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**Abstract:** End of life care for people with advanced chronic disease is a growing international imperative, with the majority of deaths in the world now related to chronic disease. The provision of care that meets the needs of people with advanced chronic disease must be guided by appropriate policy. The key policy areas impacting directly on end of life care are related to chronic disease, palliative care and, increasingly, aged care.

This paper describes the outcomes of an audit of Australian chronic disease and end of life/palliative care policies. We identified that chronic disease health policies/strategies demonstrate a focus on prevention, early intervention and management, with scant recognition of end of life care needs. The majority assume that a referral to palliative care will address end of life care needs for people with chronic disease. By contrast, palliative care policies recognise the need for the incorporation of a palliative approach into advanced chronic disease care, but there are few connections between these two policy areas. Whilst palliative care policies intersect with carer and advance care planning policies, chronic disease policy does not. Key concerns requiring consideration when developing policy in this area are discussed and possible policy options identified.

## INTRODUCTION

Governments around the world have become increasingly aware of the threat to public health posed by the emergence of an epidemic of chronic disease.<sup>[1]</sup> The United Nations has reported that non-communicable diseases - ie chronic diseases and cancers - are causing a growing proportion of all deaths worldwide, as population growth and ageing drive large increases in the burden of mortality.<sup>[2]</sup> Non-communicable diseases are now the largest global cause of death with cardiovascular diseases, diabetes, cancers and chronic respiratory diseases accounting for more than 65% of all deaths in 2008.<sup>[1]</sup>

In Australia, the rise in chronic diseases has been particularly striking. The most common causes of death in Australia in 2007 were chronic disease related, and this increased with age.<sup>[3]</sup> Diabetes is expected to become the leading cause of disease burden by 2023,<sup>[3]</sup> with an associated projected increase in the incidence of end stage kidney disease (ESKD) of nearly 80% by 2020.<sup>[4]</sup> The 2010 Australian Intergenerational Report estimated that people aged 65 years and over will increase from 13% to 22.6% by 2050, with a subsequent increase in the number of people with complex health needs, who will require specific care at the end of their life.<sup>[5]</sup> This change is anticipated in other developed nations.<sup>[2]</sup> (Tables 1, 2 and 3)

### INSERT TABLES 1, 2 & 3 HERE

The increase in chronic diseases, both in Australia and other developed nations, has been accompanied by the development of a range of health policies focused around chronic disease management. These policies attend to prevention, early intervention and management as they relate to chronic disease. Relatively little attention, however, has been paid to end-of-life care,<sup>[6]</sup> despite the fact that the majority of chronic diseases are life limiting, and that those approaching the end of their lives will require specific care.

Currently, there is an assumption that a referral to palliative care services will address the end of life needs of people with chronic diseases. However, palliative care services have been designed largely to meet the needs of cancer sufferers, for whom there is often a clear transition to an “end of life” period, which triggers referral and a shift to a different style of care. However, there is growing evidence that, for a number of chronic diseases, there is no clear transition to end-of-life, but rather, a slow period of decline, where both interventional care and a palliative approach are required.<sup>[7-9]</sup>

One way to assess the extent to which there is an appropriate transition from interventional to palliative care is to examine those policies and service frameworks which influence the funding and provision of health services in this domain.<sup>[10]</sup> The Palliative Care Council of New Zealand undertook a review of government health policy in relation to the provision of Palliative Care Services in New Zealand, and noted that end of life care for people with

chronic disease was not adequate; however, the Council did not look specifically at interactions with chronic disease policies or strategies.<sup>[11]</sup> In the UK, the National End of Life Care Program (developed as part of the End of Life Care strategy) is working with the National Health Service to develop care frameworks for specific chronic diseases such as heart failure,<sup>[12]</sup> chronic obstructive pulmonary disease,<sup>[13]</sup> neurological diseases<sup>[14]</sup> and kidney failure.<sup>[15]</sup>

In Australia, there has been little examination of how the various policies related to chronic disease and end of life care (and increasingly healthy ageing) interact and facilitate service provision for people with chronic disease approaching the end of their life. We examined Australian health policies to identify the level of priority placed on end of life care for people with chronic disease and whether policy directions and guidance were provided for service planners to develop high quality end-of-life care for people with chronic disease. This paper therefore describes and analyses Australian health policy to address the following questions:

1. How well do chronic disease, palliative care and ageing policies and strategies intersect to ensure that people with advanced chronic disease, and their carers, receive the care specified in these policies?
2. What links are there between the policies, strategies, funding and service provision required to meet the needs of people with advanced chronic disease at the end of their life?

The paper concludes with a series of new options with the aim of stimulating consideration of a new policy framework.

## **MATERIALS AND METHODS**

We performed a systematic search of all Australian federal, state and territory government websites for national and state policies relating to end of life care and chronic disease. Websites were initially identified using Google, and then searched to identify relevant, current or recent policies and strategies relating to end of life care/palliative care and chronic disease management, as well as primary health care and disability care. Search terms used included “chronic disease”; “integrated care”; “palliative care”; “end of life care”; “disability”; “primary health care” AND “policy/strategy/framework”; “state health plan”; health action plan”; health priorities”. A specific search was undertaken to identify policies and strategies related to advance care planning and carers. Palliative Care Australia and state Palliative Care Council websites were reviewed to identify current activities and advocacy related to palliative care policies and strategies, including proposed revisions/renewals. A further search was undertaken to identify policies and strategies related to ageing/aged care. Again, federal, state and territory government websites and relevant community organisations such

as the Council on the Ageing (COTA) were searched. Search terms included “ageing”; “healthy ageing”; “aged care”; “seniors”; “older Australians” AND “policy/strategy/framework”; “action plan”; “plan”

Policies were categorised into those relating to chronic disease, palliative care and aged care and each was reviewed using the following questions:

- a. Do the chronic disease and ageing policies/strategies/frameworks mention palliative/end of life care and vice versa?
- b. If so, what is the context?
- c. How extensive is the discussion of chronic disease/end of life/palliative care?
- d. Are there any actions/outcomes/measures associated with the mention of chronic disease/end of life/palliative care? If so, what are they?

## RESULTS

In Australia, a complex web of policy, strategic plans, action plans, service delivery models and health reform processes guide the provision of chronic disease and palliative care services. These policies range across the health, aged care, community services and human services domains in federal, state/territories and local government jurisdictions. Policies and strategies in Australia are generated at a national level by the Australian government and by each of the eight states and territories that make up the Commonwealth. In terms of funding responsibility, a variety of different government agencies fund chronic disease and palliative care services. In the Australian Department of Health and Ageing (DoHA), the Population Health Division has responsibility for Chronic Disease Management (through the Chronic Disease Branch) and Palliative Care (through the Cancer and Palliative Care Branch). DoHA funds personal care services for people over 65 years with chronic and complex diseases through packages of care such as Community Aged Care Packages (CACAP) and Extended Aged Care at Home (EACH) packages<sup>[16]</sup> and programs such as Home and Community Care.<sup>[17]</sup> However, people under 65 years are funded through Disability Services at a state level, where access to funding and services is much more problematic<sup>[18]</sup> Other areas of DoHA influencing chronic disease services are the Primary and Ambulatory Care Division (responsible for general practice, Medicare Locals and a variety of primary care initiatives) and the Ageing and Aged Care Division, responsible for community care and aged care packages. Each state has a Department of Health and states and territories are primarily responsible for hospital and community health services and funding (excluding general practice). Thus, any policy audit needs to consider the various levels at which policies and strategies are developed and service provision occurs

### *Chronic Disease and Palliative Care*

Most chronic disease policies and strategies note the importance of a continuum of care, focussing particularly on prevention, early intervention and management, but with little consideration of end of life care. All palliative care policies recognise the growing need for end of life care for people with chronic disease. Throughout all chronic disease policies/strategies there is an assumption that all clinicians and health workers will participate in chronic disease care, from prevention, through early intervention to active disease management. The National Palliative Care Strategy states that the scope of palliative care includes primary care providers in a variety of settings and should be available in both generalist and specialist care,<sup>[19]</sup> whilst the NSW Palliative Care Strategic Framework states that: *palliative care has to be recognised as core business for health services*<sup>[20]</sup>. Whilst the provision of chronic disease care by a wide variety of health professionals is supported by a range of action plans, educational opportunities, funding and infrastructure, there is no evidence that such processes have been developed for the provision of end of life care.

Table 4 summarises national, state and territory policies with respect to chronic disease and palliative care and outlines the results of the policy audit.

- Although there is a National Chronic Disease Strategy (NCDS)<sup>[21]</sup> and a National Palliative Care Strategy (NPCS),<sup>[19]</sup> only South Australia (SA) has current policies in both areas.
  - The *SA Chronic Disease Action Plan for South Australia 2009 – 2018*<sup>[22]</sup> reflects the NCDS, noting the importance of advance care planning in end of life care.
- Whilst Victoria<sup>[23]</sup> and New South Wales (NSW)<sup>[20]</sup> have current palliative care strategies, their chronic disease management frameworks have moved to specific programs of integrated care, implemented at more local levels. There appear to be few formal links between these programs and palliative care services.
  - The Victorian *Health Priorities Framework 2012-2022*, and the associated Metropolitan and Rural and Regional Health Plans focus on chronic disease management, and note the importance of end of life care.<sup>[24]</sup>
  - *Future Directions for Health in NSW. Towards 2025* notes the importance of addressing chronic disease, but makes no mention of end of life care.<sup>[25]</sup>
- Western Australia (WA) and the Northern Territory (NT) do not have Palliative Care strategies; their chronic disease strategies specifically identify end of life and palliative care as action areas with targets to be measured.
  - The WA Chronic Health Conditions Framework nominates specific service components for end of life care.<sup>[26]</sup>
  - The Health Networks Branch of WA Health released a *Pathway for Renal Palliative Care Services in Western Australia* in July 2012.<sup>[27]</sup>

- The NT *Chronic Conditions Prevention & Management Strategy 2010-2020* and associated Implementation Plan clearly identify access to palliative care as a key action area.<sup>[28]</sup>
- The Australian Capital Territory (ACT) currently has neither a palliative care nor chronic disease strategy; the *Primary Health Care Strategy 2011 – 2014* has a major focus on chronic disease, but end of life care is not mentioned.<sup>[29]</sup> A draft *ACT Palliative Care Services Plan 2012-2017* was released in September 2012 and is currently out for consultation.<sup>[30]</sup> It recognises the growing importance of end-of-life care for people with advanced chronic disease and has identified six key goals with 15 associated strategies for implementation over the next five years.
- Tasmania has a current *Chronic Disease Action Framework*, with a focus on prevention and management; palliative care is mentioned only briefly.<sup>[31]</sup>
- The *Queensland Strategy for Chronic Disease 2005-2015* refers to the development of a State-wide Integrated Strategy for Palliative Care, and states it will support this development; this policy has not been developed to date.<sup>[32]</sup>

#### INSERT TABLE 4 ABOUT HERE

#### *Ageing*

There is currently no national Ageing or Healthy Ageing policy in Australia. However, the Productivity Commission conducted an inquiry in 2010 to comprehensively review aged care and provide recommendations for future policy options. The final report of the Productivity Commission was submitted in June 2011<sup>[33]</sup> and the Australian government released their response in April 2012.<sup>[34]</sup> The report<sup>[33]</sup> recognises that “*While further advances in the management of some diseases are expected, more people will require complex care for dementia, diabetes and other morbidities associated with longevity, as well as palliative and end of life care*”<sup>(p xxii)</sup> and goes on to state that the aged care system should aim to....”*ensure that all older Australians needing care and support have access to person-centred services that can change as their needs change*”.<sup>(p xiv)</sup>

In response to the report, the Australian government is developing a 10 year action plan to address the report recommendations and identify how older Australians can stay engaged socially and economically.<sup>[34]</sup> From 1 July 2012, the Commonwealth took over the funding of basic community care services in all states and territories except WA and Victoria, and has allocated an extra \$3.7 billion over five years through the *Living Longer, Live Better* package.<sup>[34]</sup> If the reforms proposed by the Productivity Commission are enacted, this will have a significant impact on the delivery of chronic disease and end-of-life service delivery.

All states and territories have healthy ageing or ageing strategies, frameworks or action plans (see Table 5) but there is generally minimal consideration of end-of-life or palliative

care needs, other than a focus on advance care planning. A National Framework for Advance Care Directives was released in Australia in 2011,<sup>[35]</sup> and a number of states and territories are also developing advance care planning strategies. The only “Key Direction” related to end of life care in the *National Chronic Disease Strategy*<sup>[21]</sup> concerned advance care planning and this helped provide the impetus for the national framework.<sup>[35]</sup> There are also other policies at both state and national levels which mention service provision and end of life care, including primary health care policies; carers policies and disability policies (impacting on services available to people less than 65yrs).

**INSERT TABLE 5 ABOUT HERE**

## **DISCUSSION**

There are currently few intersections between chronic disease and palliative care policies, at either a national or state level and current funding mechanisms reflect this disjunction. Most jurisdictions do not have policies in both areas – only three Australian states have current palliative care policies and only two states have chronic disease policies which directly discuss end of life care. Recent reforms in ageing policy are yet to address end of life care. The policy focus to date has been on managing disease, in the context of a relatively static understanding of patient needs. There has been minimal policy guidance or agreement on how or when care at the end of life should be provided or who should provide it. This is reflected in the differing funding and administrative mechanisms for aged care, palliative care and chronic disease management.

There is little evidence that policy makers have been able to develop effective policies to drive appropriate models of care for people with advanced chronic disease as they approach the end of their lives. There appears to be little recognition of the need for care models to change as patient need changes. Palliative care policies do recognise the growing needs of people with advanced chronic disease, but these services, which developed to meet the needs of people with cancer, may not be able to meet the needs of the rapidly increasing population of people with advanced chronic disease. In addition, it is not clear that the current Australian palliative model of care is one that will actually best meet the needs of this large and diverse group of people. The existing policies which shape end-of-life care appear to be underpinned by assumptions about the trajectory of end-of-life care which may not hold for chronic diseases. There needs to be a refocussing in the development of new policy options to include some of the following perspectives.

(1) Many chronic disease policies and strategies assume that chronic disease follows a steady and identifiable progression through ill health to end-of-life and that there is a clear transition to an “end of life” period. There are also varying understandings of the length of this “end of life” period, ranging from the last weeks of life<sup>[36]</sup> to the last year of life.<sup>[37]</sup>



Contrary to the assumptions in these policies, the trajectory of many chronic diseases includes major exacerbations during which a person may die at any time, followed by periods of relative recovery and stability. This pattern can continue for a number of years, making a predictable transition to “end of life” problematic.<sup>[38]</sup> Whilst there is general agreement about the timing for referral to palliative care for people with cancer, no such consensus exists in chronic disease. Despite a number of studies attempting to identify clinical symptoms in a variety of chronic diseases which could trigger referral to palliative care,<sup>[39-41]</sup> clinicians have reached no consensus. Recent studies, including an Australian study examining end of life care for COPD, identified that there is no clear transition to end of life, making it difficult to judge the appropriate timing of referrals.<sup>[7, 42]</sup> All of these factors lead to further confusion when attempting to fund and implement services.

(2) There appears to be an assumption that care for people with advanced chronic disease should move from a chronic disease management (CDM) model of clinical care to a palliative care model. There is growing evidence, however, that appropriate care should combine elements of both active disease management and a palliative approach, as neither model alone can meet the needs of people with advanced chronic disease.<sup>[7, 43, 44]</sup> Each model has distinct characteristics which are important for the care of people with advanced chronic disease. CDM is a systems focused care model, incorporating regular review, coordinated healthcare interventions and patient self management.<sup>[45]</sup> By contrast, palliative care is patient/family centred and holistic and focuses on symptom management and support for the patient and their family.<sup>[46]</sup> Despite these differences, both models of care are structured around a multidisciplinary team approach and recognise the importance of care co-ordination and clear communication. Thus, a model of end of life care which combines elements of CDM and palliative care is feasible; however, for these two models of care to interact successfully, each may need to expand to incorporate their differing perspectives of care and blend systematic management interventions with the flexibility of person-centred care.

(3) Such a blending of care models also requires that health professionals change their philosophical understanding of the basis of care provision. Callaghan suggests that a major reason that the need for end of life care has not been recognised more widely is because many health professionals still view death as a “defeat”, noting that, whilst medicine has devised ways of keeping people alive longer with chronic diseases, health professionals have often not accepted that death is an inevitable part of living.<sup>[47]</sup> Thus, the focus in chronic disease management is often on medical interventions rather than discussions about treatment options, prognosis and patient preference, which are the focus in palliative care. By referring people with end stage chronic disease to a palliative care service rather than providing end of life care themselves, health professionals could therefore avoid discussions about death and dying and avoid caring for dying people. Health professionals’ attitudes to

dying may also reflect the attitudes of the community more generally: there is a “societal taboo” about discussing death, dying and bereavement<sup>[48]</sup> which is being recognised and addressed internationally through programs such as “Dying Matters” in the UK<sup>[48]</sup> and *The Conversation Project* in the US.<sup>[49]</sup>

(4). There is growing advocacy amongst palliative care support organisations in countries such as Australia<sup>[50]</sup>, Canada<sup>[51]</sup> and New Zealand<sup>[11]</sup> for care to be based on patient need rather than prognosis. The UK End of Life Care Strategy actively promotes and supports end of life care for people with chronic disease and advocates a person-centred approach to care,<sup>[48]</sup> as does the Australian Commission on Quality and Safety in Health Care.<sup>[52]</sup> A person centred approach to end of life care for people with advanced chronic disease would mean that care would be provided based on patient need rather than being determined by prognosis or age. Kellehear<sup>[53]</sup> has outlined a model of palliative care based on health promotion principles which has the potential to contribute to effective policy development. He suggests five key goals for developing services including: providing education for health, dying and death; providing social supports, encouraging interpersonal reorientation; encouraging reorientation of palliative care services and combating death-denying health policies and attitudes.<sup>[53]</sup>

## CONCLUSIONS

Australian chronic disease management strategies/policies document the importance of a continuum of care and access to specialist palliative care but do not generally identify specific strategies or provide funding mechanisms to support these. Existing palliative care strategies recognise the growing importance of end-of-life care and the need for integration of services for people with chronic disease, but identify few strategies to facilitate such integration. For people under 65 years with chronic diseases, there are major inequities in service provision.<sup>[7]</sup> In the wake of the report of the Productivity Commission, ageing policies currently under development may be able to clearly articulate the need for funding and support for older people as they approach the end of their life. In the meantime, the intersections and links between policies and strategies for chronic disease, palliative care and ageing and with funding and service provision are few. Current policies reflect a lack of understanding of the needs of people with advanced chronic disease and there is little consensus around how such services should be provided.

Outside of palliative care policy, policies impacting on care for people with advanced chronic disease do not treat end of life care as a priority. However, the growing numbers of people requiring end of life care dictate the need for health policies to prioritise this aspect of care. Whilst palliative care principles and expertise can inform a model of care for people with

advanced chronic disease, it is not clear that an actual referral to a palliative care service will provide the most appropriate care. The need to foster recognition that active disease management and palliation are complementary, not mutually exclusive, is key as is a move to truly person-centred care. The philosophical differences underlying chronic disease management and palliative models of care mean that articulation between these care models will require negotiation before people with chronic disease, and their carers and families, can access appropriate and timely end of life care.

**Conflict of Interest**

All authors state that they have had no actual or potential conflict of interest including any financial, personal or other relationships with other people or organizations, within three years of beginning the manuscript entitled: *Australian health policy and end of life care for people with chronic disease: an analysis* that could inappropriately influence, or be perceived to influence, their work.

**Submission declaration**

All authors declare that the work described in the article: *Australian health policy and end of life care for people with chronic disease: an analysis* has not been published previously, that it is not under consideration for publication elsewhere, that its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out, and that, if accepted, it will not be published elsewhere including electronically in the same form, in English or in any other language, without the written consent of the copyright-holder.

**Role of the funding source**

The work described in the article: *Australian health policy and end of life care for people with chronic disease: an analysis* is part of the research undertaken by author 1 as part of her PhD research. The PhD research is funded through an Australian Postgraduate Scholarship and as such, the funding body has played no role in study design; collection, analysis and interpretation of data; in the writing of the report; and in the decision to submit the article for publication.

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**Table 1: Mortality rates for Australia and the average among OECD countries, for selected causes of death(a), by sex, 2009(b) (deaths per 100,000 population) [1]**

	Males		Females	
	Australia	OECD Average	Australia	OECD Average
Coronary Heart Disease	98.9	117.5	52.3	60.4
Stroke	36.0	54.8	33.9	42.3
Lung cancer	39.9	51.9	19.5	19.0
Chronic lower respiratory disease	4.6	4.8	3.4	25.0
Diabetes	15.1	18.4	10.4	14.1

Table 2: Leading underlying broad causes of death in Australia(a), by age group, 2007 <sup>[55]</sup>

	All Ages <i>% of deaths</i>		15 – 24 <i>% of deaths</i>		25 – 44 <i>% of deaths</i>		45 – 64 <i>% of deaths</i>		65- 84 <i>% of deaths</i>		85 & over <i>% of deaths</i>	
	M	F	M	F	M	F	M	F	M	F	M	F
<b>Cancer and other tumours</b>	32.3	26.0	8.2	14.2	14.5	35.0	42.6	55.8	37.5	33.3	20.0	12.1
<b>Cardiovascular disease</b>	31.3	36.5			12.8	11.5	24.5	13.9	31.6	32.4	42.3	48.6
<b>Respiratory system diseases</b>	8.6	8.2						5.9	9.5	8.8	11.6	8.7
<b>Injury and Poisoning</b>	7.3		72.1	53.8	50.3	27.7	10.0	7.1				
<b>Endocrine related disorders</b>									4.1	4.8		
<b>Nervous system disorders</b>			4.4	5.6								
<b>Digestive disorders</b>							5.4					
<b>Mental Disorders</b>		5.4									5.9	8.3
<b>Ill defined conditions</b>			5.6	7.8	5.9	4.5						

Table 3: Estimated Leading Causes of Death in 2030, by Income Group, with chronic disease related deaths highlighted <sup>[3]</sup>

	World		High Income Countries.		Middle Income Countries.		Low Income Countries.	
	% of total deaths	(rank)	% of total deaths.	(rank)	% of total deaths.	(rank)	% of total deaths	(rank)
Ischaemic Heart Disease	13.4	(1)	15.8	(1)	12.7	(2)	13.4	(1)
Cerebrovascular Disease	10.6	(2)	9.0	(2)	14.4	(1)	8.2	(3)
HIV Aids	8.9	(3)			6.2	(4)	13.2	(2)
COPD	7.8	(4)	4.1	(5)	12.0	(3)	5.5	(4)
Lower Respiratory Infections	3.5	(5)	3.6	(6)			5.1	(5)
Trachea, bronchus lung cancers	3.1	(6)	5.1	(3)	4.3	(5)		
Diabetes Mellitus	3.0	(7)	4.8	(4)	3.7	(6)	2.1	(9)
Road Traffic Accident	3.9	(8)			2.5	(9)	3.7	(7)
Perinatal conditions	2.2	(9)					3.9	(6)
Stomach Cancer	1.9	(10)	1.9	(9)	3.4	(7)		
Alzheimers and other dementias			3.6	(7)				
Colon and Rectal Cancers			3.3	(8)				
Prostate Cancer			1.8	(10)				
Hypertensive Heart Disease					2.7	(8)		
Liver Cancer					2.2	(10)		
Diarrhoeal Diseases							2.3	(8)
Malaria							1.8	(10)

**Table 4: Australian Chronic Disease and Palliative Care (and related) Policies at December 2012**

	<b>Chronic Disease</b>	<b>Palliative Care</b>	<b>Other*</b>
<b>National</b>	National Chronic Disease Strategy 2006	Supporting Australians to Live Well at the End of Life. The National Palliative Care Strategy. 2010.	<ul style="list-style-type: none"> <li>* Building a 21<sup>st</sup> Century Primary Health Care System - The National Primary Health Care (PHC) Strategy</li> <li>* National Carers Strategy</li> <li>* National Framework for Advance Care Directives</li> <li>* National Disability Strategy 2010 - 2020</li> </ul>
<b>QLD</b>	Queensland Strategy for Chronic Disease 2005-2015.	<b>No current policy.</b> Previous Strategic Directions for Palliative Care Services 2000-2005	<ul style="list-style-type: none"> <li>* Directions for Aged Care 2004-2011</li> <li>* Carers (Recognition) Act 2008</li> <li>* Queensland Carer Action Plan, 2011–2014</li> </ul>
<b>NSW</b>	<b>No current policy.</b> The Connecting Care (Severe Chronic Disease Management) Program supports CDM focussed through local health districts.	Palliative Care Strategic Framework 2010-2013.	<ul style="list-style-type: none"> <li>* Future Directions for Health in NSW. Towards 2025</li> <li>* Towards 2030: Planning for our changing population The Integrated Primary and Community Health Policy 2007 – 2012</li> <li>* Carers Action Plan 2007-2012</li> </ul>
<b>ACT</b>	<b>No current policy.</b> Previous: <b>Chronic Disease Strategy 2008 -2011</b>	Consultation currently being undertaken on the Draft ACT Palliative Care Services Plan 2012-2017. Previous: Palliative Care Strategy 2007 - 2011	<ul style="list-style-type: none"> <li>* ACT Primary Health Care Strategy 2011 - 2014</li> <li>* <b>Caring For Carers Policy (2003)</b></li> <li>* access health. Healthcare for all in the ACT (2007)</li> </ul>
<b>VIC</b>	<b>No current policy.</b> The Integrated Chronic Disease management program in Victoria co-ordinates CDM and care is focussed through PCPs.	Strengthening palliative care: Policy and strategic directions 2011–2015	<ul style="list-style-type: none"> <li>* Victorian Health Priorities Framework 2012-2022 Metropolitan Health Plan</li> <li>* Victorian Health Priorities Framework 2012-2022: Rural and Regional Health Plan</li> </ul>
<b>TAS</b>	Connecting Care: A Chronic Disease Action Framework for Tasmania 2009 – 2013	<b>No current policy.</b> Previous Tasmanian Palliative Care Plan 2002 – 2005	<ul style="list-style-type: none"> <li>* Tasmania’s Health Plan. Primary Health Services Plan (2007)</li> <li>* Tasmania’s Health Action Plan (2010)</li> </ul>

	Chronic Disease	Palliative Care	Other*
SA	Chronic Disease Action Plan for South Australia. 2009 – 2018	Palliative Care Services Plan 2009-2016	<ul style="list-style-type: none"> <li>* South Australia’s Health Care Plan 2007-2016</li> <li>* GP Plus Health Care Strategy (2007)</li> <li>* Health Policy For Older People 2010 – 2016</li> <li>* Health Service Framework for Older People 2009 – 2016</li> </ul>
WA	WA Chronic Health Conditions Framework 2011–2016	<b>No current policy</b> Pathway for Renal Palliative Care Services in Western Australia. July 2012.	<ul style="list-style-type: none"> <li>* WA Health Operational Plan 2011-2012</li> <li>* WA Primary Health Care Strategy; Acts Amendment (Advance Health Care Planning) Bill 2006</li> </ul>
NT	Chronic Conditions Prevention & Management Strategy 2010-2020	<b>No current policy.</b> Previous: Palliative Care Strategy 2005–2009	<ul style="list-style-type: none"> <li>* Building the Territory for all Generations – A Framework for Active Ageing in the Northern Territory (2007)</li> </ul>

\* “Other” policies have some reference to chronic disease management and/or end-of-life/palliative care

**Table 5: Australian Ageing Policies at December 2012**

<b>Victoria</b>	<i>Improving care for older people: a policy for Health Services 2003</i>	Notes the need to: <i>1) adopt a strong person-centred approach to the provision of care and services</i> <i>2) better understand the complexity of older people’s health care needs</i> <i>3) improve integration within Health Service’s community-based programs and between Health Services and ongoing support services available in the broader community.</i> And that <i>care planning includes discussion with the older person and their carers regarding their future care and palliation wishes</i>
<b>NSW</b>	<i>NSW Ageing Strategy 2012</i>	Notes the need to: <i>Support people in the “Middle Years” to undertake advance care planning; complement existing processes around designing palliative care services.</i>
<b>Queensland</b>	<i>Positively Ageless. Queensland Seniors Strategy 2010–20</i>	Provision of support for Advance Care planning and associated legal documentation
<b>South Australia</b>	<i>Improving with Age - Our Ageing Plan for South Australia. 2006</i>	Notes the importance of <i>“high quality palliative care services are available to meet the individual needs of older people within hospitals, the community and at home”</i>
<b>Western Australia</b>	<i>Age-friendly WA Strategy 2012</i>	The Department for Communities is encouraging local government authorities to embrace the World Health Organisation’s Age-friendly Communities concept which is part of an international effort to prepare for the ageing of our community. Local government council areas are being funded to develop ageing strategies
<b>Tasmania</b>	<i>Inclusive Ageing: Tasmania 2012-2014 Strategy</i>	No mention of care needs at the end-of-life
<b>Northern Territory</b>	<i>Building the Territory for all Generations - A Framework for Active Ageing in the Northern Territory. 2007</i>	Notes that the NT government will: <i>Provide appropriate support for and access to culturally secure and technically sound palliative and respite services</i>
<b>Australian Capital Territory</b>	<i>ACT Strategic Plan for Positive Ageing. 2010-2014. Towards an Age - Friendly City</i>	No mention of care needs at the end-of-life