National Strategic Framework for Chronic Conditions

Contents

Abbreviations ......................................................................................................................... 3
PREAMBLE ............................................................................................................................. 4
INTRODUCTION ....................................................................................................................... 6
THE NATIONAL STRATEGIC FRAMEWORK FOR CHRONIC CONDITIONS .......................... 7
THE CHALLENGE OF CHRONIC CONDITIONS ..................................................................... 9
  Chronic Conditions – a definition ..................................................................................... 9
  Current status and impact of chronic conditions ............................................................... 9
  Priority Populations .......................................................................................................... 10
  The Cost of Chronic Conditions ....................................................................................... 10
  International and national challenges .............................................................................. 11
  Determinants of Health ..................................................................................................... 12
THE NATIONAL STRATEGIC FRAMEWORK FOR CHRONIC CONDITIONS ....................... 14
  Vision .................................................................................................................................. 14
  Principles ............................................................................................................................ 14
  Enablers .............................................................................................................................. 14
  Partners ............................................................................................................................... 15
  Objectives ........................................................................................................................... 16
  Strategic Priority Areas ...................................................................................................... 16
  Outcomes ........................................................................................................................... 17
  Measuring Progress ........................................................................................................... 17
OBJECTIVE 1: Focus on prevention for a healthier Australia ................................................ 18
  Strategic Priority Area 1.1: Risk reduction ........................................................................ 19
  Strategic Priority Area 1.2: Partnerships for health ........................................................... 21
  Strategic Priority Area 1.3: Critical early life stages ......................................................... 22
  Strategic Priority Area 1.4: Timely and appropriate detection ........................................... 23
OBJECTIVE 2: Provide effective and appropriate care to support people with chronic conditions and optimise quality of life ................................................................. 25
  Strategic Priority Area 2.1: Active engagement ................................................................. 27
  Strategic Priority Area 2.2: Continuity of care ................................................................. 29
  Strategic Priority Area 2.3: Accessible health services .................................................... 31
  Strategic Priority Area 2.4: Information sharing ............................................................... 33
  Strategic Priority Area 2.5: Supportive systems ............................................................... 34
OBJECTIVE 3: Target priority populations ........................................................................... 35
  Strategic Priority Area 3.1: Community and culture ......................................................... 36
  Strategic Priority Area 3.2: Targeted action ..................................................................... 38
REFERENCES ......................................................................................................................... 40
Abbreviations

CALD: Culturally and Linguistically Diverse
DALYs: Disability Adjusted Life Years
GP: General Practice
My Health Record: The Australian Government’s National Electronic Health Record, previously known as the personally controlled electronic health record or PCEHR
QoL: Quality of Life
WHO: World Health Organization
YLLs: Years of Life Lost
PREAMBLE

Acknowledgements

Many individuals and organisations have given their time and expertise to the development of the National Strategic Framework for Chronic Conditions (the Framework). The Australian and all state and territory governments would like to thank organisations and individuals for providing feedback through this online public consultation, as well as those who participated in the scoping and national targeted consultation workshops during 2015.

Jurisdictional Working Group

The Framework is being developed through the Australian Health Ministers’ Advisory Council’s Community Care and Population Health Principal Committee with valued input from a Jurisdictional Working Group. The Working Group has provided advice on all aspects of the Framework development process. Membership comprises a Commonwealth Chair, members from each jurisdiction as well as a representative from New Zealand and the National Aboriginal and Torres Strait Islander Health Standing Committee.

Expert Advice

Advice from a range of experts has been sought throughout the development of the Framework, in particular relating to chronic conditions, their risk factors, the outcomes and measurability.

Purpose

The Framework supersedes the National Chronic Disease Strategy 2005 and associated National Service Improvement Frameworks as an overarching policy for the prevention and management of chronic conditions in Australia. It provides guidance for the development and implementation of policies, strategies, actions and services to address chronic conditions and improve health outcomes.

Audience

The Framework is directed at decision and policy makers at national, state and local levels.

While primarily a tool for governments, the Framework may also be a useful resource for the non-government sector, stakeholder organisations, local health service providers, private providers, industry and communities who advocate for and provide care and education for people with chronic conditions and their carers.

Timeframe

The timeframe of the Framework is eight years (2017 to 2025), with a review anticipated after three years.
PART 1: Setting the Scene

Part 1 explores the impact of chronic conditions in Australia and outlines the approach of the Framework.
INTRODUCTION

Chronic conditions are the leading cause of illness, disability and death in Australia\(^1\). Tackling chronic conditions and their causes is the biggest challenge facing Australia’s health system\(^2\). Along with our ageing population, increasing consumer expectations and the high cost of pharmaceuticals and treatments, ever-increasing rates of chronic conditions are putting unprecedented strains upon individuals, communities and the health system.

Over the past 40 years, the burden of disease in Australia has shifted from infectious diseases and injury well-suited to an episodic care model, to chronic conditions requiring attention to prevention activities and coordinated management. Chronic conditions are occurring earlier in life and Australians may live for a longer period with complex care needs. This means individuals require more services from a range of providers across the health system over extended periods of time. Change is required to deliver a more sustainable health system that responds more effectively to chronic conditions.

A focus on prevention can significantly reduce the volume and severity of chronic conditions and provide long-term cost savings and better health outcomes. Strategies to effectively manage chronic conditions to minimise multimorbidities, complications and associated disabilities and to optimise quality of life are equally important.

By reducing the impact of chronic conditions, there is more to be gained than building an economically viable and sustainable health system. Reducing the physical, psychological, social and financial impacts of chronic conditions will improve quality of life and enhance health outcomes for individuals, families and communities. Furthermore, the unequal burden of chronic conditions and the higher prevalence of risk factors in priority populations must be acknowledged\(^3\). Greater emphasis towards identifying and supporting these populations in terms of both their risk of developing, and the impact of, chronic conditions is needed.

Considerable change is under way through ongoing national reforms that will significantly affect the health system. In particular, recent landmark reforms include the Pharmaceutical Benefits Scheme and Pharmacy Agreement. Other complementary reforms to deliver a more sustainable, person-centred health system include: the establishment of Primary Health Networks, the redevelopment of the My Health Record; the Healthier Medicare initiative; implementation of the broad ranging recommendations of the National Mental Health Commission’s Review; reform to improve aged care services as well as the National Medical Training Advisory Network project.

Like Australia, other countries face the challenge of the increasing prevalence of chronic conditions. To address this, the World Health Organization (WHO) has developed a Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020\(^4\). The Global Action Plan aims to reduce the burden of noncommunicable diseases by 2025, through a set of nine global targets and 25 indicators\(^5\). As a member state of the WHO, Australia has an international commitment to address noncommunicable diseases in line with the Global Action Plan. International and national experience indicates a multisectoral response is most effective and should involve governments at all levels, the non-government and private sectors, communities and individuals. The Framework supports Australia’s international commitments and provides national guidance in the prevention and management of chronic conditions.
THE NATIONAL STRATEGIC FRAMEWORK FOR CHRONIC CONDITIONS

The National Strategic Framework for Chronic Conditions (this Framework) is the overarching chronic conditions policy document that sets the direction and outcomes required to achieve the Vision that all Australians live healthier lives through effective prevention and management of chronic conditions.

Working within the guidance of this Framework will contribute to the long term sustainability of the health system and reduce the impact of, and provide better care for people with, chronic conditions.

Figure 1 - Concept map of the National Strategic Framework for Chronic Conditions

Figure 1 illustrates the relationship between the components of this Framework and depicts the essential elements that interact to direct policies, strategies, actions and services.
Overview to this Framework

This Framework:
- moves away from a disease-specific approach;
- identifies the key principles for the effective prevention and management of chronic conditions;
- complements state-based, national and international chronic condition policy;
- acknowledges and builds on work already in place that supports chronic conditions;
- supports a stronger emphasis on coordinated care across the health sector;
- accommodates strategies and policies without changing the responsibilities of the federal or state and territory governments; and
- provides flexibility to accommodate future and emerging priorities and allows for innovation for the prevention and management of chronic conditions.

National action is required to strengthen Australia’s approach to reducing the impact of chronic conditions. A coordinated national approach needs to accommodate the variable policy environments in Australia, including the range of perspectives and practices that are supported by current evidence and existing state, national and international policy. There is already a range of existing national and state-based strategies and actions that target chronic conditions (Refer Figure 2). This Framework does not replace current policies or strategies, but provides guidance for the development of new and innovative approaches to address chronic conditions and enhances current disease specific policies.

The health sector cannot work in isolation from other sectors and services. This Framework provides the platform from which the health sector may take a leadership role, where appropriate, to foster advocacy, engagement and partnering with external sectors. Relevant external sectors may include environment, housing, education, employment, transport and social services. Coordinated efforts can influence the social and environmental factors that impact the development and progression of chronic conditions and the associated burden of disease in Australia.
THE CHALLENGE OF CHRONIC CONDITIONS

Chronic Conditions – a definition

Various terminology is used to describe chronic health conditions, including “chronic diseases”, “noncommunicable diseases”, and “long-term health conditions”. In this Framework, the use of the term “chronic conditions” encompasses a broad range of chronic and complex health conditions across the spectrum of illness, including mental illness and injury. This broad definition is intended to move the focus away from a disease-specific approach.

International policy from the WHO focusses primarily on noncommunicable diseases. However, both communicable and noncommunicable diseases can become chronic and the origins of chronic conditions are varied and complex.

Chronic conditions:

- have complex and multiple causes;
- usually have a gradual onset, although they can have sudden onset and acute stages;
- occur across the life cycle, although they become more prevalent with older age;
- can compromise quality of life and create limitations and disability;
- are long term and persistent, and often lead to a gradual deterioration of health and loss of independence; and
- while not usually immediately life threatening, they are the most common and leading cause of premature mortality.

This definition aligns with the definition of noncommunicable diseases used by the WHO, without referring to a specific disease group.

Current status and impact of chronic conditions

Chronic conditions are currently Australia’s biggest health challenge. The escalating prevalence of chronic conditions, combined with a population that is living longer with multimorbidities, is placing an increasing demand on the health system.

As chronic conditions are characterised by a broad range of often complex health conditions, their overall prevalence is difficult to quantify, however evidence indicates the following:

- About half of all Australians have a chronic disease, and around 20 per cent (one in five) has at least two chronic conditions.
- In Australasia in 2010, chronic conditions accounted for approximately 85 per cent of the total burden of disease.
- Premature mortality (that is, deaths among people aged less than 75 years) from chronic disease accounted for 83 per cent of all premature deaths in Australia in 2007.
- Changing lifestyles, ageing population, improvements in managing infections and reducing infant deaths have meant that chronic conditions have become increasingly common.
- The likelihood of having one or more chronic conditions increases with age, and in Australia’s ageing population there is a corresponding increase in multimorbidities.
- Nearly 40 per cent of Australians aged 45 and over have two or more chronic diseases.
- Having more than one chronic condition is associated with worse health outcomes, more complex disease management and increased health costs.
Priority Populations

Priority populations are negatively impacted by chronic conditions more than the general population. This is demonstrated by a higher prevalence of chronic conditions and a greater burden of disease in these groups. Priority populations can include: Aboriginal and Torres Strait Islander people; people from culturally and linguistically diverse (CALD) backgrounds; older Australians; carers; people experiencing socio-economic disadvantage; people with a mental illness; people with a disability; and those living in rural and remote areas.

Examples of the prevalence of chronic conditions in some priority populations include:

- Just under one in five Australians (4.2 million people) reported having a disability in 2012. Of these, 1.4 million people needed help with basic daily activities of self-care, mobility and communication15.
- Australians aged 15-64 years with severe or profound disability are extensive users of professional health services, with higher rates of consultations with general practitioners, specialists and other health professionals than people without disability. This high use is associated with their high prevalence of multiple long-term health conditions, and comorbidity of mental disorders and physical conditions16.
- In general, people (particularly men) living in outer regional and remote areas and people in lower socioeconomic groups tended to have higher rates of risk factors for chronic conditions17.
- Chronic diseases are also commonly associated with ageing, and older people are more likely than younger people to have multiple long-term health conditions. For example, in 2009, around half of persons aged 65-74 years had five or more long-term health conditions, increasing to 70 per cent of those aged 85 years and over18.

Despite improvements in recent years in Aboriginal and Torres Strait Islander health, Aboriginal and Torres Strait Islander people experience poorer health and have worse general health outcomes than other Australians. They have a burden of disease two to three times greater than the general Australian population and are more likely to die at younger ages, experience disability and report their health as fair to poor19. The reasons for the differences include disparities in social and economic factors, in health behaviours and in access to health services20. Further to this:

- Approximately two in three Aboriginal and Torres Strait Islander people (67 per cent) reported that they had at least one long-term condition in 2012–1321; and
- One-third (33 per cent) of Aboriginal and Torres Strait Islander people reported having three or more long-term conditions22.

The Cost of Chronic Conditions

People with chronic conditions use health services and medicines frequently and over extended periods of time: a pattern which is compounded with the presence of multimorbidities. Consequently, chronic conditions are associated with high health care expenditure, and health care costs are expected to rise with the increasing prevalence of chronic conditions, escalating treatment costs and increasing demand for services.

Most information regarding the economic impact of chronic conditions in Australia is sourced from disease-specific data that focuses on a select group of chronic conditions, namely cardiovascular disease, diabetes, cancer, mental illness, respiratory conditions, musculoskeletal conditions and obesity. Estimates based on disease-specific allocated health care expenditure indicate that the four most costly disease groups are chronic – cardiovascular diseases, oral health, mental illness and musculoskeletal conditions – incurring direct health care costs of $27 billion in 2008-09 (36 per cent of allocated health expenditure)23.
Taking into account the broad definition of chronic conditions used in this Framework, it is likely that the true economic burden of chronic conditions is considerably greater than can be demonstrated with available data. Most expenditure is associated with admitted patient hospital services, out-of-hospital services, medications and dental services. Additionally, the economic impact of chronic conditions would be greater if non-health sector costs, such as residential care and lost productivity from compromised health, illness and death, were considered. Chronic conditions are also associated with non-economic costs, including personal, social and community costs such as loss of independence, social isolation, family impacts and potential disability and aged care considerations.

**International and national challenges**

The escalating burden of chronic conditions is a global health issue. The WHO’s ‘Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020’ follows on from commitments made by Heads of State and Government. The Global Action Plan recognises the primary role and responsibility of Governments in responding to the challenge of noncommunicable diseases and the important role of international cooperation and solidarity to support national efforts.

Dialogue on strengthening international cooperation on noncommunicable diseases recognises:
- the socio-economic impact of noncommunicable diseases is significant;
- the massive disconnect between the scale and complexity of the problem and the lack of resources dedicated to tackle it;
- that even more important than increasing resources is the necessity of getting national policies right, in particular those beyond the health sector; and
- the potential for noncommunicable diseases to be integrated into other development programs through strategic partnerships, including the role of information and communications technology in empowering individuals to manage their own health.

Australia faces similar challenges to other economically developed countries in relation to chronic conditions. Unbalanced diets heavy with unhealthy (high fat, high sugar, high salt) foods, physical inactivity and sedentary behaviour, the prolonged burden of tobacco-related disease and harmful alcohol consumption are common characteristics. Improved health care that increases survival from, but prolongs life with, chronic conditions places extended and intensive demands on the health system along with social and economic burdens on individuals, families, communities and economies. There is increasing international recognition that preventive measures are an essential means of reducing this burden. Prevention activities, together with well managed chronic conditions, will provide better population health, social and economic outcomes for all Australians.
Determinants of Health

The determinants of health are many, varied and interact to raise or lower the health status of individuals and populations. The determinants of health fall into four main categories:

- **Physical environment** – for example, housing, sanitation and the natural and built environments;
- **Social environment** – for example, education, employment, political structures, relationships and culture;
- **Economic factors** – for example, income, expenditure and affordability; and
- **Individual characteristics** – for example, sex, genetics and physical or mental determinants.

The factors within each of these categories and their interactions influence: knowledge, attitudes and beliefs; social norms and opportunities which can ultimately impact health (Refer Figure 3).

**Figure 3 – Influence of the Determinants of Health**

While some determinants that influence chronic conditions sit within the realm of the health sector there are many determinants that fall outside the boundaries of health. This Framework takes the approach of promoting, where practical, the benefits of fostering partnerships and encouraging coordinated efforts within and outside of the health sector to minimise the impacts of the determinants of health and positively influence the health of all Australians.
PART 2: The Framework

Part 2 sets out the Vision, Objectives and Aspirational Outcomes of this Framework.
THE NATIONAL STRATEGIC FRAMEWORK FOR CHRONIC CONDITIONS

Vision

All Australians live healthier lives through effective prevention and management of chronic conditions.

Principles

Eight governing Principles have been identified as the foundational tenets that enable the successful prevention and management of chronic conditions for all Australians. The Principles should be clearly evident in the planning, design and implementation of policies, strategies, actions and services aimed at preventing and/or managing all chronic conditions.

The Principles are:

- **Equity** – all Australians receive safe, high quality health care irrespective of background or personal circumstance.
- **Collaboration and Partnerships** – identify linkages and act upon opportunities to cooperate and partner responsibly to achieve greater impacts than can occur in isolation.
- **Access** – high standard, appropriate support and services are available, accessible and affordable for all Australians.
- **Evidence-based** – rigorous, relevant and current evidence informs best practice and strengthens the knowledge-base to effectively prevent and manage chronic conditions.
- **Person-centred approaches** – the health system is shaped to recognise and value the needs of individuals, their carers and their families, to provide holistic care and support.
- **Sustainability** - strategic planning and responsible management of resources delivers long-term improved health outcomes.
- **Accountability and Transparency** – decisions and responsibilities are clear and accountable, and achieve best value with public resources.
- **Shared Responsibility** – all parties understand, accept and fulfil their roles and responsibilities to ensure enhanced health outcomes for all Australians.

Enablers

Six specific Enablers have been identified that will assist in achieving the Vision of this Framework. Appropriate use of the Enablers will give effect to successful policies, strategies, actions and services that will support people with, or at risk of developing, chronic conditions.

The Enablers comprise:

- **Governance and Leadership** – supports evidence-based shared decision-making and encourages collaboration to enhance health system performance.
- **Health Workforce** – a suitably trained, resourced and distributed workforce is supported to work to its full scope of practice and is responsive to change.
- **Research** – quality health research accompanied by the translation of research into practice and knowledge exchange strengthens the evidence base and improves health outcomes.
- **Data and Information** – the use of consistent, quality data and real-time data sharing enables monitoring and quality improvement to achieve better health outcomes.
- **Technology** – supports more effective and accessible prevention and management strategies and offers avenues for new and improved technologically driven initiatives.
- **Resources** – adequate allocation, appropriate distribution and efficient use of resources, including funding, to address identified health needs over the long-term.
Partners

The effective prevention and management of chronic conditions is strongly influenced by the contributions made by a wide range of Partners. Partners in the prevention and management of chronic conditions include:

- Individuals, families and carers.
- Communities.
- The public health sector
- All levels of government
- Non-government organisations.
- The private sector, including private health providers, industry and private health insurers.
- Researchers and academics.

All Partners have shared responsibility for health outcomes according to their role and capacity within the health care system. Greater cooperation between Partners can lead to more successful individual and system outcomes.
Objectives

The Vision is supported by the following three (3) Objectives:

1. Focus on prevention for a healthier Australia.
2. Provide effective and appropriate care to support people with chronic conditions and optimise quality of life.
3. Target priority populations.

Strategic Priority Areas

Strategic Priority Areas have been identified under each Objective. These are the core priority areas where Partners should focus attention to achieve each of the Objectives. Partners can readily identify, plan and implement their own policies, strategies, actions and services against the Strategic Priority Areas.

<table>
<thead>
<tr>
<th>Objective 1: Focus on prevention for a healthier Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Priority Area 1.1 Risk reduction</td>
</tr>
<tr>
<td>Strategic Priority Area 1.2 Partnerships for health</td>
</tr>
<tr>
<td>Strategic Priority Area 1.3 Critical early life stages</td>
</tr>
<tr>
<td>Strategic Priority Area 1.4 Timely and appropriate detection</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective 2: Provide effective and appropriate care to support people with chronic conditions and optimise quality of life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Priority Area 2.1 Active engagement</td>
</tr>
<tr>
<td>Strategic Priority Area 2.2 Continuity of care</td>
</tr>
<tr>
<td>Strategic Priority Area 2.3 Accessible health services</td>
</tr>
<tr>
<td>Strategic Priority Area 2.4 Information sharing</td>
</tr>
<tr>
<td>Strategic Priority Area 2.5 Supportive systems</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective 3: Target priority populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Priority Area 3.1 Community and culture</td>
</tr>
<tr>
<td>Strategic Priority Area 3.2 Targeted action</td>
</tr>
</tbody>
</table>
Outcomes

Outcomes have been described for each Strategic Priority Area. They describe the result of actions, rather than the actions required, to allow flexibility for Partners to develop and implement their own strategies, policies, actions and services within the boundaries of their specific health responsibilities and governing authorities.

A phased outcome approach has been used to recognise that a continuum of progress is required to meet each Objective. It is acknowledged that relevant Partners will be at different stages along this continuum; therefore timeframes for the achievement of each outcome have not been specified.

Phase 1 Outcomes are intended to be achieved in the shorter-term, whereas Phase 2 Outcomes build upon the Phase 1 Outcomes and represent longer-term achievements.

Aspirational Outcomes outline the ambitious long-term results that would be seen if collective action was successful against each of the Phase 1 and Phase 2 Outcomes. The Aspirational Outcomes are offered to stretch responses and to foster innovative and creative solutions to meet the challenges of the burden of chronic conditions in Australia.

Measuring Progress

Progress should be measured at various levels and is the responsibility of all Partners. Each layer of this Framework - the Objectives, the Strategic Priority Areas and the Outcomes - contributes to achieving its Vision – all Australians live healthier lives through effective prevention and management of chronic conditions.

Due to the complexities associated with the prevention and management of chronic conditions there is no single indicator to determine the impact of this Framework. Rather, a description of what success will look like by 2025 has been included at the Objective level, and example measures of progress have been provided for each Strategic Priority Area. The example measures of progress are not a comprehensive list but are provided to demonstrate the range and breadth of information that may be available to monitor the impact of collective action under each Strategic Priority Area. In addition, Partners should evaluate their own strategies, policies, actions or services to ensure that these activities are contributing to the outcomes described in each Strategic Priority Area.

More robust and relevant data and information may become available in the future. Partners should take these opportunities to review and refine the measures they use to track and monitor progress against this Framework’s Objectives, Strategic Priority Areas and Outcomes.
OBJECTIVE 1: Focus on prevention for a healthier Australia

What success will look like in 2025:
1. Fewer Australians live with chronic conditions or associated risk factors.
2. Australians with chronic conditions, or associated risk factors, develop them later in life and receive timely interventions to achieve optimal health outcomes.

Prevention is key to improving the health of all Australians, reducing health related expenditure and ensuring a sustainable health system. Changing lifestyles, characterised by poor diet and nutrition, physical inactivity, the harmful consumption of alcohol and tobacco use, and population ageing, all contribute to the current chronic conditions burden which is placing increasing demands on the health system and the economy more broadly. Prevention generates long-term health and economic benefits, delivers the greatest improvement in health outcomes and improves the health of future generations.

A small number of risk factors account for much of the morbidity and mortality attributed to chronic conditions. Targeting common preventable risk factors and determinants of health is an effective way to prevent chronic conditions. However, not all chronic conditions are preventable, and health outcomes for people with non-preventable chronic conditions can also be improved through preventive action.

Preventive action to reduce common risk factors and promote healthy behaviours can:
- prevent the occurrence, or delay the onset, of chronic conditions;
- slow disease progression in people with chronic conditions;
- reduce the risk of developing additional chronic conditions, complications and/or associated disabilities;
- support an improved quality of life; and
- reduce demand on the health-care system.

Action to prevent chronic conditions is a shared responsibility. Positive sustainable change for individuals, families, communities, governments and the economy requires an inclusive approach whereby all Partners respond to the challenges in a cooperative and coordinated manner.

A comprehensive approach to prevention will strengthen the skills and capabilities of individuals to take greater responsibility for their own health, and influence the physical and social environments at a community and population level to achieve positive cultural change.

The Strategic Priority Areas and Aspirational Outcomes in this Objective are as follows:

<table>
<thead>
<tr>
<th>Objective 1: Focus on prevention for a healthier Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Priority Areas</strong></td>
</tr>
<tr>
<td>1.1: Risk reduction</td>
</tr>
<tr>
<td>1.2: Partnerships for health</td>
</tr>
<tr>
<td>1.3: Critical early life stages</td>
</tr>
<tr>
<td>1.4: Timely and appropriate detection</td>
</tr>
</tbody>
</table>
Strategic Priority Area 1.1: Risk reduction

Health risk factors are attributes, characteristics or exposures that increase the likelihood of a person developing a disease or health disorder. The risk factors for chronic conditions can be categorised as follows:

- **Behavioural risk factors** – these are the most common risk factors for many chronic conditions. As such, they are often a major focus for prevention strategies and interventions. For example, smoking, poor diet and nutrition, harmful consumption of alcohol or physical inactivity.

- **Biomedical risk factors** – relate to the condition, state or function of the body that contributes to the development of chronic conditions. The effects of a single biomedical risk factor can be intensified when additional biomedical risk factors or behavioural risk factors are present. For example, high blood pressure, high blood cholesterol, overweight or obesity, impaired glucose tolerance, mental illness, injury or illness (communicable disease).

- **Non-modifiable risk factors** – comprise individual physical and psychological components. For example, age, sex, genetics or intergenerational influences.

- **Physical environment determinants** – comprise both the natural and built environment, can impact health in a subtle or obvious manner and can occur over the short or the long term. For example, UV exposure, air pollution, urban environment, or geographic location.

- **Social determinants** – are difficult for individuals to control, however they influence the way in which people live their lives. For example, beliefs, customs and culture, education and employment status.

Risk factors are often discussed individually; however in practice they do not operate in isolation - they often coexist and interact with one another. Many chronic conditions share common risk factors and determinants, and are often risk factors for each other.

Risk factors for chronic conditions should be addressed through a suite of evidence-based interventions targeted across the spectrum from individual to population level approaches. While in some circumstances the evidence may be limited, the evidence that does exist shows that the greatest impact is likely to come from action which occurs across multiple and different settings, sectors, age groups and life stages.
Policies, strategies, actions and services developed under this Strategic Priority Area by relevant Partners should aim to achieve the Aspirational Outcome below.

### Strategic Priority Area 1.1: Risk reduction

<table>
<thead>
<tr>
<th>Phase 1 Outcomes</th>
<th>Phase 2 Outcomes</th>
<th>Aspirational Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>People and populations identified as high risk receive evidence-based targeted interventions.</td>
<td>Evidence-based preventive health measures reduce risk factors.</td>
<td>1.1 Australians have reduced risk of developing a chronic condition.</td>
</tr>
<tr>
<td>Research builds the evidence-base around effective preventive health measures.</td>
<td>Innovative solutions, including diagnostic technology, support risk factor identification and reduction.</td>
<td></td>
</tr>
<tr>
<td>The health workforce provides appropriate advice to prevent and manage the risk factors for chronic conditions.</td>
<td>Australians make healthier choices and change their behaviours to reduce their risk of developing chronic conditions.</td>
<td></td>
</tr>
<tr>
<td>Risk factors, including biomedical risk factors, are identified early.</td>
<td>Population health literacy in chronic conditions prevention, risk factor identification and healthy behaviours increases.</td>
<td></td>
</tr>
<tr>
<td>Preventive health advice considers overall risk.</td>
<td>Healthy behaviours are the cultural norm.</td>
<td></td>
</tr>
<tr>
<td>Consistent and coordinated health promotion positively influences healthy behaviour choices.</td>
<td>The evidence-base strengthens prevention policy and action.</td>
<td></td>
</tr>
<tr>
<td>Targeted health messages and education align with community concerns.</td>
<td>Product reformulation and marketing of healthy behaviours supports reduction of risk factors.</td>
<td></td>
</tr>
<tr>
<td>People with varying levels of health literacy expect to receive health advice tailored to their needs.</td>
<td>Fiscal and regulatory levers are used, where considered appropriate, to incentivise healthy behaviours.</td>
<td></td>
</tr>
<tr>
<td>People are able to navigate health information to meet their needs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individuals and communities are motivated and skilled to positively modify behaviours.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk factors for chronic conditions are promoted in non-health sectors and settings, including industry.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data collection and sharing improves health professional management of risk factors.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Example measures of progress

- Levels of risky alcohol consumption.
- Prevalence of insufficient physical activity.
- Mean population intake of salt/sodium.
- Rates of current daily smokers.
- Prevalence of raised blood pressure.
- Prevalence of overweight and obesity.
- Proportion of persons obese.
- Absolute risk for cardiovascular disease measurement and reduction in 45-74 year olds.
- Prevalence of specific preventable chronic conditions (particularly in younger age groups).
- Rates of product reformulation.
- Rates of consultation with health care providers where risk factors are the primary concern.
**Strategic Priority Area 1.2: Partnerships for health**

The physical, mental and social health of Australians can be positively or negatively influenced by the physical and social environments in which people are born, live, work, learn, play and age. The complexity and diversity of these influences means they are often positioned beyond the boundaries of the health sector. Establishing and maintaining physical and social environments that promote health and combat risk factors is essential to preventing chronic conditions.

Strong, cooperative and productive partnerships between governments at all levels, non-government organisations, the private sector, industry, researchers and academics, communities, and individuals, families and carers are crucial to successfully preventing and supporting those with chronic conditions. When partnerships are developed and are effective, the benefits can exceed those achieved when action is taken in isolation. Effective partnerships are characterised by:

- the sharing of responsibility and expertise;
- enhanced cooperation and understanding within and across sectors;
- an extended breadth and reach of communication and action;
- more efficient resourcing and reduced duplication;
- sustained, multifaceted and strategic approaches that meet the needs of identified populations; and
- mutual benefits for all Partners.

Within the health sector, partnerships can ensure consistent and coordinated national and local prevention strategies. In addition, leadership from the health sector to advocate, engage and collaborate with Partners outside of the health sector, including private health insurance and industry, can enhance efforts to establish and maintain evidence-based multi-pronged prevention approaches that meet local requirements and the needs of priority populations.

*Policies, strategies, actions and services developed under this Strategic Priority Area by relevant Partners should aim to achieve the Aspirational Outcome below.*

<table>
<thead>
<tr>
<th>Strategic Priority Area 1.2: Partnerships for health</th>
<th>Phase 1 Outcomes</th>
<th>Phase 2 Outcomes</th>
<th>Aspirational Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cross-sector partnerships promote healthy local environments and settings.</td>
<td>Action and collaboration by Partners supports the planning and creation of healthy environments.</td>
<td><strong>Aspirational Outcome:</strong> 1.2 Partnerships within and across sectors prevent chronic conditions and promote health and wellbeing.</td>
<td></td>
</tr>
<tr>
<td>Investment in prevention strategies engages multiple sectors wherever practical.</td>
<td>Regulatory and legislative changes are introduced where considered appropriate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partnerships encourage healthy behaviours and promote a healthy culture where people live, learn, work and play.</td>
<td>New, non-traditional and responsible partnerships emerge.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decision-making processes involve all Partners.</td>
<td>Responsible partnerships that promote population health and foster healthy environments are recognised as best practice.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partners build on common goals to create health promoting environments.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consistent and robust data collection and sharing occurs between relevant sectors to promote health.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Example measures of progress**

- Evidence of joint health promotion activities undertaken by responsible partnerships.
- Number of effective partnerships between Primary Health Networks (PHNs) and Local Health Networks (LHNs).
- Reach and impact of partnerships.
- Impact of partnerships on non-health settings.
Strategic Priority Area 1.3: Critical early life stages

Targeted prevention and timely interventions to address health risks earlier in life, at transition periods and during developmentally sensitive stages can reduce the risk of developing chronic conditions and can positively influence behaviour into adult life.

Different experiences and events can influence the risk of developing chronic conditions through different life stages and across generations. For example:

- maternal health and nutrition can affect infant birth weight and organ development;
- breastfeeding, nutrition, weight gain and socioeconomic factors impact physical and mental development throughout infancy and childhood;
- during childhood and adolescence, the influence of environmental and socioeconomic factors, carer responsibilities, disability, and the development of risk factors and/or unhealthy habits are critical factors that can create adverse health outcomes and impact on the development of chronic conditions; and
- the risk of developing a chronic condition due to epigenetic factors and social determinants may affect successive generations.

Prevention interventions delivered in a range of settings (e.g. GPs, schools, communities and families), using multiple strategies (e.g. educate about good nutrition, promote physical activity and discourage sedentary behaviour) can positively influence behavioural risk factors in young Australians. There is an expected positive impact of these interventions on chronic conditions in later life.

Policies, strategies, actions and services developed under this Strategic Priority Area by relevant Partners should aim to achieve the Aspirational Outcome below.

<table>
<thead>
<tr>
<th>Strategic Priority Area 1.3: Critical early life stages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1 Outcomes</td>
</tr>
<tr>
<td>Prevention opportunities targeted to critical early life stages, such as maternal health (in utero), 0-17 years and 18-24 years.</td>
</tr>
<tr>
<td>Health workforce provides antenatal, postnatal and early life support to reduce risk factors for chronic conditions.</td>
</tr>
<tr>
<td>Research better identifies the critical age points for focussed prevention interventions to reduce behavioural risk factors in adulthood.</td>
</tr>
<tr>
<td>Interventions target to multiple settings (e.g. GPs, schools, family and community), using multiple strategies, covering a range of behavioural risk factors.</td>
</tr>
</tbody>
</table>

Example measures of progress

- Proportion of babies born of low birth weight.
- Prevalence of preventable chronic conditions by age group.
- Immunisation rates for vaccines in the national schedule.
- Proportion of children with all developmental health checks (6, 12, 18 month and 4 years).
- Proportion of mothers who breastfeed exclusively to 6 months.
Strategic Priority Area 1.4: Timely and appropriate detection

Detection of chronic conditions involves assessing an individual’s risk of developing a chronic condition and detecting and diagnosing chronic conditions in a timely and appropriate manner. The concept of ‘timely and appropriate’ detection aims to avoid: over-diagnosis; over-medicalisation; unnecessary, intrusive and costly procedures; inaccurate or inconclusive test results; and high financial outlay for individuals and families.

The benefits of timely and appropriate detection, paired with appropriate follow up, include:

- an opportunity to improve an individuals’ understanding of their condition;
- delayed progression and more effective treatment or management of chronic conditions;
- reduced risk of developing additional chronic conditions, complications and/or associated disabilities;
- improved health outcomes for people with chronic conditions; and
- improved quality of life.

There are a diverse range of tools available to detect chronic conditions, ranging from population-level screening programs to individual risk assessments. Integrated risk assessments are an important tool to identify those individuals at high risk of developing a chronic condition, and when used effectively can trigger appropriate follow up processes or diagnostics to ensure timely detection. Communication and coordination between health care providers, medical services and individuals will enhance the effectiveness of chronic conditions risk assessment and detection.
Policies, strategies, actions and services developed under this Strategic Priority Area by relevant Partners should aim to achieve the Aspirational Outcome below.

<table>
<thead>
<tr>
<th>Strategic Priority Area 1.4: Timely and appropriate detection</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 1 Outcomes</strong></td>
</tr>
<tr>
<td>Health workforce delivers comprehensive health checks, referral pathways, evidence-based screening and genetic counselling as appropriate.</td>
</tr>
<tr>
<td>Information sharing and appropriate follow-up or referrals occur between health care providers across settings and sectors.</td>
</tr>
<tr>
<td>Participation in health checks, integrated risk assessments and evidence-based screening programs is promoted and encouraged for individuals or groups with an increased risk of chronic conditions.</td>
</tr>
<tr>
<td>Delivery of local targeted activities in collaboration with local or national public awareness campaigns.</td>
</tr>
<tr>
<td>People recognise their risk of developing a chronic condition and take appropriate action.</td>
</tr>
</tbody>
</table>

**Example measures of progress**

- Number of health checks completed.
- Referral rates for risk factor management or diagnostic assessment.
- Participation rates in screening programs (e.g. national cancer screening programs).
- Diagnostic assessment rate (percentage of people who returned a positive screening test, and had a follow-up diagnostic assessment)
- Time between positive screen and diagnostic assessment.
- Absolute risk for cardiovascular disease measurement and reduction in 45-74 year olds.
OBJECTIVE 2: Provide effective and appropriate care to support people with chronic conditions and optimise quality of life

What success will look like in 2025:

1. Australians with chronic conditions receive coordinated, person-centred and appropriate care.
2. Australians experience fewer complications or multimorbidities associated with chronic conditions.
3. Fewer Australians die prematurely due to specific chronic conditions (deaths in people aged under 75 years).

All Australians are entitled to effective and appropriate quality health care. The care provided to people with chronic conditions should be clinically appropriate, evidence-based, safe and accessible. Providing this care for people living with chronic conditions has numerous benefits, including:

- slowing disease progression;
- helping to prevent and delay the onset of additional chronic conditions, complications, and associated disabilities;
- improving health and wellbeing; and
- enhancing quality of life.

Effective and appropriate care improves overall health and social outcomes for people with chronic conditions, their carers and families.

People with chronic conditions also require joined-up and coordinated health care which can be complex and traverse a range of different health care providers, settings and sectors. Collaborative relationships across health sectors are also needed to strengthen continuity of care and facilitate information sharing. In addition, an adequately resourced health workforce is essential to provide care that is of a high standard to those that need them, when they need them, in a way that meets individual needs.

Addressing risk factors will also contribute to long-term management strategies for chronic conditions by helping to slow disease progression and reducing the risk of developing additional chronic conditions, complications and associated disabilities. Objective 1 addresses risk reduction in Strategic Priority Area 1.1.
The Strategic Priority Areas and Aspirational Outcomes in this Objective are as follows:

<table>
<thead>
<tr>
<th>Strategic Priority Areas</th>
<th>Aspirational Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1: Active engagement</td>
<td>2.1 People with chronic conditions and their carers are active partners in the management of their own health.</td>
</tr>
<tr>
<td>2.2: Continuity of care</td>
<td>2.2 Australians receive seamless, holistic and coordinated care across the health system to manage their chronic conditions.</td>
</tr>
<tr>
<td>2.3: Accessible health services</td>
<td>2.3 People with chronic conditions access timely, affordable, safe, appropriate and high quality health services.</td>
</tr>
<tr>
<td>2.4: Information sharing</td>
<td>2.4 Effective sharing of consistent, relevant health information and data improves performance and health outcomes.</td>
</tr>
<tr>
<td>2.5: Supportive systems</td>
<td>2.5 Health infrastructure and services better meet the needs of people with chronic conditions.</td>
</tr>
</tbody>
</table>
Strategic Priority Area 2.1: Active engagement

Active engagement means taking a person-centred approach that puts people at the centre of their own health care and empowers them to play an active role in their own health care. People with chronic conditions should not manage their health in isolation, nor play a passive role. Wherever possible, individuals need to be actively engaged in shared decision-making processes, and care partnerships need to be created between individuals and their health professionals, carers, families and communities as appropriate.

Chronic conditions have a range of potential impacts on a person's individual circumstances, including broader social, emotional and economic effects. Actively engaging people in the care of their chronic conditions allows individuals to set goals and values appropriate to their health and social needs, including advance care planning. It allows personal factors to be considered, such as home and family life, psychosocial factors, constraints caused by their ill health, participation in the workforce, economic and community contribution and participation in school and educational activities.

Decisions and behaviours required to improve health and wellbeing are often undertaken on a daily basis by people themselves. However, active engagement is more than just effective self-management. For people with complex care needs and limited capacity for self-management, active engagement in the decision-making process is especially important to enable them to work in partnerships with health professionals and gain more control over their health.

Health literacy and technology have the capacity to facilitate active engagement. Health literacy is critical to empowerment and affects people’s capacity to make good decisions about their health and health care and take appropriate action. Improving health literacy is essential to activating people in their own health care.

Improvements in technology and telehealth have the potential to enable people to take more control over their health and support person-centred care. The health workforce is a critical partner in delivering health information and services to people who have varying levels of health literacy: active engagement necessitates a health workforce with strong capabilities in effective communication techniques.

Supporting individuals to make informed decisions about their health and wellbeing can build confidence and understanding that empowers them to take action to maximise their health and maintain best quality of life at any stage of illness.
Policies, strategies, actions and services developed under this Strategic Priority Area should aim to achieve the Aspirational Outcome below.

<table>
<thead>
<tr>
<th>Strategic Priority Area 2.1: Active engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 1 Outcomes</strong></td>
</tr>
<tr>
<td>Workforce supports delivery of information and services to people who have varying levels of health literacy.</td>
</tr>
<tr>
<td>People receive sufficient and relevant information and support to learn more about their chronic conditions and its management.</td>
</tr>
<tr>
<td>People participate in the management of their chronic conditions as a recognised and valued member of the care team.</td>
</tr>
<tr>
<td>Goal setting and care planning for people with chronic conditions enhances social, economic and community engagement and supports improved quality of life.</td>
</tr>
<tr>
<td>Care plans developed and refined in partnership with patients and, where appropriate, their families and carers, are implemented through a flexible team based care approach.</td>
</tr>
<tr>
<td>Innovative care models support uptake of referrals and active self-management.</td>
</tr>
<tr>
<td>Technology supports better self-management and active engagement.</td>
</tr>
</tbody>
</table>

**Example measures of progress**

- Number of people with chronic conditions who have an established care plan.
- Self-assessed health status.
- Health literacy levels.
- Proportion of people with chronic conditions who are employed (workforce participation), undertaking educational activity (educational participation) or active in their community (community participation).
Strategic Priority Area 2.2: Continuity of care

Continuity of care is achieved by having a system that is integrated, that coordinates care for individual health needs, and that works seamlessly to provide people with timely access to the services they require.

Australia’s health system has tended to operate as a disparate set of service sectors rather than an integrated service system. Services are not always well aligned to support the ongoing care required for managing an increasing number of people living with chronic conditions. Further communication barriers can exist between the various sectors that provide care for people with chronic conditions. There is an increasing need for health sectors such as aged care, primary care, hospitals, and mental health services, to consider how integration or better coordination of services can enhance health service delivery. Innovative solutions and technology may be required to achieve this.

Most people with chronic conditions require services from multiple health care providers, often across disciplines and across different service sectors (e.g. mental health, disability services, allied health). People with more than one chronic condition require more complex care and medication management, and often experience worse health outcomes and increased health costs. Management and care for people with chronic conditions requires coordination, flexible service delivery and team-based care. This should be underpinned by a well-resourced health workforce with capacity to communicate effectively across sectors and to provide continuity of care.

A barrier to continuity of care can be transition points across the health system. Transition points occur across the lifespan, and between health care providers and services such as: hospital to primary health care and aged care; maternity to community-based care; and paediatric to adult health services. These transitions should be made navigable and as seamless as possible to prevent a decline in health outcomes.

Achieving effective, coordinated care across the health system requires concentrated effort at the system level and strong partnerships to deliver the change that is required. Utilising local or community-based approaches will also contribute to efficient and sustainable service delivery, and help to meet local needs. Overall, the most effective strategies and initiatives that support continuity of care and improve health outcomes are multifaceted and include:

- communication and support for providers and individuals;
- structural arrangements to support integration such as coordinating care for people within and between different health services; and
- strong relationships between health sectors.

Continuity of care and accessibility are implicitly intertwined: inaccessible health services can be a barrier to achieving continuity of care. Accessible health services are addressed in Strategic Priority Area 2.3. Policies, strategies, actions and services developed to improve continuity of care may also contribute towards achieving Outcomes in Strategic Priority Area 2.3, and vice versa.
Policies, strategies, actions and services developed under this Strategic Priority Area by relevant Partners should aim to achieve the Aspirational Outcome below.

### Strategic Priority Area 2.2: Continuity of Care

<table>
<thead>
<tr>
<th>Phase 1 Outcomes</th>
<th>Phase 2 Outcomes</th>
<th>Aspirational Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with multiple chronic conditions or complex care needs are supported to navigate and access coordinated care across multiple health settings and services.</td>
<td>Seamless transitions are achieved between services and across health care settings for people with chronic conditions.</td>
<td><strong>2.2 Australians receive seamless, holistic and coordinated care across the health system to manage their chronic conditions.</strong></td>
</tr>
<tr>
<td>Effective transfers/discharge pathways exist between health services, particularly between the acute and primary care settings.</td>
<td>Health services deliver well-coordinated and holistic care to people with chronic conditions.</td>
<td></td>
</tr>
<tr>
<td>Innovative funding and care models enhance coordination and flexible team-based care.</td>
<td>Standardised assessment, screening and referral processes, information exchange and care planning support efficient health workforce communication.</td>
<td></td>
</tr>
<tr>
<td>The health workforce works in flexible multidisciplinary teams to address multiple chronic conditions.</td>
<td>Health service planning addresses gaps in national and local needs.</td>
<td></td>
</tr>
<tr>
<td>Clinical care provided across the health system reflects evidence-based best practice guidelines.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effective communication pathways are established within and across health services, settings and sectors.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A universal electronic health record (My Health Record) is used to securely share health information between people and their health care providers.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Example measures of progress

- Discharge plans for complex care needs within 5 days of discharge.
- Uptake and use of My Health Record.
- Waiting times for services (e.g. elective surgery, EDs, GPs, public dental services).
- Patient experience of the health system.
Strategic Priority Area 2.3: Accessible health services

Accessible health services are those that are physically available, affordable, appropriate and acceptable\(^40\). In 2009, the National Health and Hospitals Reform Commission found that fragmentation in the health system leads to uneven access to services and quality of care\(^41\).

People with chronic conditions should receive the right care, at the right time, in the right place, by the right team. They need access to a broad range of health services across a variety of settings, and often require flexibility in service provision to allow quality, culturally safe and appropriate care, when it is most needed. Currently, this requires navigation of an overly complex health system that can create barriers to access.

Improving people’s access to health information and their capacity to use it effectively will improve individual health literacy and assist individuals to navigate the health system. Technology, telehealth, and digital technology can be harnessed to provide flexible, accessible health services that are responsive to individual needs. This may include utilising non face-to-face services where clinically appropriate, enabled by telephone, videoconferencing or other digital health platforms. Used effectively and appropriately, technology can improve communication and information sharing and enhance collaboration across health settings and services.

A well distributed health workforce is crucial for accessibility and must be supported to provide timely, high-quality and safe health care across the health system.

Inaccessible health services can negatively impact continuity of care. Policies, strategies, actions and services developed to achieve Outcomes in Strategic Priority Area 2.2 (Continuity of care) may contribute towards achieving Outcomes in Strategic Priority Area 2.3 (Accessible health services), and vice versa.
Policies, strategies, actions and services developed under this Strategic Priority Area by relevant Partners should aim to achieve the Aspirational Outcome below.

<table>
<thead>
<tr>
<th>Strategic Priority Area 2.3: Accessible health services</th>
<th>Phase 1 Outcomes</th>
<th>Phase 2 Outcomes</th>
<th>Aspirational Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information about how and when to access health services is readily available and provided to people in an appropriate manner through a range of mechanisms.</td>
<td>Coordinated action minimises access barriers, particularly in communities experiencing inequitable health outcomes.</td>
<td>2.3 People with chronic conditions access timely, affordable, safe, appropriate and high quality health services.</td>
<td></td>
</tr>
<tr>
<td>Technological improvements broaden access to health services, including through appropriate use of telehealth and digital health options.</td>
<td>Australians quickly and readily navigate the health system through a range of innovative options (physical and/or supported by technology).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The health workforce is suitably trained, resourced and distributed to meet areas of need.</td>
<td>Flexible service delivery and care teams are available to areas and populations with the greatest access barriers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The health workforce works to its full scope of practice.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Innovative and flexible service provision options encourage enhanced access to health information and services.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Example measures of progress**

- Number of potentially avoidable hospitalisations due to specific chronic conditions or their complications.
- Waiting times for services (e.g. elective surgery, EDs, GPs, public dental services).
- Patient experience of the health system.
- Out-of-pocket costs as a proportion of service cost.
- Number of people deferring recommended treatment due to financial barriers.
- Number and type of health workers employed in rural and remote locations, or where access barriers are known to exist.
Strategic Priority Area 2.4: Information sharing

Quality information is a prerequisite for an efficient and effective health system that provides safe, evidence-based care. Data and research need to be connected at the system and population levels to facilitate better exchange of health information, improve collection and sharing of reliable and accurate data, and build the evidence base. Information collection and sharing is critical to building the evidence base to inform prevention, provide effective and appropriate care, and identify and better target priority populations.

Readily available, quality data and relevant research findings are also needed to inform continuous quality improvement processes, avoid duplication of effort and fragmentation in health information and data, and improve the safety and quality of care delivered.

Further, improved data capture, availability and coordination is needed to enable a clearer understanding of the health, social and economic impacts of chronic conditions, and, in turn, better support efforts to identify the most effective and efficient means of preventing and managing chronic conditions.

Quality information, as well as knowledge exchange and translation, is needed to grow the evidence base, support new and innovative solutions, and identify successful, clinically safe strategies for the prevention and management of chronic conditions at the individual, local, state and national levels. This requires more transparent health information and data, and quality information sharing and data linkage, to generate strong evidence and understand the bigger picture.

Policies, strategies, actions and services developed under this Strategic Priority Area by relevant Partners should aim to achieve the Aspirational Outcome below.

<table>
<thead>
<tr>
<th>Strategic Priority Area 2.4: Information sharing</th>
<th>Phase 1 Outcomes</th>
<th>Phase 2 Outcomes</th>
<th>Aspirational Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Effective data sharing occurs across health settings, services and sectors, such as acute and primary care settings, aged care, disability and mental health services.</td>
<td>A connected health system has timely and secure access to accurate health information and data.</td>
<td>2.4 Effective sharing of consistent, relevant health information and data improves performance and health outcomes.</td>
</tr>
<tr>
<td></td>
<td>A universal electronic health record (My Health Record) is used to securely share health information between health care providers.</td>
<td>Real-time, secure data sharing occurs across the health system and between all Partners as appropriate.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The health workforce uses health information effectively, including informing quality improvement processes.</td>
<td>Quality, transparent data and research findings are readily available and drive new evidence-based solutions.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consistent data collection meaningfully informs the design, innovation and continuous quality improvement of services and policy at national and local levels.</td>
<td>Research findings inform new solutions to service delivery that respond to changing population needs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Relevant and robust research, knowledge exchange and translation occurs to strengthen the evidence-base and support new and innovative solutions.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Example measures of progress

- Evidence of continuous quality improvement processes in health service delivery.
- Uptake and use of My Health Record.
- Improved data linkage between existing health data sets.
- Evidence of new and innovative policy and service delivery solutions that improve performance and health outcomes.
Strategic Priority Area 2.5: Supportive systems

With the increasing number of people with chronic conditions and multimorbidities, it is becoming increasingly important that health infrastructure and services are designed to support the needs of people with chronic conditions.

Current health reforms are already going some way to implement the change required to enable the health system to respond more effectively to chronic conditions and their complications. Proposed new models of primary health care, innovative funding models, incentive payments, and reforms to Medicare, are some of the more recent developments. However, creating systems that better support people with chronic conditions is not necessarily the responsibility of the health sector alone.

People with chronic conditions often require support from services outside of health (e.g. social services, transport, flexible workplace arrangements, clustering of medical services etc). Consultation between relevant Partners and people with chronic conditions is essential to identify these requirements, and to design, plan and implement innovative solutions to optimise the ways in which these services support the health system. This will require long-term plans, collaborative partnerships across sectors, coordinated action at the local, state and national levels, and strong governance arrangements to ensure that funders, providers, communities and individuals are engaged in the process.

The health sector can lead by engaging Partners from within and external to the health sector, working within the boundaries of current political directions and community governance arrangements.

*Policies, strategies, actions and services developed under this Strategic Priority Area by relevant Partners should aim to achieve the Aspirational Outcome below.*

<table>
<thead>
<tr>
<th>Strategic Priority Area 2.5: Supportive systems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 1 Outcomes</strong></td>
</tr>
<tr>
<td>The health sector responsibly engages relevant Partners to lead and assist the planning of necessary health infrastructure, and influence planning and delivery of external services.</td>
</tr>
<tr>
<td>Coordinated action reduces duplication and improves efficacy of health services.</td>
</tr>
<tr>
<td>Continued commitment to health reforms that aim to more effectively respond to chronic conditions.</td>
</tr>
<tr>
<td>Collaborative research partnerships examine cross-sectoral issues and inform evidence-based responses.</td>
</tr>
</tbody>
</table>

**Example measures of progress**

- Implementation of health reforms e.g. Healthier Medicare reform package.
- Uptake and use of My Health Record.
- Evidence of responsible partnerships that work to meet the needs of people with chronic conditions.
- Evidence of innovative models of care, and funding models, that better meet the needs of people with chronic conditions.
- Patient experience of the health system.
- Number of potentially avoidable hospitalisations due to specific chronic conditions or their complications.
OBJECTIVE 3: Target priority populations

What success will look like in 2025:

1. Priority populations have reduced risk of developing a chronic condition and are as healthy as other Australians.
2. Priority populations experience fewer complications or multimorbidities associated with chronic conditions.

Chronic conditions impact all Australians, but some populations are disproportionately affected due to a range of physical, social and other factors. This is demonstrated by a higher prevalence of chronic conditions and a greater burden of disease in these priority populations, resulting in inequitable health outcomes.

Priority populations include:
- Aboriginal and Torres Strait Islander communities;
- people from culturally and linguistically diverse (CALD) backgrounds;
- older Australians;
- carers;
- people experiencing socio-economic disadvantage;
- those living in rural and remote locations;
- those living with a disability or a mental illness; and
- those who are incarcerated.

Whole-of-population approaches to prevention and management (included under Objectives 1 and 2) are for all Australians, including priority populations. Given the disproportionate burden experienced by priority populations, targeted action is also required to ensure that they receive high quality and safe health care and information, and experience equitable health outcomes. The health system at all levels must be responsive to the specific needs of priority populations to effectively address chronic conditions through:
- delivery of culturally safe and appropriate services;
- provision of accessible health services that are effective, high quality and affordable;
- flexible service provision; and
- recognition of the urban, regional, rural and remote diversity of Australia.

The Strategic Priority Areas and Aspirational Outcomes in this Objective are as follows:

<table>
<thead>
<tr>
<th>Strategic Priority Areas</th>
<th>Aspirational Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1: Community &amp; culture</td>
<td>3.1 Strong communities and culturally appropriate health services improve health outcomes for people at risk of, or with, chronic conditions.</td>
</tr>
<tr>
<td>3.2: Targeted action</td>
<td>3.2 Targeted action for priority populations reduces health inequities and improves health outcomes associated with chronic conditions.</td>
</tr>
</tbody>
</table>
**Strategic Priority Area 3.1: Community and culture**

A person’s culture informs their views of health and wellbeing, and their preferences for health care, treatment options and service delivery. Communities have an important role to play in identifying local health needs for people with chronic conditions, and in providing leadership and support to ensure that these needs are met.

Health services should be culturally safe and appropriate to meet the social, cultural, and linguistic needs of people and communities to reduce disparities in health outcomes. Culturally appropriate health services:

- respect the culture, knowledge and experience of individuals, families and communities;
- are flexible to meet local needs and, as appropriate, are provided at the local level to minimise the need for people to move away from their family, community and cultural home;
- are supported by a culturally competent health workforce that understands the different values, beliefs and priorities associated with social, emotional and cultural wellbeing, and who have the ability to work effectively in cross-cultural situations; and
- engage individuals and communities to empower them as active participants in the prevention and management of chronic conditions.

Empowerment is the process by which people gain control over the factors and decisions that shape their lives and is achieved through communication and consultation. It implies community ownership and action. Communities should be empowered to identify local health needs and be engaged in the development and implementation of innovative, locally responsive health services that meet the specific needs of their community.

Responsible partnerships, combined with strong community leadership and advocacy can optimise access, quality and sustainability of culturally appropriate health services to address chronic conditions.

Investment in community empowerment and culturally safe and appropriate services will build stronger more resilient communities, improve social and emotional wellbeing, promote healthy behaviour, and help to realise a shift in community culture around what constitutes “healthy” behaviour.
Policies, strategies, actions and services developed under this Strategic Priority Area by relevant Partners should aim to achieve the Aspirational Outcome below.

<table>
<thead>
<tr>
<th>Strategic Priority Area 3.1: Community and culture</th>
<th>Phase 1 Outcomes</th>
<th>Phase 2 Outcomes</th>
<th>Aspirational Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local community knowledge informs health promotion initiatives targeted to meet different social and cultural needs.</td>
<td>Culturally safe and locally responsive health services for people with chronic conditions are accessible within communities.</td>
<td>3.1 Strong communities and culturally appropriate health services improve health outcomes for people at risk of, or with, chronic conditions.</td>
<td></td>
</tr>
<tr>
<td>Resources are directed to support culturally safe health services.</td>
<td>Services are delivered in a culturally safe way involving people from the same cultural background.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flexible services provide local solutions to community needs.</td>
<td>Communities are engaged in research specific to their cultural and/or population health needs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information and technology better support local needs.</td>
<td>Health workforce effectively engages with diverse communities in a culturally appropriate manner.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The cultural competency of the health workforce is strengthened.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policies, resources and processes reduce cultural and linguistic barriers for people and communities.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Culturally appropriate programs and initiatives enhance personal and community empowerment and build more effective health service delivery.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communities engage in the planning, design and implementation of locally responsive and culturally appropriate services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Targeted programs for individuals and families, combined with population-level support, increase access to culturally appropriate health services.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Example measures of progress**

- All previous example measures of progress, disaggregated (where possible) by: age, sex, geographic location, socioeconomic status, indigenous status, CALD status or those with a disability, mental illness or multimorbidities or carer responsibilities.
- Evidence of community consultation in addressing local health needs.
- Number and type of health workers employed in rural and remote locations, or where access barriers are known to exist.
- Number of Aboriginal and Torres Strait Islander health staff actively working in communities.
- Number and type of health resources available in different languages.
Strategic Priority Area 3.2: Targeted action

Priority populations are disproportionally impacted by chronic conditions due to the higher prevalence and greater burden of disease amongst these populations. Not only do people within priority populations have a higher risk of developing a chronic condition, they are also more likely to experience inequitable care, more rapid progression of their chronic condition and have higher rates of associated hospitalisation and death\(^4^5\). Targeted action is needed to reduce this gap in health equity. Targeted actions aimed at a population sub-group should take into account the sub-group’s shared characteristics to more effectively meet their specific needs.

The inequity in health outcomes in priority populations is the result of a complex interaction between the physical environment, social determinants and other factors, including individual behavioural risk factors.

Targeted actions for priority populations are required to:

- reduce access barriers to appropriate health information and high-quality, safe health services, including addressing health literacy;
- improve screening and detection for those at high risk of developing chronic conditions;
- offer health services that are relevant, timely, accessible, affordable and respectful;
- better match services for individual needs; and
- support the health workforce to better meet the health needs of priority populations.

Targeted delivery and/or appropriate adaptation of evidence-based initiatives designed for the wider population, as well as purpose-built policies, strategies, actions and services, are effective mechanisms for addressing chronic conditions in priority populations.

Due to the disparity in health outcomes for priority populations, equal focus is not sufficient: greater investment and sustained efforts are required to positively advantage priority populations and achieve equitable health outcomes.
Policies, strategies, actions and services developed under this Strategic Priority Area by relevant Partners should aim to achieve the Aspirational Outcome below.

### Strategic Priority Area 3.2: Targeted action

<table>
<thead>
<tr>
<th>Phase 1 Outcomes</th>
<th>Phase 2 Outcomes</th>
<th>Aspirational Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interventions target priority populations and reduce their risk of developing a chronic condition.</td>
<td>Evidence-based interventions are tailored to priority populations to actively improve equity.</td>
<td>3.2 Targeted action for priority populations reduces health inequities and improves health outcomes associated with chronic conditions.</td>
</tr>
<tr>
<td>Evidence-based health promotion and education targets the needs of priority populations.</td>
<td>Priority populations are positively advantaged in preventing and managing chronic conditions.</td>
<td></td>
</tr>
<tr>
<td>Targeted consumer information and education enables self-management where appropriate and encourages engagement with health services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate health services are accessible to priority populations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Targeted programs for individuals and families, combined with population-level support, increase access to appropriate health services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health workforce distribution and scope of practice meet the needs of priority populations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate collection and use of information and data better supports priority populations.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Example measures of progress

- All previous example measures of progress, disaggregated (where possible) by: age, sex, geographic location, socioeconomic status, indigenous status, CALD status or those with a disability, mental illness or multimorbidities or carer responsibilities.
- Life expectancy in priority populations relative to the general population.
- Infant/young child mortality rate in priority populations relative to the general.
REFERENCES


