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

WA Chronic Conditions Outcomes Framework Consultation Pack

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Contents

We acknowledge the traditional owners of the lands across Western Australia on which this consultation will take place and need to be responsive to. We pay our respects to the past and present, and future elders of the Aboriginal Community.

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1. BACKGROUND

1.1 Purpose

This project aims to develop a Western Australian Chronic Conditions Outcomes Framework (hereafter, the Framework). The purpose of the Framework is to set state-level priorities, and guide localised and collective action to improve the prevention, early intervention and management of chronic conditions in Western Australia (WA). We aim to develop a Framework that is practical, and that will be used to:

- improve program and service planning and decision making, coordination and delivery
- guide investment through commissioning and procurement
- create a clearer line of sight for how community-level programs link to state-level priorities and outcomes.

1.2 The importance of strategic frameworks for chronic conditions

Chronic conditions are the leading cause of illness, disability and death in Australia.[1] Chronic conditions result in a profound economic burden to individuals, their families, health systems, and societies, as recognised by the World Health Organization. With the ageing population, high community expectations about quality of life, and the increasing prevalence and burden of chronic health conditions, these costs will only increase without effective and targeted investment in interventions.[2],[3]

The Western Australian, as well as Commonwealth government, have existing policies and frameworks for chronic conditions. They provide strategic guidance on how all players in the system work together, and the levels of care and service we hope to achieve. Chronic conditions are typically managed by many different health professionals and it is therefore important to have a consistent strategic level plan to which various services can align.

1.3 Why an outcomes framework?

Measuring outcomes helps us better understand:

Are our efforts making a difference?

Are the lives of people, and communities better as a result?

Developing a framework for outcomes involves selecting the ***most relevant and important*** results from any activity or work. For example, a Chronic Conditions Outcomes Framework will communicate a ***shared understanding of the most important changes we hope to see*** for people living with chronic conditions. This in turn will guide the efforts of services and systems.

1.4 Informing documents

It is important to acknowledge and build on the work already done in the space. We are not starting from scratch and there are many strategic policy documents that this Framework will align with (see Appendix 1). Two key informing documents have been identified as critical:

[1] Australian Institute of Health and Welfare 2014. Australia's health 2014. Australia's health series no. 14 . Cat. no. AUS 178. Canberra: AIHW, as cited in Australian Health Ministers' Advisory Council, 2017.
[2] World Health Organization. Preventing chronic diseases: A vital investment. WHO Global Report. Geneva: WHO; 2005, as cited in Department of Health, Western Australia (2011).
[3] Department of Health, Western Australia. WA Chronic Health Conditions Framework 2011–2016. Perth: Health Networks Branch, Department of Health, Western Australia; 2011.

- *WA Chronic Health Conditions Framework 2011–2016*[4] (the previous WA Framework)
- *National Strategic Framework for Chronic Conditions (2017)*[5] (the National Framework)

These frameworks acknowledge that many people are impacted by more than one chronic condition (co-morbidity or multi-morbidity) and emphasise that coordinating and integrating services is just as important as providing the right services. It is also noted that the new Framework will align to relevant strategies and recommendations from the Sustainable Health Review Final Report 2019[6].

1.5 Consultation process and focus

A framework of this nature requires collaboration and input from a diverse range of people and perspectives. A panel of 40 people has been established to work together to make recommendations on the nature and content of the framework. This panel has representation of lived experience, government and non-government providers, policy makers and people with a range of cultural, geographic and clinical perspectives.

This panel has had its first meeting, to explore the draft framework and help shape the focus of this consultation.

This consultation recognises that chronic conditions touch the lives of many people, who all have diverse experiences and needs. Broad consultation will happen in two phases during the project. In the first phase, we are asking for your support to help us understand:

- What outcome areas the framework should focus on?
- What key principles should underpin the framework?
- What barriers and needs exist?

2. UNDERSTANDING CHRONIC CONDITIONS

2.1 Defining chronic conditions

The WA Framework will adopt the National Framework definition of chronic conditions which states that chronic conditions share the following characteristics:

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

[4] Department of Health, Western Australia. WA Chronic Health Conditions Framework 2011–2016. Perth: Health Networks Branch, Department of Health, Western Australia; 2011.
[5] Australian Health Ministers' Advisory Council, 2017, National Strategic Framework for Chronic Conditions. Australian Government. Canberra.
[6] Sustainable Health Review. (2019). Sustainable Health Review: Final Report to the Western Australian Government. Department of Health, Western Australia. URL: https://ww2.health.wa.gov.au/Improving-WA-Health/Sustainable-health-review-delivery/Final-report

2.2 Prevalence

While the term ‘chronic conditions’ covers a diverse group of conditions, 10 chronic conditions are the focus of prevalence data reported by the Australian Bureau of Statistics (ABS). They are selected because they are common, pose significant health problems, and have been the focus of ongoing national surveillance efforts.[7] These conditions 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

Chronic condition prevalence data for 2020–21 is based on self-reported data from the ABS 2020–21 National Health Survey. This data indicates that:

- Almost half of Australians (47%, of 11.6 million people) were estimated to have one or more of the 10 selection chronic conditions in 2020-2021.
- Mental or behavioural conditions; back problems; and arthritis were the most common of the 10 selection chronic conditions. It is estimated that 5.0 million (20%) people 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 arthritic, 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.

2.3 Priority populations

Priority populations are those that are negatively impacted by chronic conditions more than the general population, which results in inequitable health outcomes. In the National Framework, priority populations include, but are not limited to:

- Aboriginal and Torres Strait Islander people
- People from culturally and linguistically diverse backgrounds (CaLD)
- Older Australians over 45 years
- Carers of people with chronic conditions
- People experiencing socio-economic disadvantage
- People living in remote, or rural and regional locations
- People with disability.

Aboriginal people can experience chronic conditions up to 20 years earlier and experience poorer health outcomes than non-Aboriginal people.

2.4 Social determinants of health effecting chronic conditions

Although genetics is a significant driver for many chronic conditions, whether a person develops a chronic condition or not also depends on lifestyle factors. The risks of developing a chronic condition can be increased by physical inactivity, poor nutrition, being overweight and obesity, smoking, excessive alcohol intake and hypertension.

[7] ABS (Australian Bureau of Statistics) (2018) National Health Survey: first results, 2017–18, ABS website, accessed 14 February 2022.

Many of the underlying causes of poor health develop from the social, environmental, economic, and cultural contexts in which people live, work and play (referred to as the 'social determinants of health'). Often, these are not within a person's direct control, and instead they require coordinated, system level change.

Partnerships with wider agencies outside of health, are critical in addressing these issues and fostering conditions that enable people to live healthier lives.

2.5 Barriers and enablers: What needs to be measured to support improvement

The Primary Health Care Advisory Group's 2015 report on: Better Outcomes for People with Chronic and Complex Health Conditions states that "Our current health system is not optimally set up to effectively manage long-term conditions."[8] The report, and the National Framework also reveal that patients often experience:

- a fragmented system, with providers and services working in isolation from each other rather than as a team
- uncoordinated care
- difficulty finding services they need
- at times, service duplication; at other times, absent or delayed services
- a low uptake of digital health and other health technology by providers to overcome these barriers
- difficulty in accessing services due to lack of mobility and transport, plus language, financial and remoteness barriers
- feelings of disempowerment, frustration and disengagement.[9]

3. PROPOSED FRAMEWORK STRUCTURE

This section outlines a proposed structure for the Framework which is arranged to guide localised and collective action to improve the prevention, early intervention and management of chronic conditions in Western Australia (WA).

The structure of the Framework is presented below, highlighting the high-level elements such as vision, principles, priority groups and domains (Figure 1). These elements are yet to be confirmed through consultation, and the other more detailed elements such as barriers and enablers, partners and stakeholders and strategies or objectives are also yet to be mapped.

[8] Department of Health, Primary Health Care Advisory Group. 2015. Better Outcomes for People with Chronic and Complex Health Conditions. Australian Government. Canberra.
[9] Australian Health Ministers' Advisory Council, 2017, National Strategic Framework for Chronic Conditions. Australian Government. Canberra.

Principles

1. **Person-centred care:** Engage with consumers meaningfully to better support their health literacy, self-management capacity, and ability to make decisions about their care
2. **Life course:** Intervene early and promote lifelong health and wellbeing
3. **Whole of population approach:** Tackle health inequality through addressing service gaps and barriers for vulnerable populations, and promote health for everyone
4. **Integration and service coordination:** Deliver services based on interdisciplinary care planning and case management, through cross-sector collaboration and partnerships
5. **Systems approach:** Prioritise a more connected health system, working effectively across multidisciplinary teams as well as a range of sectors, to collectively address social determinants of health

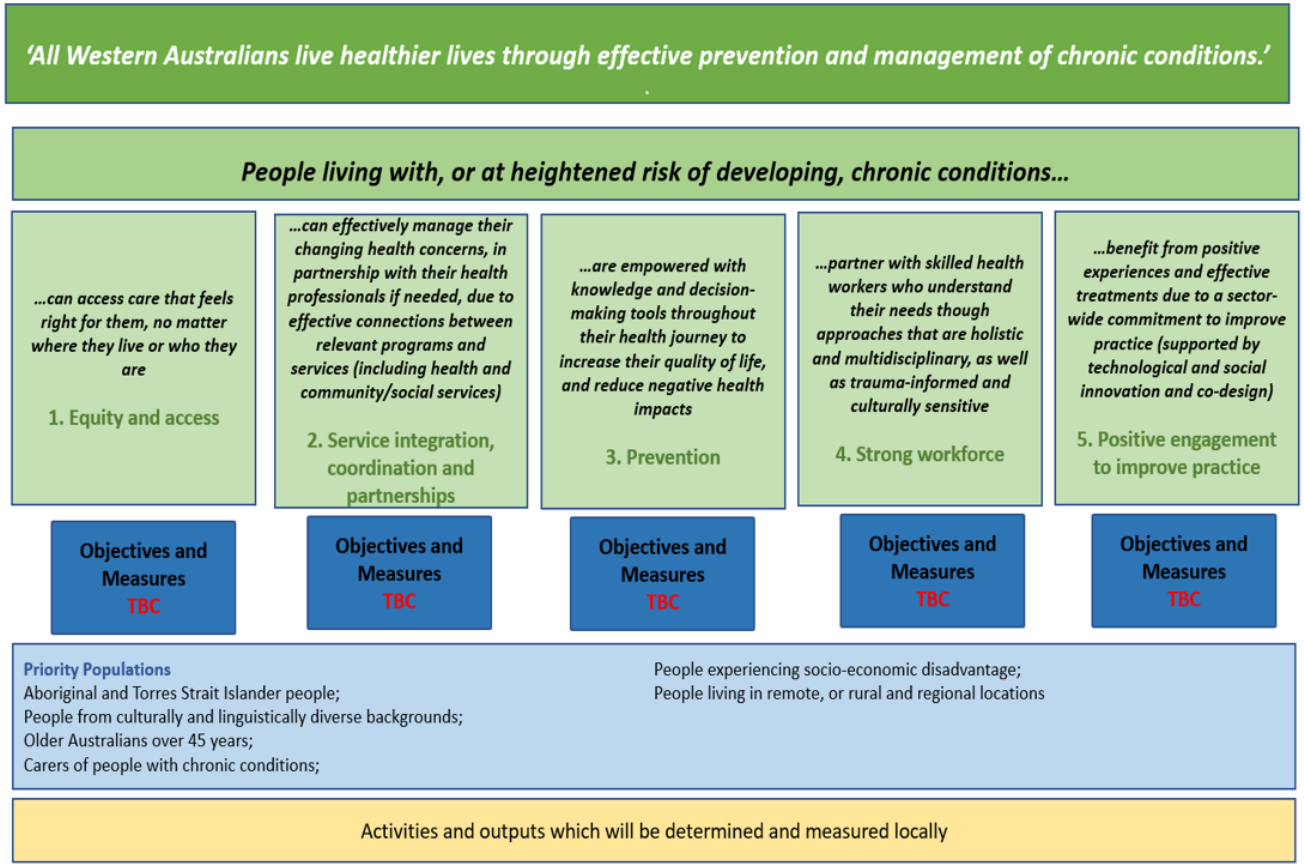

Figure 1: Proposed framework structure

4. DRAFT FRAMEWORK ELEMENTS

The following draft elements for the Framework have been drawn from a range of existing policy documents and literature, including those outlined in Appendix 1. Rather than starting from scratch, the 'building blocks' of other frameworks have been synthesised and were presented to the first Panel workshop for preliminary discussion to inform this stage of consultation. They are not yet agreed on and will now be refined and their selection informed through this consultation.

4.1 Vison

During the first Panel Workshop, there was a lot of feedback on another suggested vision. Based on an analysis of this feedback, and the values that emerged from the Panel as a group, we suggest that the proposed vision of the Framework can borrow from the National Chronic Conditions Framework (although situating this in Western Australia rather than Australia). Deliberately aligning it with the national framework may be beneficial in creating synergies between and state and national system.

Based on this we propose:

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

4.2 Principles

As with the vision, we originally summarised the principles expressed across other frameworks, and these were taken to the Panel Workshop to be discussed and rated. After analysis was completed, the following Principles are proposed.

1. **Person-centred care:** Engage with consumers meaningfully to better support their health literacy, self-management capacity, and ability to make decisions about their care
2. **Life course:** Intervene early and promote lifelong health and wellbeing
3. **Whole of population approach**: Tackle health inequality through addressing service gaps and barriers for vulnerable populations, and promote health for everyone
4. **Integration and service coordination:** Deliver services based on interdisciplinary care planning and case management, through cross-sector collaboration and partnerships
5. **Systems approach:** Prioritise a more connected health system, working effectively across multidisciplinary teams as well as a range of agencies and sectors, to collectively address social determinants of health

4.3 Domains, or outcome areas

Five Draft Domains have been developed for the Framework. These are the strategic pillars, or outcome areas, that the objectives and measures will be organised under. Feedback from the Panel Workshop indicated a strong preference for the Framework to focus on what it can deliver for people living with, or at risk of developing, chronic conditions, and therefore person-centred approaches were emphasised.

In response to this feedback, we have written each domain with supporting person-centred outcome statements that can more richly describe the change we hope to make in the lives of individuals, their families and communities, if the intent of each domain was achieved.

Five domains are proposed, as follows.

	People living with, or at heightened risk of developing, chronic conditions:
1. Equity and access	…can access care that feels right for them, no matter where they live or who they are
2. Service integration, coordination and partnerships	…can effectively manage their changing health concerns, in partnership with their health professionals if needed, due to effective connections between relevant programs and services (including health and community/social services)
3. Prevention across the care continuum	…are empowered with knowledge and decision-making tools throughout their health journey to increase their quality of life, and reduce negative health impacts
4. Strong workforce	…partner with skilled health workers who understand their needs through approaches that are holistic and multidisciplinary, as well as trauma-informed and culturally sensitive
5. Positive engagement to improve practice	…benefit from positive experiences and effective treatments due to a sector-wide commitment to improve practice (supported by technological and social innovation and co-design)

4.4 Life course perspective

Population and life course perspectives are embedded in many frameworks, although not often clearly defined. The approach below is proposed and will be refined during the project, including the language and the definitions (e.g., age cut offs) for the various life stages.

Babies and toddlers' health	Kids' health	Teenagers' health	Young adults' health	Pre-conception and pregnancy	Women's health	Men's health	Senior's health

4.5 Care continuum

Care continuum defines the stages of health that a person might experience over their life course, as part of a chronic condition, or during a period of illness. It is possible to move forwards and backwards along this care continuum as it is not necessarily a linear process. Each stage involves different:

- intensities of care provided to a person e.g. well population self-manage potentially with support from a nurse practitioner, GP or other community care health professional, whereas management of an existing chronic condition might require medication or surgical intervention, with regular check-ups by a specialist
- health professional groups e.g. from primary care to higher levels of specialist involvement
- intervention methods e.g. information giving, knowledge building, medication, surgery etc.
- outcomes focus e.g. reducing risk factors, preventing or limiting acute episodes

The care continuum can help health professionals to follow a person's journey with their chronic condition and take preventative steps with that person, to reduce the likelihood of their condition worsening.

The Framework proposes to adopt the following stages on the care continuum.

Well population	At risk population	Early detection and diagnosis	Management (stable)	Management (acute)	End of life

5. GLOSSARY OF TERMS

Collective action	When a number of people, stakeholders or organisations work together to achieve the same goal. It is purposeful and involves a shared agenda and degrees of coordination and integration.
Co-morbidity or multi-morbidity	The simultaneous presence of two or more diseases or medical conditions in a patient.
Incidence	A measure of the number of new cases of a characteristic that develop in a population in a specified time period.
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 or obesity) at a specific point in time or during a given period of time; regardless of when they first developed the characteristic.
Service providers	Broadly defined as organisations or agencies providing or managing a service, including government departments, public Health Service Providers (e.g., South Metropolitan Health Service, North Metropolitan Health Service etc.), non-government organisations, and private providers.
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). For more information visit: https://ww2.health.wa.gov.au/About-us

6. APPENDIX 1: STRATEGIC CONTEXT

The Framework will need to link to and be implemented alongside a range of policies and strategies from partner organisations in health and other sectors, in particular:

- *WA Aboriginal Health and Wellbeing Framework 2015 – 2030*
- The *Sustainable Health Review Final Report* outlines 8 Enduring Strategies and 30 Recommendations to progress the sustainability agenda and identify changes required across the WA health system, with priorities that must be considered in implementation
- Prevention of chronic conditions in the well population and at-risk population addressed by the *WA Health Promotion Strategic Framework* (update currently in progress)
- Primary care through the *WA Population Health Strategy*, which provides strategies on managing health care in the community (metropolitan, rural and remote), where appropriate, and creating strong linkages with the hospital sector
- *WA Chronic Conditions Self-Management Strategic Framework 2011–2015*, which provides detailed strategies to promote active participation by people in their own health care in their own communities
- The hospital sector by engaging with health services to develop strategies for the Framework's implementation in line with the *WA Health Clinical Services Framework 2010–2020*[10] and Activity Based Funding and Management approach
- Rural and remote health by engaging with country health services to develop strategies for the Framework's implementation, in alignment with their primary health care, service delivery, and workforce development policies Local health service provider policies
- *National Health Reform Agreement (NHRA) – Long-term health reforms roadmap*

[10] This version is currently being updated