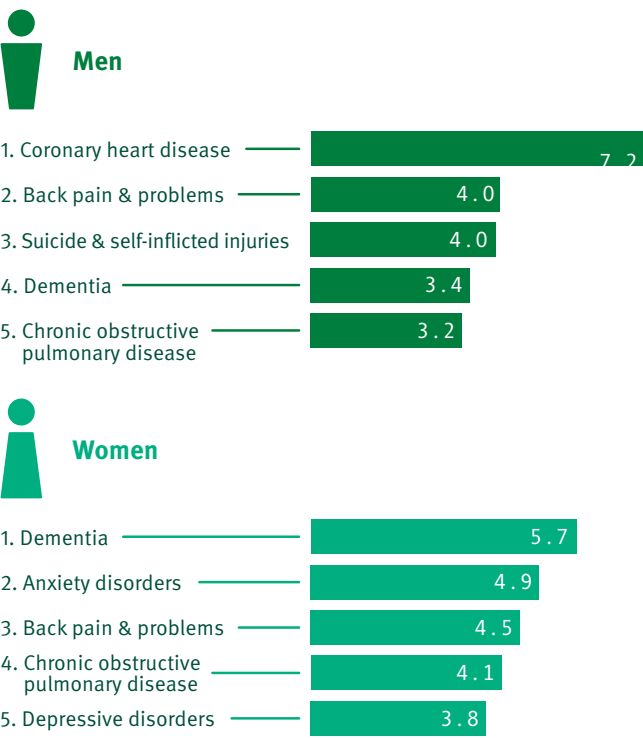
The recently released *2026 Intergenerational Report* reinforces the importance of addressing these risks as Australia’s population ages.⁶⁴ The number of Australians aged 85 and over is projected to almost triple, from approximately 625,000 to 1.9 million by 2065-66, increasing demand for health and care services.⁶⁵

Australia’s disease profile is also changing. Chronic conditions account for approximately 90 per cent of all deaths, with cancer remaining a leading cause of premature death and dementia emerging as a major cause of mortality.⁶⁶

While Australians are expected to live longer, many will spend more years managing chronic conditions.⁶⁷ Improving life expectancy must therefore be accompanied by efforts to reduce the years people spend living with disease and disability.

The Index provides further insight into the prevalence of risks that can contribute to this burden. In FY2026, approximately one in 10 Australians had multiple cardiometabolic risk factors, highlighting the opportunity to identify and address risks earlier in life.

Figure 38
Leading causes of total burden and proportion (%) of total burden by sex 2024



Source: AIHW, Australian Burden of Disease Study 2024.

Chronic disease placing increased pressure on Australia’s health system

In 2022, an estimated 61 per cent of Australians were living with at least one long-term health condition, and approximately 38 per cent were living with two or more.⁶⁸ These conditions were more common among older Australians.⁶⁹

The impact on the health system is substantial. In 2023-24, chronic conditions were associated with 55 per cent of all hospitalisations, 25.4 million bed days and longer average hospital stays.⁷⁰ They also accounted for \$98.5 billion in health system expenditure, almost 55 per cent of disease and injury spending, nearly doubling since 2013-14.⁷¹

The *2026 Intergenerational Report* shows how these pressures are expected to develop. Australian Government health expenditure is projected to rise from 4 per cent of GDP in 2025-26 to 6.2 per cent by 2065-66, with population ageing accounting for approximately one-third of the increase.⁷²

Public hospitals are projected to contribute more than 60 per cent of the growth in health spending as a share of GDP, while rising community expectations for services will place additional pressure on government expenditure.⁷³

These projections reinforce the importance of reducing the burden of preventable chronic disease and supporting Australians to remain healthier for longer.

The Index provides a more immediate view of the cardiometabolic risks contributing to this challenge. In FY2026, 63.3 per cent of Australians aged 15 and over were living with overweight or obesity, compared with the AIHW estimate of 67 per cent of Australian adults in 2022-24.

While the populations and reporting periods differ, both findings demonstrate the substantial prevalence of overweight and obesity.

Prevention makes economic sense

The growing burden of chronic disease makes prevention an important health and economic priority.

Research from the Productivity Commission (PC) demonstrates the potential benefits of investing in prevention and early intervention. Its *Delivering quality care more efficiently* report estimated that a \$1.5 billion investment over five years in a national prevention and early intervention framework could save governments \$2.7 billion over 10 years, with the net present value of total benefits reaching approximately \$5.4 billion when broader benefits are included.⁷⁴

The PC also identified opportunities to reduce potentially preventable hospitalisations by 5 per cent and emergency department presentations by 4 per cent through more integrated care services, equivalent to approximately \$600 million in annual savings.⁷⁵

The costs associated with individual cardiometabolic risk factors show the scale of the opportunity.

Overweight and obesity

In 2024, overweight, including obesity, became Australia’s leading modifiable risk factor contributing to ill health and death, overtaking tobacco use.⁷⁶

It was attributable to approximately 19,000 deaths and \$10.8 billion in health expenditure (approximately 6 per cent of health spending on disease and injury).⁷⁷

The AIHW estimates that overweight and obesity also contributed to the disease burden of other cardiometabolic conditions such as type 2 diabetes (55 per cent), hypertensive heart disease (51 per cent), chronic kidney disease (43 per cent) and coronary heart disease (28 per cent).⁷⁸

Health spending on treating conditions attributable to overweight and obesity is projected to grow by an average of 8.8 per cent between 2024-25 and 2033-34. In 2023-24, this spending was already 1.7 times higher than the spending on conditions due to tobacco use.⁷⁹

These findings reinforce the significance of the Index’s FY2026 result, which identified overweight or obesity among 63.3 per cent of Australians.

Diabetes

Diabetes prevalence has increased over time with substantial health and economic impacts.⁸⁰

In 2022-24, the AIHW estimated 6.5 per cent of Australians (1.3 million) were living with diabetes, with prevalence increasing significantly among older age groups.⁸¹ Among Australians aged 75 and over, prevalence reached almost 14 per cent, approximately eight times the rate among those aged 18-44.⁸²

In 2023-24, diabetes remained one of Australia’s 10 leading causes of death, contributing an estimated \$4.4 billion in disease expenditure, 1.3 million hospitalisations and 21,000 deaths as an underlying or associated cause.⁸³

In 2024, diabetes was responsible for nearly 150,000 years of healthy life lost.⁸⁴ Overweight and obesity, dietary risks and physical inactivity were the three leading risk factors contributing to the burden of type 2 diabetes.⁸⁵

In 2024-25, diabetes medicine accounted for 6.1 per cent of total prescriptions dispensed, with the largest increase for GLP-1 analogues, which rose 87 per cent from 1.7 million in 2021-22 to 3.2 million in 2024-25.⁸⁶

The Index provides complementary insight into diabetes prevalence and the proportion of users identified as being at elevated risk of developing type 2 diabetes, reinforcing the opportunity for earlier identification and intervention.

Smoking and vaping

Australia has made substantial progress in reducing tobacco use.

Between 2001 and 2025, the AIHW estimates the proportion of Australians smoking daily fell from 19 per cent to 5.6 per cent (1.3 million people).⁸⁷ Positively, the proportion of Australians who had never smoked rose to one of the highest levels on record, at 68.7 per cent.⁸⁸

Despite this progress, tobacco remained Australia’s second-leading risk factor for disease burden in 2024, contributing 7.6 per cent of total disease burden.⁸⁹

By contrast, daily e-cigarette use rose sharply from 0.5 per cent in 2016 to 3.5 per cent in 2022-23. It held at 3.6 per cent in 2025, with Australians aged 18-24 recording the highest rate at 8.3 per cent.⁹⁰

The Index provides an additional perspective on these behaviours. In FY2026, daily smoking was estimated at 10.1 per cent of Australians aged 15 and over, almost double the national rate reported by the AIHW.⁹¹

High blood pressure

Hypertension, or persistently high blood pressure, is a major risk factor for serious chronic conditions, including stroke, coronary heart disease, heart failure, chronic kidney disease and dementia.⁹²

In 2022, the AIHW estimated 39 per cent of Australian adults had hypertension, with prevalence increasing with age to 85 per cent among adults aged 75 and over.⁹³

Of adults with hypertension, 63 per cent did not self-report having the condition, reflecting a substantial gap in awareness.⁹⁴ Only 40 per cent had controlled blood pressure while taking antihypertensive medication.⁹⁵

In 2023-24, \$4.6 billion of health spending (2.5 per cent of spending on disease and injury) was attributable to high blood pressure, which was also the fourth-leading modifiable risk factor contributing to disease burden.⁹⁶

The Index similarly identified a substantial gap in awareness, with 77.2 per cent of Australian adults with a high blood pressure reading unaware of it.

Although the measures and populations differ, both findings reinforce the importance of accessible blood pressure checks and earlier intervention, particularly for a condition that can develop without symptoms.

The burden of chronic disease and exposure to cardiometabolic risk factors are not experienced equally across Australia.

AIHW research demonstrates differences in health outcomes associated with sex, geographical location and disadvantage. These findings reinforce the importance of prevention that is accessible and responsive to the needs of different populations.

Women's health

Women experience more of their overall disease burden from living with disease than dying prematurely.⁹⁷

In 2024, 60 per cent of women’s total disease burden was non-fatal, compared with 48 per cent for men.⁹⁸

The AIHW found overweight and obesity, smoking and hypertension were among the leading modifiable risk factors affecting women.⁹⁹ In 2022, approximately 39 per cent of women were living with multiple long-term health conditions, compared with 37 per cent of men.¹⁰⁰

The most common contributory cause of death in women was hypertension, directly involved in one in 22 deaths, compared to one in 30 deaths for men.¹⁰¹

While women generally access more health services than men, they are also more likely to delay or avoid care when needed.¹⁰² Women had higher attendance rates than men for GP visits (88 per cent compared to 80 per cent), allied health (44 per cent compared to 33 per cent) and specialist care (34 per cent compared to 29 per cent).¹⁰³

The Index adds a current perspective on how cardiometabolic risk changes across life stages, including the narrowing of women’s relative health advantage in midlife.

Disadvantage

Chronic conditions and cardiometabolic risk factors were also more common among Australians living in areas of greater socioeconomic disadvantage.¹⁰⁴

In 2022, 61-63 per cent of Australians in middle and lower socioeconomic areas had at least one chronic condition, compared with 56 per cent in higher socioeconomic areas.¹⁰⁵

AIHW research found that 70 per cent of adults in the lowest socioeconomic areas were living with overweight or obesity, compared with 62 per cent in the highest socioeconomic areas.¹⁰⁶

Diabetes death rates were 2.4 times as high in the most disadvantaged areas as the least disadvantaged areas.¹⁰⁷ Hypertension and hospitalisation rates were also higher with greater socioeconomic disadvantage.¹⁰⁸

The Index provides complementary, more frequent insights into how cardiometabolic risks are distributed among users across different communities.

Regional, rural and remote

Approximately seven million Australians live in rural and remote areas, where chronic conditions and key cardiometabolic risk factors are more prevalent than in major cities.¹⁰⁹

In 2022, 67 per cent of Australians living outside major cities had at least one long-term health condition, compared with 58 per cent in major cities.¹¹⁰

Australians living outside major cities were also more likely to engage in risky behaviours, or experience key health risk factors, including daily smoking, high blood pressure and overweight or obesity.¹¹¹

According to the AIHW, overweight and obesity affected 73 per cent of adults in inner regional areas and 74 per cent in outer regional and remote areas, compared with 65 per cent in major cities.¹¹²

The burden extends beyond risk factor prevalence. Australians living in remote and very remote areas were 2.3 times as likely to be hospitalised for diabetes as those living in major cities.¹¹³

The burden of disease and injury, mortality, potentially avoidable deaths and preventable hospitalisations all increase with geographical remoteness.¹¹⁴

Coronary heart disease was a leading cause of potentially avoidable death, with rates 2.2 times as high in remote areas and 3.6 times as high in very remote areas compared with major cities.¹¹⁵ In very remote areas, the second-leading cause was diabetes, with rates 6.7 times as high as in major cities.¹¹⁶

These findings reinforce the importance of accessible preventive health services and earlier identification of cardiometabolic risk, particularly in communities facing greater barriers to healthcare.

Productivity

The impact of chronic disease extends beyond the health system to Australia’s workforce and broader economy. As the population ages, maintaining a healthy and productive workforce will become increasingly important.

The *2026 Intergenerational Report* projects that Australia’s labour force participation rate will decline from 67.7 per cent in 2039–40 to 64.7 per cent by 2065–66, largely reflecting population ageing.¹¹⁷

At the same time, health care and social assistance is already Australia’s largest employing industry, with demand for workers expected to continue to grow.¹¹⁸

This creates a dual challenge: supporting Australians to remain healthy and participating in the workforce for longer, while improving productivity within a health and care sector facing growing demand.

Australia’s healthcare system is among the most productive globally, although improvements have largely reflected gains in quality rather than reductions in cost.¹¹⁹ Continued productivity improvements will be important to meeting future demand without health expenditure and workforce requirements growing at the same rate.

The *2026 Intergenerational Report* identifies technology and artificial intelligence as opportunities to support productivity.¹²⁰

Prevention has an important role to play. Reducing the impact of preventable chronic disease supports workforce participation and reduces pressure on a health system required to care for an ageing population.

Technology to support earlier intervention

Improving productivity alone will not address Australia’s growing chronic disease burden. Earlier identification and more accessible preventive care will also be critical, supported by technology that makes health information and services easier to access.

The PC’s research into *Innovations in care for chronic health conditions* identified opportunities to improve wellbeing, increase health system efficiency and reduce reliance on hospital services.¹²¹

However, barriers to the broader adoption of effective innovations remain, including fragmented information systems and limited mechanisms to enable their wider use.¹²²

The PC’s research into digital healthcare estimated that better integration of digital technology could deliver savings of up to \$5.4 billion annually and up to \$355 million through fewer duplicated tests.¹²³

It also identified opportunities to improve access to care through digital innovations, including telehealth, which already saves patients around \$895 million annually in travel time.¹²⁴

Wesfarmers Health’s 523 SiSU Health Stations make preventive health checks more accessible, while generating large-scale, real-time data that complements national surveys with more frequent insights into emerging cardiometabolic risk.

Together, the evidence points to the need for a stronger focus on prevention – identifying risk earlier, improving access to health information and supporting action before more serious conditions develop.

Call to action



Scan your
way to more
rewards

Goodie bags just for you

Exclusive member-only offers

Collect points and get a
\$5 reward voucher



How is your
health tracking?

Take a
free medical grade
health check

FREE Health Check

In less than 5 minutes, measure



Blood
pressure



Heart
rate



BMI



Body
fat %

and more...



Blood Pressure Release Button

Call to action

While genuine progress has been made and there is evidence that sustained attention to cardiometabolic risk factors can improve the health of all Australians, now is not a time for complacency.

As a result, this year Wesfarmers Health provides four overarching recommendations.

Wesfarmers Health recognises that closing Australia's cardiometabolic health gap will take coordinated effort across government, business and the health sector, including the community and not-for-profit sector. No single stakeholder can do this alone.

Read together with the global and domestic evidence set out earlier, government strategies and best-practice clinical literature, this year's findings sharpen exactly where action is most urgent.



Prevention

1. Embed prevention and health literacy across every life stage.
Help every Australian understand, track and act on their cardiometabolic risk throughout their lives.

Prevention and health literacy are currently treated as discretionary rather than core components of the health system, despite clear evidence that early detection and sustained engagement reduce long-term disease burden and costs. Embedding both as permanent, funded priorities is essential to shifting the system from acute care to prevention.



Access and equity

2. Build a more accessible, digitally-enabled health system.
Expand free, technology-enabled health services including screening and access to telehealth to overcome barriers of distance, cost and workforce shortages, while strengthening national health data.

Access to preventive health services remains uneven across Australia, shaped by distance, disadvantage and workforce availability alike. Expanding free, technology-enabled services, such as SiSU Health Stations, can help address these barriers by making preventive health services more accessible and scalable, without requiring an already stretched health workforce or constrained health budget to grow at the same pace.



Women's health

3. Improve the detection, diagnosis and treatment of women's cardiometabolic disease.
Address gaps in data, funding and diagnosis, with a particular focus on midlife risk.

Australia's clinical tools, research base and specialist workforce for cardiometabolic disease have historically been developed around men, leaving women's distinct risk patterns under-recognised and under-treated, particularly in midlife. Addressing this gap requires deliberate reform, not incidental improvement.



Productivity

4. Scale workplace prevention as a national priority.
Invest in proven workplace cardiometabolic prevention initiatives as national productivity infrastructure.

An ageing population and rising chronic conditions will place pressure on workforce participation and productivity. Scaling a proven, low-cost preventive health model, such as SiSU Health Stations, into workplaces and the broader community offers a direct, cost-effective lever to protect both health outcomes and national economic performance.

Prevention



Recommendation 1
Embed prevention and health literacy across every life stage.
Help every Australian understand, track and act on their cardiometabolic risk throughout their lives.

Prevention and health literacy are currently treated as discretionary rather than core components of the health system, despite clear evidence that early detection and sustained engagement reduce long-term disease burden and costs. Embedding both as permanent, funded priorities is essential to shifting the system from acute care to prevention.

Action 1:
Set a prevention investment target and build the framework to govern it.

Commit to lifting preventive health expenditure to at least 5 per cent of total health spending by 2030, in line with the *National Preventive Health Strategy*, with a specific sub-target for cardiometabolic disease. Formally respond to the Productivity Commission’s *Delivering quality care more efficiently* report and commit to implementing the National Prevention and Early Intervention Framework.

Wesfarmers Health’s belief that a focus on cardiometabolic disease is important is supported by the evidence. The AIHW found more than one third (35.8 per cent) of Australia’s total disease burden was attributable to modifiable risk, with four of the five largest risk factors captured by the Index:¹²⁵

- Overweight and obesity (8.3 per cent)
- Tobacco (7.6 per cent)
- High blood pressure (4.4 per cent)
- High blood plasma glucose (4.2 per cent) (exposure closest to diagnosed diabetes)

The other risk was dietary (4.8 per cent), which sits outside the four factors the Index records.¹²⁶ Clinical tools, strategies and funding continue to be built on one condition, with prevention and health literacy falling between the gaps.

Preventive health spend

While Australia’s healthcare system remains among the leading in the world, Australia falls behind on prevention efforts.¹²⁷ Australia’s focus has largely been on acute care, building more hospitals and treating people once they are sick, rather than preventing them from becoming sick.

Government prevention expenditure remains at approximately 3 per cent of total government health expenditure, below the *National Preventive Health Strategy*’s own 5 per cent target.¹²⁸ In 2024-25, hospital spending grew 4.0 per cent in real terms, against 1.2 per cent for primary healthcare.¹²⁹ This is in stark contrast to other countries like Canada and the United Kingdom which spend approximately 5-7 per cent on prevention (Figure 39).¹³⁰

To shift the dial, Australia needs to significantly improve prevention investment. Australians are living longer, but not necessarily in good health and prevention is a clear lever to address that gap.

Governments should commit to increasing prevention spend to at least 5 per cent by 2030, in line with the *National Preventive Health Strategy*.¹³¹ Consideration should also be given to setting a specific sub-target for cardiometabolic disease given the scale of its share of Australia’s preventable disease burden.

Figure 39
Prevention spending as a share of health expenditure
Source: OECD Health Statistics, 2025

Country	Share of total health spending on prevention
Australia	3 . 1%
Canada	6 . 9%
UK	5 . 6%
OECD average	3 . 4%

Preventive health framework

Australia continues to embark on various prevention initiatives without clear government stewardship or funding incentives. Prevention initiatives are typically underfunded through ordinary government policy and budget processes because their benefits are realised well beyond the forward estimates governments plan against. This is a structural bias against the investments this Index shows are most needed.

Wesfarmers Health welcomed the Australian Government’s decision to ask the PC to inquire into *Delivering quality care more efficiently*.¹³² Wesfarmers Health supports the report, particularly recommendation 3.1. It calls for a National Prevention and Early Intervention Framework to guide government investment, supported by an independent advisory board. ¹³³ The PC estimates an investment of \$1.5 billion over the first five years could save governments \$2.7 billion over the following decade, with total benefits of about \$5.4 billion.¹³⁴

The Australian Government should formally respond to and act on the PC’s final report into *Delivering quality care more efficiently*, with a particular focus on recommendation 3.1. Further work and consultation will be needed to finalise the framework’s design, including pricing and costing.

The PC has separately found substantial barriers to the development and broader diffusion of healthcare innovation.¹³⁵ It is a priority for government to respond as left alone and without a funded framework, good prevention practice will continue to be limited. Other prevention activity will also remain fragmented and the system will keep defaulting to acute care. This shift is made more urgent by an ageing population, rising bed block and a growing chronic disease burden.

Action 2:
Replace separate strategies with one National Cardiometabolic Disease Strategy

From 2032, develop a National Cardiometabolic Disease Strategy, combining the *National Obesity Strategy*, *National Diabetes Strategy* and *National Strategic Action Plan for Heart Disease and Stroke*, supporting the *National Strategic Framework for Chronic Conditions 2026-35*. Consideration should be given whether to include the National Hypertension Taskforce’s target of 70 per cent treated and controlled by 2030.

Cardiometabolic disease strategy

Cardiovascular and metabolic diseases have historically been managed as separate fields, with separate specialists, separate guidelines and separate funding lines. That is changing. In June 2026, the American Heart Association, the American College of Cardiology, the American Diabetes Association and the American Society of Nephrology released the first ever joint clinical guideline for cardiovascular-kidney-metabolic syndrome, setting out a four-stage model and a connected pathway.¹³⁶ Wesfarmers Health also recognises that the Australian Heart Foundation is now taking this approach.¹³⁷

The release of the *National Strategic Framework for Chronic Conditions* points to a new approach to tackling chronic issues.¹³⁸ This is welcome but more work is required to ensure everyone understands heart, metabolic and kidney conditions as one connected and often preventable progression, not three unrelated conditions.

To support the *National Strategic Framework for Chronic Conditions*, the Australian Government should develop a National Cardiometabolic Disease Strategy by 2032. This should combine the existing *National Obesity Strategy*, *National Diabetes Strategy* and the *National Strategic Action Plan for Heart Disease and Stroke*.¹³⁹ A more holistic approach is warranted to enable strategic investment. This new strategy should also consider embedding the National Hypertension Taskforce’s national target of 70 per cent of Australians with hypertension having it treated and controlled by 2030.¹⁴⁰

Prevention

Action 3:
Fund and measure health literacy for the public and ensure new evidence reaches healthcare professionals

Fund the implementation of the *National Health Literacy Framework* at genuine scale, with a dedicated budget and timeline to enable Australians to find, understand and act on their own health information. Consideration should be given to publicly reporting against the *National Health Literacy Framework* by leveraging the National Preventive Health Monitoring Dashboard.

Health Literacy Framework

Wesfarmers Health recognises that the Australian Government recently launched the *National Health Literacy Framework* as part of the *National Preventive Health Strategy 2021-2030*.¹⁴¹

The ABS found up to 60 per cent of Australians had lower health literacy and those with more chronic conditions found it more difficult to engage with providers.¹⁴² Improving health literacy by 25 per cent could save Australia \$7.3 billion per year (0.29 per cent of annual GDP).¹⁴³

The Australian Government should fund the *National Health Literacy Framework*, with a clear implementation budget and timeline. An action plan is essential to embedding such strategic initiatives into practice. This Framework highlights that everyone has a role to play in addressing health literacy, not just government. Settings must enable Australians to take responsibility for managing their own health and wellbeing.

The proposed holistic approach to cardiometabolic disease will also require deliberate re-education for clinicians trained to treat heart, metabolic and kidney conditions as separate referral pathways and for the public who mostly think of these conditions as three unrelated diagnoses.

As such, governments need to support continuing professional development for GPs and specialists and use the *National Health Literacy Framework*.

Measuring health literacy

Australia’s health and care system is complex for consumers to navigate. It is critical that Australia seeks to improve health literacy levels as higher levels are associated with stronger engagement with preventive health services, including screening, immunisation and primary care.¹⁴⁴

Concerningly, there has not been a recent survey to understand Australia’s current health literacy which could have changed due to the uptake of innovative and technological solutions. Governments need to consider how best to track Australia’s health literacy on an ongoing basis to support greater efforts to enable Australians to manage their health and wellbeing.

The most effective way to improve health literacy is through free, convenient, personalised engagement and measurement. Consideration should be given to publicly reporting against the *National Health Literacy Framework* by leveraging the existing National Preventive Health Monitoring Dashboard.¹⁴⁵ This year’s Index highlights that many Australians are unaware of their own health risks, with more than three in four Australian adults with a high blood pressure reading unaware of it.

Action 4:
Make ‘reach 50 without the Big 5’ the national goal and close the awareness gap

Adopt ‘reach 50 without the Big 5’ as an explicit national goal for cardiometabolic prevention and design public health messaging, screening guidance and school and workplace health education around it. Consideration should be given to funding near-continuous population health data drawing on sources like SiSU Health data alongside national surveys.

Awareness and control

Australia accepts that cardiometabolic conditions are connected, illustrated through the *National Strategic Framework for Chronic Conditions 2026-35* which is built around multimorbidity and continuity of care.¹⁴⁷

International research has also found that people who reach age 50 with none of the five classic risk factors live more than a decade longer free of cardiovascular disease, on average, than those who reach 50 carrying all five.¹⁴⁸ These risk factors include high blood pressure, high cholesterol, being underweight or living with overweight or obesity, diabetes and smoking.¹⁴⁹ For example, modifying blood pressure in midlife delivered the single biggest gain in extra years of life free from cardiovascular disease.¹⁵⁰

Governments should ensure that ‘reach 50 without the Big 5’ is embedded in prevention policy, providing an explicit national goal for cardiometabolic prevention. These findings reframe how chronic conditions and prevention should be tackled, with a much greater emphasis on addressing risk at the earliest stages before cardiometabolic disease develops.

While this Index does not capture kidney function or heart disease itself, it captures the early stages of this model: excess weight, high blood pressure and diabetes. Australians at these stages carry a higher risk of the cardiovascular disease that the later stages describe. Realising the benefits of this more integrated and holistic approach will require Australia to update the supporting strategies and guidelines.

Prevention also has two roles and this year’s Index demonstrates that Australia is doing much better at one than the other. Awareness is finding risk that nobody yet knows exists. Of Australian adults measured with a high blood pressure reading this year, 77.2 per cent were unaware they had it, with 39.3 per cent not having had a blood pressure test in the past 12 months.

Governments should design public health messaging, screening guidance and school and workplace health education around it. This shifts the emphasis from finding disease that already exists to lifelong risk-factor literacy for most Australians who do not yet have any.

High blood pressure is not the only condition Australians are unaware of, with pre-diabetes (elevated blood glucose that has yet to progress to type 2 diabetes) affecting approximately 16 per cent of Australian adults. An estimated nine in 10 people are unaware they have it.¹⁵¹ Both conditions sit at the earliest, most reversible stages of the cardiometabolic pathway this Index tracks, exactly where the ‘reach 50’ goal above is won and lost. Both are missed for the same reason: no one looked, not because nothing could be done.

The other role of prevention is control. This is simply about making sure the risk that has already been found does not progress. Positively, the Index estimates the current treated-and-controlled blood pressure rate at 52.1 per cent, 17.9 percentage points short of the 70 per cent target, but 12.5 percentage points above the National Hypertension Taskforce’s own most recent national estimate.¹⁵²

Awareness and control are different problems requiring different fixes and both need to be tracked and funded as distinct priorities, not simply folded into prevention. This suggests that real-time station data can help track progress that the system’s own surveys are slower to capture.

Prevention:

Action 5:
Fund an open, validated cardiometabolic risk tool

Fund the Australian evidence needed to build, validate and publish a single, whole-of-life Cardiometabolic Risk Assessment Tool that assesses cardiovascular, metabolic and kidney risk together. It should include critical inputs and be developed in line with the TRIPOD+AI standard, with the model and validation published so it can be independently checked.

A shared way to measure connected risk

Strategies and funding alone will not manage the issue. To support these efforts, a well-designed strategy needs a shared way to measure the risk it is trying to manage. AusCVDRisk, Australia’s national cardiovascular risk calculator is endorsed by a range of bodies and is built on the AUS-PREDICT equations, is validated only for Australians aged 30 to 79 and sits apart from the separate tools clinicians use to assess metabolic and kidney risk.¹⁵³

A holistic risk assessment tool should be developed and embedded into clinical practice, reflecting an interconnected model of disease rather than relying on three separate calculators used by three separate specialists.

There are four features that limit what the existing tool can do for the connected risk this Index describes:¹⁵⁴

- No metabolic input unless a person is already diabetic
- No sex-specific marker
- Ethnicity is not in the equation
- Closed model

While Australia has a leading cardiovascular risk calculator, it is built as a standalone cardiovascular tool, validated only for Australians aged 30-79 and sits apart from the separate tools clinicians use to assess metabolic and kidney risk. An interconnected model of disease needs a genuine way to measure it.

International practice suggests understanding the TRIPOD+AI statement which sets out what a prediction model should report.¹⁵⁵ A risk tool that shapes how Australians are assessed and treated should meet that standard.

“Low awareness of high blood pressure, Australia’s leading modifiable CVD risk factor, remains a critical issue. Effectively tackling this challenge requires a multi-channel approach, using formats such as kiosk BP screening that leads to professional clinical diagnosis.”

Prof. Alta Schutte

SHARP Professor of Cardiovascular Medicine, UNSW Sydney; Global Co-Director of the Cardiovascular Program, The George Institute; Co-Chair, National Hypertension Taskforce

Access and equity



Recommendation 2
Build a more accessible, digitally-enabled health system.
Expand free, technology-enabled health services including screening and access to telehealth to overcome barriers of distance, cost and workforce shortages, while strengthening national health data.

Access to preventive health services remains uneven across Australia, shaped by distance, disadvantage, and workforce availability alike. Expanding free, technology-enabled services, such as SiSU Health Stations, can help address these barriers by making preventive health services more accessible and scalable, without requiring an already-stretched health workforce or constrained health budget to grow at the same pace.

Action 6:
Fund by need, not just distance, and reach priority populations through services they trust

Weight health equity funding by disadvantage alongside remoteness. Target prevention funding and cost to the most disadvantaged communities.

Access is more complex than it may appear. The Index found Australians in outer regional areas were more likely to report having their blood pressure checked in the past 12 months (45.6 per cent) than those in major cities (40.3 per cent). It is one of the few measures on which Australians outside the major cities fare better than those in them.

Treating access as simply the physical distance to a clinic risks missing Australia’s broader cardiometabolic health gap. A single mother in outer suburban Sydney facing cost-of-living pressures and a farmer three hours from a GP may face similar barriers to preventive care for very different reasons. Funding models need to reflect these realities so Australians can access the care they need.

Regional health

This year’s Index confirms that cardiometabolic risk rises with remoteness. Australians in outer regional areas are 1.4 times as likely to carry two or more of the four risk factors tracked by the Index as those in major cities, with daily smoking 1.4 times as common, obesity 1.3 times as common and high blood pressure 1.3 times as common.

Disadvantage

The Index shows an even larger effect from disadvantage. Australians in the most disadvantaged postcodes are 2.5 times as likely to carry two or more risk factors as those in the least disadvantaged postcodes, with daily smoking 2.4 times as common, diabetes 2.0 times as common and obesity 1.8 times as common.

Priority populations

Geography and disadvantage do not affect all Australians equally and for some populations these risks compound. While SiSU Health Stations are predominantly located in Priceline Pharmacies, the network can be extended more broadly across Australia.

Access and equity

Reaching these populations requires investment in services communities already trust, not simply more of what already exists elsewhere.

The *National Health Literacy Framework* recognises that priority populations face additional barriers to accessing clear, trustworthy health information.¹⁵⁶ Information needs to be written, translated and delivered in ways that reach these communities.

GLP-1s have changed the way people across the globe can address cardiometabolic risk factors (overweight, diabetes, high blood pressure). These are important considerations for government, particularly for priority populations who may carry greater risk.

Action 7: Ensure mental health telehealth rules work for rural Australians

When the Senate Inquiry into *Rural, regional and remote Medicare access and funding* reports, respond by reviewing mental health telehealth eligibility requirements.

Mental health: when the map does not match the access problem

Mental health and cardiometabolic health cannot be separated. The AIHW estimates that almost 80 per cent of premature deaths among people with mental illness are due to potentially preventable physical conditions such as type 2 diabetes or cardiovascular disease.¹⁵⁷

For Australians in regional and rural areas, mental health care is harder to reach and the rules that govern access lean on a tool that was built for a different purpose. The Modified Monash Model (MMM) classifies every location from MM1 to MM7 by remoteness and town size and was developed to target health workforce programs.¹⁵⁸ The MMM is now also used to decide who may use some Medicare services, such as telehealth group therapy under the *Better Access Initiative*, which is limited to people in MM4-7 areas.¹⁵⁹

Furthermore, from 1 November 2025, the COVID-19-era exemption that allowed patients to use Medicare-funded telehealth to see any GP for a mental health treatment plan was replaced by an ‘eligible telehealth practitioner’ requirement.¹⁵⁹

That means the patient must have seen that GP within the past 12 months, or be registered through MyMedicare with the practice, which requires at least two face-to-face visits in the past 24 months (one in MM6-7 areas).¹⁶⁰ The change followed an MBS review that was concerned about low-value care when telehealth is used poorly.¹⁶¹

The Australian Government should ensure Medicare mental health telehealth rules are fit for purpose and reflect how rural care is delivered.

Action 8: Build and fund virtual care and connected technology to extend the workforce through common standards and well-governed models

Accelerate and fund the virtual care initiatives in the National Digital Health Strategy Delivery Roadmap, in particular building the digital capabilities needed to scale virtual care in rural and remote areas (initiative 3.1.03). Funding should include training and system design for a digitally ready workforce and decision-support tools that flag risk to a clinician rather than make clinical decisions.

Develop national virtual care standards around existing, well-governed models with proportionate and consistent regulation and appropriate information sharing. Fund interoperable health records, co-designed with private providers, so results from telehealth, pharmacy and screening services can flow into a person’s health record with their consent.

Digital health: extending the workforce, not replacing it

Digital health technology will not solve these challenges alone. Deployed well it can make the existing workforce go further, rather than asking an already-stretched workforce to simply do more.

Internationally, Australia is not short of health workers per person, with 4.2 practising doctors per 1,000 people (OECD average 3.9) and 13 practising nurses per 1,000 people (OECD average 9.2), along with 7.5 long-term care workers per 100 people aged 65 and over (OECD average 5).¹⁶²

Despite this, the Australian Government’s own projections show that there will be a shortage of approximately 70,000 full-time equivalent nurses by 2035 and 1,900 FTE GPs by 2028, rising to 6,100 FTE by 2048.¹⁶³ The gap is also uneven, with fewer health workers in regional, rural and remote areas.¹⁶⁴

Digital health plays an important role in enabling Australians to access the right care, in the right place, at the right time. As our population ages and chronic disease increases, digital tools enable and complement the health workforce, extending each clinician’s reach so that Australians can access services where they live, rather than only where the workforce happens to be concentrated.

The *National Digital Health Strategy 2023-2028* is built around four outcomes: a digitally enabled health system, person-centred care, inclusive access regardless of geography and data-driven decision-making.¹⁶⁵

The Strategy also commits to specifically improving and expanding virtual care so that Australians have equitable access to health services, when and where they need them.¹⁶⁶ This addresses a key gap highlighted by the Index’s findings.

The PC has estimated that better use of digital technology in healthcare could unlock \$5.4 billion a year, while streamlining or automating up to 30 per cent of current workforce tasks using digital tools.¹⁶⁷

Virtual care standards

In 2025, more than 11 million Australians had a telehealth consultation.¹⁶⁸ The Australian Government has tasked the Australian Commission on Safety and Quality in Health Care with developing Australia’s first national safety and quality standards for virtual care.¹⁶⁹ This is a welcome move.

Good virtual care standards should build on and recognise existing frameworks like the Wesfarmers Health Telehealth Code of Practice. They need to set expectations in proportion to risk, while focusing on what makes virtual care safe and useful.

Interoperability

Interoperability is the infrastructure that enables continuity of care. The Australian Government’s *National Healthcare Interoperability Plan 2023–2028* is a welcome step and that supports international moves towards data-enabled continuous care models.¹⁷⁰

While the Australian Digital Health Agency (ADHA) is working closely with states and territories, it must also work with the private providers that deliver much of the care Australians receive.

Online telehealth services, community pharmacies and screening technology such as SiSU Health Stations all generate important patient information that should be able to move with the patient through the health system.

The Department of Health, Disability and Ageing and the ADHA have consulted on requirements for online prescribing services to share prescribing and dispensing information to My Health Record by default.¹⁷¹ These requirements must be co-designed with private providers, supported by clear conformance pathways and applied consistently to ensure providers that invest are not undermined by an inconsistent approach.

Action 9: Let pharmacists work to their full scope of practice, within clear clinical protocols

Implement the *Scope of Practice Review*’s recommendations for community pharmacy through nationally consistent, protocol-based services, defined by training, clinical safety and referral to a GP. Consideration should be given to cardiometabolic risk assessments in the longer-term, where it is clinically safe to do so.

A growing role for pharmacists

Wesfarmers Health sees a role for pharmacists in supporting the management of cardiometabolic risk factors over time. Evidence is clear that there will not be a sufficient workforce to address the increasing chronic conditions in Australia. Wesfarmers Health recognises the *Scope of Practice Review* and the expanded scope of practice trials being undertaken across the states and territories.

The *Scope of Practice Review* found that Australia’s health workforce is prevented from working to its full potential by legislative, regulatory and funding barriers, not by skills or capacity. Enabling the health workforce to work to its full scope, where it is clinically safe to do so, would make cardiometabolic checks easier for more Australians to access, more often.

Action 10:
Fund cardiometabolic screening, delivered through community-led technology

Invest in and partner with SiSU Health on government-backed, independently evaluated pilots.

Technology that reaches people and partnering at scale

Technology only extends the health workforce if it reaches people and connects them to care. A screening station delivered through a trusted pharmacy, workplace, community organisation or regional event becomes a point of contact, providing an invitation to participate, an explanation of results and a clear next step.

The *Gippsland Healthy Heart Study* and work with the Shane Warne Legacy demonstrate this approach, taking screening into supermarkets, workplaces, shopping centres and field days where people already are. Trusted local partners, including pharmacies, sporting clubs and community organisations can also help reach disadvantaged, regional and priority populations. Government investment should therefore support the delivery around technology, not simply the technology itself.

Screening must also provide a pathway to care. In the *Gippsland Healthy Heart Study*, of the 54 participants who answered a survey four weeks later, 57.4 per cent had considered talking to their GP, while SiSU Health Stations have generated more than 900,000 GP recommendations since it launched. This connection to clinical care should underpin consumer-facing digital health tools.

The case for free, technology-enabled screening rests on evidence and the next step is to build more of it with government. The *Gippsland Healthy Heart Study* found that 85.8 per cent of people had at least one cardiovascular risk factor. What is needed now is not another bespoke trial to design, but scaled, independently evaluated deployments of a model that has already been tested.

Wesfarmers Health proposes governments should consider a 24-month whole-of-state pilot designed to deploy community health stations across the state or territory, deliver free cardiometabolic health checks, engage Australians, connect people with GPs, pathology and existing support services, measure health outcomes and provide real-time population analytics.

A two-year statewide deployment would test at scale what this Index argues: free screening placed where people already are reaches people routine care misses, that results convert into GP follow-up and that machine measured data can show governments whether prevention programs are working.

The evaluation should measure reach (including regional and disadvantaged communities and Australians aged 45 and over), risk detected, GP follow-up and population-level data, and the results should be published.

The pilot will drive earlier, relevant GP engagement, and empower GPs with trusted data at first consult. The result would be an integrated prevention platform that delivers measurable benefits for individuals, communities and the health system. A successful pilot would create a proven model that could be scaled nationally.

The program would work in partnership with local government, community organisations and health providers to identify areas of greatest need, establish health actions in trusted sporting bodies and community locations and engage local ambassadors to champion healthier lifestyles.

By designing the program with communities, not simply delivering it to them, we can achieve higher participation, stronger equity and more sustainable health outcomes.

“Where you live shouldn’t decide whether you find out about your cardiometabolic health in time. Rural and regional Australians and people without a regular GP, are among those most at risk of being missed. Bringing checks to where people already are is how we begin to close that gap.”

Dr Sarah Cavanagh
Chief Medical Officer Wesfarmers Health

Women's health



Recommendation 3
Improve the detection, diagnosis and treatment of women's cardiometabolic disease. Address gaps in data, funding and diagnosis, with a particular focus on midlife risk.

Australia’s clinical tools, research base and specialist workforce for cardiometabolic disease have historically been developed around men, leaving women’s distinct risk patterns under-recognised and under-treated, particularly in midlife. Addressing this gap requires deliberate reform, not incidental improvement.

Action 11:
Re-engage women with preventive care in midlife

Develop targeted pathways that keep women engaged with preventive health checks from their mid-forties onwards, when the Index shows women falling behind men on blood pressure checks. Outreach should be strongest in disadvantaged communities, where women experience higher cardiometabolic risk.

Many women are reaching menopause without the knowledge they need

As Australia’s population ages, the number of women experiencing perimenopause and menopause is growing. Yet knowledge and understanding have not kept pace.

Australian Government research found that of women aged 35 to 55 who sought information, 35 per cent waited more than six months after symptoms began.¹⁷⁵ Of those who delayed, 40 per cent did so because they did not recognise their symptoms.¹⁷⁶ Those who looked for information most often turned to their GP (67 per cent), female friends (42 per cent) and online searches (41 per cent).¹⁷⁷

This year’s Index reinforces the unmet need. More than one in four women aged 40 to 64 said they wanted to speak to someone about perimenopause or menopause. The knowledge, tools and treatments exist, but too many women are still reaching midlife without the information they need to recognise symptoms and seek appropriate support.

Disadvantage changes the picture for women

The Index shows socioeconomic disadvantage does not affect all cardiometabolic risks equally for women. The clearest divide is in obesity.

Among women aged 20-24, obesity is more than three times as common in the most disadvantaged areas as the least disadvantaged, at 20.9 per cent compared with 6.3 per cent. Women in the least disadvantaged areas do not reach a comparable rate until their late fifties.

Disadvantage also narrows the obesity gap between women and men. In the most disadvantaged areas, women’s obesity rate is just 1.6 percentage points below men’s, compared with a 6.7 percentage point gap in the least disadvantaged areas. This pattern is not seen to the same extent for diabetes, high blood pressure or daily smoking.

For obesity, disadvantage does more than increase women’s risk. It brings forward by decades the rates otherwise seen much later in life.

Women's health

Contact with preventive care falls as risk rises

Women are more likely than men to have had their blood pressure checked in the past year, at 43.4 per cent compared with 40.6 per cent. However, this advantage is driven by younger women and disappears in midlife.

Among those aged 20-24, women are 8.3 percentage points more likely than men to have had their blood pressure checked. By their mid-forties women are no more likely than men to have had a check and by age 55-64, they are 4.5 percentage points less likely.

This decline comes at a time when women’s cardiometabolic risk is increasing. Yet among women who record a high blood pressure reading on a SiSU Health Station, those in midlife are more likely than men to already know they have high blood pressure. This suggests the gap is not simply one of awareness, but of women continuing to be reached and checked. Preventive care needs to meet women where they are during midlife. SiSU Health Stations provide one way to do this, offering blood pressure checks without an appointment or referral and a pathway to further care where needed.

Action 12:
Ask the menopause question and deliver the data

Normalise routine perimenopause and menopause symptom prompts for women in midlife across primary care, pharmacy and community health, building on this Index’s finding that a simple, low-cost question can surface demand for support. Publish national menopause and perimenopause data annually to better understand women’s experiences, needs and access to care.

Pregnancy and hormones change a woman's risk

Several conditions specific to pregnancy and to women's reproductive years raise a woman's later heart risk substantially.¹⁷⁸ Hypertensive disorders of pregnancy affect around one in 10 first pregnancies in Australia. After pre-eclampsia the risk of heart failure later is more than four times higher.¹⁷⁹

Gestational diabetes now affects almost one in five Australian births and carries close to a tenfold increase in the risk of developing type 2 diabetes later in life.¹⁸⁰ Premature menopause, before age 40, carries a more than 50 per cent higher risk of cardiovascular disease.¹⁸¹

Asking the menopause support question

Since September 2025, Stations in Priceline Pharmacies have asked women aged 40-64 whether they would like to talk to someone about perimenopause or menopause. Of the 33,141 women asked, 28.8 per cent said yes on the spot. Among women aged 45-54 it was 35.9 per cent.

Wesfarmers Health has responded to this demand by partnering with Jean Hailes for Women’s Health and launching the *Anything Menopause* program. The initiative has trained more than 3,500 pharmacists and pharmacy assistants in menopause care.¹⁸⁵ Women can now seek support from trained Priceline pharmacists without an appointment.

Yet the national picture remains incomplete. The 2022 *National Health Survey* included no questions on perimenopause, menopause or associated symptoms including hot flushes or hormone therapy.¹⁸² Wesfarmers Health welcomes the Senate Inquiry into Issues related to menopause and perimenopause and the Australian Government's committed funding to the AIHW to develop a national sexual and reproductive health dataset, with menopause identified as a priority.¹⁸³ While the data strategy has been released, national data is yet to be published.¹⁸⁴

Action 13:
Remove barriers to continuous menopause care

Enable appropriately trained pharmacists to provide greater continuity of menopause care. This should include allowing substitution between equivalent hormone therapy formulations, with continued PBS coverage and pharmacist prescribing of PBS-listed vaginal oestrogen for appropriate menopause symptoms.

Fund pharmacist-led menopause consultations with clear referral pathways to GPs, giving women an accessible local pathway to treatment and ongoing care while supporting general practice capacity.

When treatment runs out: the pharmacist gap

Around 75 per cent of women experience menopausal symptoms and one in four experience symptoms severe enough to disrupt daily life.¹⁸⁶

For women who are diagnosed and prescribed treatment, community pharmacy provides an accessible point of ongoing care. Australia has more than 5,900 pharmacies, more than 2,100 of them open after hours or on weekends and Australians visit a pharmacy around 18 times a year on average.¹⁸⁷ However, current prescribing and substitution rules can limit pharmacists’ ability to maintain treatment when medicines are unavailable.

Australia has experienced intermittent shortages of oestrogen patches since 2020, with the TGA expecting shortages of some brands and strengths to continue.¹⁸⁸ Since November 2024, a Serious Scarcity Substitution Instrument has allowed pharmacists to substitute certain patch brands or strengths without a new prescription.¹⁸⁹ However, it does not allow pharmacists to switch a patient from a patch to an equivalent gel where appropriate and available.

This means women may need to return to a prescriber simply to change the formulation of their treatment, creating another potential barrier to continuity of care, particularly where access to a GP is limited.

There is a similar gap in the treatment of vaginal and urinary symptoms associated with menopause. These symptoms are common, can worsen over time and can contribute to recurrent infections, yet only a small proportion of women receive vaginal oestrogen, a safe and effective treatment available on the PBS.¹⁹⁰ Community pharmacists cannot currently prescribe this treatment themselves, despite often being one of the most accessible health professionals for women seeking advice.¹⁹¹

Expanding pharmacists’ ability to maintain and provide appropriate menopause treatment could help close the gap between access to advice and access to care.

Action 14:
Make menopause care permanent, preventive and visible

Commit to making perimenopause and menopause Medicare health assessment items permanent beyond their 30 June 2027 sunset and extend eligibility beyond women already experiencing symptoms to support earlier screening and preventive care.

Progress but more to be done

Wesfarmers Health welcomes the Australian Government’s \$792.9 million women’s health package, the largest in Medicare’s history, covering new PBS-subsidised menopausal hormone therapies, Australia’s first rebate for menopause and perimenopause health assessments, new funding to train health professionals and the first national menopause clinical guidelines.¹⁹²

While these are genuine steps, the new Medicare menopause assessment items are only available to women already experiencing symptoms, are not a screening service, and are legislated to expire on 30 June 2027.¹⁹³ This means women with no symptoms yet are still not covered: nothing in the new items is designed to catch risk before symptoms start.¹⁹⁴

“Midlife is when many women's heart and metabolic health risks start to rise, partly due to the hormonal changes of perimenopause and menopause. That makes this stage of life an important time to prioritise health. Priceline pharmacists are trained to talk about menopause and a free five-minute SiSU Health check can be a simple first step.”

Mel Gannon
Chief Pharmacist Wesfarmers Health

Productivity



Recommendation 4

Scale workplace prevention as a national priority.
Invest in proven workplace cardiometabolic prevention initiatives as national productivity infrastructure.

An ageing population and rising chronic conditions will place pressure on workforce participation and productivity. Scaling a proven, low-cost preventive health models, such as SiSU Health Stations, into workplaces and the broader community offers a direct, cost-effective lever to protect both health outcomes and national economic performance.

Action 15: Make regulation fit for purpose

Review the regulatory settings that shape who can deliver care, where and how, so they reflect current evidence and technology, while protecting safety and quality.

Australia continues to grapple with structural economic pressures, fiscal constraints, an ageing population and cost-of-living pressures.¹⁹⁵ Productivity growth has also stalled.¹⁹⁶ Among the factors that can be addressed, the health of Australians can and will influence productivity. Investing in prevention enables Australians to be more productive and enjoy longer lives, while placing less demand on an already overstretched health system.

Regulation to support productivity

Productivity in health depends on the funding and regulatory environment. With an ageing population, workforce shortages and the uptake of technological advancements, Australia must ensure relevant regulation delivers quality care while lifting productivity.

A range of government reviews, such as the *Scope of Practice Review*, the *Independent review of Australia’s regulatory settings relating to overseas health practitioners* and an array of PC reports highlight that regulations can be outdated.¹⁹⁹ These show that the workforce and service delivery can be held back by legislative, regulatory and funding barriers, rather than the skills or capacity.²⁰⁰

Regulation should be reviewed to determine whether it still does what it was intended to do: deliver safe, quality care, at reasonable cost and ensure that consumers can access the services they require. In instances where regulation hinders the ability of Australians to access services, it should be updated using a risk-based approach with governments, clinical bodies, providers and other stakeholders. Fit-for-purpose rules must improve consumer access while maintaining quality and safe care.

With a federated system, reform can occur at different stages, while other reform may not recognise what healthcare professionals are trained for. Wesfarmers Health welcomes the work of all governments to address scope of practice, enabling Australians to access services from their local pharmacist.²⁰³

Without this work being undertaken, Australians and the broader health sector are left to navigate outdated rules that vary by setting. Consistent, predictable rules that allow services to invest and scale with confidence will support lifting productivity while improving Australians’ access to care.

Action 16: Make workplace cardiometabolic screening core infrastructure

Invest in and host SiSU Health Stations as standard, ongoing workplace infrastructure, rather than one-off wellness initiatives, providing employees with routine, low-friction access to understand their cardiometabolic risk factors.

Various government reports have identified health and technology as key levers to address productivity.²⁰⁶ While Australians born today are expected to live longer, men spend 9.9 years and women spend 11.7 years living in ill health.²⁰⁷

Globally, Australia stands out for the wrong reason. Its ‘morbidity gap’ is one of the largest recorded at 13.9 years and is 2.9 years wider than in 1990, with high blood glucose and high body mass index among the leading contributors to the global gap.²⁰⁸ These findings have significant implications for labour markets and social protection systems.²⁰⁹

While Australia has one of the most productive health systems in the world, the PC has indicated this is largely related to the ability to provide more effective care, rather than doing more with less.²¹⁰ Modifiable risk factors account for more than one third of Australia’s total disease burden, led by overweight and obesity, tobacco use, dietary risks, high blood pressure and high blood glucose.²¹¹ This is a preventable burden on the years Australians spend unwell.

Australia needs to make workplace cardiometabolic screening core infrastructure to provide access to routine screening and increase awareness of related risk factors. This approach closely aligns with the *National Preventive Health Strategy*, which supports secondary prevention, focusing on early detection and best practice to reduce long-term effects.²¹² It also supports the *National Strategic Framework for Chronic Conditions*, which suggests the use of risk prediction tools to provide insights into early diagnosis and population-based risk identification.²¹³

The Index highlights that ill health is not confined to older Australians; it is already present among working-age Australians. For example, 67.5 per cent of those aged 18-24-year-olds with a high blood pressure reading had not had it checked in the past 12 months. Left undetected, that risk shows up earlier as absence, reduced performance at work and early exit from the workforce.²¹⁴

Furthermore, 20.5 per cent of users who initially recorded a high blood pressure reading without being on medication reported taking blood pressure medication when they returned to a Station at least 300 days later. This compares with 4.4 per cent of repeat users who started medication without a high reading at the Station. This highlights that detection can lead to real action and the workplace is one of the few settings where working-age Australians can be reached routinely.

Building a healthier Australia is not a cost to productivity. Done well, it is one of the most direct ways to improve it.

0.8%

long-term labour productivity growth, 2023-24¹⁹⁷

1.2%

long-term rate assumed¹⁹⁸

\$20,700

less GDP per person by 2065-66, if growth stays at 0.8%²⁰¹

\$76.4B

GDP retained over the working lives of Australians with hypertension, if all were treated and controlled²⁰²

Productivity slows due to ill health

Labour productivity is a main driver of wages and living standards, yet has been slowing for many years. Between 2003-04 and 2015-16, the 20-year average annual labour productivity growth rate was approximately 1.7-1.8 per cent, but this fell to just 0.8 per cent in 2023-24.²⁰⁴ The *2026 Intergenerational Report* assumes long-term labour productivity growth of 1.2 per cent a year across the next 40 years, a rate Australia’s long-term trend has now fallen below and which was downgraded from 1.5 to 1.2 per cent in 2022.²⁰⁵ This will have significant impacts on Australia’s standard of living.

Action 17:
Target older workers specifically to undertake workplace screening

Direct workplace screening awareness campaigns specifically at employees aged 45 and over. This group are under-represented among SiSU Health Station users relative to their share of the population despite carrying the greatest risk and potential productivity and retention benefit from early detection.

Targeted prevention to address an ageing workforce

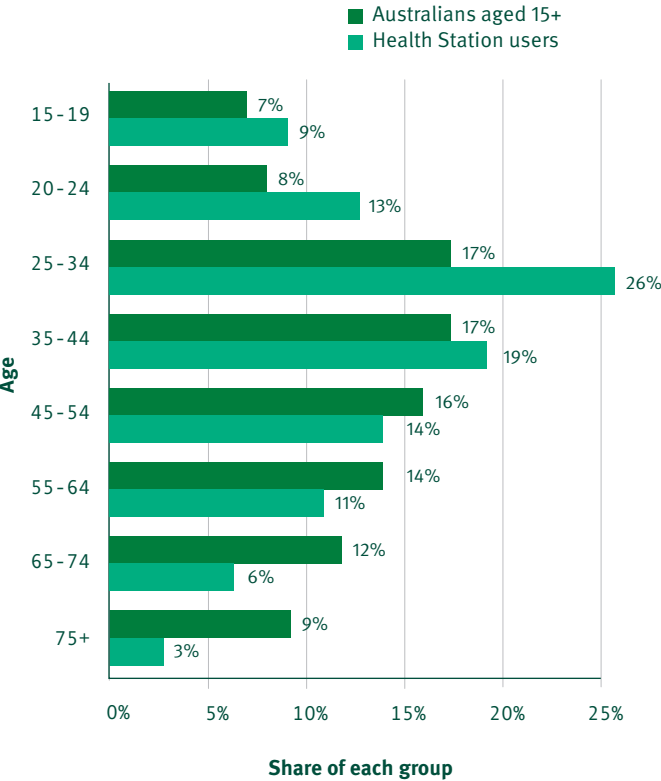
Australia needs to use every possible lever to support greater workforce participation as the workforce ages. The 2026 Intergenerational Report projects that the labour force participation rate will rise to 67.7 per cent by 2039-40 before declining to 64.7 per cent by 2065-66.²¹⁵ In parallel, the population aged 65 and over will increase by 87.1 per cent between 2025-26 and 2062-63, compared with 10.4 per cent among Australians aged 20 and under.²¹⁶

Australia must target workplace campaigns towards workers aged 45 and over to enable greater awareness among the population carrying more cardiometabolic risk, while also potentially improving productivity and retention. The Index findings highlight that this cohort carries greater risk yet is under-represented among the people using free screening (Figure 40).

Each additional working year matters in supporting Australia to maintain a strong and productive economy. The current trajectory means the number of Australians per retiree will decrease, impacting the number of Australians able to contribute meaningfully to the economy.²¹⁷ Evidence suggests that reducing the burden of cardiovascular disease from cutting new cases of type 2 diabetes could improve GDP by nearly \$70 billion.²¹⁸

A general awareness campaign will miss the opportunity to address the population whose ill health places the largest burden on Australia’s health system. Taking specific action will also help sustain the workforce participation rate and allow Australians to live healthier lives.

Figure 40
Age of Station users vs Australian population FY2026



Action 18:
Recognise the non-government and private sector as delivery partners in national prevention policy and initiatives.

Recognise employers, community pharmacies, private health insurers and health-technology providers as named delivery partners in the National Preventive Health Strategy and in the proposed prevention investment framework.

The role of governments and business

Governments are fiscally constrained and the 2026 Intergenerational Report and recent budgets show it.²¹⁹ It is projected that government payments will rise to 27.7 per cent of GDP over the next 40 years, with Commonwealth health spending increasing from 4 per cent of GDP in 2025-26 to 6.2 per cent by 2065-66.²²⁰ Concerningly, public hospitals will contribute to more than 60 per cent of that increase, a trend that highlights that Australia remains focused on acute care, rather than preventive health (Figure 41).²²¹

Australia’s mixed health system works best when the public and private sectors complement each other. The private sector can play an increasing role in delivering prevention services and it should be recognised as a delivery partner in prevention policy and initiatives.

Australia’s mixed public and private system is a key strength and the envy of the world. While government funds most health services, non-government sources still fund a significant portion which cannot be disregarded (Figure 42). In 2023-24, non-government spending grew by 3.7 per cent in real terms while government spending fell by 0.1 per cent.²²² Australians are willing to engage with and pay for services where they provide a benefit to them.

Recent ABS data indicates the total health care and social assistance industry employs approximately 2.4 million Australians, 15-16 per cent of the workforce.²²³ While only 28 per cent are directly employed by governments (more than one in four), the private and not-for-profit sector employs 72 per cent (almost three in four) (Figure 42).²²⁴

While governments pay for most of the care, the private and not-for-profit sector employs most of the people who deliver it. The private sector also delivers a range of services including:²²⁵

- Hospitalisations: 40 per cent
 - Elective surgery: 67 per cent
 - Emergency admissions: 8 per cent
 - Acute mental health: 60 per cent
 - Rehabilitation: 82 per cent
 - Chemotherapy: 53 per cent
- Dental: 85 per cent delivered privately
- General practice: 82-83 per cent of Australians saw a GP in the last year, with nearly all general practices privately owned and operated as small businesses
- Community pharmacy: effectively 100 per cent privately owned and operated
- Private health insurance: 46 per cent of the population holds private hospital cover and 55.5 per cent holds some form of cover including extras

Much prevention activity can take place outside hospitals and clinical settings. It is clear the private sector already operates these services, including SiSU Health Stations located inside pharmacies and workplaces, which allow Australians to check their cardiometabolic risk factors. This aligns with the broad range of government strategies across obesity, prevention, diabetes and chronic conditions.²²⁶

Figure 41
Components of Australian Government health spending as a share of GDP 2005-06 to 2065-66

Source: Treasury, 2026 Intergenerational Report

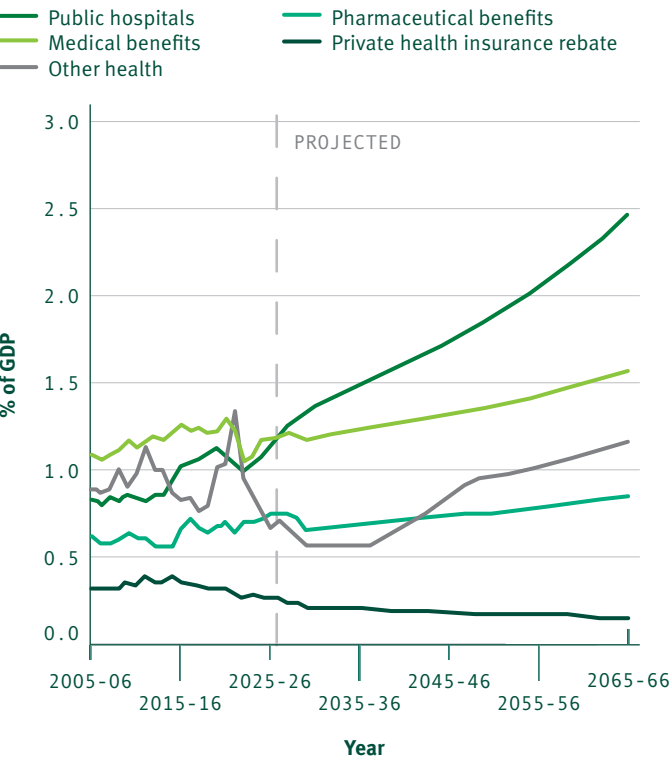


Figure 42
Australian healthcare funding and workforce employment

Source: ABS, Public Sector Employment and Earnings, 2024-25; AIHW, Health expenditure Australia 2024-25

Measure	Government	Private / non-government
Who funds it	70.0% (\$203.5 billion of \$290.7 billion)	30.0% (individuals 15.9%, private health insurers 7.6% and others)
Who employs the workforce	28.0% (669,000)	72.0%

Action 19:
Co-invest in workplace prevention. Track and report productivity return

Governments should co-invest and support businesses that adopt on-site cardiometabolic screening to track and report absenteeism, presenteeism, workforce participation and retention over time. Governments may evaluate prevention investment using Productivity-Adjusted Life-Years (PALYs) alongside existing measures to build greater evidence to guide future investment decisions.

Prevention is the government’s own productivity agenda

Australia’s productivity growth is not simply slowing. Its current trajectory of 0.8 per cent is below the forecast rate of 1.2 per cent over the next 40 years.²²⁷

The Australian Government’s Economic Reform Roundtable focused on three priorities (productivity, economic resilience and budget sustainability) supported by a five-pillar productivity agenda:²²⁸

- A more dynamic and resilient economy
- Net zero transformation
- A skilled and adaptable workforce
- Harnessing data and digital technology
- Delivering quality care more efficiently

Workplace prevention supports many of these pillars by protecting the health of the existing workforce, generating real-time, machine-measured population data and addressing risk before acute care is necessary.

Such prevention also aligns with this agenda by keeping working-age Australians healthy, supporting participation among older Australians and by providing an early-detection touch point for working Australians who may not otherwise see a health professional.²²⁹

The PC’s own research found that quality improvements, rather than cost reductions drove productivity growth in the health sector, with more to be done to reduce sizeable risk factors.²³⁰ International comparisons also highlight that Australia’s health system ranks first overall, but only fifth on care processes (including prevention) and ninth on access.²³¹

Governments should co-invest with business in scaling proven prevention infrastructure, rather than commissioning new pilots. Scaling these initiatives will support broader productivity and help reduce long-term fiscal pressure.

The *2026 Intergenerational Report* suggests that the use of technology and prevention will help address Australia’s productivity challenges.²³² Chronic conditions account for approximately \$98.5 billion (almost 55 per cent) of health system spending on disease and injury, nearly double the 2013-14 level.²³³ This proposal supports the government’s own modelling as well as the broad range of strategies that mention risk prediction tools, early intervention and prevention.

Measuring the return, not just assuming it

Australia currently lacks a standard way to measure what prevention returns in productivity terms. There is a growing body of research starting to address this need, including work by Monash University, which developed the Productivity-Adjusted Life-Year (PALY), calculated by multiplying years lived by a ‘productivity index’ that runs from 0 (completely unproductive) to 1 (completely productive), built from data on absenteeism, presenteeism and premature exit from the workforce.²³⁴

This sits alongside existing measures such as disability-adjusted and quality-adjusted life-year measures and could be used to support employers, particularly where they fund and support health initiatives.²³⁵

Australia must track and report the productivity return on investment in workplace prevention to encourage and support the adoption of on-site cardiometabolic screening. Governments may also wish to evaluate prevention investment using productivity-adjusted measures, such as PALYs alongside conventional health measures, building the local evidence base that can guide future co-investment decisions.

There is a range of research that highlights the burden cardiometabolic disease has on productivity.²³⁶ These findings align with the Index and support the adoption of on-site cardiometabolic screening.

Scaling SiSU Health Stations will widen the real-time picture of where risk sits and how it changes over time. Targeted early lifestyle decisions that prevent cardiometabolic disease are likely to have a positive impact on both Australian health and work productivity.²³⁷

Turning insight into action

These recommendations reflect the clearest signals in this year’s Index. Future editions will track progress against them, identifying where action is most needed and where Australia is making progress.

One of the most addressable findings in this year’s Index is that undetected high blood pressure often reflects a missed check. Earlier detection creates an opportunity to act before risk progresses.

For Australians, the message is simple: know your numbers.

The challenge is making those checks easy to access. SiSU Health Stations provide free cardiometabolic health checks in everyday settings, reaching people beyond traditional clinical care. They are registered by the TGA and have prompted more than 900,000 Australians to see a GP since launch, including about 145,000 in the past year alone.

This is infrastructure that already exists and can be scaled. Greater deployment of SiSU Health Stations across the country could help more Australians understand their cardiometabolic risk, identify potential issues earlier and connect with appropriate care.

The Index shows where the gaps are. SiSU Health Stations provide one way to help close them.





Appendices

Wesfarmers Health businesses

Further information on the history of Wesfarmers Health can be found at wesfarmers.com.au/our-businesses/wesfarmers-health.



Priceline and Priceline Pharmacy

Priceline Pharmacy is a pharmacy, health and beauty store. Priceline’s first store opened in 1982 at Highpoint Shopping Centre, Victoria, and today there are more than 470 Priceline and Priceline Pharmacy stores nationally. Priceline’s Pulse Rewards has more than 10.5 million members, making it one of Australia’s largest health and beauty loyalty programs.



SiSU Health

SiSU Health provides Health Stations, which are registered on the Australian Register of Therapeutic Goods (ARTG 317543). These medical devices enable individuals to undertake a free, self-service health check, in as little as five minutes. There are more than 500 Stations located across Australia with the majority available at Priceline Pharmacy. SiSU Health partners with the Shane Warne Legacy and state governments to bring these Health Checks to community events such as the Boxing Day Test at the MCG and AFL Gather Round in Adelaide.



Australian Pharmaceutical Industries Pty Ltd

Beginning in 1910, API has grown to be one of Australia’s leading wholesale distributors of pharmaceutical goods. With locations in all Australian states, API services more than 6,000 pharmacies around the country, ensuring all Australians receive their medication within 24 hours.



Pharmacy 4 Less

Built on a foundation of professional expertise and personal service, Pharmacy 4 Less has been meeting customers' health care needs since 2007. The Pharmacy 4 Less group supports 52 franchised community pharmacies under the ‘Pharmacy 4 Less’ brand, and two franchised community pharmacies under the ‘Your Chemist Shop’ brand, with the majority of stores located in Victoria and New South Wales.



InstantScripts

Founded in Melbourne in 2018, InstantScripts has helped more than 3 million Australians access high-quality healthcare from home, 24/7, via a large team of experienced Australian-registered doctors. InstantScripts services include prescriptions for everyday medications, medical certificates, blood test requests and general-health consultations, as well as discussions about specialised conditions such as weight loss, menopause and mental health.



Soul Pattinson Chemist

Soul Pattinson Chemist has been providing pharmacy services, professional care and value for money to the community through pharmacies located across Australia for over 130 years. With more than 30 stores nationwide in regional and metropolitan locations, Soul Pattinson Chemist continues to be a trusted brand for many Australians, providing expert care and advice for the whole family.



Pharmacist Advice

Pharmacist Advice is a banner for smaller pharmacies that concentrates on providing professional service and advice. It is a niche offering where pharmacists focus on counselling patients on specific medication needs. With more than 60 stores nationally, Pharmacist Advice aims to help customers understand more about their medicine so they can achieve better health faster.



atomica

Launched in 2024, atomica is a modern beauty and wellness destination built on the philosophy of inclusivity. Designed to bridge the gap between everyday pharmacy staples and coveted global trends, the brand has rapidly expanded to 13 locations across Australia.



Club Premium

Club Premium is API’s exclusive club for independent pharmacies, offering a suite of flexible programs, tools and services. Club Premium was created to help independent pharmacies meet industry pressures head-on and run a successful, profitable business in the retail pharmacy landscape. Exclusive member benefits help pharmacies improve their day-to-day performance and overall retail services, drive sales and increase foot traffic.



MediAesthetics

The MediAesthetics business unit comprises SILK Laser Clinics, Australian Skin Clinics, Clear Skincare and The Cosmetic Clinic brands. This is a leading network of wholly owned, joint venture and franchised specialist beauty clinics across Australia and New Zealand. These brands provide a comprehensive range of non-surgical aesthetic services and proprietary cosmeceutical skincare products. These include non-invasive cosmetic aesthetics, laser hair removal, advanced skin treatments, body contouring and related skincare solutions, all delivered using state-of-the-art medical devices at accessible prices.



The Sisterhood Foundation

The Sisterhood Foundation has been proudly supporting Australian women and their families for over 15 years, raising almost \$16 million in that time. The Sisterhood Foundation’s purpose is to hear, acknowledge and address the unique health issues impacting Australian women and girls. Its mission is to build capability in frontline charities and deliver programs that create positive health outcomes in the lives of women and girls. The Foundation is the official charity for all Wesfarmers Health businesses.

SiSU Health Stations

SiSU Health is part of Wesfarmers Health. SiSU Health Stations are Class IIa Medical Devices and registered on the Australian Register of Therapeutic Goods (ARTG 317543). These medical devices enable individuals to undertake a free, self-service health check in as little as five minutes.

Where are they located?

SiSU Health Stations are found in 523 locations across Australia, including in more than 330 Priceline pharmacies. They also feature at events such as the AFL Gather Round and the MCG Boxing Day Test.

How do they work?

SiSU Health Stations guide users aged 15 and over through a quick and easy health check, measuring key health metrics. The process is automated and requires no appointment, making it a convenient option for health monitoring.

What do they measure?

SiSU Health Stations measure blood pressure, heart rate, body fat percentage, height, BMI, weight, daily smoking and vaping status (vaping has been tracked since November 2024) and diabetes risk using the AUSDRISK diabetes risk tool.

How does SiSU Health data differ from other data?

One of the key differentiators of the SiSU Health platform and national network of Stations is its ability to offer a real-time view of health data, offering more timely insights into population health and the potential impacts of changes such as new policies, infrastructure or communicable diseases.

SiSU Health data can also track changes in an individual's health profile over time, providing longitudinal insights. To improve the accuracy of this longitudinal analysis, data from shared accounts and pregnant women is excluded, with additional time-based filters also applied.

What happens after a check?

After completing a health check, users receive a link to the secure SiSU portal or app to view their results in an easy-to-read dashboard. The app provides personalised recommendations to improve their health and may suggest a consultation with a pharmacist or GP if any results fall outside the normal range.

How often should users do health checks?

It is recommended that users complete at least three health checks within the first couple of months, as certain measurements such as blood pressure can fluctuate due to factors including time of day, caffeine intake or stress levels. These initial checks help establish a more accurate baseline for what is 'normal' for each individual.

After that, using the Station regularly, ideally six times per year, can help track progress, encourage healthy habits and identify any potential risk factors that may require further attention.

How accurate is the data?

SiSU Health Stations are classified as Class IIa Medical Devices, requiring them to meet applicable regulatory standards. The data collected is based on machine measurements, supplemented by user-reported lifestyle information to create a comprehensive health profile.

How many checks have been completed?

In Australia, 5.3 million health checks have been done on SiSU Health Stations. The data in this report draws on health checks from this dataset. In the last year (1 July 2025 to 30 June 2026), there were 585,576 checks completed by 397,227 unique individuals. Of these checks, 14,419 were completed anonymously and are not counted as individuals.

How many health checks have been done in each state and territory?

SiSU Health Stations have been used extensively across Australian states and territories, with the following number of checks in each state and territory last year (1 July 2025 to 30 June 2026):

- New South Wales 210,253
- Victoria 139,879
- Queensland 119,657
- South Australia 50,247
- Western Australia 44,080
- Australian Capital Territory 10,905
- Tasmania 9,104
- Northern Territory 1,451

Note: The NT is excluded from this Index due to insufficient and non-representative data. With only one Station in the region (1,451 checks), the data collected does not accurately reflect the health outcomes of the broader NT population.

What is the sex breakdown?

Of the Australian health checks conducted in the past year (1 July 2025 to 30 June 2026), 49.5 per cent were performed by women and 50.5 per cent by men. Since inception, the breakdown of health checks by sex is 52.0 per cent women and 48.0 per cent men.

Users also have the option to choose 'non-binary' as their gender. Users who select this option represented 0.8 per cent of signed-in users in FY2026 (3,290 people).

How secure and safe is the data?

User data collected during a health check at a Station is encrypted in transit to secure cloud servers located in Australia, where it is also encrypted at rest. No data resides on the Station itself. SiSU Health also maintains International Organization for Standardization (ISO) certifications for Information Security (ISO 27001:2022) and Quality Management (ISO 13485:2016).



Appendix 3

Methodology

Between 1 July 2025 and 30 June 2026, 397,227 Australians completed 585,576 checks across more than 520 SiSU Health Stations nationally. SiSU users are not drawn at random from the Australian population, so data is weighted to estimate the prevalence of each risk factor across different locations and demographic groups.

The Index score is derived from the odds of having multiple risk factors. A score above 100 indicates a lower prevalence of multiple risk factors than Australia as a whole in FY2018, the Index benchmark year.

Participants

The FY2026 estimates in this report are drawn from 348,269 Australians who completed a health check during the year. This is a subset of all users, selected to improve the quality and representativeness of the estimates. Users must:

- Supply a home postcode with a known age and sex structure in the 2021 Census
- Be signed in to an account with an email address, so that each person is counted once

The model also excludes:

- Users whose only checks were at large events such as the Boxing Day Test, where readings are taken in atypical conditions
- Users who appear to share one account
- SiSU employees and testers

Users who report a gender different from their sex at birth are also excluded, as the Census does not provide a corresponding population against which their results can be weighted.

The number of unique participants included in each prevalence rate is given in Figure 44.

Weighted estimates

To produce FY2026 risk factor estimates, each user is assigned to a population cell by their sex, age and home postcode and their most recent measurement for the year is used. Each cell is weighted by comparing the number of SiSU users with its population in the 2021 Census. This allows estimates to reflect Australia’s age, sex and geographic profile. Weights are capped so that no single user represents more than 1,000 Australians.

If no SiSU users match a cell's combination of age, sex and home postcode, an estimate cannot be made and that population is excluded. In FY2026, 91.7 per cent of Australians aged 15 and over lived in a cell where at least one user had all four main risk factors recorded: high blood pressure, obesity, diabetes and daily smoking.

National, state and demographic estimates in this report are based on at least 1,000 users. Groups with fewer than 1,000 users are not reported, which is why separate figures are not provided for the Northern Territory. Federal electorates estimates must meet a separate precision threshold and may depend on fewer than 1,000 users, with the smallest reported electorate estimate based on 373 users.

The Index score

The Index score shows whether cardiometabolic risk is higher or lower than Australia as a whole in FY2018, before COVID-19. This year’s national score of 104 is the first since COVID-19 to exceed that benchmark.

The score is calculated from the odds of having multiple risk factors (two or more of four risk factors). These are high blood pressure, obesity, diabetes and daily smoking. A higher score means lower odds of having multiple risk factors. A score of 104 means the odds of not having multiple risk factors are 4 per cent higher than in FY2018.

Blood pressure figures elsewhere in this report are for adults aged 18 and over to allow comparison with other national sources. The four measures used to calculate the Index score are estimated for Australians aged 15 and over.

Adjusting for better capture methods

SiSU Health continually improves how users are assessed for risk factors. Recent changes have improved the capture of blood pressure and nicotine use. To maintain comparability over time, the Index score adjusts for these changes.

In October 2024, SiSU revised its in-check guidance to encourage users with an initial blood pressure reading at or above 140/90 mmHg to take a second measurement. This helps account for readings temporarily elevated by factors such as physical activity or anxiety. Before the change, 35 per cent of checks with a high first reading included a further measurement, rising to 67 per cent by June 2026.

As this can reduce the proportion of users whose final reading is high, the Index score uses the first blood pressure measurement from each check. For years before FY2025, when Stations stored only the final measurement, a fixed adjustment based on data collected in August and September 2024 is applied to maintain comparability. High blood pressure rates elsewhere in this report use the final measurement.

In November 2024, SiSU replaced its yes-or-no daily smoking question with one that lets users report smoking on some days rather than every day. A separate question on vaping and e-cigarette use was also introduced. Given the option to report less frequent use, fewer users identified as daily smokers. This change is adjusted for in the Index score. Year-on-year comparisons of daily smoking use only FY2025 data collected after the new questions were introduced.

Figure 43 shows the net effect of these adjustments on the Index scores published in earlier editions. The previous edition reported both an adjusted and an unadjusted FY2025 score but did not apply adjustments retrospectively to earlier years in the series.

Figure 43
The Index score

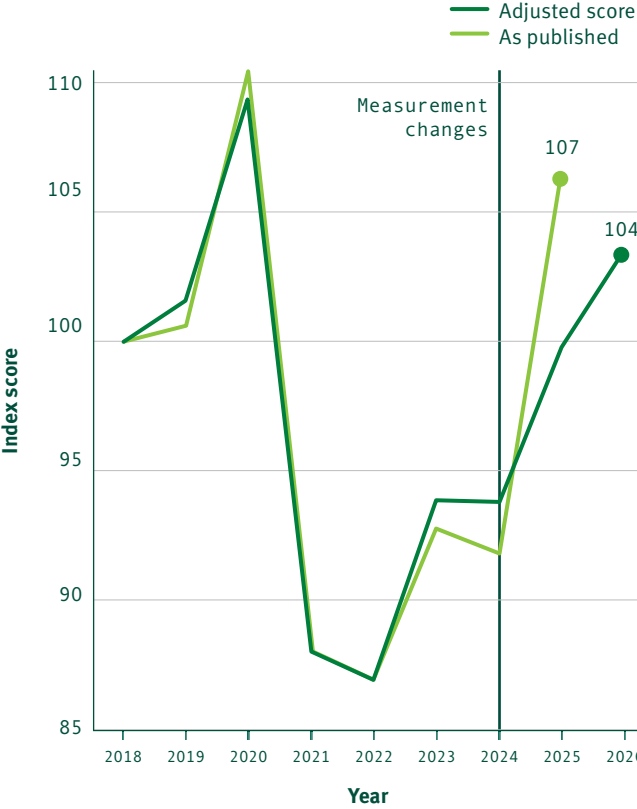


Figure 44
What SiSU Health Stations asked and measured

Measure	How	Instrument or question	What is kept	Users FY2026
Blood pressure	Measured	Oscillometric upper-arm cuff	One. A retest replaces it	314,083
Pulse	Measured	The same cuff, the same measurement	One. A retest replaces it	–
Height	Measured	Ultrasonic sensor, accurate to about 2cm	The highest of 60 samples	326,416
Weight	Measured	Platform scale, accurate to about 200g	The first reading the scale holds steady	327,241
BMI	Derived	Weight divided by height squared	Recomputed if either is measured again	325,447
Body composition	Measured	Bioimpedance through the handles	One. A repeat replaces it	279,580
Smoking and vaping	Reported	Four options, from every day to never	The answer given	313,958
Diabetes	Reported	Whether a doctor has diagnosed type 1 or type 2	The answer given	312,499
Blood pressure medication	Reported	Whether the user currently takes it	The answer given	339,069
Diabetes risk (AUSDRISK)	Reported	The published 10-item questionnaire	The answer given	250,068



Count of unique, authenticated SiSU users included in the estimation of each metric, FY2026								
		Obesity	High blood pressure [^]	Diabetes	Smoking	AUSDRISK	Vaping	All four risk factors
	All users	325,447	302,217	312,499	313,958	250,068	312,759	278,428
Sex	Female	161,381	148,863	156,380	157,157	125,684	156,504	136,192
	Male	164,066	153,354	156,119	156,801	124,384	156,255	142,236
Age	15-19	29,296	13,505	26,136	26,297	20,563	26,180	22,247
	20-24	42,646	39,060	39,476	39,679	31,427	39,524	35,201
	25-34	85,702	81,488	81,594	81,972	65,692	81,663	73,391
	35-44	62,280	61,138	60,805	61,101	49,757	60,847	54,753
	45-54	44,494	44,594	44,191	44,340	36,337	44,214	39,881
	55-64	33,652	34,224	33,510	33,640	26,600	33,532	29,928
	65-74	20,111	20,567	19,811	19,910	14,801	19,820	17,233
	75+	7,266	7,641	6,976	7,019	4,891	6,979	5,794
State or territory	ACT	5,639	5,299	5,500	5,533	4,267	5,508	4,801
	NSW	112,545	104,382	107,481	108,077	84,720	107,589	94,726
	QLD	66,360	61,163	64,027	64,348	50,261	64,078	56,348
	SA	26,716	24,365	25,581	25,667	20,988	25,596	23,248
	TAS	5,903	5,523	5,801	5,818	4,738	5,805	5,244
	VIC	82,737	77,369	79,335	79,641	65,159	79,391	71,963
	WA	24,633	23,116	23,891	23,986	19,214	23,907	21,293
City [†]	Adelaide	22,388	20,320	21,363	21,433	17,675	21,375	19,497
	Brisbane	36,979	34,050	35,606	35,791	27,991	35,639	31,415
	Canberra	5,639	5,299	5,500	5,533	4,267	5,508	4,801
	Hobart	3,734	3,409	3,622	3,634	2,934	3,625	3,268
	Melbourne	65,525	60,802	62,277	62,521	51,144	62,324	56,565
	Perth	21,962	20,723	21,370	21,458	17,156	21,385	19,034
	Sydney	88,478	81,896	84,039	84,512	66,180	84,119	74,121
IRSD quintile [‡]	1	47,643	43,723	45,007	45,249	35,176	45,039	39,495
	2	61,201	56,638	58,139	58,432	46,551	58,186	51,749
	3	70,214	65,287	67,369	67,700	53,972	67,425	59,987
	4	71,778	67,122	69,543	69,855	55,887	69,602	62,241
	5	74,611	69,447	72,441	72,722	58,482	72,507	64,956
Remoteness area (by user postcode)	Major cities	251,541	232,926	240,319	241,456	192,644	240,514	214,526
	Inner regional	52,122	48,879	50,958	51,189	40,566	51,008	45,144
	Outer regional	18,091	16,975	17,667	17,740	14,059	17,678	15,639

* Estimates for the Northern Territory have not been included in this report.
^High blood pressure counts adults aged 18 and over, so its 15–19 row is 18- and 19-year-olds.
†Cities are the Australian Bureau of Statistics' Greater Capital City Statistical Areas
‡Quintile 1 = most disadvantaged, 5 = least disadvantaged

Definitions

Terms	Definition
AUSDRISK	The Australian Type 2 Diabetes Risk Assessment Tool is a 10-item questionnaire the Australian Government publishes. Higher scores indicate a greater probability of developing type 2 diabetes over the next five years. Scores of 12 and above are denoted as high risk. Health Station users who do not report a diabetes diagnosis are asked to complete the AUSDRISK questionnaire.
Body mass index (BMI)	An indication of excess weight, calculated by dividing a user's measured weight by their measured height squared. While BMI may require additional contextualisation in the interpretation of individual health, it remains a reliable and widespread health metric.
Cardiometabolic disease	Cardiovascular disease (heart attack and stroke) and metabolic disease (obesity and type 2 diabetes) are common, preventable and related chronic diseases. Together, they are referred to as cardiometabolic disease. Cardiometabolic diseases are among the leading causes of death in Australia.
Cardiometabolic risk factor	Treatable or preventable conditions that raise the risk of cardiometabolic diseases. In this report, the rates of the following four risk factors are considered: diabetes, daily smoking, obesity and high blood pressure.
COVID-19	The widespread social changes and impacts on the Australian population, economy and healthcare system between April 2020 and September 2021 brought about by the COVID-19 pandemic. In particular, home-based lockdowns and physical distancing protocols profoundly impacted pre-existing human activity and lifestyle patterns (for example, social and physical activity and consumption of food, alcohol and cigarettes).
Daily smoking	Station users report if they smoke cigarettes or other tobacco products on a daily basis.
Daily vaping	Station users report if they use vapes or e-cigarettes on a daily basis. Data collected from November 2024.
Diabetes	Station users report a diagnosis of diabetes mellitus (type 1 or type 2).
High blood pressure	Blood pressure measured at or above 140 mmHg systolic or 90 mmHg diastolic. Blood pressure that consistently exceeds this threshold may result in a diagnosis of hypertension. A user may retest multiple times in the same session; the final reading is used. The reading alone is considered; medication is not counted. Blood pressure figures in this report, including awareness and control are for adults aged 18 and over.

High blood pressure awareness	SiSU users report if their blood pressure was measured within the last year, and if so, if their result was high. A user who records high blood pressure without stating a prior high measurement is classified as unaware. Awareness comes from the user's own report, and the share classified as unaware is a population-weighted proportion rather than a share of users.
Hypertension	A medical diagnosis of chronic high blood pressure at or above 140/90 mmHg, which a single Station measurement cannot assess. The AIHW requires readings on at least two separate occasions, one or more weeks apart. The 140/90mmHg threshold reflects the Australian guideline current at the time of writing; the Heart Foundation, Stroke Foundation and Hypertension Australia expect a revised guideline in the fourth quarter of 2026. For this report, the estimated rate of overall hypertension is derived from Health Station users who either record high blood pressure or who report being on blood pressure medication.
Hypertension control	Hypertension is controlled if the user measures below 140/90 mmHg while taking blood pressure medication. The hypertension control rate is the share of the 24.9% of Australian adults who either record high blood pressure or report taking medication, whose condition is controlled.
IRSD	The Index of Relative Socio-economic Disadvantage (IRSD) is a general socio-economic index created by the Australian Bureau of Statistics (ABS) as part of the Socio-Economic Indexes for Areas (SEIFA). It summarises a range of information about the economic and social conditions of people and households within an area. IRSD only includes measures of relative disadvantage. A user's IRSD is that of the residential postcode they supplied during a health check. Postcode areas are scored, ranked and allocated into five (quintiles) or 10 (deciles) equally sized groups. A low score or decile indicates relatively greater disadvantage.
Obesity	Body mass index of 30 kg/m ² or higher (BMI ≥30).
Remoteness area	Areas defined by the Australian Statistical Geography Standard (ASGS) that divide Australia into five classes of relative geographic remoteness. These are Major cities of Australia, Inner regional Australia, Outer regional Australia, Remote Australia and Very remote Australia. This report gives figures for three of them: Major cities, Inner regional and Outer regional Australia. Check volumes were not sufficient to derive consistent estimates for Australia's remote areas.
SEIFA	Created by the Australian Bureau of Statistics (ABS), the Socio-Economic Indexes for Areas (SEIFA) combine Census data, such as income, education, employment, occupation, housing and family structure, to summarise the socio-economic characteristics of an area. Each area receives a SEIFA score indicating how relatively advantaged or disadvantaged that area is compared with other areas.
Sex and gender	Users provide both their sex at birth and identified gender. Estimates produced as part of this report are relevant only to users whose gender identity corresponds to their sex. Sex at birth is exclusively used in metabolic and cardiovascular risk instruments such as AUSDRISK.

Disclaimers

Inherent limitations

This report has been prepared as outlined in the sections titled “Key findings” and “Methodology”. The findings in this report are generated primarily from the fully de-identified data of individuals who have undertaken a digital health check using a SiSU Health Station. Any projection to the wider Australian community is subject to the level of bias in the method of sample selection. No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by, the individuals consulted as part of the process. Australian Pharmaceutical Industries Pty Ltd and SiSU Wellness Pty Ltd are under no obligation in any circumstance to update, correct or revise this report, in either oral or written form, for events occurring after the report has been issued in final form. The findings in this report have been formed on the above basis. To the extent permitted by law, none of Australian Pharmaceutical Industries Pty Ltd, SiSU Wellness Pty Ltd, their related bodies corporate and the respective officers, employees, agents and advisers accept responsibility or liability, including without limitation for any loss, claim, damages, costs or expenses arising out of, or in connection with, the information in this report.

Third Party Reliance

This report has been prepared solely for the purposes set out in the sections titled “Key Findings” and “Methodology” and is not to be used for any other purpose. Neither Australian Pharmaceutical Industries Pty Ltd nor SiSU Wellness Pty Ltd nor its related bodies corporate, respective officers, employees, agents and advisers undertakes responsibility arising in any way from reliance placed by a third party on this report. Any reliance placed is that party’s sole responsibility.

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