Government of **Western Australia**
Department of **Health**

WA Chronic Conditions Outcomes Framework

Consultation Draft

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Acknowledgement

We acknowledge the Traditional Owners of the lands and waters across Western Australia on which this consultation took place, in particular the Whadjuk Noongar Custodians. We respect the sharing and application of Aboriginal knowledge and approaches in all of the work we do, individually and collectively.

Use of the term Aboriginal

Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander in recognition that Aboriginal people are the original inhabitants of Western Australia. Aboriginal and Torres Strait Islander may be referred to in the national context and Indigenous may be referred to in the international context. No disrespect is intended to our Torres Strait Islander colleagues and community.

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Introduction

Chronic conditions are the leading cause of illness, disability and death in Australia.[1] The impacts on quality of life, as well as the ongoing financial cost of chronic conditions, for individuals, their families, health systems, and communities, are profound and well established. With Australia's ageing population, a continued increase in the prevalence of chronic conditions is anticipated, and the significant burden will only increase without targeted investment in effective, coordinated approaches and interventions.[2,3]

A framework of this nature is designed to support the delivery of coordinated approaches and interventions, as well as address many of the insufficiencies in care regularly experienced by people living with chronic conditions, such as:

- difficulty finding services
- difficulty accessing services due to language, financial or remoteness barriers
- feelings of disempowerment, frustration and disengagement when seeking to connect with services
- a fragmented system, with providers and services working in isolation from each other
- service duplication, and at other times, absent or delayed services
- a low uptake of digital health and other health technology by providers, which may help to address some barriers.[4,5]

These indicate that our current health system is not optimally set up to effectively manage long-term conditions.[5]

The health needs of people living with or at risk of chronic conditions change over time and often require support from many health professionals. This framework outlines common goals, providing strategic guidance to bring together diverse health services. It is hoped that through collective efforts, the experience of accessing and receiving chronic conditions care, including navigating and transitioning between services through the life trajectory, will become easier for people living in Western Australia.

Purpose

The purpose of this Chronic Conditions Outcomes Framework (hereafter, the Framework) is to provide overarching policy guidance to inform localised and collective action to improve prevention and management of chronic conditions in Western Australia (WA).

The Framework aims to:

- improve program and service planning, coordination and delivery
- guide investment through strategic commissioning and procurement
- provide guidance for how community-level programs and services can align with state-level priorities and outcomes

These outcomes, developed through broad consultation, provide a shared understanding of the most critical changes we want to see for people living with or at risk of chronic conditions.

The Framework has been developed to align with and reinforce other key policies. The WA Health Promotion Strategic Framework 2022-2026 (HPSF) provides

contemporary policy direction for the prevention of chronic conditions and injury with a focus on priority risk factors and primary prevention.[6] This Framework complements the HPFS by focusing on secondary and tertiary priority outcomes across the prevention of chronic conditions.

The Sustainable Health Review (SHR) provides important strategic direction for this Framework.[7] Its implementation lays the foundations for achieving the outcomes described within this Framework, for example supporting the enablers of person-centred and sustainable care across the health system.

The Australian Government's National Strategic Framework for Chronic Conditions also sets overarching direction to inform the development of policy regarding the prevention, early intervention and management of chronic conditions in our WA context.[4] Section 4 provides further detail regarding the alignment of this Framework with other relevant strategic policies.

Audience

This Framework is intended for use by the WA health system, as well as primary and community health sector partners who choose to use it and whose work contributes to the collective goals of preventing and/or managing chronic conditions.

These include the Department of Health and Health Service Providers (HSPs), chronic condition peak bodies, Aboriginal Community Controlled Health Organisations, other primary and community mental and physical health agencies and organisations, and the WA Primary Health Alliance (WAPHA).

There are also stakeholders working outside the health sector whose work contributes to improving outcomes for people living with or at risk of chronic conditions in relation to the broader social determinants of health. These include but are not limited to, local governments, social care services, and education and research institutions. This Framework recognises the importance of this work and how outcomes can only be achieved collectively by all stakeholders.

This Framework is relevant for these many diverse stakeholders, as a resource for informing and influencing practice, supporting partnerships and enhancing coordinated and integrated ways of working together.

Chronic Conditions defined

This Framework adopts a broad definition of chronic conditions based on shared characteristics, as reflected in the Australian National Strategic Framework for Chronic Conditions[1] (National Strategic Framework). This includes physical and mental conditions that:

- have complex and multiple causes
- may affect individuals either alone or as multimorbidities
- 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
- are not usually immediately life threatening, however are the most common and leading cause of premature mortality.

As reflected in the National Strategic Framework, this broad definition moves away from a condition-specific focus to emphasise the collective needs of people living with or at risk of chronic conditions. This helps to bring focus to ways we can improve the overall systems and processes of our health sector, which may then support improvements in condition-specific prevention and management.

The Framework

This Framework is designed to unify a diverse range of activities and interventions around a central vision and set of outcomes. The headline outcomes are anchored in the experience for the health consumer, while the sub-outcomes point to the supporting system improvements required. This Framework is supported by a set of guiding principles that are critical for ensuring quality care for all.

Overview

Suggested strategies are provided in Appendix 1 as a supporting resource.

Vision

Through timely and effective chronic conditions prevention and care, all Western Australians live with the highest quality of health and wellbeing possible throughout their lives.

Guiding principles

Based on consultation, research and available evidence, five guiding principles have been identified to enable the successful prevention and management of chronic conditions. These principles should be recognisable in the planning, design and implementation of policies, strategies, actions and services aimed at preventing and/or managing chronic conditions.

Person-centred care:	Empower people, carers, families and communities by keeping their needs and context at the centre of service design and delivery.
Life course:	Identify, acknowledge and respond early to the changing health needs of individuals, families and communities over the life course.
Health equity:	Ensure equity of access to services and supports, particularly for priority populations.
Integration and service coordination:	Integrate, coordinate and partner in the design and delivery of services and supports across the health sector and beyond.
Systems approach:	Recognition and provision of supporting structures and processes to support a systems approach, that aligns with the social model of health with a focus on social determinants.

Priority populations

There are a number of population groups within our WA community who are disproportionately impacted by chronic conditions, resulting in health inequities. The priority populations for this Framework align closely with those identified in the National Framework, and include:

- Aboriginal people
- Culturally and Linguistically Diverse people (CaLD)
- People with disability
- Older adults, as defined for Aboriginal people as over 45 years of age and non-Aboriginal people over 65 years of age[i]
- People living in remote, rural and regional locations
- People experiencing socio-economic disadvantage
- People from the LGBTIQA+ community
- Carers of people living with chronic conditions.

The health system must respond to the needs of these priority population groups to provide the health care needed to help manage and prevent chronic conditions. It is important to recognise that people's experiences often intersect across population groups, therefore increasing the number of barriers to overcome in accessing health care.

As the National Preventative Health Strategy 2021-2030 states:

> "*The needs of each group are diverse and there is no one size fits all approach to improving health equity and the communities' overall health outcomes. People may identify as belonging to one or more of these population groups, and as such, may have compounding health and wellbeing experiences that must be considered. It is also important to recognise that these population groups all have inherent strengths and resilience. Many people who identify within these groups are thriving in spite of the challenges they face. Shared decision-making, strategic partnerships and involving people with lived experience at the heart of policy development and implementation are key to creating meaningful change.*"

[i] Aboriginal Western Australians experience significantly higher rates of and earlier onset of chronic conditions, in some cases up to 20-years earlier than non-Aboriginal people.[7]

Headline Outcome 1: Equity and access

People living with or at risk of chronic conditions can access the care and support they need, regardless of their location, cultural background or life context.

Often the people and communities most at risk of chronic conditions and associated complications face barriers to accessing health care, and compared to the general population, are less likely to be able to find safe, appropriate supports at the right time. Social and structural inequities experienced by these populations are associated with poorer health outcomes and higher chronic conditions prevalence.

At all levels of health care planning and delivery, an equity focus is required to enable services to be more inclusive by providing appropriate and accessible health care options for all WA communities. This requires targeted investment to support communities and priority populations where needs are greater.

Headline Outcome 1	Sub-outcomes
People living with or at risk of chronic conditions can access the care and support they need, regardless of their location, cultural background or life context.	1.1) Consumers and their support people have the ability to access services supporting self-management, including mental health supports. 1.2) Services provide timely access to appropriate support through a range of service delivery modes and offer choice in how people engage to suit varying needs and preferences. 1.3) Information regarding chronic conditions programs, services and patient pathways is readily accessible to consumers and health professionals, including priority populations. 1.4) Clear pathways exist to connect people to and between appropriate services across the care continuum, including community and primary care services. 1.5) Aboriginal people and people with CaLD backgrounds can access culturally responsive support and health care throughout WA.

See Appendix 1 for suggested strategies (page 32).

Headline Outcome 2: Strong workforce

People living with or at risk of chronic conditions partner with skilled health workers from a variety of disciplines, who have a holistic approach to care.

A person's experience of receiving health care, and their inclination to continue to receive care, will be greatly impacted by their interactions with the health workforce and the quality of care they receive. In a health care environment, it matters that a health professional has the skills and capability to apply a person-centred holistic approach, to enable them to engage in a meaningful way clinically. This includes understanding how a persons' circumstances influence and impact their health and wellbeing, and the management of risks and their condition(s).

This outcome area recognises that high-quality care requires ongoing investments in the health workforce. Investment is required to strengthen capacity and capability through effective recruitment and retention strategies, as well as ongoing training and education opportunities. A multidisciplinary, skilled and agile workforce will enable better care for our diverse WA community members. At all levels, management systems, policy and processes are also critical for enabling health care workers sufficient time and support required to practice high-quality, person-centred health care.

Headline Outcome 2	Sub-outcomes
People living with or at risk of chronic conditions partner with skilled health workers from a variety of disciplines, who have a holistic approach to care	2.1) All health workers are skilled in person and family-centred, trauma-aware and healing-informed care and are trained to be inclusive and culturally responsive. 2.2) The workforce is skilled in the application of prevention principles, across the life course, and are supported to apply targeted preventive approaches. 2.3) Health workers are appropriately trained in best practice, evidence-based care for chronic conditions, and have access to ongoing training opportunities. 2.4) Workplace culture and environments are empowering, supportive and value staff. 2.5) Health services allow health workers time to meaningfully engage with people in a holistic and person-centred way. 2.6) Health care is delivered across metropolitan, regional and remote WA, by a qualified workforce with the required expertise, skills, capability and specialisations to meet health care needs. 2.7) Aboriginal communities have access to a highly skilled and capable Aboriginal health workforce.

See Appendix 1 for suggested strategies (refer page 33).

Headline Outcome 3: Integration, coordination and partnerships

People living with or at risk of chronic conditions can better manage their health in partnership with health professionals through effective care provision and connections to programs and services.

People living with chronic conditions often require varied and ongoing support across hospital, primary and community health care settings. Navigating multiple health services and settings can create a stressful, fragmented experience, especially if the interface between services (for example, the data systems, referral systems and patient pathways) are not well developed. When transitions between services are burdensome and confusing, disengagement with and avoidance of health services is more likely. This can exacerbate health impacts, and lead to hospital presentations which may otherwise have been avoided through care in primary and community care settings.

This outcome area recognises that providers can prevent people falling through the gaps by supporting consumers with navigating and transitioning between services. Facilitating efficient consumer journeys through the health system can contribute to improved health outcomes and more sustainable use of resources across the health sector. When effective partnerships are in place, services are more able to provide consumers with choice, flexibility, a reduced reliance on hospital services. Opportunities for greater coordination and integration should be prioritised and reflected in service planning and design.

Headline Outcome 3	Sub-outcomes
People living with or at risk of chronic conditions can better manage their health in partnership with health professionals through effective care provision and being directed to programs and services.	3.1) People with lived experience are active partners in the planning, design, delivery and evaluation of patient pathways and integrated services, and are empowered to participate in shared decision-making. 3.2) Effective partnerships and collaborations across the health sector (including primary, community and hospital settings) support coordinated and integrated care arrangements. 3.3) Seamless patient journeys between services and providers are enabled by efficient data sharing, communication and information technology systems. 3.4) Health professionals have knowledge of available community and social support services, and the capability to identify and refer to suitable services 3.5) Health service providers work in partnership with Aboriginal Community Controlled Health Organisations, local Elders and community leaders to support integrated care and seamless patient journeys for Aboriginal people. 3.6) Priority population community groups, such as CaLD, inform and are integrated with patient pathways.

See Appendix 1 for suggested strategies (refer page 35).

Headline Outcome 4: Prevention across the care continuum

People living with, or at risk of developing, chronic conditions are more empowered and better supported throughout their life to improve their wellbeing and, where possible,[ii] either prevent or delay the onset or progression of chronic conditions and/or associated complications.

Chronic conditions may be prevented, delayed or more effectively managed through lifestyle and behaviour change, early detection, treatment and management. Therefore, engaging with and empowering communities through resource and service provision, and supporting self-management is key to helping the population to manage the risks of chronic conditions.

This outcome area recognises that the work in both clinical and non-clinical settings is critical for improving the health of the population across the care continuum. The health sector needs to partner with the community to help identify priorities, inform service design and delivery, and distribute information so people can better understand their health, and when, where and how to seek support. The health sector needs to proactively work with each other and with other sectors, state and local government and non-government organisations across various sectors to change environmental conditions and to develop social and environmental infrastructure that can enhance health outcomes.

Headline Outcome 4	Sub-outcomes
People living with or at risk of developing chronic conditions are more empowered and better supported throughout their life to improve their wellbeing and, where possible,[iii] either prevent or delay the onset or progression of chronic conditions and/or associated complications.	4.1) Consumers benefit from early identification of, and targeted interventions for, chronic conditions and or complications through screening and general health examinations. 4.2) People, particularly priority populations, are supported to increase their health literacy to enable early identification of health risks and engagement with relevant programs and services. 4.3) Increased provision of preventative interventions across the care continuum to reduce condition development, progression, and hospital presentation and, or admission. 4.4) People are empowered and supported to better self-manage their condition(s), recognising that all people with chronic conditions are self-managing within the context of their life circumstances and capacity. 4.5) Cross-sector initiatives between state, local government and NGOs improve social and environmental conditions to prevent the incidence or progression of chronic conditions.

[ii] Acknowledging that not all chronic conditions have preventable onset or progression, and that supporting wellbeing can prevent complications for a large proportion of the population living with chronic conditions.

[iii] Acknowledging that not all chronic conditions have preventable onset or progression, and that supporting wellbeing can prevent complications for a large proportion of the population living with chronic conditions.

	4.6) People are empowered and supported to establish and communicate their goals of care across the care continuum, including end of life.[iv]

See Appendix 1 for suggested strategies (refer page 37).

[iv] Acknowledging that end of life care needs can be greater and more complex for people with chronic conditions, and more advanced planning may be required to provide appropriate palliative care.

Headline Outcome 5: Ongoing improvement of care

People living with or at risk of chronic conditions benefit from ongoing improvements in care, informed by lived experience and research, and supported by innovation and technology.

Understandings of best practice for addressing chronic conditions, both the causes and management, are dynamic. Despite specialist academic knowledge being increasingly available, technological tools becoming more accessible and user friendly, and consumer preferences increasingly amplified through lived experience voices, this does not always translate into changes on the ground. As a result, consumers can miss the opportunity to benefit from emerging evidence and innovation.

This outcome area recognises that to improve chronic conditions prevention and management, we must establish new understandings of best practice, through ongoing support for research, technological development and engaging lived experience expertise. Data collected must be utilised in productive ways to enhance the effectiveness of systems and processes. There must also be leadership support to translate findings into new and effective ways of working, and to help overcome organisational risk and change adversity.

Headline Outcome 5	Sub-outcomes
People living with or at risk of chronic conditions benefit from ongoing improvements in care, informed by lived experience and research, and supported by innovation and technology	5.1) Increased access to and development of secure, user-friendly and accessible technological tools and platforms improve care and support seamless service delivery. 5.2) Data platforms are used to measure system performance and support timely identification of gaps in care. 5.3) Research informs understandings of and approaches to value-based care, and best-practice person-centred prevention and management. 5.4) Collaborative planning between the WA health system, federal government, primary and community health services, and other key partners, delivers innovative approaches to service delivery, models of care and funding. 5.5) People with lived experience are actively engaged in the planning, review and design of health services and their supporting systems. 5.6) Aboriginal communities and Aboriginal Community Controlled Health Organisations are meaningfully engaged in service design, delivery and review to support service improvement for Aboriginal communities. 5.7) Evaluation processes are integrated into service design to inform progress monitoring and quality improvement processes.

	5.8) The health system is proactive and responsive to emerging needs, by providing access to specialist services and appropriate care, informed by current research, and invests in research for new treatment approaches.

See Appendix 1 for suggested strategies (refer page 39).

Headline Outcome 6: Sustainability

People living with or at risk of chronic conditions are supported by health sector leadership, sustainable funding and governance structures that enable their health care needs to be met.

The funding realities of health care, how services are commissioned, governed and sustained, plays an important role across many of the outcomes in this Framework. For example, flexible funding models and enabling governance structures may be needed to support improvement of care, integration of services and a strong workforce. Additionally, equity and access and prevention considerations deliver better value if funding supports delivery of services where and when they are needed most, helping to reduce preventable burden for both consumers and the health system.

This outcome area highlights the funding and governance considerations that are often less visible but are nonetheless critical for supporting better chronic condition health outcomes. For instance, evidence-based decision making can help to improve equity, commissioning practices support service integration and governance practices can enable quality care. This line of sight between where resources are being allocated, and whether outcomes are being supported, or where reinvestment is needed, increases accountability for outcomes.

Headline Outcome 6	Sub-outcomes
People living with or at risk of chronic conditions are supported by a health sector with leadership, sustainable funding and governance structures that enable their needs to be met.	6.1) Governance, commissioning, and procurement practices support cross-agency collaboration and partnership, within and beyond the health sector. 6.2) Funding models support sustainable co-commissioning, enabling the design and delivery of integrated service models. 6.3) Funding allocation is focused on the areas of most need, informed by evidence and/or data. 6.4) Funding models are flexible to meet diverse community needs and are sustainable to ensure long-term provision of appropriate services. 6.5) Governance and funding models are subject to service and system evaluation processes, to support optimal use of resources. 6.6) Legislative mechanisms support Aboriginal data sovereignty, and contracted service providers to engage and involve Aboriginal communities in data sharing decision making. 6.7) Increased participation of Aboriginal Community Controlled Health Organisations, and other organisations representing priority populations, in chronic condition prevention and management service planning, design, delivery and review.

See Appendix 1 for suggested strategies (refer page 41).

Framework Implementation

Timeframe

This Framework has a 10-year duration, from 2023 to 2033. This timeframe is proportionate to the work required of the WA health system and its primary and community care partners to respond to this strategic guidance, by expanding on existing and adopting new approaches.

Ten years is required to see improvements realised, measure indications of change in the headline outcomes and sub-outcomes, and to make a positive impact towards achieving the overarching vision.

How to use this Framework

The Framework is intended to articulate the changes needed to improve health outcomes for people living with or at risk of chronic conditions. It aims to support advocacy and collective action for systems change and service improvement.

As a guide, suggested strategies have been included based on a review of current WA and national policies, plans and strategies that align with the headline outcomes. These are provided in Appendix 1 and are referenced in each case to their source documents. This may provide useful guidance in planning for localised implementation.

All stakeholders are invited to respond to this Framework based on their own context, and the best use of resources available to them in contributing to the headline outcomes.

Reporting and monitoring

This Framework is designed to identify system-wide measures and indicators. An initial scope of available data has shown that while some measures are available for specific sub-outcomes, work is needed to construct integrated data sets. This work will inform the development of processes for monitoring the Framework's implementation.

Through partnering with the Department of Health Data Management and Public and Aboriginal Health Teams, the Health Networks Unit will develop suitable indicators and/or measurement approaches, to measure the headline outcomes.

Framework context

This section details the key definitions, assumptions and documents that have informed the development of this Framework.

Strategic alignment

The Framework seeks to compliment other key strategic policy documents and draws strategies directly from these to ensure alignment.

The Sustainable Health Review Final Report (2019)[8]	Often referred to as the Sustainable Health Review or SHR, the final report was published in April 2019. Aiming to prioritise the delivery of patient-centred, high quality and financially sustainable health care across the State, it outlines eight enduring strategies and thirty recommendations to progress the sustainability agenda and identify changes required.
National Strategic Framework for Chronic Conditions (2017)[4]	The National Strategic Framework for Chronic Conditions is the overarching national policy document for chronic conditions. It sets the directions and outcomes to help Australians live healthier lives through effective prevention and management of chronic conditions.
WA Health Promotion Strategic Framework (2022-2026)[6]	The WA Health Promotion Strategic Framework, or HPSF, aims to lower the incidence of chronic conditions and injury by facilitating improvements in health behaviours and environments. It outlines priorities and a framework for action to improve the health of Western Australians.
WA Aboriginal Health and Wellbeing Framework 2015-2030[9]	The WA Aboriginal Health and Wellbeing Framework 2015–2030 was developed to ensure Aboriginal people in Western Australia have equitable access to high quality health care and services, while assisting community to make good health a priority through a focus on prevention. It is a high-level conceptual framework outlining a set of guiding principles, strategic directions and priority areas to improve the health and wellbeing of Aboriginal people in Western Australia.
WA Primary Health Alliance Population Health Strategy 2021-2023[10]	The WA Primary Health Alliance (WAPHA) is Australian Government funded to strengthen, improve and connect the primary care system. Aligned with the WA Primary Health Alliance Strategic Plan – *Better Health, Together* 2020-2023, this Strategy provides guidance in partnership with its Perth South, Perth North and Country WA Primary Health Networks (PHNs) regarding commissioning of services, promotion and prioritisation of integrated health, continuous improvement in primary health care practice, and empowering communities in relation to place-based population health outcomes.

National Health Reform Agreement (NHRA) – Long-term health reforms roadmap.[11]	to The National Health Reform Agreement 2020-2025 (NHRA) aims to improve health outcomes for all Australians and ensure our health system is sustainable The reform roadmap is an Addendum and provides a flexible approach to assist the Commonwealth, state and territory governments to achieve the priorities they have committed to.
WA Health Clinical Services Framework 2014–2024[12]	The WA Health Clinical Services Framework (CSF) continues to be the principal, government endorsed clinical service planning document for Western Australia's public health system. The CSF is designed to describe medium to long-term horizons and the strategic parameters that can be used by individual health services, hospitals and non-hospital service providers to inform and guide their individual clinical service/s plans.
WA Chronic Health Conditions Framework (2011–2016)[3]	Previous WA policy guidance for chronic conditions was provided in the WA Chronic Health Conditions Framework. This Framework has taken enduring priorities from this legacy policy to help inform the early stages of development.
WA Chronic Conditions Self-Management Strategic Framework (2011–2015)[13]	The WA Chronic Conditions Self-Management Strategic Framework provides detailed strategies to support chronic conditions self-management and promote active participation by consumers in their own health care. This Framework has taken enduring priorities from this legacy policy to help inform the early stages of development.
WA End-of-Life and Palliative Care Strategy (2018-2028)	The WA End-of-Life and Palliative Care Strategy 2018-2028 outlines that all people need access to quality care and services during their last expected year of life.
WA Disability Health Framework (2015-2025)	The WA Disability Health Framework provides direction for WA Health and its partners on policy development and service delivery to achieve improved health outcomes for people with disability.
WA Health Digital Strategy (2020-2030)	The WA Health Digital Strategy (2020-2030) aims to take advantage of the innovations transforming health care to drive better health outcomes for all Western Australians.

Prevalence

While the term ‘chronic conditions’ covers a diverse group of conditions, ten chronic conditions are the focus of prevalence data reported by the Australian Bureau of statistics (ABS).[17] These are selected because they are common, persistent, pose significant health problems, and have been the focus of ongoing national surveillance efforts. These include:

- arthritis
- asthma
- back problems
- cancer
- chronic kidney disease
- chronic obstructive pulmonary disease (COPD)
- diabetes
- mental and behavioural conditions (including mood disorders, alcohol and drug problems and dementia)
- osteoporosis
- selected heart, stroke and vascular diseases.[18]

The following chronic condition prevalence data is based on self-reported data from the ABS 2020–21 National Health Survey and indicates that:

- Almost half of Australians (47%, or 11.6 million people) were estimated to have one or more of the 10 selected chronic conditions in 2020-2021.
- Mental or behavioural conditions; back problems; and arthritis were the most common of the 10 selected chronic conditions. It is estimated that 5.0 million people (20% of the population) had a mental or behavioural condition, which was the most commonly reported chronic condition for both males and females. Back problems were the second most common, estimated at 3.9 million people (16%). 3.1 million (12%) had arthritis, with females (15%) more likely than males (10%) to have the condition.
- The most common chronic conditions varied by age group. Of the 10 selected conditions in 2020-21, mental and behaviour conditions were the most common conditions among people aged 15-44 (25%); back problems were the most common conditions among people aged 45-64 (23%) and 41% of people aged 65 and over were estimated to have arthritis.

The Health and Wellbeing Surveillance System provides population estimates for chronic conditions in WA, including arthritis and osteoporosis, heart disease and stroke, cancer, injury, asthma and other respiratory conditions, diabetes and mental health. The Health and Wellbeing of Adults in Western Australia 2021 report indicated that of these conditions, injury, mental health conditions and arthritis were the most common in 2021. The most common chronic conditions varied by age group, with mental health conditions the most common among people aged 16-44 (31.6%); injury the most common conditions amongst people aged 45-64 (27.8%); and arthritis the most common conditions amongst people 65 and over (50.7%).

Social determinants of health and chronic conditions

Chronic conditions outcomes are impacted by a range of intersecting social determinants that influence the health status of individuals, communities and populations. The World Health Organisation[19] defines social determinants as ‘the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.’

The determinants of health fall into four main categories[4]:

1. **Physical environment** such as housing, sanitation, natural and built environments
2. **Social environment** such as education, employment, political structures, relationships and culture
3. **Economic factors** such as income, expenditure and affordability
4. **Individual characteristics** such as sex, genetics and physical or mental determinants

In addition, the WA Health and Wellbeing Framework highlights the importance of the cultural determinants of health. These are inextricably linked with strong connections to culture and country which support both individual and collective identities, self-esteem, and improve outcomes across the other determinants of health. Cultural determinants include but are not limited to: self-determination; freedom from discrimination; individual and collective rights; importance and value of Aboriginal culture; protection from removal/relocation; connection to, custodianship, and use of country and traditional lands; reclamation, revitalisation, preservation and promotion of language and cultural practices; protection and promotion of traditional knowledge and Aboriginal intellectual property; and understanding of lore, law and traditional roles and responsibilities.[9]

These factors interact to influence knowledge, attitudes and beliefs; social norms and expectations; and means and opportunities.[4] This influences people's choices around health habits and behaviours, which impacts risk factors and management of chronic conditions.

While some of the determinants can be actively influenced within the health sector, addressing the health impacts caused by structural factors (such as housing affordability, poverty and unemployment) requires a coordinated approach with agencies and organisations such as social services, education and local government. Cross-sector collaboration to address social determinants has the potential to facilitate more effective and equitable prevention and management of chronic conditions.

Life Course Perspective

A life course perspective is important to this Framework because it recognises the cumulative impacts of a person's life experiences on their health and wellbeing. This perspective identifies key transition periods that can significantly influence a person's ongoing health and wellbeing, acknowledges relationships and the impacts of varied and diverse social determinants of health. Opportunities can be created within transition stages to support better health outcomes. For example, addressing health risks through prevention and early detection during developmentally sensitive periods such as early childhood can provide the foundations for better health throughout the entire life course.

This approach is particularly important when planning, delivering and reviewing services to support priority populations. The WA Aboriginal Health and Wellbeing Framework suggests a life course approach can address 'the intergenerational mechanisms that impact on health inequalities for Aboriginal people'. This perspective promotes drawing on the cultural strength of family and community to promote positive health behaviours and support good choices through the different stages of the life course.

Care Continuum

The care continuum defines the stages of health that a person may experience over their life course as part of living with one or more chronic condition, or during a period of illness. People may move forwards and backwards along this continuum as it is not necessarily a linear process. Each stage involves different experiences, in terms of:

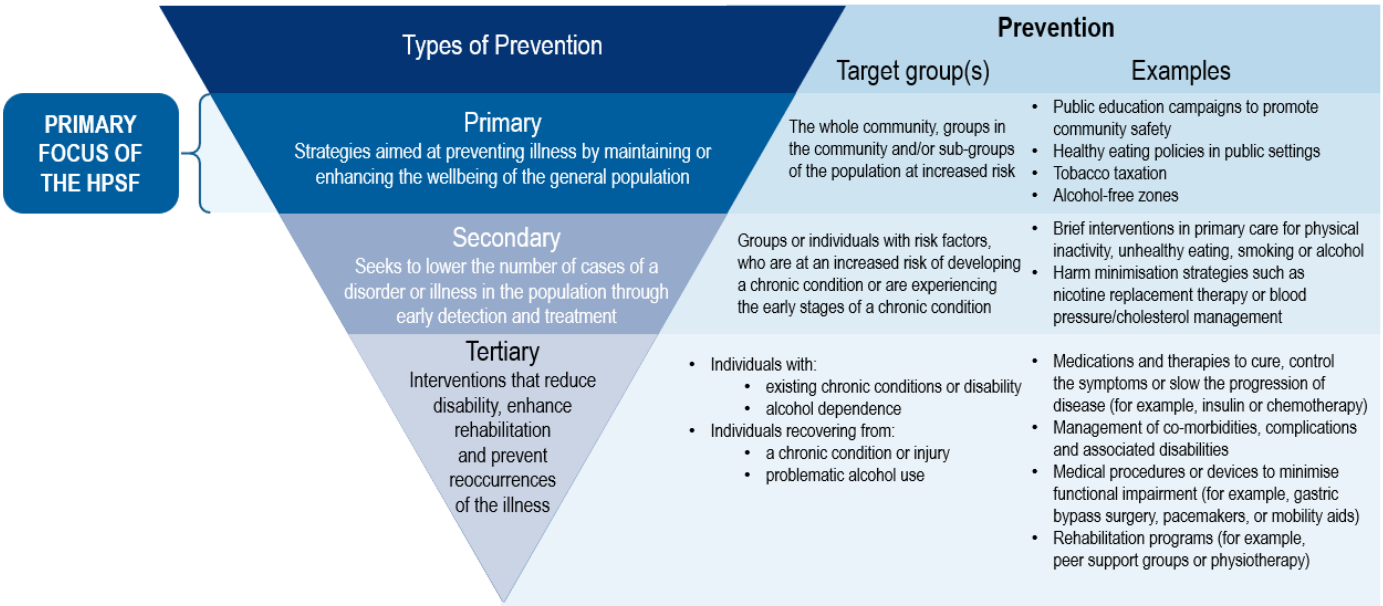
- The intensities of care provided to a person, for example, some people may only require intermittent support from a nurse practitioner, GP or other community care health professional, whereas people living with complex chronic conditions may require medication or surgical intervention, with ongoing regular check-ups by a specialist.
- The health professional groups involved, for example, from primary care to specialist involvement.
- The intervention methods, for example, education, medication or surgery.
- The outcomes focus, for example, reducing risk factors, preventing or limiting acute episodes.

Understanding the care continuum can help health professionals to support a person's chronic condition(s) journey. Providing the right care at each stage can support with, where possible, reducing the likelihood of their condition and/or complications progressing. It is also important that the end-of-life care needs and preferences of people with chronic conditions are supported through appropriate, integrated and coordinated palliative care approaches.

Prevention

Preventive approaches across the care continuum are critical to the effective prevention and management of chronic conditions. Prevention is supported in many settings by different professionals, however some of the key stakeholders include public health and health promotion, community health, primary healthcare providers and hospital and specialist care teams. The prevention needs of individuals and communities will depend on their level of risk, with increased risk requiring greater levels of intervention, management and resourcing.

Primary prevention is supported by the strategic guidance of the Health Promotion Strategic Framework, which aims to prevent the incidence of avoidable chronic conditions and injury. The HPSF diagram below outlines the target groups for different types of prevention and provides some examples.



This Framework also acknowledges the importance of primordial prevention in addressing the social determinants of health. Primordial prevention takes a whole of population approach and encompasses interventions that establish or maintain the conditions that minimise health hazards. This includes social, environmental, economic and behavioural conditions. Primordial prevention often requires cross-sector collaboration to address the socioeconomic and environmental determinants of health.

While this Framework recognises the importance of primordial and primary prevention, it aims to complement the HPSF with a focus on reducing chronic condition prevalence and impact through secondary and tertiary prevention. The vision is for implementation of this Framework, and the HPSF, to enable co-ordinated approaches to support prevention across the care continuum.

COVID-19 and emerging impacts on chronic conditions

The Framework recognises that the ongoing impacts of the COVID-19 pandemic on chronic conditions are likely to be significant. People living with chronic conditions are at increased risk of severe illness from COVID-19,[20] with potential impacts to their health, mental health and lifestyle, as well as their ability to self-manage and access quality health care. People living with chronic conditions also face potential complications as a result of COVID-19 infections.[20]

COVID-19 also poses the risk of increasing chronic condition prevalence through Long COVID. Long COVID is a complex, multi-system illness that can affect anyone even after a mild infection. According to current estimates, Long COVID affects between 5-10% of people who have had a COVID-19 infection.[21] Symptoms may persist for months following infection, or manifest as new onset chronic conditions.[21]

To support implementation of this Framework, it is important that the health sector continues to expand understandings of and responsiveness to ongoing chronic condition health care needs as a result of COVID-19.

Glossary

Aboriginal Health Practitioner	A person registered under the *Health Practitioner Regulation National Law (WA) Act 2010* (WA) with the Aboriginal and Torres Strait Islander Health Practice Board of Australia in the Aboriginal Health Practitioner or Aboriginal and Torres Strait Islander Health Practitioner profession, and whose name is entered on the register of Aboriginal and Torres Strait Islander Health Practitioners kept under that law.
Aboriginal Health Worker	An Aboriginal Health Worker provides a range of direct primary health care services and possesses as a minimum, the Advanced Certificate in Aboriginal Health Work, obtained through an accredited education provider.
Activity based funding	Activity based funding and management is a way of funding and managing public health care in WA. It means that health services are paid for every patient they see or treat, taking into account the complexity of the patient's health care needs. It provides a clear and open link between the money allocated by Government, and the health services delivered to patients and the community.[22]
Chronic conditions management	Chronic conditions management involves both self-management and clinical management by the supporting health teams. Self-management is the active participation by people in their own health care. Self-management involves: - having knowledge of the condition, - actively sharing in decision-making, - following an agreed care plan, - monitoring and managing signs and symptoms of the condition, - managing physical, emotional and social impacts - actively adopting a healthy lifestyle, and - having confidence, access and the ability to use support services. Clinical management requires an integrated care approach and includes screening, check-ups, monitoring and coordinating treatment and providing education to support self-management.[23]

Community care	The community care sector supports the physical and mental wellbeing of community members through local, community-based services.
Cross-sector	Often in reference to work, or an alliance between organisations working in different sectors, for example, the health sector and the education sector.
Cultural responsiveness	The ability of services to be respectful of, and relevant to, the health beliefs, health practices, culture and linguistic needs of diverse populations and communities. That is, communities whose members identify as having cultural or linguistic affiliations by virtue of their place of birth, ancestry or ethnic origin, religion, preferred language or language spoken at home. Cultural responsiveness describes the capacity to respond to the health care needs of diverse communities. It requires knowledge and capacity at different levels of intervention including systemic, organisational, professional and individual.[24]
Goals of care	Goals of care describe what a patient wants to achieve during an episode of care, within the context of their clinical situation. Goals of care are the clinical and personal goals for a patient's episode of care that are determined through a shared decision-making process.[v]
Health care workforce	The collection of professionals, including clinical and non-clinical, involved in delivering health care services in WA.
Health professional	A person who is a health practitioner registered under the *Health Practitioner Regulation National Law (WA) Act 2010* or is in a class of persons prescribed as a health professional under the *Health Services Act 2016.*
Health sector	The health sector comprises service providers and health professionals from a range of government and non-government organisations. Collectively they work to meet physical and

[v] Australian Commission on Safety and Quality in Health Care. Website, available at: https://www.safetyandquality.gov.au/our-work/comprehensive-care/essential-elements-comprehensive-care/essential-element-2-identifying-goals-care#:~:text=Goals%20of%20care%20describe%20what,a%20shared%20decision-making%20process.

	mental health care population needs.[vi] It will include hospitals and tertiary clinics that provide specialist care, GPs, dentists and community nurses, pharmacists and midwives, as well as community groups that help to facilitate health promoting behaviours in the community.
Incidence	The number of new cases (of an illness or event) occurring during a given period.
LGBTIQA+	'LGBTIQA+' is an evolving acronym that stands for lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual. There are many other terms (such as non-binary and pansexual) that people use to describe their experiences of their gender, sexuality and physiological sex characteristics.
Life context	Life context refers to the circumstances in which people manage their health and wellbeing. These include the key people in their life, their community, their age and their individual needs.
Lived experience	People with lived experience of chronic conditions can have personal experience of living with a chronic condition, or experience as a carer or support person. This term is broader than consumers as it can include members of the workforce with lived experience, and people that are living with chronic conditions that aren't interacting with health services.
Multimorbidity	Multi-morbidity is the presence of two or more chronic conditions in a person at the same time.[20?]
Person-centred care	The person-centred approach recognises each person as an individual human being, and not just as a condition to be treated. It involves seeking out and understanding what is important to the person, their families, carers and support people, fostering trust and establishing mutual respect. It also means working together to share decisions and plan care. There is good evidence that person-centred care can lead to improvements in safety, quality and cost-effectiveness of health care, as well as improvements in patient and staff satisfaction.[25]

[vi] Australian Institute of Health and Welfare. (2022). Health system overview. Retrieved from: https://www.aihw.gov.au/reports/australias-health/health-system-overview

Prevalence	A measure of the total number of people in a specific group who have (or had) a certain disease, condition, or risk factor (such as smoking) at a specific point in time or during a given period of time; regardless of when they first developed the characteristic.
Primary care	Primary health care includes a broad range of activities and services, from health promotion and prevention, to treatment and management of acute and chronic conditions. Primary health care services are delivered in settings such as general practices, community health centres and allied health practices.
Service providers	Broadly defined as organisations or agencies providing or managing a service, including Health Service Providers, non-government organisations, and private providers.
Social determinants of health	The conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.[19]
Social model of health	A social model of health recognises health as a dynamic construct influenced by the social determinants of health, culture, historic context, as well as a person's individual factors such as biology and genetics. It identifies the importance of the individual as a social being, part of a wide social network and community who is continually influencing and influenced by their social circumstances and environment. In practice, delivering a social model of health means understanding the social determinants of health and seeing a person' or family's social context as relevant to their medical presentation, referral and follow up process, and case management. In designing and planning health services and systems, using a social model of health means focussing on the holistic interaction between the various areas of the social model rather than addressing them as separate aspects of the individual or environment, or managing them in silos across separate agencies.[26-28]
Systems approach	A systems approach improves health by considering the multiple elements involved in caring for patients and the multiple factors influencing health. By understanding how these elements operate independently, as well as how

	they depend on one another, a systems approach can help with the design and integration of people, processes, policies, and organizations to promote better health at lower cost.[29]
Trauma- aware, healing-informed practice	An approach that understands the impact of individual and collective experiences of trauma on people, families, and communities, while using strengths-based care and support solutions that focus on individual and collective healing from trauma. This approach can be used at an individual practice level as well as used to frame the governance, processes, and policies of entire organisations.[30]
Value based health care	The measured improvement in a patient's health outcomes for the cost of achieving that improvement.[31]
WA health system	The WA health system is comprised of the Department of Health; Health Service Providers; and to the extent that contracted health entities provide health services to the State, the contracted health entities. (Section 19. (1) of the *Health Services Act 2016* p.17).

Appendix 1: Suggested strategies

Headline Outcome 1 - Equity and access

People living with or at risk of chronic conditions can access the care and support they need in a timely manner, regardless of their location, cultural background or life context.

Suggested strategies	Alignment with other Headline Outcomes				
	2	3	4	5	6
Commission community-based programs and service solutions aligning to a whole-of-person/whole-of-family care model and community-based care design principles.[8]		x			
Explore and pursue opportunities to partner with relevant agencies, community organisations and people with lived experience to tailor and target person and family-centred services, including care pathways and programs, for people with chronic conditions who have mental health and alcohol and other drug conditions, experience socio-economic disadvantage and/or have difficulty accessing and using mainstream services.[10]		x	x		
Support the expanded availability of telehealth and digital health services in areas with high demand and limited services, noting the importance of community infrastructure and expertise in more remote locations and communities.[10]	x			x	
Present health promotion and health care information in a range of formats and languages to address barriers to equitable access to information and services for CALD communities and people with disability, including complaints processes. Approaches should build on and integrate with existing mechanisms and community assets.[32-34]			x		
Ensure carers can easily access information, advice and support to aid the maintenance of their health and wellbeing, and to enable their capacity to perform their full range of care.[35]					
Pursue multicultural objectives identified in policy and strategy including, where appropriate, interpreting and translating services.[33]					x
Embed high-quality, meaningful approaches to promote culturally responsive practices amongst the health workforce, including recognising Aboriginal people's strength in their identity as a critical protective factor.[36]	x		x		

Headline Outcome 2 - Strong workforce

People living with or at risk of chronic conditions partner with skilled health workers from a variety of disciplines, who have a holistic approach to care.

Suggested strategies	Alignment with other Headline Outcomes				
	1	3	4	5	6
Across key professions, progressively support staff to work to their full scope of practice and support the expanded and integrated use of the allied health workforce to support chronic conditions prevention and management to address inefficiencies in both patient care and service expense.[8,10,37,38]					
To support workplace efficiencies and reduce administration burden for health professionals, implement fit-for-purpose technological and digital solutions, systems and supporting processes. In fostering streamlined work environments as well as greater efficiencies in continuity of care, enhance secure communication between multidisciplinary providers and with patients, and foster data and information sharing.		x		x	
Implement mechanisms for staff to voice ideas supporting systemwide sustainability, including facilitating opportunities for conversations between staff, with commitment to meaningful consideration and reflection by leadership teams.[8]					x
Implement and support mental health first aid models to support workforce mental health.[8]					
To capacity build and upskill, utilise technology-based models that support ease of access to specialist advice across geographical and service settings. This involves specialists engaging with community health services to share best practice, reduce disparities, and apply case-based two-way learning. (For example, Extension for Community Health Outcomes – ECHO used by WAPHA)[10]				x	
Building on the training priority outlined in the Department of Health Mental Health Clinical Workforce Action Plan 2022, increase investment in both creating and extending workforce training and education opportunities to enable increased levels of person-and family-centred, trauma-aware, healing-informed chronic conditions care.[38]					
Support implementation of the Mental Health Commission Lived Experience (Peer) Workforces Framework and explore expansion of lived experience workforces in chronic condition care to support clinical service delivery. Peer workforces can support in areas such as (but not limited to) social connection and emotional support, non-stigmatising advice and support, improved mental health, culturally appropriate care, and shared learnings and insights.[38,39]		x	x	x	
Support a culturally responsive non-Aboriginal workforce with capacity to understand and respond to the needs of Aboriginal people and reflect on unconscious bias through appropriate training, processes for monitoring and supporting cultural responsiveness and opportunities for Aboriginal workforce and community feedback and engagement.[9]	x			x	

Employ and support Aboriginal Health Workers more extensively in roles across health disciplines to help bridge cultural barriers and ensure the delivery of culturally responsive and safe chronic condition prevention and management care.[3,7]	x	x	x		
In relation to the employment and retention of Aboriginal staff, consider opportunities for joint training and development with WA ACCHOs, as well as training for non-Aboriginal health staff working in locations where Aboriginal populations are high.[40]					

Headline Outcome 3 - Integration, coordination and partners

People living with or at risk of chronic conditions can better manage their health in partnership with their health professionals through effective care provision and connections to programs and services.	**Alignment with other Headline Outcomes**				
Suggested strategies	**1**	**2**	**4**	**5**	**6**
Collaborate with relevant health services to establish and maintain processes supporting continuity of chronic conditions care between services at points of transition.[vii] Ensure transition services recognise and are responsive to specific needs of life-stages navigated by Aboriginal people, people with disability, CALD communities, and older Western Australians.[4,32,41-43]			x		
Collaborate to foster greater visibility and connectivity of existing chronic conditions programs of work for increased integration and coordination opportunities. For example, the WA Country Health Service Chronic Conditions Care Coordination Service (CCCS) model which is working to prevent complications and better manage patient health needs outside of hospital settings.[8]					
Build on other successful and innovative models to improve health and social outcomes for people experiencing homelessness through enhanced care coordination, discharge planning and primary care access, while also identifying and addressing the underlying social determinants. For example, the Royal Perth Hospital (RPH) Homeless Team collaboration with Perth's specialist homeless GP practice, Homeless Health care.[44]	x		x		
Informed by expert clinicians and people with lived experience, establish and steward standards for care and support that are integrated and incorporate clear pathways throughout required systems and services.[41]	x				
Integrate palliative care into formal care pathways for those with advancing life-limiting illnesses, such as Chronic Obstructive Pulmonary Disease, renal disease and end stage cardiac disease.[45]			x		
System Manager and health service providers commission and partner with community-based chronic condition programs and services that incorporate innovative approaches, supported by current data, evidence-based research and best practice examples. Include specialist support and advice to community-based clinicians and services where required and possible.[8]				x	x
Increase provision of community-based models of care to improve accessibility and alleviate pressure on hospital-based services.[8]	x			x	
Improve and increase access to health data for service integration and coordination through a range of mechanisms. Including, but not limited to, business intelligence systems to streamline data collection, and support data sharing both internally and publicly.[8]				x	

[vii] Particularly for transition from paediatric health care service settings to adult health care services, and from hospital care to Residential Aged Care facilities.

Develop and implement systems and processes to identify and make record of carers involved in chronic conditions care. This is to ensure workforce awareness and early identification of carers to support their involvement in care.[35]					

Headline Outcome 4 - Prevention across the care continuum

People living with or at risk of developing, chronic conditions are more empowered and better supported throughout their life to improve their wellbeing and, where possible, either prevent or delay the onset or progression of chronic conditions and/or associated complications.	**Alignment with other Headline Outcomes**				
Suggested strategies	**1**	**2**	**3**	**5**	**6**
Health services increase support for and integration with the inherent preventive health capabilities of primary health care professionals, including GPs, allied health, pharmacists and nurses.[37]			x		
Collaborate in the development of social and emotional wellbeing approaches for chronic conditions in primary health care through service planning, gap analysis, development of HealthPathways, as informed by and in partnership with the community.[10,38]			x		
Establish innovative partnerships between and within sectors that influence health to foster shared decision-making, drive evidence-based change and support bringing a health lens to policy to address the social determinants of health.[9,37]			x	x	
Support local governments to develop local policies including Local Public Health Plans to identify and implement priority actions that support healthy dietary patterns, community food security, and create environments and opportunities for physical activity at a local level.[46]					
Where required, explore and work in partnership with community services such as local governments, social and education services to identify and focus on local communities' strengths and experience to inform health service planning.[10]					
Design and implement WA health system structures, processes and policy to harness individual, family and community capability and enhance their potential. Work together to build on a community's positive assets to create and enhance primary and community care services close to home.[9]					
Within relevant service contexts, develop and implement measures of assessing individual self-management capabilities, for example, patient activation measures, to strengthen the provision of care most suitable to individuals' needs.[47]					
Support chronic conditions self-management through investment in and provision of tools and approaches contributing to greater health literacy. This may be partially aided through the use of innovative technological solutions (e.g., digital/virtual resources). Health literacy approaches should be tailored for and targeted to address the needs of specific priority populations.[8]				x	
Develop and support the Aboriginal workforce with specialist skills in public health (for example, health promotion and environmental health) to ensure awareness of public health priorities for Aboriginal		X			

communities, and support culturally responsive approaches to address the needs of Aboriginal communities across the continuum of care.[9]					
Foster and maintain genuine partnerships with Aboriginal organisations, communities and people to enhance the quality and cultural responsiveness of mainstream chronic condition services design, delivery and review. This includes embedding high-quality, meaningful approaches to promoting cultural safety, recognising Aboriginal people's strength in their identity as a critical protective factor.[33]	x				
Strengthen workforce capability to support Advance Care Planning, including Advance Health Directives and substitute decision makers.[45]		x			
Support and promote the implementation of end-of-life and palliative care policies and resources in all care settings, including Advance Care Planning, Goals of Patient Care Clinical Document, Care Plan for the Dying Person and Clinical Indicators to identify people with deteriorating Health.[45]		x			

Headline Outcome 5 - Ongoing improvement of care

People living with or at risk of chronic conditions benefit from ongoing improvements in care, informed by lived experience and research, and supported by innovation and technology.	Alignment with other Headline Outcomes				
Suggested strategies	**1**	**2**	**3**	**4**	**6**
Support the expanded use and the development of new innovative digital models of service delivery, including the use of telehealth, to address issues of access and limited provider choice in areas of workforce and service provider shortage.[10]	x				
To support development of innovative service models, evaluate workforce roles and scope based on community health needs and interdisciplinary models of care, complimenting purely profession-based approaches.[8]		x			
Increase the utilisation of digital health, including virtual clinics and telehealth services. Leverage existing infrastructure, such as My Health Record, to support care and improve integration. As critical partners in delivering health information, education and services, provide health workforce training and education for proficiency in the use of new technologies to support active client engagement.[4,41]		x	x		
Support research and clinical practice trials to inform the development of innovative service models and funding arrangements to enable preventive care and self-management support as routine and systemic components of primary health care delivery.[47]					X
Encourage and facilitate greater research collaboration nationally, internationally and with industry. Examples include financial incentives for research teams that can demonstrate collaboration and the development of customised research grants for specific chronic conditions/groups, including for example, chronic conditions that require a degree of collaboration.[41]					X
Establish and maintain partnerships between policy makers and clinical researchers to enable the development of evidence-informed policy and to ensure research aligns with the strategic direction of the Western Australian government and its key partners. This includes exploring opportunities within the Western Australian Future Health Research and Innovation Fund program and initiatives.[8,37]					
Utilise and improve hospital-based dashboards to identify people who will benefit from being linked with local services, community supports and social prescribing. Hospital based chronic condition care and navigation services should collaborate with the health workforce of community chronic conditions support services and programs to support referrals and promote continuity of care.[8]			x		
Health Service Providers to review current availability of disability data and improve data collection processes in partnership with people with lived experience to support disability responsive health service planning and research regarding disability-related health disparities and interventions.[32]	x				

Health services review cultural and linguistic data collected for their catchment/constituent areas, and whether it is sufficient to plan for future service delivery and program development leading to improving data collection processes in partnership with CaLD communities where needed.[33]	x				X
Increase the presence of and opportunities for presentations by those with lived experience at chronic conditions related forums and events. Critically, the participation of lived experience experts can shift the dynamic within the aim to establish collaborative pathways vital to research, its development and translation.			x		
Build the capacity of the Aboriginal workforce to undertake research and evaluation of health policies and programs and conduct priority driven research supporting identification of opportunities and health inequalities, to inform improved service delivery for Aboriginal people.[9]		x			X
Incorporate chronic condition lived experience, family and carer voices from the earliest stages of service planning, including gap analysis and development of appropriate pathways, to inform decision making. Manage ongoing involvement through active forms of engagement (such as surveys, focus groups, written communications, representation on boards, committees, working and reference groups) to regularly inform and incorporate knowledge and expertise. Representation should include both mainstream and priority populations including Aboriginal, CaLD, disability, older people and those living outside of metropolitan areas.			x		
Leverage and build on the expertise of existing lived experience, family and carer groups and organisations (examples include Consumer and Community Involvement Program, Carers WA, Health Consumers' Council) for chronic conditions research engagement and partnering. Planning for and provision of adequate time and resources are critical components of such arrangements.[41]			x		
Adapt existing, evidence-based community and health service intervention models (from national and international examples) to be fit for purpose for WA and prototype in targeted metropolitan and country areas with the goal of partnering with relevant Health Service Providers and community organisations to scale up for wider implementation.[48]			x		
Implement organisational self-assessment of health literacy practices, capabilities and responsiveness for health service providers, including their understanding of unique health literacy needs within their catchment populations.[47]				x	X

Headline Outcome 6 - Sustainability

People living with or at risk of chronic conditions **…**are supported by health sector leadership, sustainable funding and governance structures that enable their health care needs to be met.	**Alignment with other Headline Outcomes**				
Suggested strategies	**1**	**2**	**3**	**4**	**5**
Increase chronic conditions service delivery by Aboriginal Community Controlled Health Organisations through preferential procurement approaches, including targets, weighted assessments, restricted tenders or mandatory set-asides.[49]	x				x
To strengthen participation and decision-making by Aboriginal organisations and communities, agencies undertake to: sharing available, disaggregated data, particularly in the regions; establish partnerships to improve the collection, access, management and use of data; make data more transparent by informing Aboriginal organisations and communities about what data exists and how it can be accessed and helping to facilitate access; and investing in the increased capacity to collect and use data by those organisations and communities.[36,40]			x		x
Improve transparency of resource allocation to and distribution by mainstream agencies and institutions in relation to dedicated Aboriginal service delivery. This can include key performance indicators within funding arrangements.[36]					x
The System Manager and health services to collaboratively investigate and adopt innovative funding models to support the use of virtual modes of delivering health care, as well as specialist support and advice to community-based clinicians and health service staff.[8]		x	x		x
Investigate and partner in opportunities for public/private partnerships, cross sector partnerships, joint funding models, and alternative funding sources (e.g., grants, commonwealth funding etc.) to increase access to a variety of early intervention and management service and program options that can be tailored to the needs of different communities, including priority populations.[48]	x		x	x	x
In relation to Aboriginal Community Controlled Health Organisations, government investments aimed at supporting sustained capacity building; a dedicated and identified WA Aboriginal workforce; peak body support with strong governance, policy development and influencing capacity; and a dedicated, reliable and consistent funding model designed to suit the types of services required by communities.[36]		x			x
Target commissioning towards care for people experiencing complex chronic health conditions, who can be treated within primary and community care settings to support hospital services and reduce complications.[37]			x		
Utilise current data provided by General Practice, Primary Care Insights, and Local, State, and National data sets to partially inform commissioning decisions regarding development of new and review of existing chronic condition programs and services. Utilise available data to support provision on services in areas of greatest need.[10]					

Health services to build on and establish performance indicators and accountability measures for lived experience participation in health service design, delivery and policy development to support self-monitoring of progress towards greater lived experience engagement.[47]			x	x	x
Consult with CaLD communities in the development and review of programs and services to identify their effectiveness and impact.[33]					

Appendix 2: Summary of Consultation Process

This Framework was developed collaboratively with input from a diverse range of people and perspectives. The consultation involved three streams of engagement.

1. Deliberative Panel
    - A panel of 41 people was established to work together to make recommendations on the nature and content of the framework. This panel had representation of lived experience, government and non-government providers, policy makers and people with a range of cultural, geographic and clinical perspectives.
    - The panel met for three full days across the course of the consultation process to explore iterations of the draft framework and help shape the focus of the broader consultation.
2. Broader Consultation
    - Through the use of online surveys and workshops, over 100 additional people from around Western Australia provided feedback on Framework drafts.
3. Targeted Consultation
    - A series of one-on-one or small group meetings with key stakeholders across the health system supported the refinement of this draft.

Consultation method	Month	Purpose
Deliberative Panel: Workshop 1	August 2022	To provide feedback and input on the draft vision, principles, and headline outcomes that had been developed from examining related state, national, and international strategies on chronic conditions and related areas (including the Sustainable Health Review).
Broad public engagement (online survey and workshops)	September 2022	To obtain broad feedback on the vision, principles, and headline outcomes which were refined after Panel workshop 1.
Deliberative Panel: Workshop 2	November 2022	To obtain feedback to further refine the vision, principles, and headline outcomes. To obtain initial feedback on the sub-outcomes and potential headline measures that will sit alongside the headline outcomes.
Targeted workshops	December 2022	To ensure the sub-outcomes adequately cover the needs Aboriginal people and Culturally and Linguistically Diverse communities. To explore the health data opportunities for measurement and reporting of the Headline Outcomes with data experts across the health sector.

Health Network Unit (HNU) Lead review	Jan-Feb 2023	To provide feedback on critical gaps or changes required to the sub-outcomes.
Online Panel review	Jan – Feb 2023	To refine and confirm the sub-outcomes and headline measures and identify any areas of contention remaining in the Framework.
Deliberative Panel: Workshop 3	March 2023	Finalise the draft Framework and undertake a 'deep dive' discussion around continued gaps or contentious issues in the Framework.
Public online survey	June 2023	To finalise the Framework with broad public feedback.

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