Australian Government
Department of Health, Disability and Ageing

National Strategic Framework for Chronic Conditions

2026–35

Acknowledgement of Country

In the spirit of reconciliation, the Department of Health, Disability and Ageing acknowledges the Traditional Custodians of the Country throughout Australia and their connections to land, sea and community. We pay our respect to their Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples today.

Minister's Foreword

Chronic conditions are the leading cause of illness, disability and death in Australia. They affect millions of Australians every day, impacting families, communities and our health system. As our population ages and the prevalence of multimorbidity increases, the challenge of managing chronic conditions becomes urgent and more complex. Australia has made significant progress in improving the prevention and management of chronic conditions. We have strengthened our primary care system, invested in digital health and developed targeted strategies to support priority populations. Yet, we know that many Australians still face barriers to accessing timely, appropriate, and culturally safe care. We must do more to ensure that every person, regardless of who they are or where they live, can live a healthier life.

The National Strategic Framework for Chronic Conditions 2026–35 provides a refreshed roadmap for national action. It builds on the foundations of the 2017–25 Framework and reflects the insights of hundreds of stakeholders, experts, and community members. With a vision of a healthier Australia through effective prevention, early detection, intervention and management of chronic conditions, this Framework sets out five Focus Areas to guide our efforts over the next decade.

These include:

- promoting health and education to support prevention and self-management
- embedding early diagnosis and intervention across the continuum of care
- strengthening continuity of care across life stages and health sectors
- managing multimorbidity through integrated, person-centred approaches
- providing enhanced and targeted support for priority populations.

This Framework recognises that chronic conditions are not just a health issue – they are a whole-of-society issue. It calls for collaboration across sectors, investment in data and digital infrastructure, and a commitment to equity, sustainability, and climate resilience.

Developed in partnership with states and territories, guided by expert advice and shaped by the voices of Australians, this Framework is a shared commitment to improving lives. Together, we can build a future where chronic conditions are better prevented, managed, and understood, and where every Australian has the opportunity to live well.

The Hon Mark Butler MP

Minister for Health and Ageing
Minister for Disability and the National Disability Insurance Scheme

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Acknowledgements

The Department of Health, Disability and Ageing thanks all individuals and organisations who contributed to the development of The National Strategic Framework for Chronic Conditions 2026–35.

We received over 400 submissions through an open public consultation. These came from patients, carers, health organisations, academics and researchers. Their feedback ensured the Framework reflects lived experience and supports better health outcomes for all Australians.

A Working Group of senior officials from all states and territories provided advice throughout the development process. Other Commonwealth agencies, the National Aboriginal Community Controlled Health Organisation, and chronic condition organisations and peak bodies have given their time and expertise to the development of the Framework. Together, these contributions have strengthened the Framework's focus on equity, collaboration and evidence-based action. They have also reinforced a shared commitment to person-centred care and long-term improvements in the prevention and management of chronic conditions.

Executive Summary

The National Strategic Framework for Chronic Conditions 2026–35 (the Framework) sets out an approach to one of Australia's most significant health challenges, chronic conditions. These conditions account for the majority of the country's disease burden and are associated with approximately 90% of all deaths. Nearly two in five Australians live with multiple chronic conditions, highlighting the need for a coordinated and forward-looking response.

This Framework provides high-level, overarching guidance to support a comprehensive, multisectoral effort focused on prevention, early intervention and equitable health care. It promotes collaboration across governments, sectors and communities to reduce the impact of chronic conditions and improve health and wellbeing for all Australians.

The Framework outlines shared objectives, principles and priority areas to guide the development of policies, strategies and services across all levels of government. It is primarily directed at policymakers and is designed to support consistent, evidence-based decision-making. While it informs national efforts, it does not prescribe detailed actions or timelines. Instead, it provides a foundation for collective action and long-term reform across Australia's health system.

Framework on a page

Vision

All people living in Australia experience a healthier and improved quality of life through effective prevention, early detection and intervention, and management of all chronic conditions.

Purpose

To guide the development and prioritisation of policies, strategies, actions, and services to address chronic conditions in Australia.

Guiding Principles

- Equity
- Person-centred, multidisciplinary care
- Evidence based
- Collaboration and shared responsibility
- Sustainability
- Climate resilience
- Accountability and transparency

Focus Areas

1. Health promotion and education supporting self-management of risk factors and conditions
2. Embedding prevention, early detection and intervention in the continuum of care
3. Continuity of care
4. Managing multimorbidity
5. Enhanced and targeted support for priority populations

Part 1: Introduction

Chronic conditions are the leading cause of illness, disability and death in Australia. As our population ages, the impacts from chronic conditions on individuals, communities, the health system and society are growing.

This National Strategic Framework for Chronic Conditions 2026–35 (the Framework) is a refreshed and updated version of the 2017–25 Framework. An independent review of the 2017–25 Framework provided recommendations for the development of this refreshed Framework.[1] In early 2024, the Department of Health, Disability and Ageing (the Department) received over 400 survey responses to an open consultation on the refresh.

The Framework provides national guidance for a multisectoral response in the prevention and management of chronic conditions. The Framework's guidance is prioritised into areas that provide public health benefits for chronic conditions in general, rather than focusing on specific conditions. The Framework's five Focus Areas provide opportunities for addressing chronic conditions in Australia.

Health promotion and education empower people to self-manage risk factors for developing chronic conditions and in managing conditions. Prevention is a focus of the Framework but recognises not all chronic conditions are preventable. Early diagnosis and intervention are important in limiting or slowing the impacts of conditions.

Continuity of care to ensure that people's journeys through the healthcare system are not fragmented and disrupted is especially important for those who live with more than one chronic condition.

Priority populations who experience disproportionately higher prevalence and impacts of chronic conditions require tailored approaches to achieve equity of health care. This includes understanding the impacts that the determinants of health have on risk factors for chronic conditions and accessing proper care. These determinants often require cross-sector collaboration to improve health outcomes.

What are chronic conditions?

Chronic conditions include a broad range of long-term health conditions. There are many different types of chronic conditions and people can experience more than one chronic condition at the same time, known as multimorbidity. Chronic conditions can occur at various stages in people's lives, although they become more common as we age. Chronic conditions have complex and multiple causes, both preventable and non-preventable.

Types of chronic conditions include, but are not limited to:

- cancer
- heart, stroke and vascular disease
- chronic eye conditions
- diabetes
- obesity
- endometriosis
- chronic kidney disease
- musculoskeletal conditions (such as arthritis, back pain and osteoporosis)
- neurological conditions (such as dementia)
- mental health conditions
- rare diseases*
- lung and respiratory conditions (such as asthma and chronic obstructive pulmonary disease)
- genetic conditions.

* There are over 7,000 rare chronic conditions. Rare chronic conditions affect fewer than 5 in 10,000 people and 80% of rare chronic conditions have genetic causes.[2]

The above elements comprise a broad definition of chronic conditions for the purposes of the Framework. This broad definition is intended to ensure that the Framework applies across a broad range of conditions without focusing on condition-specific guidance.

Chronic Conditions in Australia

Chronic conditions in Australia

3 in 5 Australians (15.4 million) are living with at least one chronic condition

2 in 5 Australians (9.7 million) are living with multimorbidity (2 or more chronic conditions)

The proportion of Australians with multimorbidity increased by **33%**, compared to an **18%** increase in those with a single chronic condition between 2007–08 and 2022

Australians lost an estimated **4.4 million** years of healthy life due to chronic conditions in 2023, equivalent to **85%** of the total burden of disease that year

Chronic conditions are responsible for **91%** of the non-fatal burden of disease (years lived with disability or ill health)[i] across the population

78% of the fatal burden of disease (years of life lost due to premature death)

People with chronic conditions can experience challenges, such as deterioration of health, loss of independence, social isolation, discrimination, stigma, disability, mental health issues, difficulty in participating in education and employment, difficulty in managing or contributing to family life and relationships, and overall lower quality of life.[3] Chronic conditions are the most common and leading cause of illness, disability and premature death in Australia. The prevalence of chronic conditions is increasing. The prevalence of the population living with 2 or more chronic conditions (multimorbidity) has increased at a greater rate than the prevalence with 1 chronic condition (a 33% increase from 2007–08 to 2022, compared with an 18% increase for a single condition).[4] Chronic conditions make up a significant proportion of the burden of disease,[ii] responsible for 91% of non-fatal burden and 78% of fatal burden.[5] 90% of all deaths in 2022 had chronic conditions as an underlying or associated cause.[6] With a population who are older and living longer, the burden of chronic conditions continues to grow.

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[i] Years Lived with Disability (YLD) is a way of measuring how much illness affects people by counting the years they spend living with health problems or disabilities. This webpage developed by the AIHW provides further details: **Australian Burden of Disease Study: Methods and supplementary material 2018, Years lived with disability (YLD) - Australian Institute of Health and Welfare**

[ii] Burden of disease is a measure of the impact of chronic conditions. It combines years of healthy life lost due to living with ill health with years lost due to dying prematurely.

Being a carer for someone with chronic conditions can have significant health, economic and social impacts on a person. Women are more likely to be primary carers, placing them at greater risk of depression, financial stress, and poor physical health due to caring responsibilities. These impacts are often more pronounced for Aboriginal and Torres Strait Islander women who are carers and already face systemic disadvantage.[7]

A note on the reporting of the prevalence of chronic conditions

The previous (2017) version of the Framework used Australian Institute of Health and Welfare (AIHW) reports using Australian Bureau of Statistics (ABS) data on 8 selected chronic conditions to report that around 50% of people in Australia had at least one chronic condition. This refreshed Framework uses AIHW data on more (72) chronic conditions to show that 61% of people have at least one chronic condition.[8] This higher number is more likely to reflect the true prevalence of chronic conditions but may still underestimate them. Surveys that measure the prevalence of chronic conditions do not include places such as residential aged care facilities, hospitals, prisons, or people living in very remote parts of Australia — places that often have higher levels of chronic conditions.

Priority populations

Certain groups within the Australian population experience poorer health outcomes and a disproportionate burden of disease, often due to social and structural disadvantages. These groups are designated as ‘priority populations’ and include, but are not limited to, Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse (CALD) backgrounds, people with mental illness or disability, people living in remote, rural and regional areas, and people experiencing socio-economic disadvantage. Individuals may belong to more than one of these groups, compounding their health challenges. Addressing health inequities requires tailored approaches and shared decision-making to improve access to appropriate health care for prevention, early intervention and management of chronic conditions for priority populations.

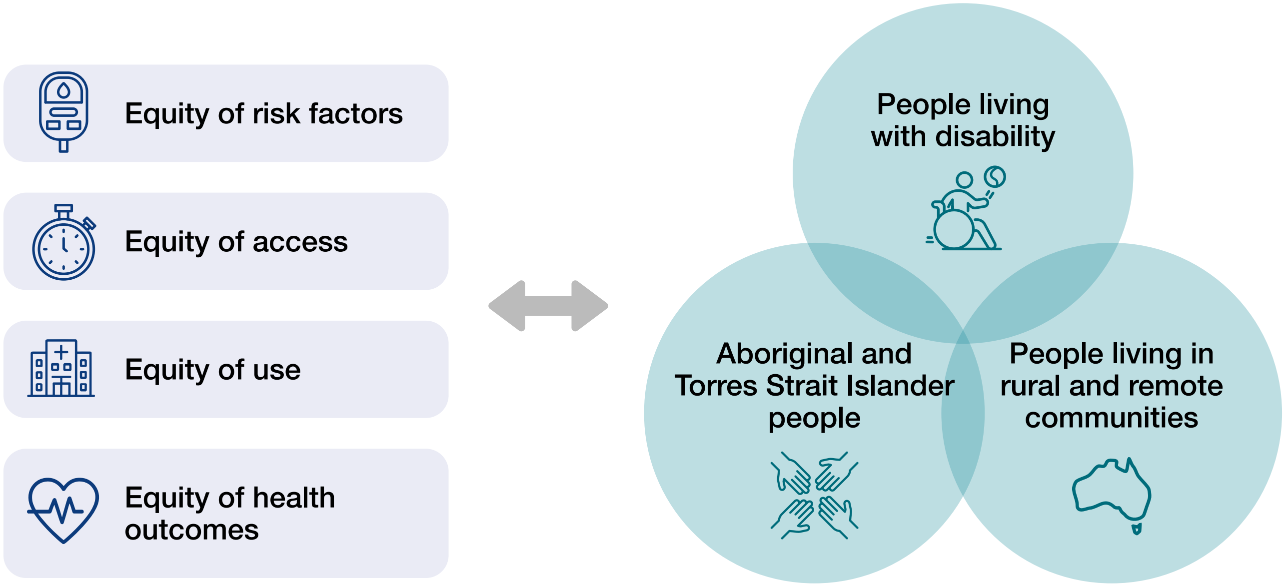
Challenges and barriers for priority populations*:

- systemic and interpersonal racism
- discrimination
- trauma
- stigma
- language barriers
- remote locations
- access to care
- access to transport
- homelessness
- housing problems (including overcrowding, lack of amenities)
- food access, availability and affordability
- domestic, family and sexual violence
- reliable digital environments

* This is not an exhaustive list of challenges and barriers. It provides a snapshot of the type of issues that may be experienced by some priority populations.

Intersectionality describes how different aspects of an individual's identity can overlap and have cumulative effects from multiple forms of systemic discrimination and marginalisation. Discrimination in society and systems, when combined with aspects of an individual's identity can combine to create distinct disadvantage for some population groups (and advantage for other groups).[9] Intersectionality recognises that aspects of an individual's identity are not independent and that one aspect alone, such as race, cannot explain the disadvantage that some populations experience. Intersectionality recognises that factors beyond the control of individuals, including determinants of health, have substantial effects on behaviour and health. Many of these factors require systemic change to have a positive impact on health.

Enhancing and targeting support for priority populations, including discussion of intersectionality, is discussed in more detail in Focus Area 5.



Determinants of health

The likelihood of developing chronic conditions and the impact those conditions have on the health of people are influenced by a variety of factors, known as the determinants of health. They are often beyond the control of individuals and the health system. This includes the social, cultural, environmental, structural, economic, biomedical, commercial, and digital environments in which we live, work, play, and age. Determinants of health have protective and adverse effects on individuals and can influence behaviours that impact on the risk of developing, and the management of, chronic conditions.

The determinants of health are discussed in more detail in the **National Preventive Health Strategy 2021–2030** and in an AIHW topic summary.[10] Most determinants of health require consideration beyond just the health sector. Collaboration across sectors, including beyond the health system, is vital to making a difference in the health of people living in Australia. More information on the determinants of health are provided in Appendix 1.

Impact on healthcare system

Most care for chronic conditions is provided in the primary healthcare setting.[11] The increasing prevalence of chronic conditions will place more pressure on the primary care sector in Australia. Challenges with timeliness and continuity of care in primary care settings may increase the likelihood of individuals seeking care from hospitals. In 2021–22, 55% of all hospitalisations were associated with chronic conditions, with average length of stay 2.3 times longer than for other hospitalisations (3.7 days, compared to 1.6 days). Hospitalisations associated with chronic conditions accounted for 74% of total patient days in 2021–22.[12]

Spending on chronic conditions in 2022–23 ($82 billion) accounted for almost half (48%) of all disease-specific expenditure. Total disease spending increased by $70.5 billion between 2013–14 and 2022–23, much of which was due to increased spending on chronic conditions ($38.2 billion).[13]

Impact on Healthcare System

Health system expenditure on chronic conditions increased by **$38.2 billion** between 2013–14 and 2022–23

Hospitalisations associated with chronic conditions accounted for **55%** of all hospitalisations and **74%** of total patient days in 2021–22

People living with **multimorbidity** have more frequent and longer medical appointments, and more medications to manage than those without multimorbidity

How should the Framework be used?

The Framework offers a shared understanding of the issues posed by chronic conditions in Australia and provides evidence-based guidance for developing strategies, plans and activities to address these challenges. The Framework's guidance does not focus on a single chronic condition, it encourages holistic and collaborative approaches for the prevention, diagnosis, early intervention, care, and management of conditions. The Framework should be read in partnership with other related policies, plans and strategies.

The Framework is primarily directed at government decision and policy makers at national, state, territory and local levels, enabling all levels of government to work together to provide coordinated leadership in the delivery of more effective and collaborative approaches to addressing the challenges of chronic conditions. The Framework's Focus Areas represent the high-level priorities to take forward to address the Vision. The Focus Areas should be viewed as intersecting and overlapping pieces of guidance for the development of approaches targeting broader positive impacts on chronic conditions.

Non-government stakeholders can use the content of this Framework towards understanding issues related to chronic conditions and the guidance informing policy decision makers. The Focus Areas are a resource to guide non-government stakeholders to design initiatives supporting the prevention and management of chronic conditions.

Recognising the wider determinants of health, the Framework acknowledges that collaboration and partnerships across government, private sector, and non-government organisations is required.

Vision

All people living in Australia experience a healthier and improved quality of life through effective prevention, early detection and intervention, and management of all chronic conditions.

Purpose

To guide the development and prioritisation of policies, strategies, actions and services to address chronic conditions in Australia.

Guiding principles

The Framework's guiding principles have been important in developing the Framework and should be considered for initiatives that are developed under the Framework's guidance.

Table 1: Guiding principles for the Framework

Guiding principle	Detail
Equity	All people living in Australia, particularly those from underserved populations, have access to and receive safe, affordable, high quality health care to meet their individual needs irrespective of identity, background, personal circumstance and where they live.
Collaboration, partnerships and shared responsibility	Stakeholders identify linkages and seize opportunities to cooperate and partner responsibly, achieving greater impacts than working in isolation. All stakeholders have a shared responsibility in identifying work that could be undertaken to address the Focus Areas to ensure enhanced health outcomes for all people living in Australia.
Evidence-based	Rigorous, relevant, and current evidence informs best practice and strengthens the knowledge base to effectively prevent and manage chronic conditions.
Person-centred, multidisciplinary care	Person-centred care focuses on the individual rather than the condition, or conditions, a person may be experiencing. It involves seeking out and understanding what is important to the individual, their families, carers, and support people. Person-centred care should consider the individual's health goals, provide individualised care planning and consider treatment burden, particularly for people with multimorbidity. The health system is shaped to recognise and value the needs and choices of individuals, their carers and families, and prioritises the use of multidisciplinary teams across care sectors (primary care, specialists, allied health care, and private and public hospitals and health settings), with a focus on information sharing, to provide holistic, culturally safe and trauma-informed care and support.
Sustainability	Strategic planning and responsible management of resources delivers long term improved health outcomes. Resources developed to aid in the prevention, diagnosis, early intervention, care and management of chronic conditions are well funded, ongoing, accessible, future-focused and have positive impact on health and quality of life.
Climate resilience	Models of care address the adverse health impacts of climate change, including extreme weather events, warmer temperatures and air pollution, and build community resilience, while also considering the environmental impacts of care provided.
Accountability and transparency	Decisions and responsibilities are clear and accountable and achieve best value with public resources.

Policy context

The Framework sits within a broader health policy context in Australia and internationally.

Australia

Since the publication of the Framework in 2017, the Australian Government has introduced and updated numerous national policies and strategies relevant to chronic conditions. The refreshed Framework has been designed to align with and reduce any duplication of health initiatives. It complements the direction and intent of related policies and strategies, which should be referred to in specific contexts. Relevant national policies, strategies and plans are referenced throughout this Framework, particularly in Part 2, with a full list provided in Appendix 2.

The Government's **Strengthening Medicare Taskforce Report** sets out a recommended pathway for major health reform in Australia. The report outlines a plan to improve access to affordable, high-quality primary care by investing in multidisciplinary care teams, expanding bulk billing incentives, supporting digital health, and modernising Medicare. These reforms aim to ensure people with chronic conditions receive timely, coordinated care. The Framework reinforces these reforms by promoting early diagnosis, timely intervention, and better integration of care across the health system.

The **National Preventive Health Strategy 2021–2030** also supports this direction by focusing on keeping people healthy and preventing illness. It promotes healthier lifestyles and reducing risk factors, and encourages early action to improve long-term health outcomes. The Strategy sets a clear goal: to increase proportion of Australians living healthier lives for longer. This aligns directly with the Framework's emphasis on prevention and early intervention. Together, these strategies reinforce the important of early intervention and coordinated care in reducing the impact of chronic conditions and improving health outcomes across the population.

Building on these healthcare reforms, the **Primary Health care 10 Year Plan 2022–2032** sets a long-term vision for a stronger, more connected and digitally enabled primary care system. It focuses on improving access, equity and integration of care, particularly for people with chronic conditions and those in rural and remote areas. The Plan also highlights the importance localised, person-centred care that is responsive to community needs.

Governments in Australia have also committed to the **National Agreement on Closing the Gap**, which includes 4 Priority Reforms and 17 socio-economic targets. These aim to enable Aboriginal and Torres Strait Islander peoples and governments to work together to overcome inequality experienced by Aboriginal and Torres Strait Islander peoples and achieve life outcomes equal to all Australians. The Framework identifies opportunities to align efforts to address chronic conditions with the National Agreement, particularly through Focus Area 5, which provides guidance on enhancing and targeting support for priority populations, including Aboriginal and Torres Strait Islander peoples.

International

The escalating burden of chronic conditions is a global health issue. The World Health Organization (WHO) has extended its **Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020** to 2030.[14] Australia has an international commitment to address chronic conditions in line with the Global Action Plan. Australia contributes to other international initiatives, providing input and ensuring alignment with international approaches. The Framework supports Australia's international commitments. This includes alignment with key objectives such as strengthening multisectoral action and partnerships, and the development of people-centred primary health care.

Part 2: Focus Areas

The 5 Focus Areas of the Framework provide direction and guidance on key areas of public health significance and can be developed to provide benefits for people, no matter what chronic condition they may have or be at risk of developing.

Each Focus Area includes Action Priorities, which provide guidance for the development and prioritisation of plans, strategies and activities to support the prevention, early detection and intervention, care, and management of chronic conditions.

Table 2: Focus Areas and Action Priorities of the Framework

Focus area	Action Priorities
1. Health promotion and education supporting self-management of risk factors and conditions	**1.1** Creating enabling and supportive environments
	1.2 Enhancing health literacy
	1.3 Building community capacity for self-management support
2. Embedding prevention, early diagnosis and intervention in the continuum of care	**2.1** Early diagnosis and intervention
	2.2 Utilising digital technology and data
3. Continuity of care	**3.1** Enhancing continuity of care
	3.2 Continuity of care across life stages and the health system
	3.3 Adherence to treatments
4. Managing multimorbidity	**4.1** Addressing fragmentation in health care
	4.2 Utilising digital health
5. Enhanced and targeted support for priority populations	**5.1** Providing culturally safe, non-discriminatory and trauma-informed care
	5.2 Improving access to appropriate information
	5.3 Improving access to healthcare services
	5.4 Addressing compounding impacts associated with intersectionality

The Focus Areas complement the Australian Government's commitment to building a stronger primary care system. Primary healthcare providers deliver critical preventive health interventions, identify risk factors and provide coordinated support to slow or reverse the progression of illness. Primary healthcare investment (including strengthening and supporting the health workforce) can ease the pressure on tertiary health care and lessen the overall burden of chronic conditions.

Prevention remains an important focus of the primary care system. The Framework provides guidance on prevention in the context of chronic conditions and encourages alignment and consideration of the **National Preventive Health Strategy 2021–2030** as part of this activity.

Focus Area 1: Health promotion and education supporting prevention and self-management of risk factors and condition(s)

Why this is important

Health promotion and education can support efforts to prevent and reduce the risk of developing chronic conditions. The goal of health promotion is to empower individuals and communities to make healthy choices and create conditions that support wellbeing.[15] The promotion of environments that enable individuals and communities to manage risk factors, such as modifiable behaviours, and to have equitable access to health care are vital.

Health literacy is a structural barrier that inhibits equitable access to health-supporting behaviours and health care.[16] Low health literacy has an impact on the ability of everyone involved in health care to give and receive, interpret, and act on information. Health literacy plays a critical role in health promotion and education, shared decision-making, and the ability of people to effectively self-manage their condition(s). Community environments can also play an important role in enabling people to effectively self-manage chronic conditions.

Table 3. Action Priorities for health promotion and education supporting self-management of condition(s)

Focus Area	Action Priorities
1. Health promotion and education supporting self-management of risk factors and condition(s)	**1.1** Creating enabling and supportive environments
	1.2 Enhancing health literacy
	1.3 Build community capacity for self-management support

Action Priority 1.1 Creating enabling and supportive environments

Prevention is a key focus for Australia's health system. Around 36% of the burden of disease in Australia,[17] and 49% for Aboriginal and Torres Strait Islander peoples,[18] is potentially preventable through addressing modifiable risk factors such as physical inactivity, dietary risks, and harmful alcohol, tobacco and other drug use. Determinants of health impact the capacity of people to make changes to modifiable risk factors and are often outside the control of individuals. Efforts to address determinants of health should be prioritised to promote environments that support communities and individuals in risk reduction behaviours and accessing health care to manage chronic conditions.

The National Preventive Health Strategy 2021–2030 highlights the importance of creating environments that support healthier living. This includes addressing the built environment and liveability of communities, which play a role in shaping health behaviours. Key elements include urban design, walkability, access to reliable public transport, safe and inclusive green and open spaces, and food environments that make nutritious options more available and affordable. In addition to physical surroundings, social determinants such as housing quality, working conditions, social support, and opportunities for community participation influence people's ability to live healthy lives. Supportive social networks and safe, stable living conditions enable individuals to maintain healthy routines.

Commercial determinants also affect health behaviour and outcomes. These include the marketing and advertising of unhealthy products, such as fast food, alcohol and tobacco, as well as the supply chains that determine their availability and affordability. These influences can undermine public health efforts and contribute to the development of chronic conditions.

Rising temperatures, air pollution and more frequent climate-related events can worsen health outcomes and disrupt access to care. This can particularly effect people living with chronic conditions and those in rural and remote communities. The National Health and Climate Strategy outlines a plan to strengthen the climate resilience of Australia's health system. Other examples and impacts of the determinants of health are described in Appendix 1.

Action Priority 1.2 Enhancing health literacy

Health literacy relates to both an individual and to the healthcare environment.[19] Addressing health literacy requires strategies to build both the capacity of individuals to make informed choices and also the capacity of the health system to support this. Efforts to improve health literacy should consider identified Action Priorities.

Individuals

For individuals, health literacy relates to the ability to assess, understand, and apply information to make good decisions and actions about their personal health and health care. Health literacy activities should also consider how people may access health promotion and education information.

Digital health literacy is increasingly important as digital technology grows in Australia's healthcare system. Enhanced digital literacy empowers consumers in the self-management of conditions with tools including My Health Record and electronic prescriptions. Initiatives to enhance digital health literacy should consider and build upon existing resources, such as the Good Things Foundation's work on closing the digital divide.[20]

Healthcare environment

The health literacy environment relates to the infrastructure, policies, processes, materials, people and relationships that make up the health system and have an impact on individual health literacy. A key element of building the capacity of the health system is providing support for healthcare providers. Healthcare providers should be trained and skilled in the delivery of health information that supports client comprehension and ability to make informed choices about their own care. Healthcare providers should also be trained and skilled in building trust and providing a shared decision-making environment with clients to clearly understand client goals. Healthcare providers must be cognisant of potential bias and discrimination that may hinder diagnoses and provision of adequate care, particularly for priority populations.

Action Priority 1.3 Building community capacity for self-management support

Effective self-management should supplement or complement other efforts to improve chronic conditions health care, such as person-centred, multidisciplinary care and continuity of care. People should not be left to self-manage conditions in the absence of appropriate care. People should be empowered to share in decision-making and goal setting with their healthcare provider.[21] Empowering people is more effective in improving health outcomes than just providing information or advice.[22]

Strong community engagement is important for enhancing health literacy and enabling communities to build capacity for self-management of chronic conditions. Communities can shape health promotion and educational resources appropriate to their specific circumstances. Co-design and incorporating lived experience into the development of initiatives that are aimed at building capacity in communities is vital. Community leaders and champions can raise awareness and drive efforts to build capacity and have demonstrated real positive impacts on communities.

Self-management should be assisted by material being available in different languages, in simple to read formats (including ‘Easy Read’), and the availability of interpreting services. It is equally important for initiatives to be culturally safe and appropriate for the communities they are intended to assist.

Communities can provide ready access to resources including helplines, hubs, and care and navigation supports to support self-management. Community-led evaluation will help ensure health promotion and self-management remain relevant, effective and responsive to the needs of the communities they aim to support.

Participation in leisure and recreational activities can aid in chronic condition self-management by supporting a person’s physical, mental and social wellbeing following the onset of a chronic condition. This is particularly relevant for populations in rural and remote areas where formal rehabilitation services may be limited, but diverse community-based leisure opportunities exist.[23]

Focus Area 2: Embedding early diagnosis and intervention in the continuum of care

Why this is important

Early diagnosis and intervention are vital to ensuring that chronic conditions can be managed as early as possible in their progression. Some chronic conditions are not preventable due to factors such as genetics and the normal process of ageing. Early diagnosis and effective intervention are therefore particularly important for people who live with non-preventable chronic conditions. Early intervention can improve immediate health outcomes and quality of life. It also has long-term benefits, including reducing the severity of condition progression, enhancing independence for individuals, and decreasing long-term costs on the healthcare system. Utilising digital technologies and data can play a key role in improving early diagnosis and intervention.

Table 4: Action Priorities for embedding prevention, early detection and intervention in the continuum of care

Focus Area	Action Priorities
2. Embedding prevention, early diagnosis and intervention in the continuum of care	2.1 Early diagnosis and intervention
	2.2 Utilising digital technology and data

Action Priority 2.1 Early diagnosis and intervention

Early diagnosis and intervention are influenced by awareness and knowledge of certain conditions by the health workforce, particularly for conditions that can be difficult to diagnose (such as pelvic pain related conditions and rare conditions). Relevant ongoing education and training of the health workforce, along with awareness raising initiatives for healthcare providers can assist in diagnosing chronic conditions and provide opportunities for appropriate early intervention.

Mental health conditions are a consideration for early intervention, especially when they occur alongside with chronic physical conditions. Around 1.7 million adults in Australia (8% of the population) are living with both a mental health condition and a long-term physical health condition.[24] People with a mental condition often have poorer physical health than the general population, highlighting the two-way relationship between mental and physical health.[25] Mental health conditions may precede, result from, or share risk factors and comorbidities with chronic physical conditions.[26] Acting early to identify and manage mental health conditions can lead to better overall health outcomes.

Electronic clinical decision support (eCDS) tools could play an integral role in early diagnosis and intervention (as well as care and management) of chronic conditions by healthcare providers. eCDS tools can be incorporated into software used by healthcare providers. These tools may include prompts and clinical guidance to help raise awareness and support adherence to evidence-based protocols for providing appropriate care for individuals.

Chronic conditions risk assessment and prediction tools

Developing approaches that address chronic conditions in general, rather than taking a condition-specific approach, should be explored. This includes developing risk assessment tools that can be applied to more than one chronic condition.

Shared predictors across existing risk assessment tools (sociodemographic factors, anthropometric measurements, modifiable lifestyle risk factors, and medical history) present opportunities to expand on these common elements and strengthen linkages to risk of developing various chronic conditions and/or chronic conditions with overlapping risk factors.

The development of common risk assessment tools should consider the number of questions, user friendliness, evidence-based information, partnership with Aboriginal and Torres Strait Islander and other communities, and how to provide results that guide future action (such as directing an individual to a healthcare professional and/or making lifestyle adjustments). Risk assessment tools can be self-administered by individuals or be administered by a health professional in consultation with an individual.

Risk prediction tools are useful for providing insights into early diagnosis and population-based risk identification. Policy makers may use population-based risk prediction models for insight into which population groups may be at increased risk for developing particular chronic conditions. These models can be used to inform appropriate prevention and risk reduction strategies, including opportunistic and population-based screening programs.[27] Risk prediction tools require robust data collection and validation, along with comprehensive training to ensure healthcare providers can apply them effectively.[28]

Management of flare ups

Chronic conditions can ‘flare-up’, where symptoms of a condition that has been present for some time can suddenly worsen. The severity and duration of flare-ups varies. Flare-ups can be painful and debilitating. Management plans are important for people living with chronic conditions, and can assist in identifying warning signs, actions to take to alleviate or manage symptoms, treatment adjustments, and when medical assistance is required. Healthcare providers should encourage the shared development of management plans with individuals who are living with conditions that may be subject to flare-ups. The impact of flare-ups on mental health should also be incorporated into management plans. The development of support resources for flare-ups for chronic conditions should be encouraged.

Management of mental health

Poor mental health can increase the risk of developing multiple chronic conditions,[29] while living with a chronic condition may exacerbate mental health challenges. Preventive mental health measures and early intervention can help reduce the risk of both the onset and progression of chronic conditions. Likewise, effective management of physical health conditions can support improved mental health.[30] Addressing this interconnectedness requires a coordinated approach to care that integrates both physical and mental health services.

Closing the divide between physical and mental health is essential. Action Priority 4.1 provides guidance on integrated approaches, and the Department of Health, Disability and Ageing’s website provides access to national mental health policies and plans that should be considered alongside this Framework. Strengthening relationships among providers, patients and caregivers is key to enhancing care coordination.

Action Priority 2.2 Utilising digital technology and data

The Productivity Commission notes that enhancing the integration of digital technology within the healthcare sector could result in annual savings exceeding $5 billion. This could lead to shorter hospital stays, fewer duplicated tests, and increased time that healthcare providers can dedicate to person-centred care.[31]

Incorporating the principles of co-design, equity, and addressing system-level factors when designing digital health initiatives must be considered.[32] Development of initiatives in Aboriginal and Torres Strait Islander contexts must emphasise community partnership, ownership, and control over their own data and research at a regional level.

Social media and mobile health

The use of digital technology may encompass the use of social media for public health campaigns and more targeted mobile health (mHealth) applications. mHealth applications include the use of smartphones, sensors, personal digital assistants, wireless monitoring devices, or other wireless devices for the purposes of health promotion and medical assessment/treatment. mHealth applications can provide more targeted information and functionality aimed at modifying behaviour to promote health and manage chronic conditions. Effectiveness of approaches using digital technology should be assessed on longer-term measures for improving health outcomes, rather than media engagement and immediate responses.[33]

Multimorbidity trajectory modelling

The trajectories of multimorbidity in older adults can provide valuable insights into current and future health trends of ageing populations. Healthcare providers may use these trajectories to identify individuals on a path to developing chronic conditions. Once identified, possible interventions can be recommended to shift the person towards a healthier trajectory.[34] Trajectory modelling for other cohorts should be explored.

Artificial intelligence-based tools

The use of artificial intelligence-based tools could advance early chronic condition detection and individualised health care. Artificial intelligence-based tools might be used to predict the risk of developing chronic conditions. These tools would leverage extensive data from hospitals and online medical systems. This is a rapidly evolving area and faces real-world application challenges, including access to data, data variability, the potential for overdiagnosis, the need for comprehensive, real-time validation, and building trust with stakeholders in relation to the technology.[35]

Focus Area 3: Continuity of care

Why this is important

Good continuity of care has been shown to result in positive experiences, greater satisfaction and increased treatment adherence for individuals.[36] Continuity of care has also been linked with fewer hospital admissions and lower mortality.[37]

Continuity of care can be challenging for people with chronic conditions. Chronic conditions can develop and progress across different stages of the life. Care might be required across different areas of the health system, including moving across different GPs, allied health, private health, specialists, hospitals, and aged care, and into palliative care.

Non-adherence, where individuals do not or are unable to undertake their treatments, as prescribed by healthcare providers, can impact on continuity of care and effective management of chronic conditions. Supporting better medication adherence and timely adjustments to treatment when health goals are not met can improve health outcomes and reduce avoidable complications and hospital admissions from poorly controlled chronic conditions.[38]

Table 5. Action Priorities for continuity of care

Focus Area	**Action Priorities**
3. Continuity of care	**3.1** Enhancing continuity of care
	3.2 Continuity of care across life stages and the health system
	3.3 Adherence to treatments

Action Priority 3.1 Enhancing continuity of care

Principles for safe and high-quality transitions of care

The Australian Commission on Safety and Quality in Health Care's **Principles for safe and high-quality transitions of care** (Principles) provide national-level guidance on transitions of care.[iii] These principles should be followed during development of approaches to improve continuity of care in the context of transitioning between different areas of the healthcare system.

[iii] The Principles define transition of care as when all or part of a person's health care is transferred between care providers. This may involve transfer of responsibility for some aspects of a person's health care, or all of their health care, on a temporary or permanent basis.

Key elements for enhancing continuity of care

Initiatives aimed at enhancing continuity of care for people living with chronic conditions should consider focusing on:

- communication and information sharing
- collaboration and team-based care
- system and system level integration and coordination.

Communication and information sharing (information continuity)

Information sharing between healthcare providers should be prioritised when developing continuity of care initiatives.

In addition, in the context of continuity of care, the following should be considered:

- information sharing arrangements (including data access) and communication between healthcare providers (including referral systems)
- warm handover processes between clinical services
- detailed documentation to prevent knowledge loss
- introducing effective shared decision-making.[39]

Health information sharing between healthcare providers ensures that individuals experience continuity of care on their pathway through the health system. Ensuring that healthcare providers have access to up-to-date and complete medical history of an individual assists healthcare providers to assess the needs and treatment options for people with chronic conditions.

Electronic medical records are essential for supporting continuity of care for people with chronic conditions. Programs such as MyMedicare and My Health Record help share important health information between healthcare providers. This enables coordinated and consistent care across different settings. However, some individuals are concerned about sharing personal health data. Building trust in digital health systems requires clear communication about the benefits of data sharing, strong privacy safeguards, and giving individuals control over their information. Healthcare providers must also be transparent and accountable in how they manage data.[40]

State and territory governments play a key role in developing and implementing electronic or digital medical record systems, particularly in public hospitals and health services. These systems must also connect to primary health care, specialists and private hospitals to ensure continuity of care, so that people receive seamless care across different settings.

Collaboration and team-based care (relational continuity)

Multidisciplinary care is a key element that contributes to continuity of care. Multidisciplinary teams can comprise teams of providers suited to managing the specific health conditions being addressed, as well as coordinators that can help to ensure care remains person-centred. Regular contact between team members working in primary and secondary care services and between public and private health services can support swift transitions between care levels and enhance outcomes and continuity of care.[41] Multidisciplinary care should also ensure there are clear referral pathways to streamline processes for individuals and assist healthcare providers in understanding and communicating all services available to support individuals.

Primary care networks can work to support multidisciplinary care for people living with chronic conditions. Co-location of primary healthcare providers can facilitate accessibility for individuals while also encouraging collaboration and information sharing between providers. Primary care networks can improve continuity of care by allocating resources for primary care coordinators and implementation of interoperable electronic medical records systems. Chronic conditions registries in primary care networks may also assist in tracking of process and clinical outcome indicators and provide reminders to primary care coordinators to ensure individuals are progressing according to agreed care plans.[42]

Finally, community care organisations can improve relational continuity, streamline flexible care delivery, timely communication, cultural safety, and information exchange.[43]

System and system-level integration and coordination (management continuity)

System-level integration and coordination can enhance continuity of care by focusing on care coordination across sectors and consideration about how and when to use limited resources for best effect. Involving the community and developing the workforce (both public and private sector) should be through a planned and inclusive approach.[44]

Health system navigation services are a valuable example of system-level integration and care coordination. Navigation services support people living with chronic conditions who need to access multiple health services and advice from different care providers. These services are particularly beneficial for people with low health literacy, language or communication barriers, lack of experience with the health system, cognitive or intellectual disability, cultural safety barriers, and socio-economic disadvantage.

GP Chronic Condition Management Plans are an example of Medicare Benefits Schedule (MBS) items, subsidised by the Australian Government, that support coordination between an individual's usual medical practitioner and other healthcare providers, such as allied health providers.

Continuity of care during health emergencies

The impacts and adjustments made during the COVID-19 pandemic can provide insights on possible future approaches to managing health emergency responses (including those caused by pandemics and/or climate-related disasters). Minimising disruption of care for people with chronic conditions could be supported by some of the following broad approaches:

- using telehealth and telemedicine where possible
- enhancing self-management support by primary care teams and private health programs through telehealth consultations, educational resources, and tools and resources to monitor vital signs, symptoms, and medication adherence at home
- prioritising continuity of care for regional and remote communities, including Aboriginal and Torres Strait Islander communities, and proactive care for at-risk individuals
- ensuring medication supply to minimise disruption
- improving infrastructure and resourcing for chronic condition management during health emergencies through additional recruitment and training, and collaboration with private and community health providers.[45]

Action Priority 3.2 Continuity of care across life stages and the health system

Providing continuity of care across life stages requires care coordination that adapts delivery and tailors information according to an individual's circumstances, resources and needs.[46] Continuity of care for people with chronic conditions can be challenging when transitioning across key life stages.

Although this Action Priority focuses on continuity of care across life stages and the health system, the provision of age-appropriate care is always important to consider. This should be done alongside the guidance provided below. Chronic conditions can develop at any stage of life. Healthcare providers should be cognisant of age-appropriate care to ensure optimal diagnosis and treatment methods are utilised, and that communication and engagement are considered.

Transitioning from paediatric to adult care

Young people with complex healthcare needs may face challenges when transitioning to adult care. Improved transitions should be prioritised. Transition preparation planning and education is important to increase youth autonomy while recognising parent/carer roles. Collaborative educational programs between paediatric and adult care providers can enhance capacity of care for youth across diverse clinical settings. A national approach that is co-designed with youth and their families/carers and healthcare providers would further enhance this effort. Flexible funding and age cut-offs can assist in providing individualised timing for transitions to adult care.

Pregnancy

Pregnancy planning is important for people with chronic conditions to support preconception health optimisation.[47] The **Australian Pregnancy Care Guidelines** do not currently address preconception or specific needs for people with chronic conditions as this may require specialised care tailored to their specific needs. Improving access to information about how chronic conditions can affect pregnancy and how to optimise health prior to conception, will assist people. Information can be provided by healthcare providers, online resources, support groups, and the experiences of other people with similar conditions. Mental and emotional wellbeing, in addition to physical health, should also be prioritised. Immunisation history prior to conception and during pregnancy can also guide appropriate measures to protect mother and baby.

The effect of pregnancy and childbirth on chronic conditions should also be considered and relevant information provided. For Aboriginal and Torres Strait Islander peoples, guidance in Focus Area 5 should be incorporated into pregnancy care to provide culturally safe and non-discriminatory environments to ensure children are born healthy and strong.

Perimenopause and Menopause

Perimenopause and menopause are key transition periods in life. In addition to managing symptoms of perimenopause and menopause, this stage of life also presents an opportunity to prioritise early intervention for other chronic conditions that may be more likely to be experienced during or after menopause. Healthcare providers should include consideration of the risk of developing chronic conditions such as cardiovascular disease and osteoporosis and ensure that appropriate diagnostic measures are considered, early intervention is prioritised, and that any behavioural modifications are explored. Consideration should also be given to the potential for flare-ups of existing chronic conditions and/or exacerbation of menopause symptoms due to existing chronic conditions.

Healthy ageing

Chronic conditions become more common with increasing age, affecting 94% of Australians 85 years and over.[48] Supporting older people to manage these conditions while maintaining independence is essential to healthy ageing. This includes access to coordinated care, support for daily living, and services that help people remain in their homes and communities for longer.

Continuity of care is especially important for older people with chronic conditions who often interact with multiple parts of the health system.[49] In-home aged care providers can play an important role in supporting older people with chronic conditions to source clinical care, assistive technology, and home modifications to support their health goals. Supporting older people to live independently in their homes is an Australian Government priority which is also supported through the **Commonwealth Support at Home Program**.

Advance care planning

There may be times during a chronic condition journey when an individual is unable to make informed decisions for themselves in relation to the care they receive. Advance care planning documents a person's values, beliefs and preferences to guide decision-making at a future time when that person cannot make or communicate their decisions.[50] This ensures care follows an individual's preferences and helps family and carers to make decisions about care.

End-of-life/Palliative care

Palliative care is person- and family-centred treatment, care and support for people living with a life-limiting illness. Among Australians 40 years and over who died from predictable deaths (not sudden deaths) in 2019–20, 80% may have benefited from receiving palliative care in the last year of life, based on conditions that generated a need for palliative care.[51] 78% of these predictable deaths involved chronic conditions such as cancer, chronic obstructive pulmonary disease, organ failure and dementia. Early access to high-quality palliative care improves the quality of life of individuals, their families and carers.

Transitioning between healthcare sectors

Continuity of care can be improved by considering the transition points between care sectors as a condition progresses. For example, when transitioning from hospital to home it is important to incorporate appropriate discharge planning to ensure that consumers have consistent care provision, support and follow-up. This requires collaboration and planning between hospital and primary care sectors and is facilitated by having established trusted relationships, pathways and shared responsibilities between care sectors. Discharge planning can be particularly important for priority populations who may experience challenges in accessing appropriate primary care.[52]

GP Chronic Condition Management Plans are an example of MBS items that support transitioning between an individual's usual medical practitioner and other healthcare providers, such as allied health providers. Similarly, private health care chronic condition management plans can extend and complement care provided by Medicare-funded programs for those individuals who have access to private health insurance.

Hospital in the Home (HITH) programs, delivered by jurisdictions, also support continuity of care during transitions from hospital to home by providing acute care in familiar surroundings. These programs help reduce the length of hospital stays or avoid admissions altogether, lower the risk of hospital-related adverse events, and improve access to social support, while maintaining high-quality clinical care. HITH teams coordinate with other healthcare providers to ensure treatment plans are followed after discharge, helping to maintain consistent care for people with chronic conditions.

Action Priority 3.3 Adherence to treatments

Effective management of chronic conditions often relies on treatments, including pharmacological and other therapies, that aim to prevent progression and alleviate symptoms. However, their effectiveness depends on how consistently individuals adhere to prescribed regimens. Non-adherence to treatments can have significant impacts on the prevention and management of chronic conditions. Initiatives should consider five general factors that impact on non-adherence:

Table 6: Factors affecting treatment adherence

Factors	Adherence interventions should consider:
Social and economic factors	Addressing cost of treatment, access to healthy food and safe drinking water, ability to safely store medication at home, health literacy, provision of effective social support networks and access to services, including transport and health care. Interventions should support and respect cultural beliefs about illness and treatment.
Healthcare team and system-related factors	Raising awareness about non-adherence, providing clinical tools to assist healthcare providers in addressing non-adherence, and improving communication between healthcare providers and individuals and/or carers relating to adherence. Insecure access to medications, and other determinants of health should be taken into consideration by healthcare teams. Extreme weather impacts on supply chains may become more frequent due to climate change.
Condition-related factors	Educating individuals (and their carers) on the importance of adherence, considering the impact of polypharmacy and the impact of mental health on adherence, recognising a person’s ability to self-manage and adhere to treatment can be influenced by a variety of factors, including severity of symptoms, rate of progression of conditions, and co-morbidities and risk perception.[53]
Therapy-related factors	Tailoring to the needs of the individual, noting that complexity and duration of treatment regimes, frequent changes in treatment (including changes in medicine formulation and brand changes), and the immediacy of beneficial, observable effects (and side effects) impact on adherence.
Person-related factors	How well-equipped individuals are in the context of health literacy and types of motivational tools that may assist, including the use of digital technology. Empowering individuals with an understanding of chronic condition trajectory and progression with or without adherence may also assist. Services that de-stigmatise chronic conditions can assist in motivating individuals to seek care and adhere to treatments.

Pharmacological treatments

Use of pharmacological treatments for people with chronic conditions, including consideration of polypharmacy, should be actively considered in alignment with existing national policies and strategies. Health providers have responsibility for reducing inappropriate polypharmacy and its safety implications.[54] Deprescribing is a person-centred intervention, conducted under medical supervision, that reassesses the role of medicines in a person's care. Deprescribing can result in ceasing the use of medicines that have no clear benefit, may cause harm, and no longer fit within current care goals.[55]

Pharmacological treatments should also align with the **Medication Safety Standard** of the **National Safety and Quality Health Service Standards** and the **National Strategy for Quality Use of Medicines**. These standards and strategy include medication reconciliation at transitions of care, regular review of polypharmacy, regular review and involvement of community pharmacists, and improving people's ability to solve problems related to medication such as managing multiple medications.[56]

Focus Area 4: Managing multimorbidity

Why this is important

In 2022, 9.7 million Australians (38%) were living with multimorbidity.[57] People with multiple chronic conditions often require complex health care, may need to access multiple specialists and allied health services, and may require multiple medications. Their ability to participate in education or employment can be impacted, and their quality of life can be reduced.

Fragmented health care means that people with chronic conditions often need to retell their circumstances when seeing different care providers. This places significant pressure on individuals and their carers to self-advocate and to self-manage chronic conditions, particularly for individuals living with multimorbidity. Fragmentation also places pressure on healthcare providers who may not have access to complete patient history, which may create gaps in knowledge and impact on healthcare provision and coordination across the health system. Fragmentation can be exacerbated by:

- diverse sources of funding that may be subject to different requirements and reporting mechanisms
- lack of consistent, standardised formats for gathering information across the health system
- use of outdated technology in clinics
- differences in state, territory and Commonwealth data arrangements
- individuals and providers being reluctant to share information due to lack of trust.[58]

Table 7: Action Priorities for managing multimorbidity

Focus Area	Action Priorities
4. Managing multimorbidity	4.1 Addressing fragmentation in health care
	4.2 Utilising digital health

Action Priority 4.1 Addressing fragmentation in health care

Person-centred, multidisciplinary care

Person-centred, multidisciplinary care facilitates integration and coordination of care which is vital to addressing fragmentation. Person-centred care focuses on the individual rather than the condition(s) a person may be experiencing. It involves seeking out and understanding what is important to the individual, their families, carers, and support people. Conversations about treatment and care should be guided by the individual's unique circumstances and their priorities and preferences regarding health and quality of life outcomes, and shaped through collaboration with their family, carers and healthcare providers. This shared decision-making process is central to person-centred care and is an important component of effective multimorbidity care and management.[59]

Addressing the needs of individuals (and their family and carers) with multimorbidity who also experience cognitive impairment or 'invisible' impacts, like chronic pain and fatigue, should be considered. Collaborative design of interventions involving individuals, caregivers, and healthcare providers could enhance the effectiveness of care for people with multimorbidity.[60]

Common features of successful integrated and collaborative care include:

- a multidisciplinary team care approach that promotes enhanced communication and collaboration across levels of care and sectors
- co-location of services
- structured treatment plans and scheduled follow-ups
- coordinated case management
- a structured clinical governance approach
- incorporation of individual engagement and self-management
- shared access to clinical information.[61]

Clinical guidance and decision support systems

Health providers need up-to-date, evidence-based guidance to ensure they can provide appropriate care for people with multimorbidity. There is limited clinical guidance available at present on managing multimorbidity; clinical guidelines tend to focus on individual conditions. Standardised approaches based on single-disease recommendations may be inappropriate for individuals with multimorbidity and complex care needs that require multiple care providers and healthcare providers.

Establishing a unified plan in line with the overarching goals set by the individual, supported by efficient information sharing between providers, can support predictability and feasibility in the individual's life.[62] In addition, enhancing decision support systems by developing clinical practice guidelines and other guidance material for multimorbidity, and utilising computer-interactable guidance within clinical decision support systems, may facilitate addressing fragmentation and improving care for people living with multimorbidity.[63] Nationally consistent approaches to the development of clinical guidelines for chronic conditions and governance arrangements around how clinical guidelines can best be integrated into electronic clinical decisions support systems are priorities for government.

Community-based care

Community-based care is a healthcare model shaped by the needs, beliefs, and values of the community it serves, fostering community engagement and adherence. Community-based programs can support longer-term management of multimorbidity outside of hospitals, potentially reducing emergency department visits. In addition to the features of integrated and collaborative care highlighted above, characteristics of successful community-based care include planned healthcare usage and a personalised approach that addresses the social needs of individuals.[64]

The Aboriginal Community Controlled Health Organisations (ACCHO) sector is an example of successful community-based care that has been delivering multidisciplinary, team-based care shaped by the needs of its communities for more than 50 years.

Social prescribing

Social prescribing offers opportunities to connect people with non-clinical services in the community to improve health and wellbeing and may provide opportunity for people with chronic conditions, particularly those who are experiencing loneliness and social isolation.[iv] The WHO has developed **a toolkit on how to implement social prescribing**[v, 65].

Polypharmacy

Care for people with multimorbidity should also consider the impact of polypharmacy, where medications are prescribed for individual conditions without due knowledge or consideration of other medications and/or impacts of medications on other chronic conditions that an individual may be experiencing.[66] Polypharmacy can increase the risk of adverse drug events and drug interactions and is associated with suboptimal prescribing. Person-centred care should focus on the individual and all factors impacting on their health, rather than focusing on each chronic condition in isolation.[67]

[iv] Social prescribing is a means of connecting individuals to a range of non-clinical services in the community to improve their health and wellbeing.

[v] **A toolkit on how to implement social prescribing.**

Action Priority 4.2 Utilising digital health

Innovative approaches to managing multimorbidity include the integration of digital health solutions. Development of approaches to utilise digital health to address the prevention and management of chronic conditions, including multimorbidity, in the context of this Framework should align with the **Digital Health Blueprint 2023–2033** (the Blueprint). In particular, the Blueprint's guiding principles and outcomes provide a basis for considering how digital health interventions should be focused.

eCDS can provide benefits for healthcare providers in the management of chronic conditions, including multimorbidity. However, there are challenges in ensuring that eCDS are up to date, contain trusted information and guidance, and are able to integrate with other electronic health systems. Efforts to improve eCDS should be prioritised and consider the Australian Government's goals to modernise the national digital health infrastructure.

Standardised data and real-time sharing capability for information exchange will enable improved management of chronic conditions, particularly multimorbidity, by multidisciplinary teams using digitised care plans. Digitised care plans can integrate and pre-populate patient information from various sources, such as general practice records, hospital discharge summaries, and pathology reports. Efforts to standardise data and real-time sharing capabilities should be encouraged.

Future interventions and healthcare delivery may benefit from exploring the potential benefits of digital health and artificial intelligence. These technologies might reduce treatment burden and improve the ability of individuals to self-manage their health and navigate healthcare systems. However, it is important for such interventions to address the risk of widening health inequality that could result from increased use of digital health. This is particularly important for vulnerable groups who may be at higher risk of multimorbidity such as older individuals, those with lower socio-economic status, individuals with cognitive disability, people in remote areas without reliable internet access, and those facing language barriers.[68]

Anticipating the progression of chronic conditions in the early stages of ageing presents unique opportunities for timely intervention. The development of tools that utilise data-based health trajectories in older adults may help primary care providers identify individuals heading towards poor health outcomes. Based on the individual's current condition and projected trajectory, clinicians can determine suitable clinical, environmental, or lifestyle adjustments, aiming to reduce the onset of chronic conditions and potentially lessen the impact of ageing. Many chronic conditions share risk factors, which means that these adjustments may have benefits across a variety of chronic conditions.

Delaying these changes and maintaining the health of older adults offers immediate benefits, such as the increased likelihood of ageing in their own homes rather than in long-term care facilities. These models could be integrated into prediction algorithms, enabling real-time analysis of electronic medical record data at a population level, with prompt notifications sent to relevant clinicians.[69]

Focus Area 5: Enhanced and targeted support for priority populations

Why this is important

Equity is a guiding principle of this Framework. Part 1 identified that priority populations experience inequitable health outcomes. This Focus Area aims to facilitate approaches that enhance and target support for priority populations with a view to providing equitable access to appropriate care for all priority populations. Some priority populations are referenced specifically below but many of the challenges, barriers, and guidance in the Action Priorities will apply more broadly to other priority populations. Intersectionality is important to recognise in the context of targeting support for priority populations. The cumulative impacts of being part of multiple priority populations requires systemic change.

Aboriginal and Torres Strait Islander peoples

Several factors contribute to the disproportionate burden of chronic conditions experienced by Aboriginal and Torres Strait Islander communities. This includes higher prevalence, incidence, and earlier onset of chronic conditions compared to non-Indigenous people living in Australia.[70] The ongoing effects of colonisation are a key factor, including structural and interpersonal racism, discrimination and bias, dispossession of culture, land and language, and intergenerational trauma. Aboriginal and Torres Strait Islander peoples frequently face inequitable access across all levels of health care, poor access to suitable housing, food and essential services, limited access to culturally safe health care, and climate-sensitive health conditions.

Around half (49%) of Aboriginal and Torres Strait Islander peoples were living with at least one chronic condition in 2022–23, an increase from 40% in 2012–13, with 1 in 5 (22%) reporting 2 or more chronic conditions.[71] As chronic conditions become more prevalent with age, and the Aboriginal and Torres Strait Islander population has a younger age structure than the non-Indigenous population, crude prevalence rates should not be directly compared between these groups. Multimorbidity also contributes to complex health needs, ill health, reduced quality of life, disability, and premature death.[72]

37% of Aboriginal and Torres Strait Islander peoples reported living with disability in the 2022–23 National Aboriginal and Torres Strait Islander Health Survey. The availability of disability support services, particularly in remote areas was identified as a significant barrier to receiving appropriate care in the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.[73]

32% of Aboriginal and Torres Strait Islander peoples in remote areas and 55% of very remote areas live in overcrowded, and poorly maintained homes with non-functional facilities. These housing conditions are linked to the development of preventable diseases such as scabies and subsequently chronic illnesses including rheumatic heart disease.[74] Energy insecurity and lack of access to basic household items like refrigeration can impact the delivery of educational material and health campaigns and the ability to store medication and manage conditions like diabetes.

Approximately 50% of Aboriginal and Torres Strait Islander peoples access health care from an ACCHO. ACCHOs contribute to improving Aboriginal and Torres Strait Islander peoples' health and wellbeing through the provision of comprehensive primary health care, and by integrating and coordinating care and services. However, there are individuals without access to ACCHOs, or who choose to access health care via non-ACCHO services. Aboriginal and Torres Strait Islander peoples who rely on mainstream services that may not provide culturally safe environments may not receive optimal care for effectively preventing and managing chronic conditions. This highlights the importance of all services embedding culturally safe and trauma-informed care to ensure appropriate and accessible care and social and emotional wellbeing for Aboriginal and Torres Strait Islander peoples.

Aboriginal and Torres Strait Islander Peoples

49% of Aboriginal and Torres Strait Islander peoples (485,400 people) are living with at least one chronic condition*

Among First Nations people, those living in non-remote areas (**52%**) were more likely to have at least one chronic condition than those in remote areas (**34%**)

Among First Nations people aged 15 years and over, the proportion of current daily smokers decreased from **37%** to **29%** between 2018–19 and 2022–23

1 in 5 Aboriginal and Torres Strait Islander adults who had indicators of diabetes (HbA1c) did not have a previous diabetes diagnosis

Among First Nations people aged 15 years and over who had used the internet in the last 3 months, **2 in 5** had used it to access health services

First Nations people living in non-remote areas were almost twice as likely not to see a GP when they needed to at least once in the last 12 months (**17%**) than those in remote areas (**9%**)

*This is a crude proportion and should not be used for comparison with data for non-Indigenous people. The Aboriginaland Torres Strait Islander population has a younger age structure then the non-Indigenous population, and prevalence of chronic conditions is strongly related with age.

People living in rural and remote areas

Rural and remote Australia consists of a diverse range of locations and communities. Geographical isolation contributes to inequities in health outcomes. Compared to metropolitan areas, people living in rural and remote areas experience higher rates of chronic conditions and face barriers to accessing timely and appropriate health care.

Factors that drive health inequity in rural and remote areas include limited access to health care and health providers, fewer education and employment opportunities, higher rates of risky behaviours (such as tobacco smoking and alcohol use), and higher rates of occupational and physical risk.[75]

People living in *Inner regional* and *Outer regional and remote* areas experience higher rates of chronic conditions, compared with those in *Major cities* (both 67%, compared with 58%).[76] Multimorbidity is more common in *Inner regional* areas (46%) and *Outer regional and remote* areas (45%) than in *Major cities* (35%).[77] Despite this, people living outside of *Major cities* have lower use of chronic condition management services.[78] The rate of potentially preventable hospitalisations[vi] for chronic conditions was highest for residents of *Remote* and *Very remote* areas (17.0 and 25.3 per 1,000 population, respectively) and lowest for residents of *Major cities* (9.9 per 1,000).[79]

Multicultural communities

Multicultural communities are made up of people with a range of characteristics including their country of birth, ancestry, their parents' country of birth, languages spoken and religious affiliation. Multicultural communities include people from CALD backgrounds. A range of information is often needed to identify the unique characteristics of a person that may affect their healthcare needs.

People born in many overseas countries experience higher rates of common chronic conditions than the Australian-born population. Among people who arrived in Australia over a decade ago, those with low English proficiency experience higher rates of chronic conditions than those with high proficiency.[80] This pattern also occurs among humanitarian migrants. The likelihood of chronic conditions and being in fair-poor health was higher among those with low proficiency in spoken English.[81]

People with multicultural backgrounds can experience the following challenges and barriers that can put them at greater risk of poorer quality health care, service delivery, and health outcomes:

- racism and discrimination
- stigma associated with health conditions
- language barriers, including lack of translated materials or access to interpreting services
- lower health literacy
- difficulties navigating the health system
- economic challenges such as unemployment and income disparities
- social isolation and lack of community support
- lack of culturally sensitive care
- impacts of torture and trauma that may require complex needs-based approaches (including for refugees).

[vi] Potentially preventable hospitalisations are for conditions where hospitalisation is considered preventable if timely and adequate health care has been provided through population health services, primary care and outpatient services.

People with disability

Chronic conditions and disability often coexist. Half (50%) of the population with one of the selected chronic conditions also experience disability.[82] There is a 2-way relationship between chronic conditions and disability. People with chronic conditions are more likely to develop disability, and people with disability are more likely to develop a chronic condition. Some people with disability experience barriers accessing health services including unacceptable or lengthy waiting times, cost, inaccessibility of buildings, and discrimination by health providers.[83]

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission) heard from people living with disability that unconscious bias, prejudice and a lack of trauma-informed care from health services and systems created intersectional barriers for accessing appropriate and timely health care. Other factors identified by the Disability Royal Commission that limit access to health care, include low health literacy among the disability workforce, challenges attending health appointments, and difficulties navigating the health system.[84] These barriers can contribute to late identification and poor management of complex and chronic health conditions among people with disability.

LGBTQIA+ people

Sexuality and gender diverse people, and people with innate variations of sex characteristics are estimated to constitute over 5% of the Australian population.[85] LGBTQIA+ communities are not a homogenous population, and people may be simultaneously part of multiple groups.

While LGBTQIA+ people experience higher prevalence of mental health conditions and higher prevalence of risk factors for chronic conditions, comprehensive national data on physical chronic conditions is limited due to underrepresentation in health data collections and challenges in capturing diverse identities.

Sexuality and gender diverse people and people with innate variations of sex characteristics often have poorer physical and mental health outcomes than the general population, which could be mediated by reducing stigma, discrimination, social isolation and difficulty in obtaining appropriate health care.[86] In a large national survey, less than half of the sexuality diverse respondents reported feeling accepted ‘a lot of the time’ when they accessed a health or support service.[87]

Table 8: Action Priorities for enhanced and targeted support for priority populations

Focus Area	Action Priorities
5. Enhanced and targeted support for priority populations	5.1 Providing culturally safe, non-discriminatory and trauma-informed care
	5.2 Improving access to appropriate information
	5.3 Improving access to healthcare services
	5.4 Addressing compounding impacts associated with intersectionality

Action Priority 5.1 Providing culturally safe, non-discriminatory, and trauma-informed care

Non-discriminatory care

Non-discriminatory care must be a focus for all health providers. Non-discriminatory care should aim to reduce or eliminate the variety of factors that priority populations experience that can lead to delays and/or avoidance in seeking health care. For example:

- past experiences, stigma, and fear of judgement related to specific health issues, such as obesity, mental health, substance use or past/current contact with the child protection and/or youth justice systems
- healthcare providers who communicate only with caregivers or assume people with neurocognitive conditions (such as dementia) cannot make their own decisions or will not benefit from access to wellness or allied health services
- past experiences of racism within the healthcare system can lead individuals to fear that they may encounter further discrimination[88]
- unwelcome environments, such as being treated disrespectfully by staff
- not asking whether a client identified as Aboriginal or Torres Strait Islander (asking helps to ensure Aboriginal and Torres Strait Islander peoples are provided access to any additional services and supports available to them)
- insufficient cultural understanding among healthcare providers (for example, men's or women's business, taboo or sensitive topics, days of cultural significance, mistrust of authority and/or healthcare providers)
- use of discriminatory or non-inclusive language and lack of interpreting services or information in language can hinder communication, understanding and delivery of effective health care
- lack of easy-to-understand information and lack of clear healthcare pathways can result in delays to treatment or access to services.

People with disability

The Disability Royal Commission made recommendations to improve healthcare access for people with disability, including legislating a right to equitable access to health services and embedding that right in key health policy instruments.[89]

The Australian Government acknowledges the need to improve health outcomes and health equity for people with disability. Relevant disability strategies and guidelines should be considered in the development of measures aimed at improving the prevention, diagnosis, early intervention, and management and care of chronic conditions for people with disability.

Culturally safe care

Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander peoples have a holistic, whole of life view of health, which is all-encompassing considering kinship and connection with Country, as well as social, emotional, physical, spiritual and cultural wellbeing of both individuals and the families and Communities in which they live.[90] Culturally safe care that acknowledges this is vital for Aboriginal and Torres Strait Islander peoples. Culturally safe practice is the visible result of ongoing critical reflection about knowledge, skills, attitudes, behaviours and power differentials by health providers themselves as they strive to deliver safe, accessible and responsive health care, free of racism.[91] Culturally safe care for Aboriginal and Torres Strait Islander peoples should:

- embed Aboriginal and Torres Strait Islander leadership in governance, service design, delivery and evaluation aligned with Priority Reform 1 of the National Agreement on Closing the Gap
- embed culture within engagement, communication and care delivery, including staff, protocols, leadership and practices
- ensure all staff in health settings are trained and develop skills and practice in cultural safety, including client facing staff and management/executive, to ensure that culturally safe environments are provided and that the burden is not entirely placed on Aboriginal and Torres Strait Islander staff
- be place-based, culturally appropriate, consider the impacts of intersectionality and intergenerational trauma, and be designed in partnership with Aboriginal and Torres Strait Islander communities
- recognise that all healthcare providers must provide culturally safe and trauma-informed care, including during transitions between healthcare sectors, noting that Aboriginal and Torres Strait Islander peoples will not always seek, or be able to seek, health care from an ACCHO, or receive health care from an Aboriginal and Torres Strait Islander Health Worker or Practitioner who make up only a small percentage of the total health workforce.[92]

Effective comprehensive health care for Aboriginal and Torres Strait Islander peoples with chronic conditions requires multidisciplinary, integrated, coordinated, person-centred, and culturally appropriate approaches to health service delivery. These approaches must consider the cultural and social determinants of health, structural determinants of health inequity and individual community needs and strengthening self-management and client navigation of the health system.[93] This model of care exists within ACCHOs and encompasses the pillars of comprehensive primary health care:

- first contact of care
- coordination of care and appropriate referral pathways
- continuity of care.[94]

The effectiveness and value of ACCHO service models illustrates that Aboriginal and Torres Strait Islander peoples must be partners in co-designing and leading care that is targeted for Aboriginal and Torres Strait Islander peoples.[95] In addition to the above points about culturally safe care, the following elements are important to consider in the context of enhancing and targeting support for care for Aboriginal and Torres Strait Islander peoples with chronic conditions:

- incorporating, and valuing the contribution, of Aboriginal and Torres Strait Islander Health Workers and Providers within multidisciplinary teams
- linking with community care and social support services
- embedding Aboriginal and Torres Strait Islander representation and shared decision-making processes in regional health policy activities
- providing education and enabling empowerment
- providing language and communication support by using persons' first language, or a translator, and traditional protocols and values
- reducing institutional racism and structural barriers in health care that adversely impact on Aboriginal and Torres Strait Islander peoples
- working in partnership with Aboriginal and Torres Strait Islander communities, leaders and organisations to create culturally safe and responsive referral pathways from primary to tertiary care and back to primary care to ensure continuity and avoid disconnection
- supporting and growing the ACCHO sector to deliver holistic and culturally safe care and services to Aboriginal and Torres Strait Islander communities, in recognition of the value of their service models.[96]

Efforts to prevent and manage chronic conditions align strongly with the National Agreement on Closing the Gap. They contribute to achieving Target 1, ensuring everyone enjoys long and healthy lives, and support Priority 5 of the **National Aboriginal and Torres Strait Islander Health Plan 2021–2030**, which focuses on early intervention. Providing culturally safe care and targeted support for Aboriginal and Torres Strait Islander communities also advances Target 14, promoting social and emotional wellbeing. Strengthening the ACCHO sector further supports Priority Reform Area 2, helping build a strong, community-led health system.

Multicultural communities

Culturally safe and responsive health care is important for multicultural communities. Care for people with multicultural backgrounds who have chronic conditions can be improved by:

- providing language and communication support
- cultural competency training for healthcare providers
- developing multilingual health materials
- supporting the use of interpreting services
- providing accessible health system navigation support
- incorporating cultural practices in treatment plans (including dietary practices).[97]

Multicultural service providers, or those with multicultural capacity, can ensure people in multicultural communities have access to healthcare that they can understand and feel comfortable in accessing.[98]

Trauma-informed care

Trauma can impact both mental and physical health, including chronic conditions. It can impact on people's access to health care, their interactions with the healthcare system, and their ability to follow through with prescribed treatments. Trauma-informed care is vital in all healthcare settings and is founded on six core principles. This includes safety, trustworthiness, providing opportunity for choice, collaboration, empowerment, and respect for diversity.

The following examples of approaches that incorporate trauma-informed care provide guidance in considering approaches for addressing chronic conditions, including:

- the Healing Foundation, which is a national Aboriginal and Torres Strait Islander organisation that promotes trauma-aware, healing-informed practice to help government, policymakers, and workforces understand their role in intergenerational healing[99]
- practice guidelines for treatment of complex trauma and trauma-informed care and service delivery, developed by the Blue Knot Foundation and funded by the Department[100]
- the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT), which is a network of Australia's 8 rehabilitation agencies that work with survivors of torture and trauma who have come to Australia from overseas.[101]

Action Priority 5.2 Improving access to appropriate information

Information for individuals

The availability of appropriate evidence-based information for people from priority populations will assist in the prevention, early intervention, and management of chronic conditions. Engaging consumers in the development of health and cultural literacy policy design and implementation will assist in improving engagement, acceptability, and utilisation of policies.

Examples of providing accessible information include, but are not limited to:

- providing simple messaging
- use of Auslan and language interpreters in primary health care
- presentation of text and documents in easy-to-read format with images ('Easy Read'), which is often created for people with intellectual disability but is also helpful for other priority populations, including people with low literacy, people from multicultural backgrounds, and older people
- partnering with Aboriginal and Torres Strait Islander communities to tailor information that is culturally appropriate, and place-based.

It is important for people to know the rights they can expect when receiving health care. The **Australian Charter of Healthcare Rights** describes the rights of all people in all places where health care is provided in Australia.

Information for Aboriginal and Torres Strait Islander communities

Priority Reform 4 of the National Agreement on Closing the Gap highlights the importance of sharing disaggregated data and information with Aboriginal and Torres Strait Islander organisations and communities and enable them to obtain a comprehensive picture of what is happening in their communities to help them make decisions about their future. By acknowledging the need to work towards the principles of Aboriginal Data Sovereignty through Aboriginal Data Governance, these efforts ensure that data is managed in ways that respect the rights and authority of Aboriginal and Torres Strait Islander peoples. Priority 12 of the **National Aboriginal and Torres Strait Islander Health Plan 2021–2031** sets out the desired outcome for shared access to data and information at a regional level.

Information for healthcare providers

Access to appropriate information is also important for healthcare providers and can include information about how to appropriately engage with people in priority populations, access to past and current medical history, and access to up-to-date and trusted clinical guidance.

Action Priority 5.3 Improving access to healthcare services

Healthcare service improvements can be guided by considering conceptual frameworks of healthcare access. Conceptual frameworks can highlight how the steps people go through in seeking health care can be affected by individual and systemic factors. The Australian Institute of Health and Welfare provides discussion of frameworks in the context of use of primary health care by Aboriginal and Torres Strait Islander peoples.[102]

Multidimensional approaches

Outreach programs can increase access to health care by emphasising local partnerships and cultural safety. Outreach programs are well-suited to regional and remote community settings which are often underserved in the healthcare sector but can also be of benefit in metro areas for priority populations such as people from multicultural backgrounds and Aboriginal and Torres Strait Islander peoples.[103]

The objectives of outreach programs are to:

- reduce access barriers such as distance, cost, and cultural safety issues (including provision of services through ACCHOs and telehealth)
- strengthen local service capacity through upskilling and increased workforce
- enhance service coordination by forming collaborative partnerships.

The development of non-invasive techniques for diagnosis can increase accessibility for some priority populations and the potential for remote assessment can facilitate diagnosis in rural and remote locations, noting accuracy is dependent on healthcare provider training and experience.

Digital health interventions

Digital health interventions can be effective for promoting lifestyle changes including smoking cessation, improvements in eating behaviours, weight reduction, and increased physical activity.[104] Digital health interventions can include the following:

- personalised apps
- multimedia and visual elements
- self-monitoring and remote monitoring tools
- reminders, tips, rewards, incentives, coaching and progress tracking
- coaching
- quit tips[105]
- progress tracking
- community support.

Harnessing digital health interventions, including smart-home technologies, can play a pivotal role in enhancing care by:

- fostering better adherence to treatment
- facilitating communication with healthcare providers, and timely interventions
- reducing travel times, costs, and waiting times for appointments and diagnosis
- reducing the risk of contagion and infections (including during pandemics)
- ensuring continuity of care during incidents and emergencies such as climate-related disasters and extreme weather events
- promoting ageing in place and allowing people to remain safely in their own homes or appropriate housing and reduce hospitalisations and avoid institutionalisation.

Digital health uptake faces significant barriers to technology adoption. These include socio-economic status, certain health conditions, cognitive and physical impairments, technological infrastructure (for example, in remote communities), amongst others. Enablers of technological adoption include improving access to technology and digital literacy, accommodating cognitive and physical impairments (such as wearable devices with larger screens), ensuring user-friendly and secure technology.[106]

Home-based care

Supporting people who have difficulty maintaining independence at home, due to chronic conditions and ageing, to live independently in their homes will help avoid costly residential care. This is a priority for the Australian Government in the aged care space. Older people with chronic conditions can benefit from having an aged care provider or advocate, who already has rapport with the older person, assisting in the delivery of health care, including home-based care.

The delivery of these services is critical to many communities, but consideration is required in relation to adequate funding, potential barriers and risk factors. For example, Aboriginal and Torres Strait Islander peoples, may experience barriers where overcrowding and poor-quality housing have an impact on safety, wellbeing and access to resources.

Home-based care is largely focused on aged care. Programs aimed at delivering home-based services for younger people may provide improved access to care for people not eligible for the above programs.

Action Priority 5.4 Addressing compounding impacts associated with intersectionality

Intersectionality recognises the overlapping aspects of a person's identity, such as race, ethnicity, gender, sexual orientation, disability, and mental health, can create unique experiences of disadvantage. These intersecting identities can compound the impacts of chronic conditions through systemic discrimination, marginalisation and unequal access to opportunities.[107] Intersectionality provides a lens to understand how multiple forms of discrimination and marginalisation overlap and intensify inequities. Applying this lens can help identify gaps in policy and service delivery, and fix systems that reinforce intersecting inequities.

A person-centred approach, supported by shared decision-making, is essential for addressing intersectionality in the prevention and management of chronic conditions. This approach focuses on understanding the whole person, including their lived experience and the external factors that shape their health. It involves listening actively, building trust, recognising complexity, and tailoring care to individual needs. Shared decision-making ensures that people are active participants in their health care, with their experiences guiding clinical decisions. Person-centred care helps deliver services that are respectful, inclusive and responsive to diverse backgrounds, helping people achieve more equitable health outcomes.

To effectively embed intersectionality into chronic condition strategies, governments must also take coordinated action across sectors to address the broader systemic barriers that affect health. Health systems must work in partnership with other sectors such as housing, education, employment and justice to respond to the full range of factors influencing health. The WHO's Health in All Policies (HiAP) model provides a practical framework for this collaboration, encouraging shared responsibility and long-term partnerships.[108]

HiAP approaches are supported by four pillars:

- governance and accountability through whole-of-government plans, fostering a culture of collaboration, and harnessing existing structures and mechanisms
- leadership at all levels, including advocating for, and fostering a culture of collaboration, establishing a network of HiAP champions, and joint identification of issues to achieve shared goals
- ways of working and work methods including developing collaborative partnerships based on trust and open communication, understanding policy priorities of partners, and co-designing policy plans
- resources, financing, and capabilities through having dedicated HiAP roles and budget, and capabilities for knowledge translation.

Embedding intersectionality into chronic condition strategies will help systems respond more effectively to the needs of people experiencing multiple, overlapping forms of disadvantage. This will improve equity, access, and outcomes for priority populations. As an evolving concept in public health, strengthening the evidencebase on intersectionality will support effective and inclusive policy and practice.

Part 3: Monitoring Chronic Conditions

> **Monitoring is the systematic and ongoing collection, analysis, and reporting of key health measures. Effective monitoring of chronic conditions plays a critical role in providing insights into chronic conditions and their impacts on individuals, health systems and society, to support evidence-based decision-making, resource allocation, and timely response to emerging priorities.**

This high-level Framework complements existing strategies, many have their own established indicators or measures for tracking progress against targets. Existing measures that are routinely reported on and relevant to the Framework are included in:

- the **National Preventive Health Strategy**
- the **Australian Health Performance Framework**
- the **Aboriginal and Torres Strait Islander Health Performance Framework**
- the **Cultural safety in health care for Indigenous Australians: monitoring framework**
- **Measuring What Matters**
- Part E of the **Report on Government Services**.

Domains for monitoring Chronic Conditions

To comprehensively monitor chronic conditions, data should be regularly collected, analysed and reported across the following domains:

- prevalence (and incidence) of chronic conditions and multimorbidity
- prevention and early detection: may include prevalence of modifiable risk factors or health behaviours, screening rates and immunisation rates
- treatment and management: may include access to care, continuity of care, utilisation of healthcare services (procedures and MBS items) and medication and treatment adherence
- health outcomes: may include burden of disease, hospitalisation and readmission rates, mortality rates and quality of life
- population groups: disaggregation by age and sex, by geography; may include reporting for priority populations (such as Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse (CALD) backgrounds, LGBTQIA+ people, people with disability)
- demographics: may include population characteristics and broader determinants of health.

It is essential to monitor a comprehensive range of measures to contextualise any observed trends. For example, prevalence of conditions may increase with improved diagnosis and screening. Relevant measures for monitoring chronic conditions and corresponding data sources or reports at the national level are described in Appendix 3.

Monitoring at different levels

At the national level, monitoring provides a broad overview of population health trends and informs national policy, program and service decisions. The AIHW's **Australian Centre for Monitoring Population Health** brings together the latest data and information on the health of Australians, including monitoring chronic conditions.

At the jurisdictional level, state and territory governments can use monitoring to tailor strategies to their specific population needs and contexts. Meanwhile, monitoring at the local level (for example, by Primary Health Network or by Population Health Area) supports community health planning, service delivery and targeted interventions, particularly for priority populations.

Coordinated monitoring across all levels ensures consistency, enhances comparability and enables the scaling of effective prevention and management strategies.

Data gaps and opportunities

Data sources that are accurate, consistent and complete are essential for reliable population health monitoring. There are some existing gaps in availability of data for chronic condition monitoring, particularly for certain chronic conditions and population groups. Areas of opportunity to build the evidencebase include (but are not limited to):

- improved data collection for priority populations
- national primary health care data
- national collection of biomedical risk factor data
- linkage of clinical disease registers to administrative health data
- data on timeliness of interventions and appropriateness of care.

These opportunities may be realised over the duration of the Framework, with advances in digital health, data linkage and real-time analytics offering possibilities for enhancing monitoring. Reporting on key domains for chronic conditions monitoring, rather than specific indicators, allows adaptability as the health information system evolves.

Addressing data gaps for priority populations (such as people from CALD backgrounds and LGBTQIA+ people) is essential for achieving health equity. Priority populations are often underrepresented in administrative and survey data, limiting the ability to design, implement and evaluate policies and programs that meet their needs. Applying nationally consistent standards in data collection, such as the **Standards for Statistics on Cultural and Language Diversity** and the **Standard for Sex, Gender, Variation of Sex Characteristics and Sexual Orientation Variables**, ensures that data is inclusive, comparable and fit-for-purpose, ultimately supporting improved monitoring, and more equitable policy development and service delivery.

Monitoring is not an end in itself. It is a tool for action. By identifying trends and insights, monitoring informs priority setting for policy and program development, and continuous improvement in service delivery and health outcomes. It enables a proactive, coordinated and equitable approach to the prevention and management of chronic conditions. Strengthening monitoring at all levels will contribute to achieving the objectives of the Framework and drive better health outcomes for all Australians.

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Appendix 1: Determinants of health

Table 9: Examples and impacts of determinants of health

Determinant	Examples/Impacts
Social	Examples: Family situation, early childhood circumstances, social support and connections, housing conditions and working conditions. Impacts: Strong social support outside of family can be a protective factor, while lack of support, loneliness and social exclusion, and presence of violence and abuse can have adverse effects on health. Housing challenges, such as overcrowding, homelessness and lack of amenities, can have adverse effects. Women and children are disproportionately affected by family, domestic and sexual violence (FDSV). Some health outcomes associated with FDSV are immediate while others, such as mental illness, develop over time and persist for years after the violence has ceased.
Cultural	Examples: Connection to Country, family, kinship and community, beliefs and knowledge, cultural expression and continuity, language, self-determination and leadership. Impacts: Culture plays an important role in the health and wellbeing of Aboriginal and Torres Strait Islander peoples and people from culturally and linguistically diverse populations (CALD). Culturally safe care can be a protective factor in supporting the health and wellbeing of communities; conversely, a lack of culturally safe care can have an adverse impact.
Environmental	Examples: Climate change and extreme weather events, built environments including buildings, parks and infrastructure (transport, services and utilities). Impacts: Climate change and extreme weather events can have adverse impacts, particularly for susceptible populations. Access to transport and affordable, healthy food options can impact on ability to access health care and have a healthy diet.
Structural	Examples: Cost of healthcare, availability of timely and quality services, systemic racism and discrimination, health literacy levels and geographic location. Impacts: Living in rural and remote locations can make access to health care difficult. Systemic racism presents significant barriers for Aboriginal and Torres Strait Islander communities and CALD communities to access equitable health care and other services.

Determinant	Examples/Impacts
Economic	Examples: Education, employment, occupation and income. Impacts: Income impacts on being able to afford health care and medications. Education impacts on health literacy and ability to navigate health system and self-manage conditions.
Biomedical	Examples: Blood pressure, blood glucose levels and genetics. Impacts: Biomedical determinants can include non-modifiable factors such as genetics, which can influence the likelihood of developing chronic conditions. Biomedical risk factors such as blood pressure and blood glucose levels can be influenced by both genetics and behavioural risk factors (such as physical activity, tobacco use, diet). Behavioural risk factors are significantly influenced by other determinants of health.
Commercial	Examples: Stem from profit motive and encompass approaches used to promote products and/or choices that impact on the health of individuals and communities Impacts: Advertising and marketing can have both positive and adverse effects on behaviours. Supply chains influence the availability of affordable and quality food products, particularly for remote communities.
Digital	Examples: Wearable technologies, mobile health applications and electronic medical records, diagnostic and therapeutic tools and telehealth. Impacts: Telehealth can provide greater access to services, particularly for people in rural and remote locations; however, it requires adequate access to internet connections, devices and digital health literacy to be effective. Electronic medical records can enable greater information sharing between health service providers.

Appendix 2: Key Australian Government policies, strategies and plans relevant to the Framework

- Australian Dietary Guidelines
- Australia’s Disability Strategy 2021–2031
- Australian Framework for National Clinical Quality Registries
- Australia’s Primary Health Care 10 Year Plan 2022–2032
- Australian 24-Hour Movement Guidelines for children (5 to 12 years) and young people (13 to 17 years)
- Australian 24-Hour Movement Guidelines for adults (18 to 64 years) and older Australians (65+ years) (under development)
- Digital Health Blueprint 2023–2033
- Disability Sector Strengthening Plan
- Gayaa Dhuwi Declaration Framework and Implementation Plan (DFIP)
- Health Sector Strengthening Plan
- Measuring What Matters Wellbeing Framework
- Medical Research Future Fund (MRFF) 3rd 10-year Investment Plan (2024-25 – 2033- 34)
- MRFF Cardiovascular Health Mission Roadmap and Implementation Plan
- MRFF Dementia, Ageing and Aged Care Mission Roadmap and Implementation Plan
- National Action Plan for Endometriosis
- National Alcohol Strategy 2019–2028
- National Aboriginal and Torres Strait Islander Health Plan 2021–2031
- National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031
- National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (NATSOSPS)
- National Action Plan for the Health and Wellbeing of LGBTIQA+ People 2025–2035
- National Action Plan for The Health of Children and Young People 2020–2030
- National Agreement on Closing the Gap
- National Children’s Mental Health and Wellbeing Strategy 2021
- National Collaborative Research Infrastructure Strategy

- National Consumer Engagement Strategy for Health and Wellbeing (under development)
- National Dementia Action Plan 2024–2034
- National Digital Health Strategy 2023–2028
- National Drug Strategy 2017–2026
- National Fetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan 2018–2028
- National Framework for Protecting Australia's Children 2021–31
- National Health and Climate Strategy
- National Health Literacy Strategy (under development)
- National Health and Medical Research Strategy
- National Healthcare Interoperability Plan 2023–2028
- National Ice Action Strategy – 2015
- National Medical Workforce Strategy
- National Medicines Policy
- National Mental Health and Suicide Prevention Agreement
- National Men's Health Strategy 2020–2030
- National Nursing Workforce Strategy (under development)
- National Obesity Strategy 2022–32
- National Oral Health Plan
- National Osteoarthritis Strategy 2018
- National Palliative Care Strategy 2018
- National Plan to End Violence Against Women and Children 2022–32
- A National Policy Roadmap for Artificial Intelligence in Healthcare
- Nurse Practitioner Workforce Plan 2023
- National Preventive Health Strategy 2021–2030
- National Roadmap for Improving the Health of People with Intellectual Disability
- National Roadmap to Improve the Health and Mental Health of Autistic People 2025–2035
- National Rural Health Strategy
- National Strategic Action Plan for Inflammatory Bowel Disease
- National Strategic Action Plan for Osteoporosis 2019
- National Strategic Action Plan for Arthritis 2019
- National Strategic Action Plan for Pain Management
- National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023
- A National Strategy for Clinical Quality Registries and Virtual Registries 2020–2030

- National Strategy for Injury Prevention (under development)
- National Strategy for the Quality Use of Medicines
- National Strategy to Prevent and Respond to Child Sexual Abuse 2021–30
- National Silicosis Prevention Strategy 2023–2028 and Accompanying National Action Plan (under development)
- National Tobacco Strategy 2023–2030
- National Women's Health Strategy 2020–2030
- Newborn Bloodspot Screening National Policy Framework 2018
- Paediatric Palliative Care National Action Plan
- Post-Acute Sequelae of COVID-19 Research Plan
- Primary Health Research Plan
- Recommendations from the Disability Royal Commission
- Statement on Sex, Gender, Variations of Sex Characteristics and Sexual Orientation in Health and Medical Research
- Strengthening Medicare Taskforce Report
- Targeted Translation Research Accelerator Research Plan (Diabetes and Cardiovascular Disease) Working together to deliver the NDIS | NDIS Review
- 2025–2030 Addendum to the National Health Reform Agreement

Appendix 3: Key measures for monitoring Chronic Conditions

Monitoring will use existing reporting for chronic conditions where possible. National data sources are provided as examples of measures for monitoring chronic conditions. Other data sources may be available for monitoring at the jurisdiction or local level, or for selected population groups.

Table 10: Key measures for chronic conditions and mapping to specific Priority Areas

Measure	Domain	National data sources	Reporting	Comments
Prevalence and incidence of chronic conditions	Prevalence and incidence	**National Health Survey** **Intergenerational Health and Mental Health Study** **Ten to Men: The Australian Longitudinal Study on Male Health** **Australian Longitudinal Study on Women's Health** Condition-specific registries **National Health Data Hub**	**Measuring What Matters** **Australia's Health Performance Framework** **Australia's Health**, '**Chronic conditions**' topic summary **Report on Government Services**, Part E Health	Presented by sex, age and across remoteness and socio-economic areas Key measures that are specific to male and female health are described in the **National Men's Health Strategy 2020–2030** and the **National Women's Health Strategy 2020–2030**.
Prevalence of multimorbidity and comorbidity	Prevalence and incidence	National Health Survey	Measuring What Matters Australia's Health, 'Multimorbidity' topic summary	Reflects the complexity of managing multiple chronic conditions and identifies patterns in co-occurring conditions. Presented by sex, age and across remoteness and socio-economic areas

Measure	Domain	National data sources	Reporting	Comments
Burden of disease - total burden (disability-adjusted life years) - fatal burden (years of life lost) - non-fatal burden (years lived with disability)	Health outcomes	**Australian Burden of Disease Study**	Australian Burden of Disease Study (annual web report)	Quantifies the overall impact of chronic conditions on population health, combining both premature death and years lived with disability. Helps identify which conditions cause the greatest health loss. Presented by disease or disease group.
Life expectancy - health-adjusted life expectancy	Health outcomes	Australian Burden of Disease Study	**National preventive health monitoring dashboard** Measuring What Matters	Similar to burden of disease, health-adjusted life expectancy reflects long-term impact of chronic conditions on population survival and years lived in good health.
Deaths - mortality by cause of death - potentially avoidable deaths - survival rate	Health outcomes	National Mortality Database	Australia's Health Performance Framework Report on Government Services, Part E Health	Potentially avoidable deaths measures deaths that could have been prevented with timely and effective healthcare or public health action.
Disease progression - sequelae/ complications/stages	Health outcomes	Condition-specific registries Linked administrative health data (such as National Health Data Hub)		Condition-specific registries are the primary sources for tracking disease stages, complications, and outcomes over time. Linked data analysis across hospitalisation and prescriptions can indicate disease progression patterns for some conditions.

Measure	Domain	National data sources	Reporting	Comments
Unplanned health service use - emergency department presentations - potentially preventable hospitalisations - hospital readmissions	Health outcomes Treatment and management	National Non-Admitted Patient Emergency Department Care Database National Hospital Morbidity Database Linked hospitalisations data		Frequent emergency visits or hospital readmissions often indicate gaps in ongoing care, poor condition management or lack of access to timely support. Potentially preventable hospitalisations refer to hospital admissions that could have been avoided through timely and effective primary care or early disease management and are used as indicators of access to and quality of primary healthcare services.
Effects of fragmented healthcare - mortality following hospital discharge - hospital readmission following hospital discharge - prescription supply following hospital discharge	Health outcomes Treatment and management	Linked hospitalisations, prescribed medicines and deaths data (such as National Health Data Hub)	Australia's health performance framework	(4.1) Unplanned hospital readmission or death after an index hospitalisation can indicate fragmented health care. Linked data can reveal gaps and overlaps in health service provision.

Measure	Domain	National data sources	Reporting	Comments
Health system expenditure - investment in public health - health expenditure by disease or disease group	Health outcomes Treatment and management	Health Expenditure Database Disease Expenditure Database	National preventive health monitoring dashboard Health expenditure Australia (annual web report) Health system spending on disease and injury in Australia (annual web report)	Health system expenditure shows how resources are distributed across the healthcare system and across different conditions.
Prevalence of risk factors and determinants of health	Prevention and early detection	National Health Survey National Health Measures Survey National Drug Strategy Household Survey National Perinatal Data Collection Personal Safety Survey Census of Population and Housing Labour Force Survey Household Income and Labour Dynamics in Australia (HILDA) Australian Early Development Census	National preventive health monitoring dashboard Australia's health performance framework **Australian Urban Observatory**	(1.1, 1.3, 2.1) Includes risk factors and determinants of health for individuals, as well as the physical, social and policy environment of communities.

Measure	Domain	National data sources	Reporting	Comments
Burden attributable to risk factors - leading risk factors contributing to disease burden	Prevention and early detection Health outcomes	Australian Burden of Disease Study	Australian Burden of Disease Study (annual web report)	Burden attributable to risk factors identifies which modifiable behaviours and exposures contribute most to disease and disability.
Participation in preventative health checks and screening - participation in screening programs - MBS claims for preventative health checks	Prevention and early detection	**Medicare Benefits Schedule** National Perinatal Data Collection Condition-specific screening registers	National preventive health monitoring dashboard Australia's Health Performance Framework **Interactive report card: Australian women's preventative health checks, screening and vaccinations**	(2.1, 5.3) **Population-based screening programs** are described on the Department's website. **MBS health assessment items** are described on the Services Australia website.
Immunisation and vaccination rates - childhood immunisation coverage - adolescent immunisation coverage	Prevention and early detection	**Australian Immunisation Register**	National preventive health monitoring dashboard	(2.1, 5.3) The **National Immunisation Program Schedule** is described on the Department's website.
Health literacy - ability to access, understand and use health information	Prevention and early detection Treatment and management	**Patient Experience Survey** **Health Literacy Survey** **General Social Survey**		(1.2, 5.2) Health literacy affects a person's ability to understand, manage, and make informed decisions about their health. Higher health literacy supports better self-management, treatment adherence, and navigation of the healthcare system.

Measure	Domain	National data sources	Reporting	Comments
Accessibility of healthcare services - unmet needs - waiting times (e.g. emergency department care, elective surgery) - leave events (left/ discharged at own risk of did not wait) - cost	Treatment and management	National Non-Admitted Patient Emergency Department Care Database National Elective Surgery Waiting Times Data Collection National Hospital Morbidity Database Patient Experience Survey	Australia's health performance Framework Report on Government Services, Section 12 (annual report)	(5.3) Timely access to care is essential for effective management of chronic conditions and prevention of complications. Barriers like cost, wait times, and geographic location can impact health outcomes.
Use of healthcare services for managing chronic conditions - MBS claims for chronic condition management services - GP attendance rate	Treatment and management	Medicare Benefits Schedule		(5.3) Uptake of chronic condition management plans, GP enhanced primary care services and allied health services to support management of chronic conditions.
Patient experiences of health care - patient involved in decisions about care and treatment - easy-to-understand explanations - patient perceptions of coordination and integration	Treatment and management	Patient Experience Survey National Aboriginal and Torres Strait Islander Health Survey	Measuring What Matters	(5.1, 5.2, 5.3) Access, barriers and experiences of healthcare services (GPs, specialists, dental professionals, hospitals and EDs).

Measure	Domain	National data sources	Reporting	Comments
Health workforce - workforce by geography - workforce sustainability	Treatment and management	National Health Workforce Dataset Medical Education and Training Data Collection	**Health Workforce Data website** Report on Government Services	(5.3) Headcount and hours worked by profession (medical practitioners, allied health, nursing and midwifery)
Safety and effectiveness of health care - avoidable mortality - avoidable hospital admissions - mortality rates following hospitalisation - adverse events	Health outcomes Treatment and management	National Hospital Morbidity Database	Australia's health performance Framework **Australian Commission on Safety and Quality in Health Care**	Monitoring these events helps identify risks, improve clinical practices and ensure that patients with chronic conditions receive safe, appropriate health care.
Treatment - medication use and adherence - outcomes following medication use	Treatment and management	Pharmaceutical Benefits Scheme Linked prescription and hospitalisation data (such as National Health Data Hub) National Health Survey Condition-specific registries		(3.3) Consistent and correct use of prescribed medicines is essential for managing symptoms, preventing complications, and improving long-term outcomes.

Measure	Domain	National data sources	Reporting	Comments
Continuity of care - patient journey across services and sectors - patient journey across life stages	Health outcomes Treatment and management	Linked administrative health data (such as National Health Data Hub and National Disability Data Asset) Intergenerational Health and Mental Health Study Longitudinal health surveys (such as Ten to Men and the Australian Longitudinal Study on Women's Health)		(2.2, 3.1, 3.2) Longitudinal survey and linked administrative data can support analysis of transitions of care across healthcare services, across sectors (e.g. social services and aged care), and across life stages.
Digital health - use of digital health services - MBS claims for telehealth items	Treatment and management	Medicare Benefits Schedule data	**Australian Digital Health Agency** (annual report)	(2.2, 4.2) Digital health enables better care coordination and timely access to health information. Includes adoption of digital health services by consumers and healthcare providers.
Cultural safety of healthcare services	Treatment and management	National Aboriginal and Torres Strait Islander Health Survey **Online Services Report** for Aboriginal and Torres Strait Islander peoples	**Cultural safety in health care for Indigenous Australians: monitoring framework**	(5.1) Cultural safety helps build trust, improve engagement and support better health outcomes through inclusive and respectful care.

Measure	Domain	National data sources	Reporting	Comments
Aboriginal and Torres Strait Islander peoples	Priority populations	**National Aboriginal and Torres Strait Islander Health Survey** Australian Burden of Disease Study National Aboriginal and Torres Strait Islander Social Survey Australian Reconciliation Barometer (survey)	**Aboriginal and Torres Strait Islander Health Performance Framework** **Regional Insights for Indigenous Communities** **Cultural safety in health care for Indigenous Australians: monitoring framework** Australian Burden of Disease Study: impact and cause of illness and death in Aboriginal and Torres Strait Islander peoples (web report)	(5.1, 5.2, 5.3) National data is often presented by Indigenous status. Measures should include improved data collection (including completeness and consistency).
People living in rural, regional and remote areas	Priority populations	See comment	Australia's Health, '**Rural and remote health**' topic summary	(5.1, 5.2, 5.3) National data is often presented by remoteness area based on the **Australian Statistical Geography Standard Remoteness Structure** or **Modified Monash Model**

Measure	Domain	National data sources	Reporting	Comments
People from CALD backgrounds	Priority populations	Census of Population and Housing National Health Survey **Building a New Life in Australia** Linked CALD status and health data (such as Australian Migrants and Census Integrated Dataset and Person Level Integrated Data Asset)	**Permanent migrants in Australia**, ABS release ‘**Cultural and linguistically diverse Australians**’, AIHW topic page	(5.1, 5.2, 5.3) The set of cultural and language indicators described in the **ABS Standards for Statistics on Cultural and Language Diversity** are not routinely captured in national health data. Some data sources capture country of birth (e.g. ABS Death Registrations collection). Measures should include improved data collection (including completeness and consistency). Refugee and humanitarian entrant status can be identified using the Settlement Database and linked with health data.
People with disability	Priority populations	Survey of Disability, Ageing and Carers National Health Survey Household Income and Labour Dynamics in Australia (HILDA)	**Reporting on Australia’s Disability Strategy 2021–2031** **People with disability in Australia** **Disability, Ageing and Carers, Australia: Summary of Findings** Measuring What Matters	(5.1, 5.2, 5.3) Measures should include improved data collection (including completeness and consistency). This may include more consistent information about the type and severity of disability and linkage to data about chronic conditions.

Measure	Domain	National data sources	Reporting	Comments
LGBTQIA+ people	Priority populations	Census of Population and Housing National Drug Strategy Household Survey Linked LGBTQIA+ status and health data (such as Person Level Integrated Data Asset)	'**LGBTIQ+ communities**', AIHW topic page **Estimates and characteristics of LGBTI+ populations in Australia**, ABS release	(5.1, 5.2, 5.3) The **Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables** aims to standardise the collection of data related to sex, gender, variations of sex characteristics and sexual orientation. Measures should include improved data collection (including completeness and consistency). The small size of the population can make it difficult to report meaningful findings from population surveys
People with mental health conditions	Priority populations	National Study of Mental Health and Wellbeing National Health Survey		(5.1, 5.2, 5.3) Measures should include improved data collection (including completeness and consistency). This may include more consistent mental health indicators and linkage to data about physical chronic conditions.
Impacts of intersectionality	Priority populations	Linked demographic and health data (such as Person Level Integrated Data Asset) Census of Population and Housing		(5.4) The Census includes information about multiple aspects of identity. Linkage of this information with health data (such as PLIDA) can provide insights into overlapping vulnerabilities.
Population - total population - age profile of population	Demographics	Census of Population and Housing	Measure What Matters	Presented by sex, age and across remoteness and socio-economic areas, and other geographies. Can be used to calculate rates or proportions, or projections based on population changes.

Abbreviations and glossary

Abbreviations and acronyms

Acronyms and abbreviations	Definition
ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
AIHW	Australian Institute of Health and Welfare
CALD	Culturally and linguistically diverse
eCDS	Electronic clinical decision support
HiAP	Health in All Policies
HITH	Hospital in the Home
LGBTQIA+	Lesbian, gay, bisexual, transgender, intersex, queer and asexual, or people otherwise diverse in gender, sexual orientation and/or innate variations of sex characteristics
MBS	Medicare Benefits Schedule
mHealth	mobile health
WHO	World Health Organization

Glossary

Term	**Definition**
Aboriginal or Torres Strait Islander	A person who identifies themselves as being of Aboriginal or Torres Strait Islander origin
Aboriginal Community Controlled Health Organisation (ACCHO)	Health services operated by Aboriginal communities to provide culturally safe and comprehensive primary health care
Advanced care planning	Documenting a person's preferences for future health care in case they become unable to make decisions
Burden of Disease	A measure of the years of healthy life lost, either through premature death or through living with illness due to disease and/or injury. It is a measure used to quantify the burden of disease and injury in a population
Chronic conditions	A diverse group of disease/conditions, such as heart disease, cancer and arthritis, which tend to be long lasting and persistent in their symptoms or development
Chronic condition management plan	Structured plans developed by healthcare providers to coordinate care for individuals with chronic conditions
Clinical decision support	Tools and systems that provide evidence-based guidance to support clinical decisions
Co-design	Collaborative design of health interventions involving individuals, caregivers and healthcare providers
Continuity of care	Consistent and coordinated health care across different providers and settings over time
Culturally safe care	Care that is respectful of and responsive to the cultural identity and needs of individuals, particularly Aboriginal and Torres Strait Islander peoples and people from CALD backgrounds
Data linkage	Bringing together (linking) information from two or more data sources believed to relate to the same entity, such as the same individual or the same institution. The resulting data set is called linked data.
Determinants of health	Any factor that can increase the chances of ill health (risk factors) or good health (protective factors) in a population or individual
Digital health	The electronic management of health information. This includes using technology to collect and share a person's health information to support healthcare delivery

Term	Definition
Health equity	Ensuring that everyone has a fair opportunity to attain their highest level of health
Health in All Policies (HiAP)	An approach that integrates health considerations into policymaking across different sectors to improve population health
Health literacy	The ability of people to access, understand and apply information about health and the health care system to make decisions that relate to their health
Intersectionality	The ways in which different aspects of a person's identity can expose them to overlapping forms of discrimination and marginalisation
Multimorbidity	The presence of two or more chronic conditions in a person at the same time
Outreach program	Health initiative that extends services to under-serviced populations, often in remote or regional areas
Palliative care	An approach to treatment that improves the quality of life of patients and their families facing a life-limiting illness, as well as reducing the physical and emotional stress of dying
Person-centred care	Care that is focused on the individual's preferences, needs and values, involving shared decision-making
Polypharmacy	The concurrent use of multiple medications by a person, often associated with multimorbidity
Primary health care	These are services delivered in many community settings, such as general practices, community health centres, Aboriginal health services and allied health practices (for example, physiotherapy, dietetic and chiropractic practices)
Risk factor	Risk factors are attributes, characteristics or exposures that increase the likelihood of a person developing a disease or health disorder
Self-management	The ability of individuals to manage symptoms, treatment and lifestyle changes associated with chronic conditions
Shared decision-making	A collaborative process where healthcare providers and patients make health decisions together
Social prescribing	Connecting people with non-clinical community services to improve health and wellbeing
Trauma-informed care	An approach to health care that recognises and responds to the impact of trauma, based on principles of safety, trust, choice, collaboration, empowerment and respect for diversity

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