SELF-CARE FOR HEALTH: A NATIONAL POLICY BLUEPRINT

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ABOUT US

The Mitchell Institute for Education and Health Policy at Victoria University is one of the country's leading education and health policy think tanks and trusted thought leaders.

Our focus is on improving our education and health systems so more Australians can engage with and benefit from these services, supporting a healthier, fairer and more productive society.

The Australian Health Policy Collaboration is led by the Mitchell Institute at Victoria University, and brings together leading health organisations and chronic disease experts to translate rigorous research into good policy. The national collaboration has developed health targets and indicators for preventable chronic diseases designed to contribute to reducing the health impacts of chronic conditions on the Australian population.

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The Mitchell Institute also acknowledges and thanks the extensive network of over 50 expert contributors who generously participated in the Expert Working Groups (EWGs) to develop the consensus-driven priority policy actions presented in this Blueprint (see inside back page for EWG membership acknowledgements). A number of these experts who also co-authored sections of the Blueprint's background technical paper, co-chaired working groups and were instrumental in the synthesis of the Blueprint's priority policy proposals are additionally acknowledged in the citation. The expert collaborators for this work have brought the rigour of evidence, independent analysis and personal and professional experience to the development of considered and sound policy directions for Australia that are designed to enable and support better health for all.

CONTENTS

EXECUTIVE SUMMARY

This paper makes the case for new policy to promote and expand the role of self-care in the Australian health system. Based on the evidence of what works, the Blueprint presents a suite of priority policy proposals for implementation in Australia to support self-care through health policy and practice. A network of over 50 experts – comprising academics, health professionals, healthcare consumers and other self-care, chronic disease and health policy experts – discussed, refined and endorsed these policy priorities.

The World Health Organization (WHO) defines self-care as "the ability of individuals, families and communities to promote health, prevent disease and maintain health and to cope with illness and disability with or without the support of a health-care provider." The WHO definition is inclusive of other terms and similar concepts in use, such as self-management, patient empowerment, consumer enablement and patient activation. In this paper, self-care is used as an umbrella term that largely encompasses the scope of these related terms and concepts and is intended to describe both self-care capability (ie. knowledge, skills and confidence to engage in effective self-care) and self-care activity (ie. health behaviours and day-to-day activities that constitute self-care) of individuals.

While the term 'self-care' implies a focus on the autonomy and actions of individuals, the underlying drivers and determinants of self-care capability are a range of environmental, economic and social factors that sit beyond the individual. Governments and policymakers play a major role in creating environments that either inhibit or enable self-care, and are influential in the development of self-care capabilities at the population level.

The concept of self-care is complementary, and central, to the concept of prevention in health. In many communities across Australia, including rural, indigenous and socioeconomically disadvantaged communities, health status and health outcomes are starkly different to those in advantaged and well-resourced communities. Targeted support for self-care through health services and within these communities through preventive health strategies and enhanced primary care capabilities would reduce health inequities and improve health outcomes in these communities. It is clear from current evidence that the benefits of self-care are realised when it is an integral part of the healthcare system and is understood and operationalised as a collaboration between individuals and health care providers.

Self-care for health: a national policy blueprint provides a framework for action to achieve integration of self-care across Australia's health system. It identifies outcome measures that will indicate progress and proposes seven guiding principles, three strategic priorities and 12 'action areas' for policy development related to self-care (see Blueprint outline on page 5). The Blueprint then outlines nine priority policy proposals for implementation that will:

- improve health literacy for all;
- build self-care into health care practice;
- enable consumers to be active partners in health care;
- assure the quality and accessibility of digital health information; and
- develop measures for individual self-care and self-care support by health services.

Structural policy approaches included in the set of proposals are:

- implement funding and service models to support self-care;
- drive investment in preventive health and self-care;
- establish a national approach to enabling and supporting self-care; and
- support individual and population health through all public policies.

A supporting technical paper *Self-care for health: background paper for Australia's national self-care policy blueprint* has been published as a companion paper to the Blueprint. It includes a more comprehensive overview of the evidence relevant to the nine priority policy proposals and outlines the extended body of work undertaken by the expert working groups, including the broad suite of policy options discussed by each group. **The supporting technical paper also includes the complete list of references cited in the Blueprint**.

A high-level evidence review examining the health benefits associated with increased levels of self-care and the potential role for self-care within the Australian context was also published as a supporting paper. *Self-care in Australia: evidence and policy implications* highlights the significant evidence for self-care and better health and provides further context for the development of the Blueprint.

SELF-CARE POLICY BLUEPRINT OUTLINE

VISION

Better health for all, through better self-care by all

LONG-TERM OUTCOMES

- All services and health professionals provide self-care support as an integral component of health care provision
- High participation rates in effective self-care activities and behaviours across the population

MEDIUM-TERM OUTCOMES

- Informed and empowered individuals
- Health service models that support and facilitate self-care
- A well-supported health workforce which values and promotes self-care
- Supportive public policies that provide access and opportunities for self-care

STRATEGIC PRIORITIES

- Address structural health system issues to better enable self-care
- Embed self-care support for individuals across health services
- Promote and support informed self-care and health behaviours for all individuals

ACTION AREAS

Address structural health system issues to better enable self-care

→ Establish funding models to support self-care and collaborative care for people with chronic and complex health needs.

→ Implement specific investment strategies in preventive health and individual self-care engagement and support.

→ Establish cross-government policies and programs to address the socioeconomic, cultural and geographical factors that influence self-care capability and opportunity.

Embed self-care support for individuals across health services

→ Redesign services to facilitate and support self-care by individuals and address health service cultures which may inhibit self-care, particularly in primary care.

→ Support and promote consumer engagement, both in shared decision making for individual treatment / care planning and the co-design of health services.

→ Embed self-care as core learning across all health professional education and training and improve access to self-care education and training for the current health workforce.

→ Develop health workforce roles and scopes of practice to better support self-care.

→ Develop and adopt validated, comprehensive measures and evaluation and monitoring mechanisms to assess self-care by individuals and self-care support across health services.

Promote and support informed self-care and health behaviours for all individuals

→ At the population level, provide access and exposure to the information and education required to develop or enhance health literacy, knowledge and overall self-care capability.

→ Develop and implement targeted approaches that enhance access to self-care support, improve health literacy and reduce health inequities for at-risk, disadvantaged and vulnerable groups and individuals.

→ Provide access to and drive the use of evidence-based self-care and behaviour change interventions to support physical and mental health.

→ Promote and support enhanced e-health literacy and the use of digital health technologies and interventions to facilitate self-care.

UNDERPINNING PRINCIPLES

Systemic approach: focus on improving self-care capability and opportunity across the population
Evidence-based action: act now using best available evidence, continue to build evidence
Tackling health inequity: work to address social determinants which impact self-care and redress health disparities attributable to socioeconomic disadvantage
National agenda with local actions: build local and regional capacity to support individual self-care
A life course approach: support the development of self-care capabilities at all ages
Shared responsibility: develop complementary actions by governments, individuals and other groups
Responsible partnerships: avoid ceding policy influence to vested interests

INTRODUCTION

Individual capability to care for one's health develops during the course of life, beginning with early childhood experience and growing with learning and experience over time. The ability to care for your own health and wellbeing – to maintain good health, to improve health, and to manage established health conditions – not only adapts to changing health needs across the life course, but is deeply influenced by changing health information and fashions, cultural beliefs, social and cultural norms and the availability of sources of information and support [1]. Having the knowledge, confidence and ability to seek expert advice and help from health professionals is a vital component of informed self-care [2, 3].

The benefits of self-care for individuals and for the health of populations include improved wellbeing and lower morbidity, mortality and health care costs [4, 5]. The growing international emphasis on self-care as a complementary component of health care indicates the benefits of promoting, informing and supporting self-care for population health and better health outcomes, particularly amongst those individuals and groups at highest risk of poor health [1].

This Blueprint sets out a national policy approach to build self-care capability and enhance self-care activity in all aspects of health and health care. It highlights that the benefits associated with self-care cannot be achieved for the whole population through a singular focus on individuals' health behaviours and lifestyle choices. Equal focus should be applied to enable and facilitate the provision of self-care support throughout the health system and broader community, including targeted approaches for individuals and groups requiring the most support to effectively self-care. Many individuals and groups, particularly those with the most complex health, social and economic needs, have their ability to make informed choices constrained by their circumstances. Supporting individual self-care requires the application of evidence about what works, and there is good evidence that focused and personalised approaches work, even for those with the most complex needs [4, 5].

Effective self-care involves a collaboration between individuals, healthcare systems and services [2]. This, in turn, requires a social context in which self-care is acknowledged as a component of health care and supported and enabled [6]. Currently, there is limited attention to self-care in Australian health policy, and healthcare practices often do not acknowledge how people care for themselves [6]. This is paradoxical given that public health strategies over decades have emphasised the importance of self-care or responsibility, whether for reduced tobacco consumption, prevention of exposure to infectious diseases such as HIV/AIDS, and vaccination for protection from diseases. The contemporary experience of social isolation and self-protection to prevent transmission of COVID-19 has emphasised the importance of self-care, awareness of risk and preventive measures, and the role of individual actions to provide protection for the health of others [7].

The experience and lessons of COVID-19 can be used to reduce the critical gap in health and public policy with respect to promotion of and support for self-care in all health care [7]. Health and health care should be regarded as co-produced by health professionals with individuals and communities. As national strategies for primary care and preventive health are being informed by the experience of COVID-19 and developed through 2020–21, this is a timely opportunity to acknowledge and cement self-care's crucial place in health policy and practice.

WHAT IS SELF-CARE?

Self-care describes the role of individuals in preventing disease, managing their health and actively participating in their health care [6]. Self-care encompasses all individual activities which contribute to physical and mental health and overall wellbeing. This includes daily behaviours and activities such as regular tooth brushing to prevent tooth decay, self-management of minor ailments or chronic health conditions, self-directed use of medications and informed use of digital health technologies, through to collaborative co-management of established complex conditions with health professionals. The World Health Organization (WHO) provided the first formal, high-level definition of self-care in 1983:

Self-care in health refers to the activities individuals, families and communities undertake with the intention of enhancing health, preventing disease, limiting illness, and restoring health. These activities are derived from knowledge and skills from the pool of both professional and lay experience. They are undertaken by lay people on their own behalf, either separately or in participative collaboration with professionals [8].

A subsequent WHO working group, convened for World Health Day 2013, produced an updated and simplified version:

Self-care is the ability of individuals, families and communities to promote health, prevent disease, and maintain health and to cope with illness and disability with or without the support of a health-care provider [9].

Increased attention to self-care and associated concepts in research and policy over the last decade has led to the adoption of various new terms, including consumer enablement, and patient empowerment, engagement and activation – each having overlapping and often multiple meanings. Furthermore, self-management and self-care are often thought of as synonymous despite the former only describing self-care relating to established health conditions. The resulting ambiguity and inconsistency inhibits the effective use of existing evidence related to self-care [5] [11].

In this paper, self-care is used as an umbrella term that largely encompasses the scope of these related terms and concepts and is intended to describe both self-care capability (ie. knowledge, skills and confidence to effectively engage in self-care) and self-care activity (ie. health behaviours and day-to-day activities that constitute self-care) of individuals.

Analysing the overlapping features of the different related concepts does provide a strong indication of some factors or components that are critical to optimise self-care activity and capability effective self-care. Two prominent themes that feature in almost all of the emergent concepts and terms relating to self-care are shared decision-making and individual self-efficacy. Shared decision-making refers to health professionals and consumers working together to make health-related decisions and agree on appropriate evidence-based treatment and care plans that balance clinical risks and expected outcomes with consumer preferences and values. Self-efficacy refers to an individual's confidence to exert control over their motivation and behaviour and is one indicator of an individual's capacity to engage in self-care [5] [11].

Health literacy, defined as the capacity to access, understand, appraise and use information to make health-related decisions in everyday life, is also consistently identified as an essential precursor or critical component of effective self-care in individuals [1, 6].

Self-care support – beyond the individual

While the term 'self-care' implies a focus on the autonomy and actions of individuals, it is influenced, enabled and informed by a range of external forces that sit beyond the individual [6, 12]. The underlying socioeconomic, geographical and cultural factors which significantly affect health status and health outcomes are also closely linked to an individual's capacity to self-care [13]. Governments and policymakers are largely responsible for creating environments which either inhibit or enable self-care, and play a major role in the development of self-care capabilities at the population level [14]. Health professionals and service providers also play an essential role in supporting and facilitating self-care by healthcare consumers. Other key self-care stakeholders include families, communities and health and industry organisations [9]. It is important to think about self-care from two complementary perspectives, one focused on the capacity of individuals to self-care, and another focused on how self-care is supported through policy and within the health system [14].

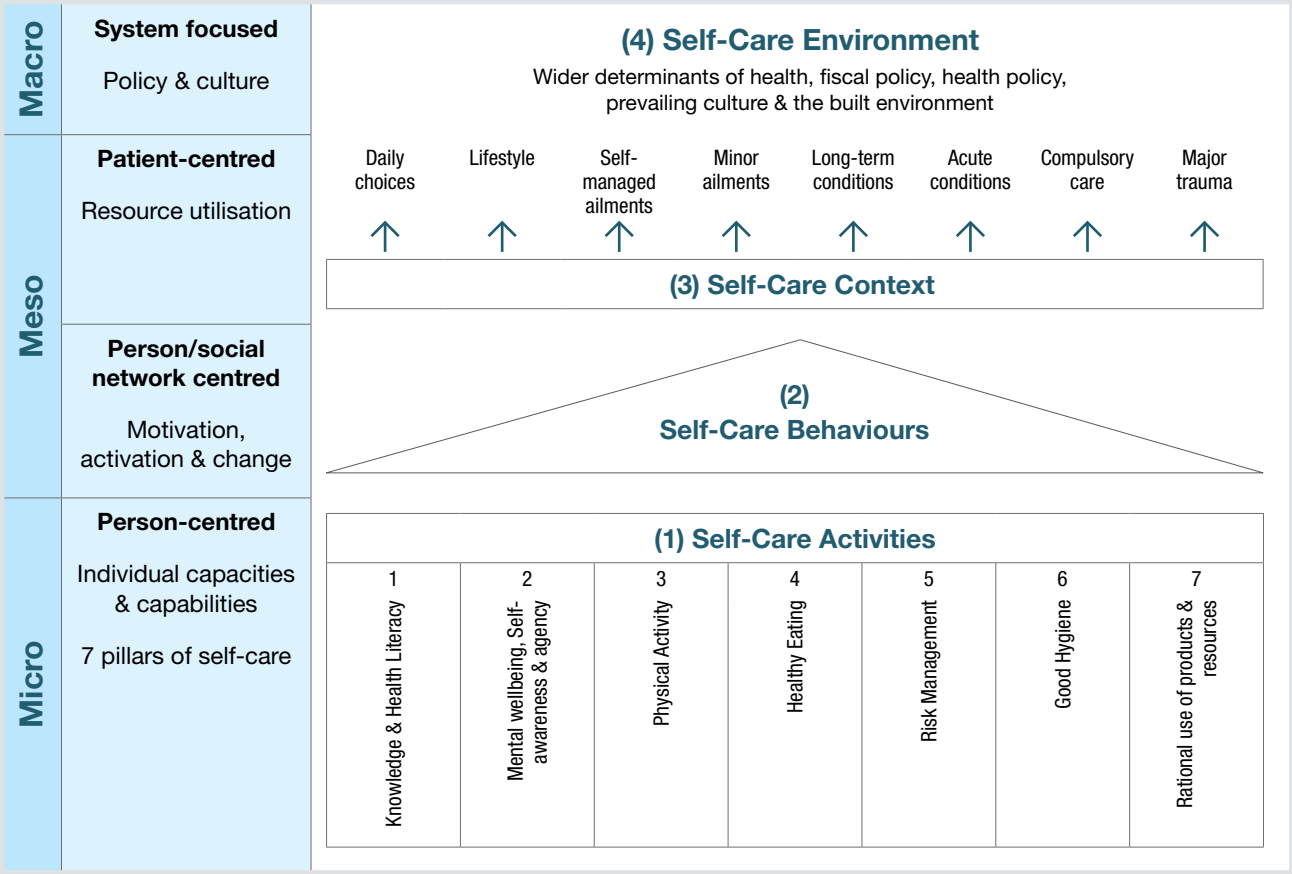
CONCEPTUALISATIONS OF SELF-CARE

Self-care is a complex concept and can be difficult to describe or define in practice. People take care of their health in a myriad of ways, and the dynamic nature of what constitutes self-care has led to the development of various conceptual models which aim to visually represent the components of self-care, the role of self-care in health or the broader self-care environment [1, 12]. Of existing frameworks and models, the Self-Care Matrix (see Figure 1) best illustrates a holistic self-care 'system', identifying four 'cardinal dimensions of self-care' [12]:

- **Self-Care Activities** - based on the International Self-Care Foundation's Seven Pillars of Self-Care model, which presents examples of common activities that constitute independent self-care (however in the context of the Blueprint they would be better described as a combination of self-care activities and capabilities);
- **Self-Care Behaviours** - includes the beliefs, principles and practices which influence motivation, health behaviours and self-care activity;
- **Self-Care Context** - illustrates the broad continuum on which self-care activities occur, from daily choices and reducing risk factor exposure to prevent disease to self-managing minor ailments and chronic conditions right through co-managing aspects of acute care in collaboration a team of health professionals; and
- **Self-Care Environment** - describes the broader determinants of self-care capability and levels of self-care activity in individuals and populations (e.g. socioeconomic status, cultural factors, health policy landscape etc.)

Despite the 'cardinal dimensions' and other framework components not necessarily aligning with the conceptualisation and system-framework adopted for the development of this Blueprint (see outline on page 5), the Matrix is able to effectively illustrate that self-care cannot be reduced to individual responsibility and should be supported by the health system and broader public policy levers. (See supporting background papers for more information and examples of conceptual self-care models).

Figure 1: The Self-Care Matrix: a unifying framework for self-care [12]



THE ROLE OF SELF-CARE IN ADDRESSING DISEASE BURDEN

From a public health perspective, self-care plays an important role, both for individuals' health status and for health system performance [4]. For individuals, capacity to self-care, including the ability to make informed decisions and use available health resources, is an essential component of the effective prevention and management of disease [2, 3]. Increased self-care activity can also contribute to improved mental wellbeing, self-efficacy and autonomy of individuals, particularly among vulnerable populations [4, 15, 16]. For the health system, there are many advantages to enabling, promoting and supporting self-care [2, 4].

Self-care is a cost-effective and logical approach that can reduce disease burden, improve health outcomes for all and ease the pressure on national health systems from preventable health conditions [2].

Self-care and prevention

The concept of self-care is complementary, and central, to the concept of prevention in health [17]. Successful policy initiatives that have addressed health risks, particularly public health campaigns to reduce tobacco and alcohol consumption, have included direct and indirect self-care support for individuals to limit exposure to these risk factors [18]. However, there has been little policy attention directed towards the potential to use similar approaches to engage and support individuals in protecting or improving their health and reducing their risks of preventable chronic disease [6]. There is evidence that up to 80% of heart disease, stroke and type 2 diabetes, and over a third of cancers, could be prevented through evidence-based self-care – eliminating or reducing exposure to the risk factors of tobacco use, unhealthy diet, physical inactivity and excessive alcohol consumption [19]. In Australia, this means that by 2025, an estimated 29,300 lives could be saved through the effective prevention of chronic disease [20].

Self-care and the management of chronic diseases

People living with long-term chronic diseases are the most frequent users of healthcare services in Australia. It is widely accepted that informed and empowered individuals with access to continuous self-care support are central to effective chronic disease management models of care [21]. Research suggests that enabling and promoting self-care across the population can improve health outcomes and physical functioning for many individuals [22]. Providing comprehensive self-care support through structured consumer education programs to people living with chronic conditions leads to increased self-care activity, which is associated with improvements across a wide range of disease-specific and generic chronic disease outcomes [3, 23-27]. Increased self-care activity has been shown to improve clinical indicators, symptom management, hospital admissions and in some instances, event-free survival[1] in people living with cardiovascular disease, hypertension, cerebrovascular disease and diabetes [3, 23-29]. Furthermore, enhanced self-care support and chronic disease self-management programs have been shown to be positively associated with improved adherence to treatment and medication. There is also growing evidence regarding the important role of self-care in managing mental health conditions and improving emotional wellbeing [5, 15, 30].

1 Event-free survival refers to the absence of heart-related events (eg. heart failure).

Reducing the spread and impact of infectious diseases

Protecting the health of the public during the emergence of new threats from infectious diseases requires informed self-care by individuals in concert with government-led population health and protection strategies, public health expert leadership, and with effective collaboration between healthcare providers, research communities and broader communities [31]. Until recently, little research or policy attention has been directed to identifying and managing the psychological and social factors likely to influence human behaviour during infectious disease epidemics and seasonal variations in patterns of infectious illnesses such as influenza or other viral diseases. Lessons learned from the current COVID-19 pandemic [7] and previous global threats such as the Ebola epidemic of 2014–16 indicate the need to build resilient health systems capable of optimising population health during all the health threats and circumstances, including crises and their aftermath [32]. Resilient health systems are characterised by the involvement of all actors, from individuals and communities to institutions and structures, in protecting health and optimising health outcomes [32]. The evidence suggests that resilient health systems also deliver everyday benefits and positive health outcomes. This double benefit — improved performance in both bad times and good – has been called "the resilience dividend" [33]. Self-care is a vital element in health system resilience.

The economic case for self-care

Australia spent $185.4 billion on health in 2017–18 – more than $7,485 per person [34]. This represents a larger increase in spending than previous years, after four years of below-average expenditure growth [34]. Expenditure on health care is projected to continue to rise faster than both national income and personal incomes. In terms of overall economic activity, health expenditure accounted for 10.0% of gross domestic product in 2017–18 and in 2016–17, above the median of 9.1% among Organisation for Economic Co-operation and Development member nations [34].

People who lack the skills to undertake self-care effectively incur higher health service costs [35, 36]. Australians make an estimated 232,507–922,012 unnecessary visits to emergency departments annually, at a cost of $124.5–$493.8 million, and 8.8–26.6 million avoidable general practitioner (GP) appointments at a cost of $397 million to $1.2 billion, for self-treatable health conditions and minor ailments [37]. Other economic modelling that examined the cost-saving potential of self-care in Australia found that maximising self-care would save $1,300–$7,515 per hospital patient per year, and significantly lower hospital readmission rates [38]. The potential for health system savings has been emphasised by US analysis which shows that having just 5% of American adults living with one or more chronic conditions participate in an evidence-based, six-session self-management education program would deliver annual health system savings of USD$3.3 billion [39-41].

A VISION FOR SELF-CARE IN AUSTRALIA

Better health for all, through better self-care by all

Informed self-care of their health by most people would reduce preventable health conditions throughout the population and preventable health care costs. Systematic support for self-care by individuals would improve population health and reduce health service demand.

LONG-TERM OUTCOME MEASURES

All services and health professionals provide self-care support as an integral component of health care provision

Informed and enabled health professionals who support consumer self-care for better health, together with health service models that enable and encourage self-care and measurably improve wellbeing, will reduce population levels of risk factors for preventable disease and contribute to lower morbidity, mortality and health care costs.

High rates of effective self-care activities and behaviours across the population

High participation in self-care for health by individuals will be achieved through active engagement of health services providers in supporting self-care for patients and consumers, together with ready access to quality-assured self-care information and evidence-based interventions for health professionals and consumers.

MEDIUM-TERM OUTCOME MEASURES

Informed and empowered individuals

Providing health care and other environments where individuals are exposed to information and supported to develop health knowledge and skills will equip people with capabilities that will enable them to be as healthy as possible throughout their lives.

Health service models that support and facilitate self-care

Innovative service models should be explored and research undertaken on which models are best suited to the delivery of self-care support in different service contexts. Collaborative care models, in which continuity of care, care coordination and multidisciplinary team-based practice are routine, and systematic components of service delivery should be prioritised.

A well-supported health workforce which values and promotes self-care

Health professionals and other care workers who are skilled in self-care support and shared decision-making with health consumers will enable self-care to be a central component of health care interactions, to prevent disease and to reduce health service demand.

Supportive public policies that provide access and opportunities for self-care

The environments and communities in which individuals live and work can both enable and inhibit self-care. Public policies such as urban planning and housing that support individual and community opportunities to self-care and facilitate disease prevention and positive health behaviours are a major driver of self-care activity.

CORE PRINCIPLES TO GUIDE SELF-CARE POLICY AND ACTION

Embedding self-care as a component of all health care, a key tenet of health policy and a common element in everyday life for all, will require comprehensive and coherent commitment from policymakers, health professionals and services and ongoing investment in community information and awareness. Seven principles have been established to shape policies and actions to reduce the impact and incidence of preventable chronic diseases in Australia [42]. These principles are directly relevant to the parallel and complementary challenge to implement and support population-wide self-care for health.

Self-care capability and chronic disease share many common risk factors [1, 7, 43] that extend beyond the more commonly understood 'health behaviours' or self-care 'activities' (eg. smoking, nutrition, alcohol and physical activity) to a range of social and environmental determinants [1, 12]. Taking joint action across multiple 'cardinal dimensions of self-care' (as described in the Self-Care Matrix) [12] will produce the greatest impact on individual and population health outcomes.

These principles are:

SYSTEMIC APPROACH	Focus on improving self-care capability and opportunity across the population
EVIDENCE-BASED ACTION	Act now using best available evidence and continue to build evidence
TACKLING HEALTH INEQUITY	Work to address social determinants which inhibit self-care and redress health disparities attributable to socio-economic disadvantage
NATIONAL AGENDA WITH LOCAL ACTIONS	Build local and regional capacity to support self-care by individuals
A LIFE COURSE APPROACH	Build self-care capability at all ages
SHARED RESPONSIBILITY	Develop complementary actions by governments, individuals and other groups
RESPONSIBLE PARTNERSHIPS	Avoid ceding policy influence to vested interests

STRATEGIC PRIORITIES AND SELF-CARE ACTION AREAS

Three strategic priorities are considered essential to achieving support of self-care as a central component of health and health care and to see it implemented as a system-wide tenet of health policy, services and practice.

The priorities provide the framework for 12 action areas, developed through an expert consensus approach and review of relevant literature that will contribute to the achievement of each priority. These action areas were identified as essential to the development of effective and systematic self-care and self-care support.

Address structural health system issues to enable self-care

The first strategic priority focuses on the structural health system components that can enable self-care. These are:

- funding models to support self-care and collaborative care for people with chronic and complex health needs;
- new or redesigned investment strategies in preventive health and individual self-care engagement and support; and
- cross-government policies and programs to address the socioeconomic, cultural and geographic factors that influence individuals' self-care capability and opportunities.

Most health systems, including Australia's, are based on an historical model that developed to treat acute rather than chronic conditions, in patients who were generally not considered active participants in their own care [44-46]. The increasing prevalence of people living with preventable complex chronic conditions is regularly identified as a challenge for Australia's health system [47]. However, the impact on health care services is poorly understood, and policy and service responses to date have been patchy and failed to address the structural issues which inherently undermine the system [48, 49].

Health care financing is arguably the most significant driver of the quality, accessibility and coordination of care [50, 51], all of which are important precursors for the provision of best practice self-care support. Faced with the challenges of an ageing population and increasing chronic disease prevalence, Australia's health system requires fit-for-purpose payment models that incentivise the delivery of coordinated and collaborative primary care and promote self-care support [46].

Despite the marked social gradient in exposure to risk factors, capacity to self-care, prevalence of chronic disease and life expectancy, current health services are underpinned by antiquated funding models that mostly ignore the social and economic factors that predispose people to risk of preventable health conditions. A cross-government approach that builds self-care capacity in individuals across the life course, starting with the early years, could address health disparities related to socioeconomic disadvantage and prioritise self-care support for the communities most in need.

Embed self-care support for individuals across health services

The second strategic priority is to have self-care support for individuals embedded in and across health services. The five action areas identified to achieve this priority are the:

- redesign of services to enable health professionals to better support self-care;
- support for consumer engagement in shared decision-making about health care and treatment and in co-design of appropriate health services;
- inclusion of self-care as core learning for all health professionals and care workers;
- development of health workforce roles and scopes of practice to support self-care; and
- development of validated, comprehensive measures and monitoring mechanisms to assess self-care by individuals and self-care support across health services.

Many people lack skills, motivation and confidence to manage their own health and health care and look for support and assistance from health services and health professionals [21]. Enabling self-care at the health service level requires acknowledging the central role and unique expertise of consumers in their own health and health care and engaging and supporting them, their families and their carers, to manage and prevent disease and maintain and improve health as effectively as possible.

Health professionals and other care workers play a key role in facilitating and supporting self-care [52]. Health professionals and service providers should ensure consumers are equipped with the necessary knowledge and skills to understand the information and suggested self-care activities provided during a healthcare episode. This includes self-care activities to:

- manage already established conditions (eg. how to manage symptoms, deal with flare-ups, adjust medicines and access appropriate specialist or allied health care); and
- reduce risk factors and prevent or slow the progression of disease (eg. smoking cessation, improving diet and physical activity levels and limiting alcohol intake).

The ways that healthcare providers deliver health education influences the treatment adherence and self-care activity and capability of consumers [53-55]. Effective and adaptable communication skills in health professionals build rapport and trust with consumers [56]. Healthcare consumers who do not feel heard by their healthcare provider are less successful with self-management practices and are more likely to withhold relevant information and not return for follow-up appointments [53]. There is strong evidence to suggest patients prefer individually tailored recommendations accompanied by actionable strategies rather than generic education following a diagnosis [53, 55].

Promote and support informed self-care and health behaviours for all individuals

The priority recognises that enabling self-care by individuals requires:

- access and exposure to information and education to enhance health literacy, knowledge and overall self-care capability;
- targeted approaches to reduce health inequities, support self-care and improve health literacy in at-risk, disadvantaged and vulnerable groups and individuals;
- access to evidence-based self-care and behaviour change interventions that support physical and mental health; and
- support for enhanced e-health literacy and the use of digital health technologies and interventions to facilitate self-care.

It is important to recognise that most people want to look after themselves, and the community response to the COVID-19 pandemic management strategies has shown that they are willing and able to do so when provided with the necessary information and support [7]. Health and relevant public policies and services should be focused on creating opportunities for individuals to engage in self-care [2, 16]. Research indicates that people want more independence and responsibility in the management of their health, and that they require more information about options, risks and what constitutes responsible self-care [57].

A NATIONAL POLICY BLUEPRINT FOR SELF-CARE IN ALL HEALTH CARE

The WHO has established a conceptual framework for self-care that recognises that people are accessing new information, products and interventions through retail outlets, pharmacies and the internet, as well as following the established self-care practices of their community and society [1, 14]. The framework recognises that safe, enabling environments which support self-care are essential and that the health system's support for disease prevention and the self-management of chronic conditions is an integral part of self-care. Accountability for health outcomes is reflected at multiple levels in the framework, and accountability of the health sector is important for equitable support for quality self-care interventions.

The Mitchell Institute worked with a range of experts and organisations to consider the role of self-care by individuals and in health services and the broader Australian health system. The Institute began this work with an audit of self-care policy and practice in Australia, followed by a workshop of practitioners and experts on the enablers of and barriers to self-care in Australia [6]. Twelve self-care priority action areas were identified. These were considered by expert working groups (EWGs), which reviewed the evidence relevant to each action area, including initiatives, interventions, health care practices and public policies that are effective in supporting self-care for better health. The EWGs then considered the best-fit policy options that could be implemented in Australia to advance the role of self-care as a core component in health care for all.

This national policy Blueprint comprises a suite of nine evidence-based, feasible priority policy actions that reflect the consensus across the wide-ranging network of experts involved in this work. The Blueprint presents the case for these policy initiatives, outlining how each will contribute to advancing the role of self-care for better health and disease prevention. Policy options relating to health care financing, health workforce, digital health interventions and the provision of health information are all included.

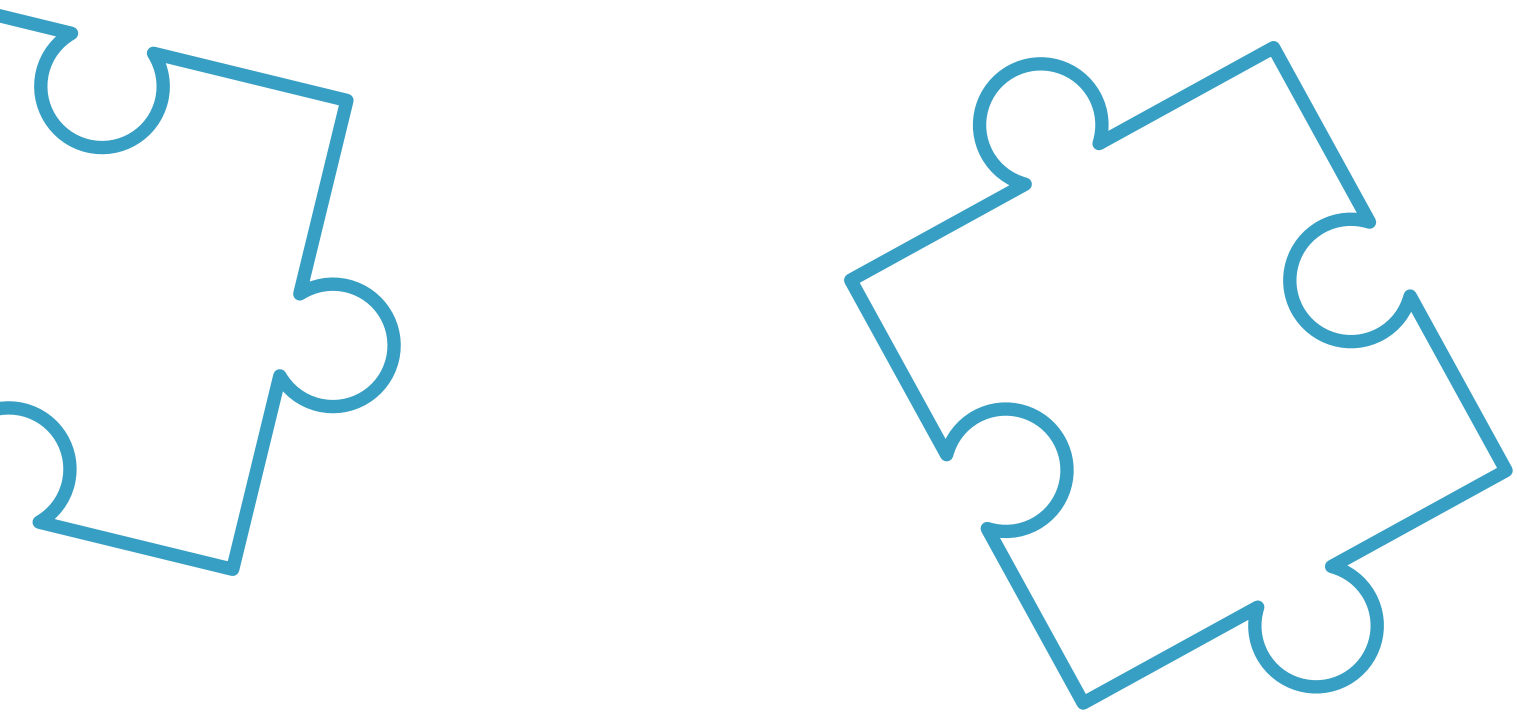
An accompanying technical paper, *Self-care for health: background paper for Australia's national self-care policy blueprint*, and a supporting evidence review, provide a comprehensive overview of the evidence supporting self-care for better health, the nine priority policy proposals and the full scope of work undertaken by the expert working groups.

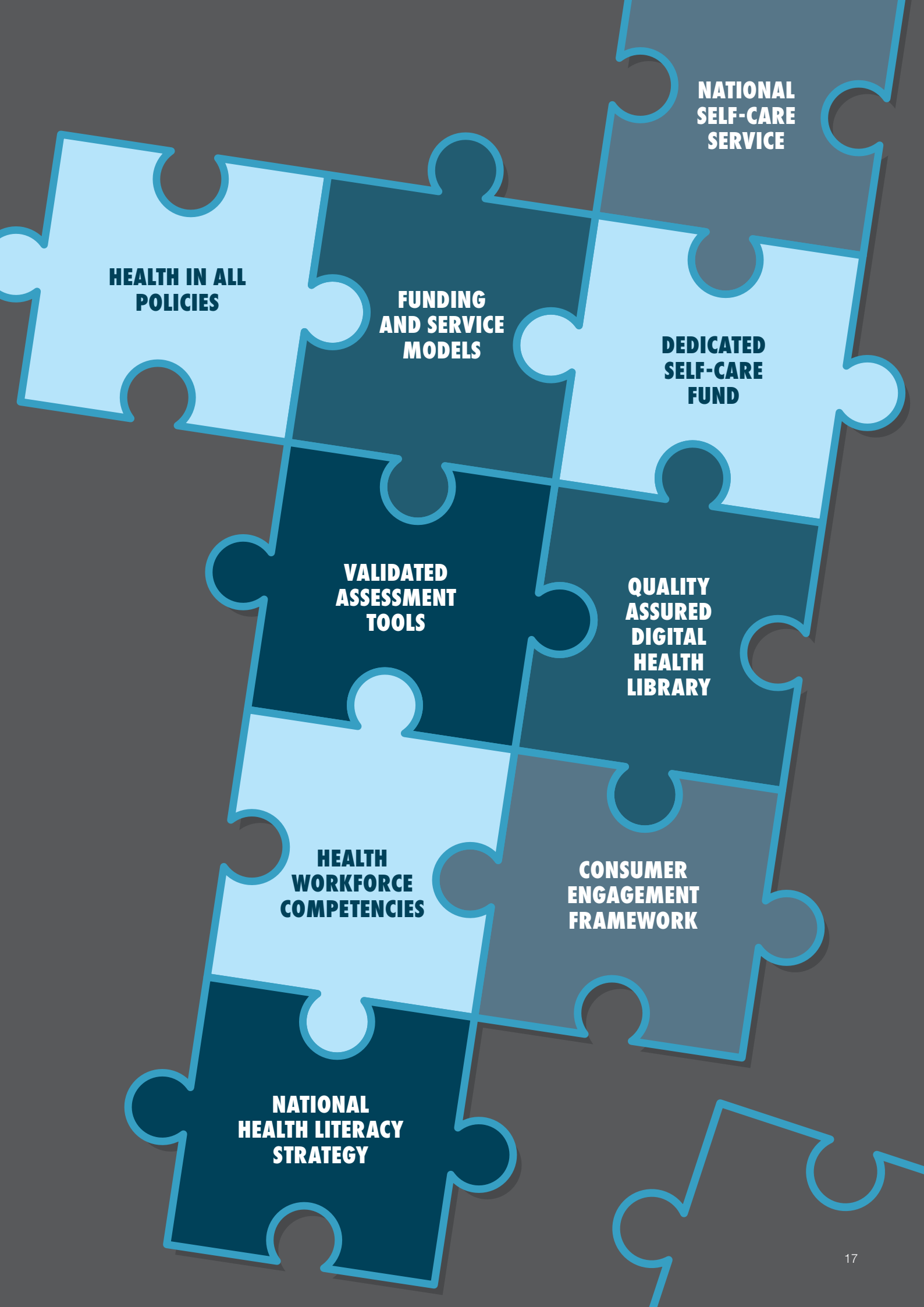
Rapid changes in health service provision and delivery, brought about by the urgent response to the impacts of COVID-19, have highlighted the separate and connected health policies and services that are critical to the health and wellbeing of the population. Telehealth services for individuals, to manage health care and support individual health and wellbeing, have been expanded dramatically; digital health information for communities and individuals has been employed systematically; skills development for the health workforce has been prioritised and other investments to support individual health care and health protection have been made.

The policy priorities presented in this Blueprint are a suite of separate initiatives that will address one or more of the barriers and gaps that currently inhibit the potential for self-care in all health care. Each policy priority, once implemented, will make a difference. Their connected implementation will amplify the difference and expand the reach and impact of each. Connected and strategic implementation will embed self-care as a core component of good health and of all health care. Together, the policies will improve population health through the prevention and better management of disease, and decrease health inequities by systematically reducing the impact of socioeconomic disadvantage and the other social determinants of health.

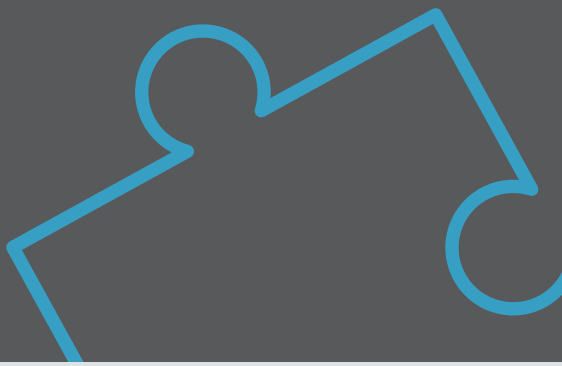
SELF-CARE FOR ALL, BY ALL: NATIONAL PRIORITY POLICY PROPOSALS

The Blueprint presents nine connected and strategic priority policy proposals to embed self-care as a core component of good health and all health care. The jigsaw identifies a logical and feasible approach to achieving all three of the Blueprint's strategic priorities, building from a national health literacy strategy.




NATIONAL SELF-CARE SERVICE
HEALTH IN ALL POLICIES
FUNDING AND SERVICE MODELS
DEDICATED SELF-CARE FUND
VALIDATED ASSESSMENT TOOLS
QUALITY ASSURED DIGITAL HEALTH LIBRARY
HEALTH WORKFORCE COMPETENCIES
CONSUMER ENGAGEMENT FRAMEWORK
NATIONAL HEALTH LITERACY STRATEGY

IMPROVING HEALTH LITERACY FOR ALL



Up to 60% of Australians lack adequate health literacy skills to meet the demands of everyday life – that is, the capacity to access, understand, appraise and use information to make health-related decisions [58, 59]. Low health literacy is linked with poor health across the life course, reduced capacity to engage in self-care to maintain or improve one's health, and increased healthcare costs.

Investment in strategies that build individual and population health literacy capacity is critical for disease prevention and management and improved population health, as well as for health protection during public health emergencies such as the COVID-19 pandemic. A national health literacy strategy would contribute to the prevention and more effective management of infectious and chronic diseases, and improved health status for all.

The problem

Low health literacy is associated with a range of poor health outcomes, and may also reduce a person's ability to implement health promoting behaviours and follow self-care recommendations [60-62]. Multiple studies have found that limited health literacy is associated with poor self-care, including less use of preventive health care and increased hospitalisations [63, 64]. It also carries a significant economic burden [65], accounting for approximately 3–5% of total healthcare costs [66].

There is strong evidence of an association between socioeconomic disadvantage and limited health literacy [67-70]. Individuals in more disadvantaged communities and at-risk or marginalised population groups are less able to access and engage in self-care activities than individuals who are well resourced and experience low rates of disadvantage [71]. Low health literacy in the Australian population inhibits the development of self-care capabilities for all [72] and intensifies the obstacles to good self-care faced by groups and individuals with the worst health [73]. The Royal Australian College of General Practice has also reported that limited health literacy may significantly reduce consumers' ability to access and utilise the National Disability Insurance Scheme (NDIS) [74].

The evidence

Health literacy can be improved through accessible information, structured education activities, and effective communication. Settings-based community-level approaches such as those implemented through libraries and community centres can improve health knowledge and behaviours, and health literacy skills [75-79]. Interventions and programs targeted and tailored to specific population groups are also effective, including for culturally and linguistically diverse populations and refugee groups. [80-83].

Evidence suggests that both community-based interventions across various settings and health service quality improvement activities are required to improve health literacy related self-care outcomes [86-88]. The Australian Commission on Safety and Quality in Health Care (ACSQHC) has incorporated health literacy indicators into the National Safety and Quality Health Service Standards [89] and self-assessment tools have been developed to guide organisational health literacy quality improvement activities [90-92]. This includes healthcare providers ensuring safe environments for consumers to ask questions, and healthcare workers honing their ability to recognise low health literacy based on health consumers' responses to questions and behaviours [93].

Primary health care is the universal entrance to health care for all. Strengthening support for health literacy at the primary care level, particularly for at-risk vulnerable populations, can to contribute to reducing health inequities across the population [94].

System-level changes to health and social settings are required to build health literacy and facilitate self-care. Several countries now have health literacy policies, and some have established health literacy as a priority within broader health strategies ranging from structured guidelines, such as accreditation standards, to more programmatic approaches [95-97]. These policies commonly promote a universal approach (targeting all patients and/or communities), with some also emphasising high priority or at-risk groups.

Priority policy proposal

Develop a national health literacy strategy aimed at improving health literacy and self-care capability for all.

The national strategy should:

- Identify and target the health literacy needs of disadvantaged and at-risk individuals, communities and population groups through all primary health care services and health promotion initiatives.
- Build system capacity through the National Safety and Quality Health Service Standards and accreditation processes and by:
  - establishing health literacy competencies and embedding them into professional education and continuing professional development and workforce accreditation standards;
  - implementing organisational self-assessment of health literacy practices, capabilities and responsiveness for health service providers, including their understanding of health literacy needs within their catchment populations;
  - developing concise, valid and reliable measures for health literacy to be used in periodic population surveys and as a practical screening instrument for tailored interventions; and
  - investing in medical and health research to identify and address health literacy needs in disadvantaged communities and at-risk population groups, particularly culturally and linguistically diverse communities, using place-based approaches that engage communities in their implementation.

BUILDING SELF-CARE INTO HEALTH CARE PRACTICE

There is substantial potential to improve the competency and skills of health professionals and paraprofessionals (i.e. other care and support workers) to effectively support self-care, particularly in primary health care. Establishing core competencies and defining roles for optimised self-care support by relevant health disciplines and other care worker roles will enhance the capabilities of health professionals and paraprofessionals and enable greater workforce flexibility for service providers to support self-care by all health consumers [98].

Health workforce self-care competencies should include:

- understanding professional roles and responsibilities in supporting self-care for disease prevention, treatment of minor ailments and self-management of chronic conditions;
- understanding and demonstrating skills in collaborative, multidisciplinary and ongoing team-based care with an explicit focus on shared decision-making;
- relevant health literacy competencies and skills;
- communication skills that engage and motivate consumers; and
- skills to assess and identify individual self-care capability across a diverse range of healthcare consumers and to tailor interventions accordingly.

The problem

Self-care support is not well defined and is not explicitly considered an essential component of healthcare practice by health professionals and service providers [99, 100].

Self-care and self-management are conceptualised differently by health professionals, paraprofessionals (ie. other care and support workers) and consumers [101], which may explain mixed evidence of effectiveness of self-care and self-management interventions. Consumers accessing multiple services across the health system report inconsistent advice and inadequate self-care support from different health professionals [102].

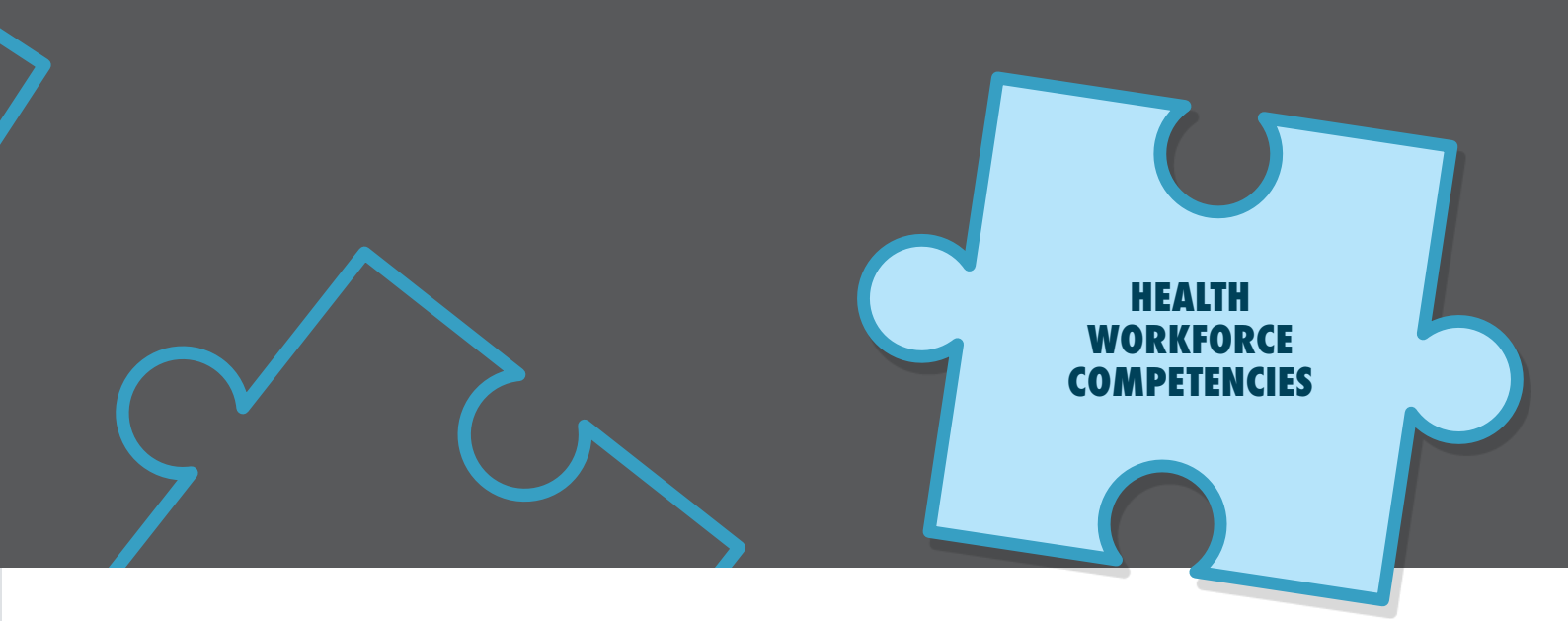
Health professional and paraprofessional education and training on self-care and its role in achieving optimal consumer health outcomes is patchy and often inadequate [103-105]. Insufficient numbers of health professionals and other care workers that are appropriately and explicitly trained to enable self-care or self-management has been identified as a barrier to the provision of best practice self-care support by health services [100]. A narrow focus on practitioner-led models of care is also a barrier to effective self-care support in primary care settings [52].

Paraprofessional and community worker roles (eg. disability support workers, personal care workers and link workers in social prescribing initiatives) have considerable potential to support self-care. However, restricted access to education and training programs is a barrier to enhancing the self-care support capabilities of this workforce [106].

The evidence

Effective self-care by healthcare consumers is reliant on the ability of healthcare workers to initiate and support consumer engagement in health care planning, decision-making and interventions, otherwise referred to as collaborative care [53, 107, 108]. Appropriate education and training of healthcare workers is essential, particularly for primary health care providers [103, 104], to facilitate collaborative care and improve self-care support [53, 107, 108].

An increasing body of literature suggests that a health workforce capable of facilitating and supporting



self-care in individuals can reduce GP consultations, reduce admissions to hospital, improve symptom control and produce better health outcomes [109, 110]. Some evidence identifies the specific components of self-care practice, education and training of health professionals and paraprofessionals associated with improved patient outcomes and essential for the provision of best practice self-care support [102, 104, 111, 112].

Several studies have identified specific areas in which specialised training is required to give health professionals and service providers the skills to facilitate and optimise self-care [102, 111, 113]. These include the need for health professionals and other care workers to:

- be trained in motivational interviewing – a counselling philosophy and technique to enhance patient engagement in a range of self-care behaviours [102, 104, 111, 112];
- support consumers with chronic health conditions to engage in self-care and behaviour change techniques and concepts including self-efficacy, motivation and goal-setting [114-118];
- understand and implement shared health care planning and decision-making with all consumers [119];
- be skilled in strategies such as health coaching, care planning and peer-led groups to improve health literacy, self-care capability and self-care activity, for which there is an emerging evidence base [112, 117, 120-123]; and
- understand the social determinants of health and identify social support structures and resources that can effectively improve self-care [124-126].

Self-care interventions, particularly for individuals and in communities affected by socioeconomic disadvantage, are most likely to be effective when multiple strategies, including social and other supports, are employed [127]. For multi-sectoral collaborative care to be enabled and effective, health professionals and service providers need to be familiar with a range of support services and strategies, because individual initiatives may not suit some consumers, even to the point of being detrimental to adherence [128]. Health professionals should be aware of the breadth of community resources outside the formal health sector that may effectively encourage self-care (eg. Men's Sheds, cultural groups, etc.) [99, 129, 130]. The development of inter-professional skills and multidisciplinary perspectives is also essential to provide consumers with best practice self-care support [52].

Establishing core competencies in self-care practice and support for all relevant health professional and workforce roles would enable self-care to become a core component of all care throughout the healthcare continuum, encompassing self-medication for better health, minor ailments, reducing health risks, ongoing chronic care and acute recovery.

Priority policy proposal

Invest in the development of cross-disciplinary self-care core competencies for all relevant health professionals and other care workers, engaging with consumer representative organisations, healthcare providers, health workforce peak bodies and professional colleges in a collaborative process.

Peak bodies, professional colleges and accreditation authorities should embed self-care core competencies in professional training, education and workforce accreditation where applicable.

ENABLING CONSUMERS TO BE ACTIVE PARTNERS IN HEALTH CARE

Recognition of the value of engaging consumers in decisions about treatment and care options for their health needs has grown in recent decades. However, despite a range of policies and strategies that place the consumer at the centre of health care, consumers' lived experience and capacity to self-care continues to be overshadowed by professional expertise.

Involvement of consumers in decision-making about their health care needs, in partnership with health professionals, is recognised as contributing to better health outcomes. The ability to choose and have some control over treatment options can also increase the capacity of individuals to engage in informed self-care, such as self-management of established health conditions. Self-management programs have been shown to achieve better care, better outcomes and lower costs. A comprehensive national health consumer engagement framework is required to:

- provide guidance and resources for health services and health professionals to actively support and encourage shared health care planning and decision-making; and
- facilitate consumer participation and engagement at all levels of the health system, from peer-led health interventions and co-designed health services right through to system evaluation and policy development processes.

The problem

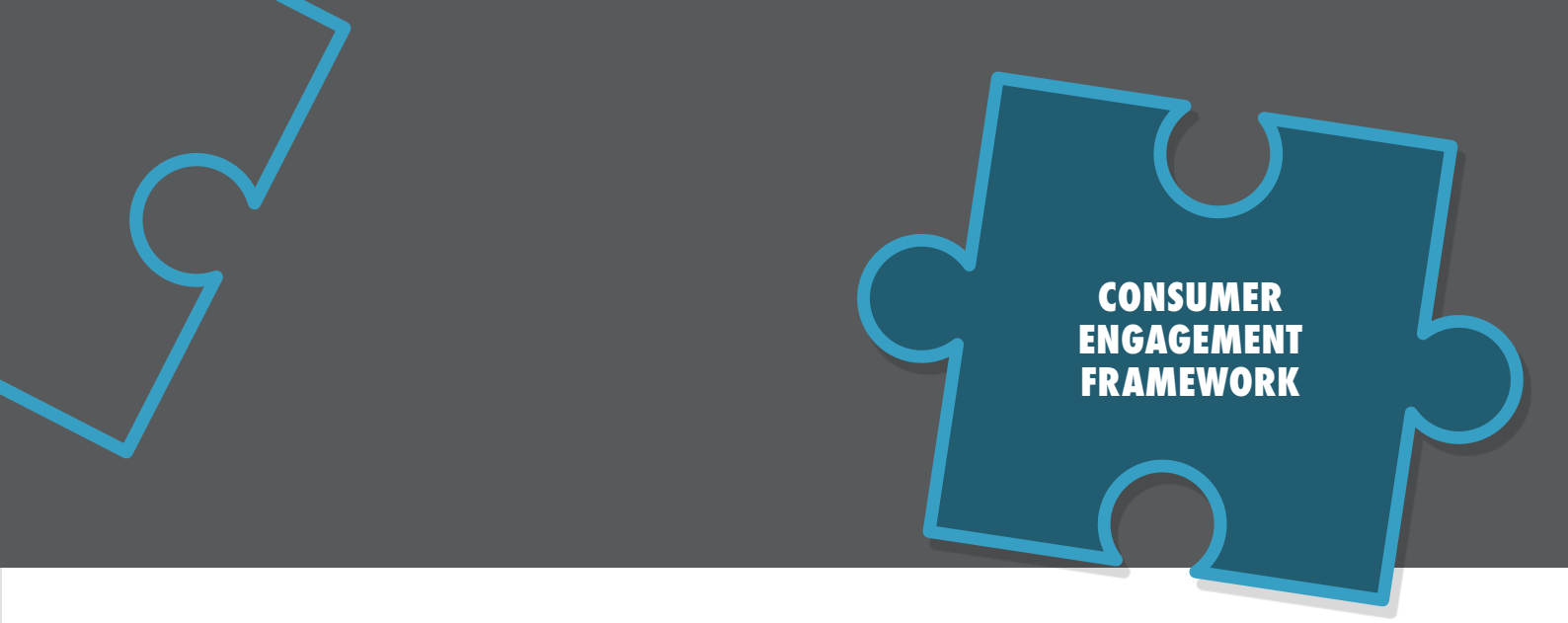
Various models of consumer engagement with treating professionals and within health services have been developed and implemented. However, these have not driven significant change across the healthcare system from the traditional health culture of 'doing to' towards a culture of 'working with' consumers. Moreover, current models of consumer engagement in health services planning have been reported to be tokenistic and confined to consumers who have become advocates ('sophisticated consumers') [131]. These consumers cannot be representative of the diversity of consumers. In particular, the voices of at-risk groups such as cultural and linguistically diverse groups [132], Aboriginal and Torres Strait Islander peoples [133] and disadvantaged communities [134] are largely unrepresented and unheard [135].

Despite standards for health service engagement with consumers and online resources for consumers to guide engagement in discussion about their health care needs, a range of barriers to meaningful consumer engagement remain [136] and contribute to suboptimal consumer engagement in health care and services. The Consumers Health Forum of Australia has emphasised the need to shift the power imbalance between service providers and consumers [137]. This includes recognising consumer expertise and enabling consumers to participate in the design and monitoring of performance of policies, services and actions which affect their health and wellbeing.

The evidence

Every day, most, if not all, individuals undertake self-care in some form, either independent of or in collaboration with others who may provide support and advice. Enabling consumers to be active participants in their own health care choices and planning is also essential to self-care [119].

Practical tools to promote consumer engagement and support self-care have been shown to be effective in mental health services [135]. The Australian National Safety and Quality Health Service Standards provide best practice examples of how to effectively engage with consumers and carers, and include examples of co-production in practice.



At all levels of health service provision, inclusion and active participation of consumers in evidence-based models of service co-design provides a basis for genuine partnerships to deliver the best outcomes across health services. Effective partnerships require recognition of the value and ability of people with a lived self-care experience to influence the services they access [41, 131] and to identify existing gaps and articulate how their needs may best be met [138, 139]. Consumers need to be confident that they have a right and responsibility to be involved in decision-making and service co-design, and to feel safe in doing so.

Recent guides on consumer and carer engagement released by the LifeSpan Integrated Suicide Prevention project [140] and the National Mental Health Commission [135] provide a framework and detailed examples of effective integration of consumers into decision-making, service planning, delivery and evaluation [141]. Similarly, the National Safety and Quality in Health Services Standards – Standard 2 offers advice across four domains, each with specific action areas to support improved engagement of consumers at individual and service systems levels, providing a useful foundation for policy development to inform and improve processes for consumer engagement [142].

Priority policy proposal

Invest in the development and implementation of a comprehensive national health consumer engagement framework.

The framework would build on existing best practice models and include system-wide performance indicators and accountability measures for consumer participation in health service design, delivery and policy development.

It should aim to enable and support systematic monitoring of:

- practices and processes for sharing decisions and planning care between consumers and treating health professionals, including communication and training for healthcare professionals; and
- the engagement of consumers as partners in the design and monitoring of policies, service planning and delivery and evaluation.

Uptake and use of the framework and performance indicators by all relevant health services and care providers should become a condition of health funding arrangements.

ASSURING QUALITY AND ACCESSIBILITY OF DIGITAL HEALTH INFORMATION

Almost all Australians (90%) now own smartphones [143], and have rapidly adopted digital health technologies and online information sources, including web-based resources and mobile apps, for health advice and support [144, 145]. Governments are also supporting digital health interventions (eg. telehealth services and electronic prescriptions) and online resources (eg. HealthDirect) [145]. Almost all Australians (≥90%) have a *My Health Record* enabling them to share health information with their healthcare providers.

However, the proliferation of technology and access to online information have dramatically increased the spread of misinformation about health and health care [146]. The development of a quality assurance framework to assess the credibility and quality of mobile health apps and web-based resources would enable health professionals and other care workers and consumers to access trusted and appropriate health information.

The problem

The vast volume of available apps and online health-focused resources is a barrier to effective uptake by both consumers and health professionals of evidence-based digital health interventions. There are over 350,000 apps in the 'health & fitness' and 'medical' categories of app stores [144] and an endless supply of online health advice, but the development and content of these apps and resources are unregulated and largely unevaluated [147].

A very small percentage of all available health apps are appropriately tested and shown to work [148-151]. Research has shown that, of common apps available in app stores:

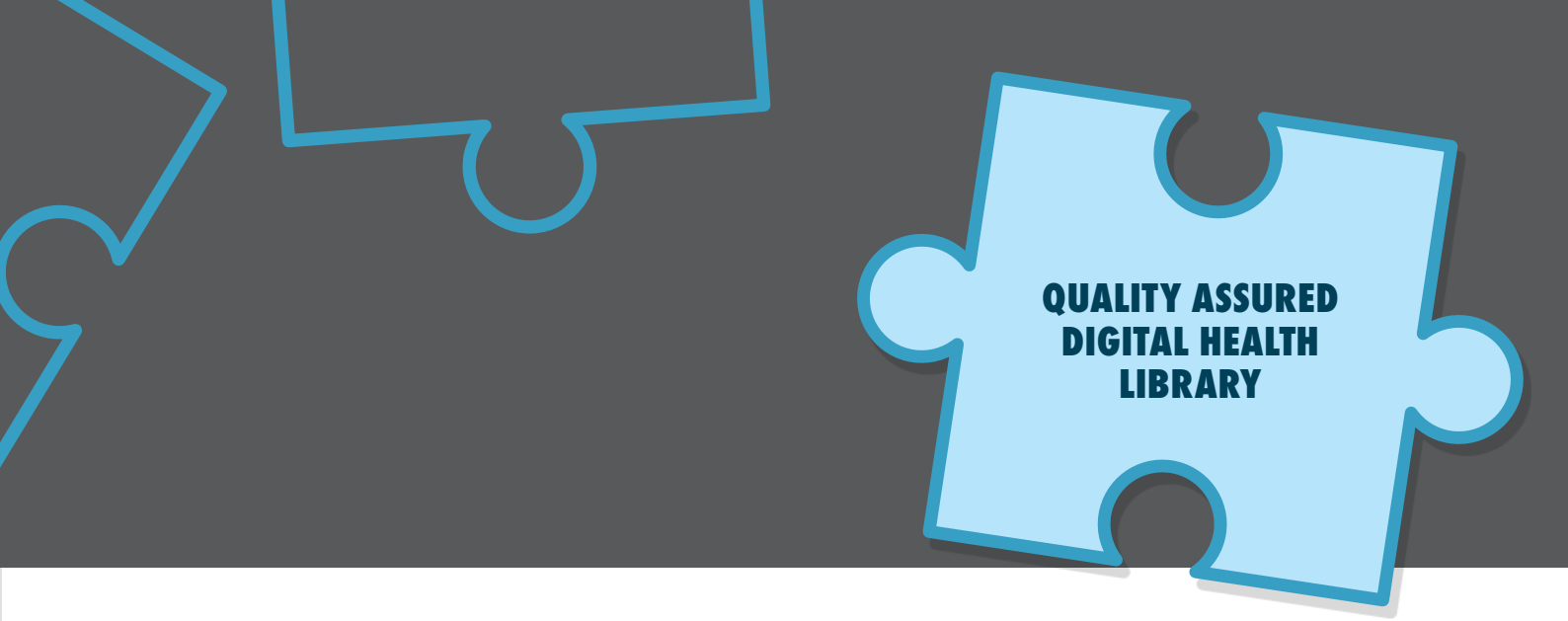
- less than 3% of mental health apps demonstrate direct health benefits associated with app use [149]; and
- less than 1% of weight management apps had been scientifically evaluated and less than 0.5% were developed with health professional input [150, 151].

General practitioners report regularly using digital health resources and apps professionally, including medical calculators and point-of-care references to support the diagnosis and treatment of a range of conditions [152]. However, only 40% of GPs report recommending apps or online resources to patients at least weekly [152]. The major barriers to app prescription by health professionals include insufficient knowledge of effective apps and the lack of a trustworthy source to access them [148, 152].

Critical thinking and appraisal skills are now considered essential to enable health consumers to effectively search for and utilise appropriate and evidence-based online health information [153, 154].

The evidence

The benefits of digital health technologies – such as personalisation, interactivity and mobility – enhance both the accessibility and impact of health information and support the delivery of self-care interventions [155]. The WHO and Australian Digital Health Agency acknowledge the significant role of digital health in improving health outcomes through increased access to health care and health information [156, 157]. The WHO identifies the potential for digital health information and interventions to improve health literacy, promote



positive health behaviour change and support disease self-management [156]. Evidence-based digital health interventions and resources that aim to support chronic disease self-management or self-care behaviours related to common risk factors for chronic disease have improved dietary patterns, weight loss outcomes, glycaemic control, physical activity measures and rates of successful smoking cessation [158-161].

Australia's response to the COVID-19 pandemic has established a broad role for telehealth in health service delivery [7, 162]. Telehealth services offer increased flexibility for consumers and enhanced efficiencies for providers [163], and the uptake by providers and consumers during the pandemic illustrates a willingness to embrace alternative modes for health interventions. [164-166].

The Organisation for the Review of Care and Health Applications (ORCHA) in the United Kingdom (UK) provides a health app library and collaborates with national health bodies and governments for evaluation of health apps. It aims to activate both consumers and health professionals to search, find and be able to use or prescribe the best health apps [167, 168]. Working with ORCHA, the National Health Service (UK) developed a library of trusted health and wellbeing apps [169]. New Zealand's Health Navigator is a similar health government-endorsed apps library [170]. Establishment of a credible and trusted online app library would support Australian health professionals' prescription of digital health interventions [152].

The Australian National Digital Health Strategy is being implemented by the Australian Digital Health Agency, which is also the system operator of the My Health Record, and is leading a national approach to the use of clinically safe digital health technology. This includes authorisation of mobile apps that connect to My Health Records to give consumers more options for accessing their health records. There are obligations on app providers relating to their commercial model, quality processes, company ownership and management, and requirements for independent audit. This could provide the basis for a national digital health information and resource library that could be hosted on an existing national online information platform such as HealthDirect, or as part of a National Self-Care Service online platform if established.

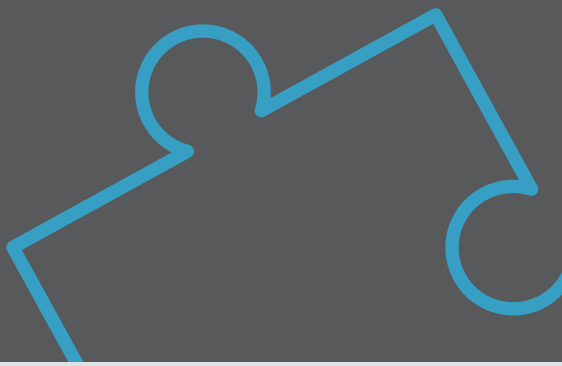
Australia's Health Star Rating front-of-pack labelling system is an example of a quality assurance framework for products that encourages and supports informed choices [171]. Similar improvements to population health could be achieved through the implementation of a quality-assured national digital health information and resource library.

Priority policy proposal

Establish a national digital health information and resource library and national quality assurance framework to assess the quality and credibility of web-based health resources and mobile health apps.

This should build on existing work towards a national approach for health mobile apps and promote voluntary participation by digital information providers. The national library would provide evidence-based online health resources and mobile health apps for consumers, health professionals and other care workers.

MEASURING AND EVALUATING SELF-CARE



Self-care is essential for disease prevention [19] and is estimated to make up more than 99% of the day-to-day care for established chronic conditions [3]. However, there is currently:

- no validated, comprehensive tool for the assessment of self-care in individuals [172]; and
- no comprehensive, widely-accepted approach or mechanism for the evaluation and monitoring of self-care support provided to consumers by healthcare providers.

At the individual level, measures that identify capacity for self-care enable support and interventions to be tailored to particular needs. For health services, measuring the level of self-care support provided to consumers can assist in identifying gaps and inform quality improvement activities to better facilitate self-care practices and support.

The problem

Self-care for the prevention and management of disease and minor ailments is a relatively new concept in policy, system planning and system performance [172, 173]. Measurement and evaluation is essential to demonstrate the effectiveness of any policy, program or intervention [174]. Without validated, generic measures and tools to comprehensively assess self-care by individuals, or to evaluate the provision of self-care support for consumers by healthcare providers, self-care activity cannot be identified as an outcome measure of health care within the health system [172].

Comprehensive, validated measurement of self-care in individuals should encompass measures that identify both:

- self-care capability (ie. requisite knowledge, skills and confidence to engage in effective self-care); and
- self-care activity (ie. health behaviours, exposure to disease risk factors and day-to-day activities undertaken by individuals that constitute self-care).

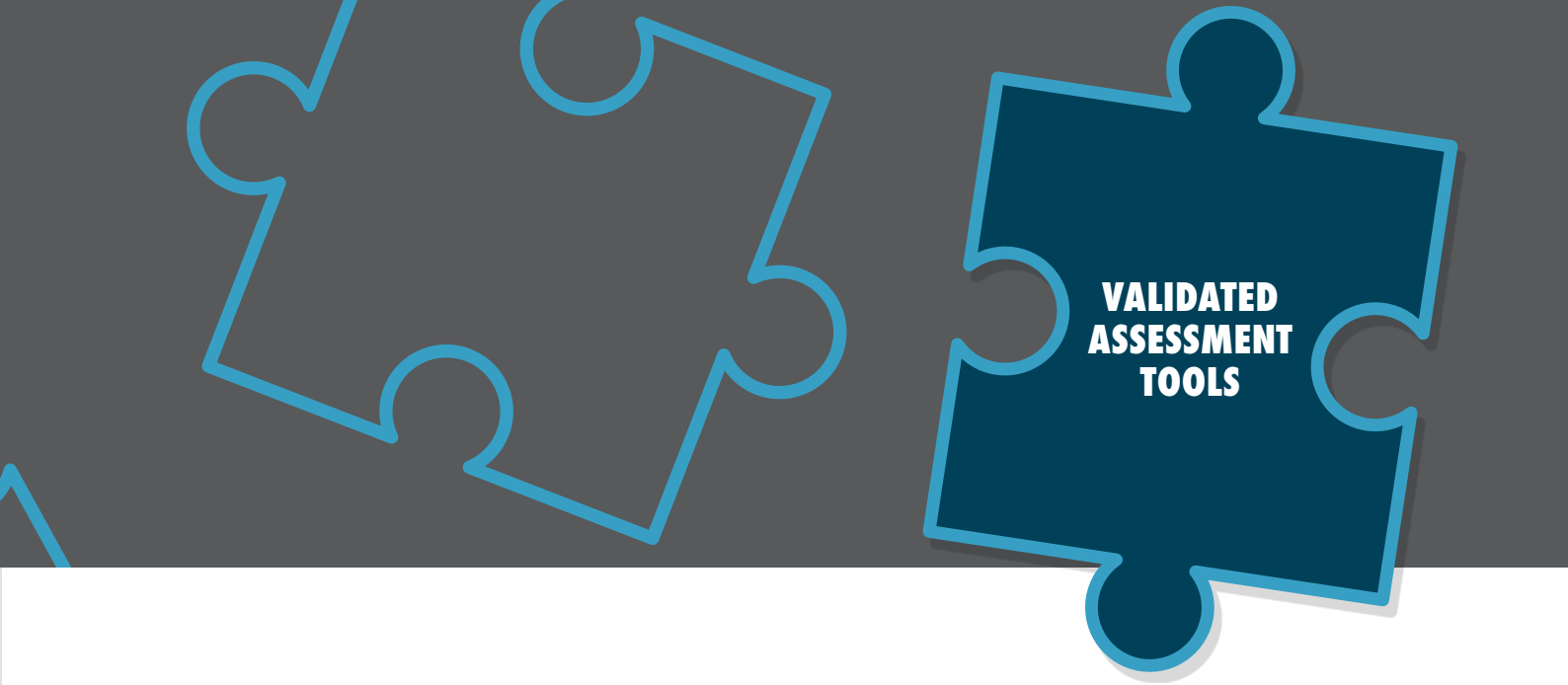
A range of tools and measures have either been designed to assess self-care or to measure elements of or concepts related to self-care, including self-management, patient activation, self-efficacy and consumer enablement [175]. However, most have not been sufficiently validated and none are systematically used by service providers in Australia [175]. Moreover, existing tools and measures designed to assess self-care tend to be for people living with chronic disease, condition-specific (eg. European Heart Failure Self-Care Behaviour Scale) and inapplicable to individuals outside of those disease cohorts [176].

The evidence

Established assessment tools for self-care or related concepts differ in approach. Some measure an individual's capacity or status regarding the concept being measured, some measure generic and/or disease-specific self-care behaviours and activities, and others are designed to assess and facilitate patient-clinician interaction [175, 176].

The Self-Care of Chronic Illness Inventory is the only example of a generic (non-condition-specific) instrument for measuring self-care in individuals living with one or more chronic conditions [176]. However, it has not been validated in Australia, and validation studies overseas have identified issues with some items in the 20-item questionnaire [176]. The instrument is also limited to measuring self-care in individuals living with chronic conditions.

Other tools measure essential components of self-care without measuring overall self-care capability and self-care activity. The Patient Activation Measure (PAM) measures an individual's self-efficacy skills



(ie. the confidence to exert control over motivation and behaviour) and subsequent capacity and willingness to engage in health and self-care. The PAM has been used to inform clinical practice through the provision of information, tailored support, interventions and health coaching to patients based on their activation level [177-180]. Patient activation has been shown to be positively associated with a higher overall level of self-care in Australia and internationally [178, 181]. The PAM has been validated in several countries and is widely used in the United States and the UK [178], but not in Australia as yet [175, 178].

Numerous validated tools are used to measure health literacy [182, 183], which is a fundamental prerequisite for self-care [184], but not sufficient to measure self-care capability and activity [175]. Most of the validated tools that represent best practice assessment of health literacy contain a large suite of measures [175, 185], and determining which measures are appropriate to include in a generic self-assessment tool will require further research.

The International Self-Care Foundation suggests that self-care has seven components, presented as the 'Seven Pillars of Self-Care', and that these could underpin measurement of an individual's overall self-care capability and self-care activity. The pillars are: health literacy, self-awareness, physical activity, healthy eating, risk avoidance, good hygiene and the rational use of products and medicines [186].

There is strong evidence to show that healthcare providers that effectively support self-care by consumers reduce consultations with GPs and hospital admissions and improve symptom control and health outcomes [109, 110]. Comprehensive evaluation and monitoring would permit verification of the effectiveness of any enhanced practices undertaken by health services and health professionals to facilitate consumer self-care [186, 187].

The Assessment of Chronic Illness Care (ACIC) and the Patient Assessment of Chronic Illness Care (PACIC) are tools that, when used together, indicate levels of self-care support. The ACIC is a questionnaire for health professional teams, developed to help health services improve care for chronic illness [188, 189]. It measures six domains, some of which are highly relevant to self-care support: community linkages, organisation of healthcare systems, self-management support, decision support, delivery system design, and clinical information systems [188].

The PACIC is the companion tool for consumers [190]. The two tools are complementary in assessing certain components of self-care support because they encompass both consumer and health professional perspectives [190]. However, they do not allow comprehensive evaluation of the level of self-care support provided by health services and a suitable assessment tool will require further research.

Priority policy proposal

Develop and implement validated assessment tools including:

- a universal measure of individual self-care status incorporating existing metrics related to self-care capabilities, patient activation and exposure to common lifestyle risk factors;
- a comprehensive tool for assessing health services' self-care support for consumers; and
- appropriate evaluation and reporting mechanisms to monitor self-care activity over time.

FUNDING MODELS TO SUPPORT SELF-CARE SERVICES

Health care financing and health service design are significant drivers of the quality, accessibility and coordination of care [50, 51], all of which are important precursors for the provision of best practice self-care support. Implementation of blended funding models[2] would remove many perverse incentives that exist within fee-for-service payment systems [50]. This would also enable multidisciplinary, integrated, coordinated and collaborative models of care, and facilitate the provision of self-care support by health services and increase self-care activity by individuals [191].

The problem

Australia's health services, and health care funding arrangements, like those in most developed countries, are based on a historical model that developed to treat acute, rather than chronic conditions, for consumers who were generally not considered active participants in their own care [44, 45, 47]. Consequently, the health system is not equipped to adequately support the preventive and self-care activities that are known to reduce the significant disease burden attributable to preventable complex chronic conditions.

Current funding mechanisms and service models do not support the delivery of efficient, coordinated, collaborative, team-based health care that includes consumers as active participants in their own care [47, 192]. The fee-for-service and largely single-episode health care provided under the Medicare Benefits Schedule (MBS) fails to incentivise the prevention and self-management of complex chronic conditions [47, 193]; and inhibits continuity of the care and collaborative care approaches, both between clinicians across disciplines and between health professionals and consumers, which are required to provide optimal self-care support [47, 194, 195].

The evidence

Multiple national health reviews have recommended that innovative health service models, underpinned by multidisciplinary team-based care and blended funding arrangements, should be prioritised to strengthen Australia's primary care system [47, 193]. People living with one or more chronic diseases achieve better health outcomes, including lower rates of potentially preventable hospitalisations and higher levels of self-care activity, when they have access to coordinated, continuous, primary health care provided by a multidisciplinary team, including a GP and one or more allied health professionals [191, 196, 197].

There is strong evidence and numerous international examples of:

- innovative service models, such as digital health care, social prescribing programs and 'patient-centred medical home' models [198, 199]; and
- sophisticated funding mechanisms that prioritise patient outcomes and incentivise self-care support by healthcare providers, including bundled payments (ie. a single payment for a 'bundle' of activity covering an end-to-end episode of care) [200].

Bundled payments are central to patient-centred medical home models of care, such as Australia's Health Care Homes trial, in which people with chronic and complex conditions can receive enhanced access to holistic coordinated care and wrap-around support for multiple health needs [201, 202]. Bundled and blended payments are the most appropriate funding mechanisms to support self-care because they increase flexibility, encourage collaboration and team-based care, minimise perverse incentives, improve care coordination (across providers and settings) and enhance care quality by reducing fragmentation [47, 200, 201].

2 Blended funding models refer to health financing arrangements that incorporate multiple funding mechanisms into a single system. Bundled payments and outcome-based funding are usually central components, complemented by fee-for-service and/or activity-based funding where appropriate.

Social prescribing is the process of referral to non-medical community programs and services. It has been shown to deliver positive health benefits and improved self-care capability in multiple service contexts internationally [203, 204]. It is estimated that 20% of Australian GP consultations address primarily social issues [199]. Enabling health and community services and the volunteer sector to work collaboratively to provide non-clinical interventions can enhance patient health outcomes [199].

To achieve best practice multidisciplinary care that supports self-care, primary health care should be financed through blended funding models that include bundled payments for the management of complex chronic conditions and chronic disease risk factors by an identified care team [47, 195, 201, 205]. Blended funding models that deliver comprehensive care for people at risk of or living with preventable chronic disease should be developed as a major component of the MBS and should provide a viable economic alternative to existing fee-for-service financing arrangements. Blended funding mechanisms could be administered through regional collaborative arrangements incorporating local hospital networks (LHNs), Primary Health Networks (PHNs) and appropriate community services.

Primary health care should be funded to:

- reduce health risks in individuals and vulnerable communities through preventive interventions and self-care information, education and support, including through multi-person and peer group shared appointment models [113, 191, 206];
- provide comprehensive team-based care services, including medical, pharmacy, nursing and other allied health services according to clinical need [192, 202];
- build the capacity of health professionals to provide self-care support [98];
- enable continuity of care across relevant community and health services to address to address social and environmental factors influencing health (eg. through funding link worker positions based in local health services as part of a social prescribing program) [199];
- facilitate the use of telehealth and other digital health interventions [163]; and
- be flexible to ensure service design and delivery are relevant to local context [8].

Priority policy proposal

Implement funding and service models that support self-care including:

- blended funding arrangements that enable and facilitate multidisciplinary primary health care services to deliver comprehensive collaborative care, preventive health and social care interventions, including explicit support for consumer self-care engagement; and
- support for research and clinical practice trials to inform the development of innovative service models and funding arrangements to enable self-care support and preventive care as routine and systematic components of primary health care delivery.

INVEST IN PREVENTIVE HEALTH AND SELF-CARE

Despite the rising rates of chronic disease in the Australian population, only 1.3% of Australia's health expenditure is dedicated to reducing shared risk factors and preventing acquired chronic disease [207]. Self-care is complementary, and central, to the concept of prevention in health. However, the role and capacity of individuals in maintaining their health and in preventing and managing disease through self-care knowledge and engagement has had insufficient recognition. A national investment fund dedicated to the development of preventive health care practice and resources, emphasising self-care information, education, training and support and governed by an independent expert body, would lead and drive the reorientation of health care towards prevention.

The problem

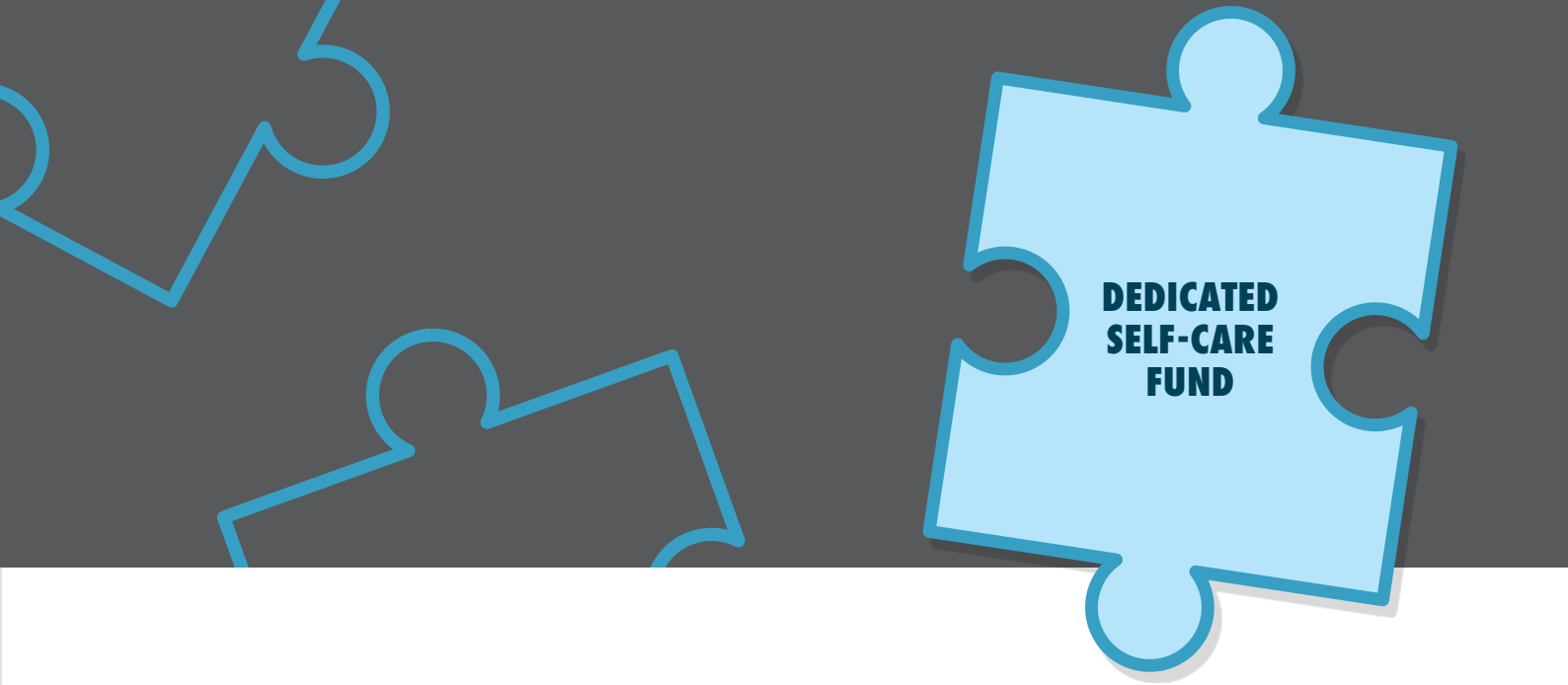
The high burden of preventable chronic disease in the Australian population is well recognised and the contributing factors to preventable disease are well known. Over a third of chronic disease burden can be prevented by addressing four shared risk factors that arise from individual behaviours and community environments: poor diet, physical inactivity, tobacco and harmful alcohol use [208, 209]. People and families in the lower two socioeconomic quintiles in Australia are at much greater risk of poor health and premature death from preventable chronic disease [210].

Despite a huge burden of preventable disease, Australia has one of the lowest levels of preventive health investment among like nations, with an estimated 1.3% or $89 per person spent on prevention annually [207]. To date, 5.8% of Medical Research Future Fund grants address preventive and public health research, and 1.7% target preventive health research [211].

The evidence

Specialised preventive health strategies have shown improved health outcomes through focused and sustained investments such as smoking cessation campaigns to improve public knowledge of health risks and preventable diseases. International and Australian experiences have also shown that specific investment programs that facilitate and support individual engagement in self-care for better health and disease prevention are cost-effective [212, 213]. The Australian study *Assessing Cost-Effectiveness in Prevention* identified a range of cost-effective health promotion interventions addressing risk factors for preventable chronic disease [212]. An English study of over 200 public health interventions, such as smoking cessation, interventions to reduce substance misuse, promotion of social and emotional wellbeing, promotion of physical activity and management of long-term sickness intervention approaches, showed that the vast majority of these interventions are highly cost-effective [214, 215].

In Australia, a striking example of a preventive health investment strategy is the vaccination program to prevent human papillomavirus (HPV) infection in women and girls, which lowered HPV rates among women aged 18–24 from 22.7% to 1.1% between 2005 and 2015 [216, 217]. A cost-effectiveness study of the two-dose HPV vaccine currently in use established that it is very cost-effective for the health system and for society [218]. Furthermore, a recent analysis estimated that Australia's investment in HPV research over 2000–14 delivered net present health gains of $56 million for a net present cost of $42 million, returning a benefit/cost ratio of 1.3 [219].



Leadership by governments and health experts during the COVID-19 pandemic has emphasised the critical importance of self-care understanding and capability by individuals for health protection and health maintenance for both individuals and communities. A dedicated long-term health prevention fund, incorporating evidence-based strategies to support better self-care and governed by an independent panel, is supported by leading Australian public health organisations and experts. Similar specialised investment strategies have been effective in addressing specific gaps in the healthcare system and enabling the rollout of innovative programs [220-222].

The recent addendum to the National Health Reform Agreement 2020–2025 has established a $100 million Health Innovation Fund (HIF) to fund trials that support health prevention and the better use of health data. The HIF could provide an appropriate vehicle for investment in evidence-based strategies to develop self-care capabilities for individuals and to embed self-care in all health care to reduce and mitigate risk of preventable health conditions. The Pharmaceutical Benefits Advisory Committee (PBAC), which recommends new medicines for listing on the Pharmaceutical Benefits Scheme, provides an effective model for implementation and administration of the HIF [223]. Establishment of an independent expert panel for the HIF, modelled on the PBAC, comprising public health and chronic disease experts, primary care clinicians and consumer representatives would establish and oversight prevention and self-care criteria and principles for investments by and outcomes of the Fund.

Priority policy proposal

A dedicated long-term preventive health and self-care innovation and development fund should be established.

The fund should be established with a mandate to facilitate and expand preventive health and self-care engagement, to invest in and support the expertise of health professionals and health services, to address disadvantage, and to lift self-care capabilities in individuals and communities. The fund would aim to reduce costs in the treatment and management of preventable health conditions through evidence-based and clinically reviewed information and training, treatment and referral resources.

The fund should be governed by an independent expert board comprising public health and chronic disease experts, primary care clinicians and consumer representatives appointed by government. The fund should complement and support the forthcoming National Preventive Health Strategy and could be incorporated within the Health Innovation Fund.

ESTABLISH A NATIONAL APPROACH

Understanding how to maintain good health, and being able to do so, contributes to better individual and population health and can reduce both individual health costs and government expenditure in primary and secondary care [36, 224-226]. Enabling health services and the health workforce to provide appropriate services to engage the Australian population in informed self-care could be achieved systematically through establishment of a dedicated national education, information and quality standards body to resource the health services system and provide public information, education and support.

A National Self-Care Service (NSCS) should be established to develop and drive the uptake of evidence-based self-care guidelines and resources by health services and to develop and disseminate self-care information and resources to healthcare workers and consumers. The Service should support a comprehensive digital information and education platform, and would complement and strengthen existing health strategies and services aimed at enabling optimal health and wellbeing in the Australian population.

The problem

Poor health literacy skills, inadequate access to appropriate evidence-based self-care information, support and interventions, insufficient self-care training of the health workforce and a lack of investment in preventive health all contribute to limiting the ability of individuals to understand and act on information about maintaining good health and reducing preventable health risks [12].

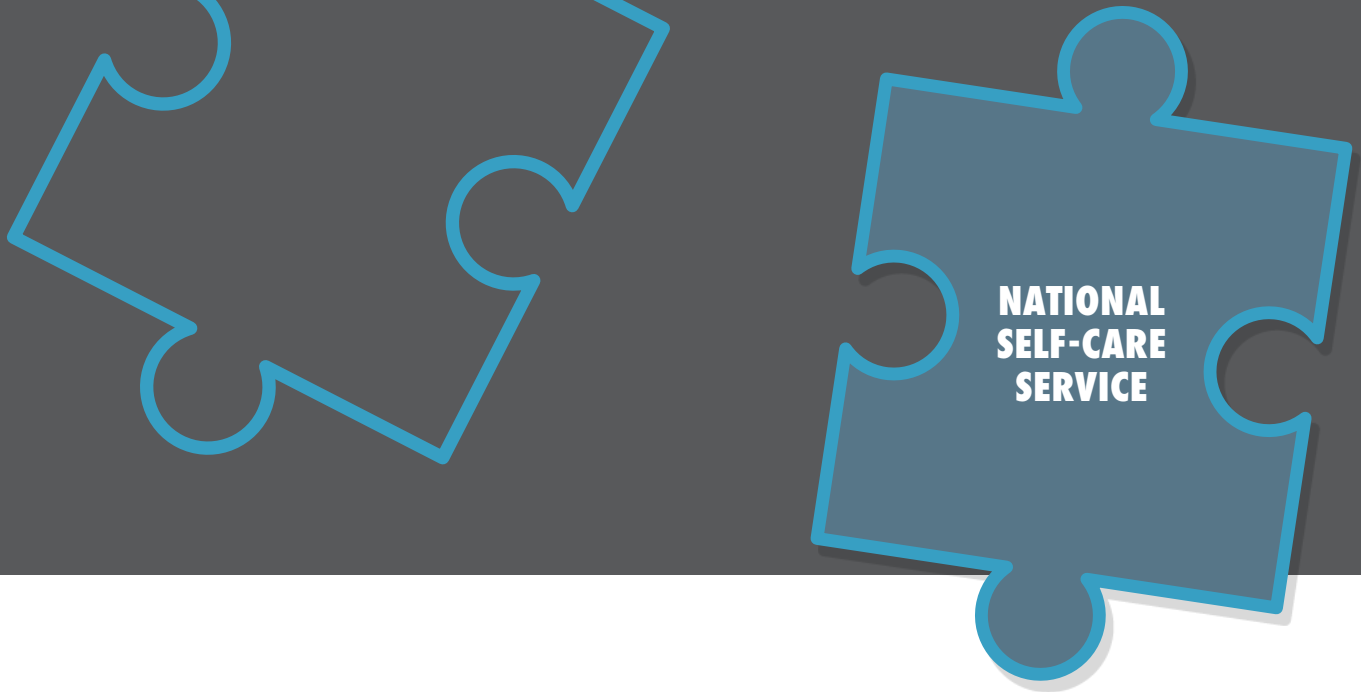
The most common risk factors for preventable chronic diseases – smoking, physical inactivity, poor diet and harmful alcohol use – are well known to be the major drivers of poor health for many Australians [227]. These risk factors occur at higher rates in socioeconomically disadvantaged communities and population groups [228].

Australia's investment in preventive health services is lower than in like countries [207], and the cost to individuals and the health system of ineffective and insufficient self-care is substantial. Individuals who lack the skills to undertake effective self-care incur higher health service costs [35, 36], and the cost to the health system of unnecessary consultations for self-treatable conditions has been estimated to be at least $511 million annually [37].

The evidence

International and national research shows that people want more independence and responsibility in managing their health but require information and guidance to do so [57, 119, 229, 230]. Providing access to evidence-based information, interventions and self-care support to assist individuals to modify risky behaviours is critical to improve preventive health and self-care practices and to reduce Australia's overall burden of disease [231].

The WHO has recognised the value and potential of self-care health interventions within health systems, and has published a consolidated guideline on self-care health interventions for sexual and reproductive health [4, 191]. Self-care health interventions should be supported by the health system, improve health outcomes and do no harm at both individual and population levels [4, 191].



The WHO has also recognised the potential for digital health to support self-care by increasing access to health information, improving health literacy, promoting positive health behaviour change and enhancing disease self-management [155, 156]. The expanded use of digital health interventions during Australia's response to the COVID-19 pandemic has been effective and is likely to have supported individual self-care [7]. Facilitating the use of digital health information and interventions via a comprehensive online platform as a major component of an NSCS would expand the potential for improved self-care activity across the population.

Self-care is explicitly recognised and supported by numerous mental health agencies and other health organisations throughout Australia [232-234]. Private health providers have invested extensively in self-care support for individuals, notwithstanding the constraints imposed by a regulatory framework which has been described as 'shackling' and unfit for purpose in the contemporary environment [192].

A national framework and approach to innovative quality improvement in health care has been shown to be effective. The National Prescribing Service (NPS) provides a model for a national approach to the development of self-care in health care [235]. The NPS is a partnership between health professionals, consumers, government and industry to systematically improve the use of medicines in alignment with government policy. A recent review of the NPS' Quality Use of Medicines program observed that the NPS has been a key implementation arm of the National Strategy for the Quality Use of Medicines, and has delivered significant savings in the costs to government of the Pharmaceuticals Benefits Scheme [236]. Effective self-care, promoted and supported systematically throughout health care services, could substantially reduce health care expenditure for individuals and health systems [226].

Priority policy proposal

Establish a National Self-Care Service (NSCS).

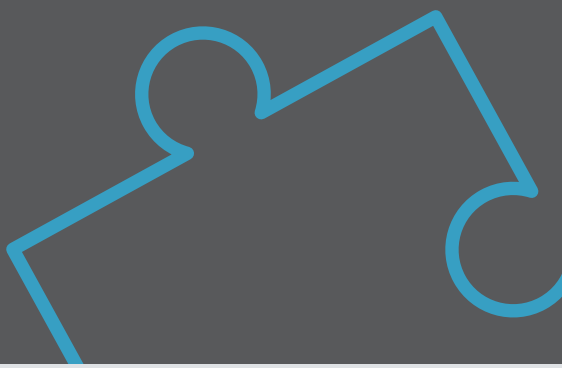
The NSCS would provide national leadership and influence system change to embed self-care in health practice and services and to engage, inform and resource individuals, families and communities in practising self-care for better health.

It should be governed by an independent board of consumer and health professional experts and should:

- develop and promote evidence-based self-care information, education, guidelines and resources for health services, health professionals and paraprofessionals;
- develop and promote information and resources for individuals, families and communities, including a digital information and education platform; and
- measure and report on the uptake of resources, guidelines and online information to inform ongoing quality improvement and outcomes of improved self-care practices and consumer engagement on population health.

The NSCS would facilitate and support implementation of the priority policies proposed in this Blueprint.

SUPPORTING HEALTH THROUGH ALL PUBLIC POLICIES



The inequality gap between communities in Australia has widened over recent years. Factors such as employment, housing, education, exposure to violence, access to medical care and socioeconomic status strongly influence health outcomes, with low socioeconomic status being a major risk factor for poor health and premature death (before age 75) [237].

Health and the capacity to self-care are influenced by these social and environmental factors and by public policies that reach beyond access to and utilisation of health care. Implementation of a cross-government 'health in all policies' (HiAP) approach enables interdependent and intersectoral strategies to promote and support individual self-care and a healthy population by addressing the social and economic risk factors that drive poor health.

The problem

Current Australian health policies and practices are largely focused on responding to health needs and have a siloed and narrow approach to the scope of health care. There is little recognition of the potential for significant investment in primary prevention to support individuals and communities to remain as healthy as possible and to have access to early interventions to limit disease progression and comorbidities [238]

Failure to tackle the health of disadvantaged Australians contributes to rising costs and burden on health services, widening health disparities and reduced productivity, employment and social participation. Reducing inequalities and improving population health and wellbeing requires inter-government and cross-government policies that aim to improve the health of whole populations and to improve health equity. Such policies should prevent and redress the adverse health impacts of social and environmental influences – the social determinants of health [19, 239, 240].

The evidence

The health of individuals and their capacity to maintain and improve their health through self-care do not exist in a vacuum. They are influenced by and the product of social, economic and environmental factors that lie beyond traditional health policies and services. The WHO has endorsed a HiAP approach as a strategy to reduce and prevent health disparities and preventable disease. The International Self-Care Foundation has also called for self-care to be included in HiAP strategies [239-241].

A growing evidence base supports a HiAP approach to self-care in health [241, 242]. This evidence is most visible with respect to populations in which chronic and complex health conditions co-exist with complex social conditions. A notable Australian example, admired internationally as a model for addressing this global concern, was the national response to the AIDS epidemic. It brought stakeholders from consumer groups and community and policy sectors together to develop policy solutions which delivered an effective preventative public health response [243].

The South Australian Government has incorporated HiAP into its development of a new agency, Wellbeing SA, with a mandate to focus on health promotion and primary prevention opportunities across policy sectors [244]. This enables collaboration and support between health agencies and others and has led to an increased focus on health impacts and benefits in the state's approach to urban planning, transport, maintaining natural environments and conserving water resources. An evaluation of the initiative found that it facilitated improved population health through successful engagement of a range of state government departments and by maintaining targeted population-based policies.

This South Australian experience illustrates that HiAP approaches should include:

- a clear mandate for joined-up government policies and actions;
- systemic processes that take account of interactions across sectors;
- shared accountability, transparency and integrated data;
- engagement of private and community stakeholders with public sector stakeholders;
- practical cross-sector initiatives that build partnership and trust;
- enabling collaborative approaches that encourage innovation and resource sharing;
- embedding of responsibilities into public sector strategies, goals and targets; and establishing agreed and comprehensive feedback and mediation mechanisms for all relevant stakeholders [240].

Priority policy proposal

All levels of Australian governments should establish 'health in all policies' approaches that emphasise the prevention of disease and support individual and community capacity for engagement in self-care to improve population health.

Effective implementation of initiatives that promote health and support self-care through a HiAP approach requires committed leadership and processes that value cross-sector problem-solving and address power imbalances, siloes and boundary issues.

SHARING RESPONSIBILITY FOR ACTION

Self-care is everyone's business. Despite the term 'self-care' implying actions by individuals, all self-care activities and behaviours are learnt from, or involve partnerships with, others and are influenced by the external environments in which people live and work.

The principles that are applied in this Blueprint call for a systemic approach, led by a national agenda supporting shared responsibility by governments, organisations and individuals, based on evidence and particularly targeting the impacts on health of socioeconomic disadvantage.

Self-care should be recognised as an essential skill for all.

The Blueprint is intended to promote and support the development of self-care for better health and disease prevention throughout all levels of health care in Australia, including population health, primary health, acute and chronic health care. It is intended to be a resource for all practitioners, service providers, administrators and organisations that aim to support and expand the role of self-care practice in health care in Australia.

In the midst of the COVID-19 pandemic, which has affected every layer of health services in Australia as well as the entire population and all sectors of the economy, self-care has become a critically important behaviour that has been emphasised by national and jurisdictional leaders and senior health officials and understood and implemented by most people. The response to the pandemic has demonstrated the shared responsibilities of governments, individuals, organisations and communities for health protection and prevention through self-care by all.

Provision of an evidence-based, expert-informed national blueprint to help advance the importance of and support for self-care in health is a timely contribution to the work of health policymakers and service providers as the impact of COVID-19 and its implications for future prevention and management of health risks are addressed.

ABBREVIATIONS AND ACRONYMS

ACIC	Assessment of Chronic Illness Care
ACSQHC	Australian Commission on Safety and Quality in Health Care
EWG	Expert Working Group
GP	General Practitioner
HiAP	Health in All Policies
HIF	Health Innovation Fund
HPV	Human Papillomavirus
MBS	Medicare Benefits Schedule
NSCS	National Self-Care Service
NPS	National Prescribing Service
NSQHS	National Safety and Quality Health Service Standards
ORCHA	Organisation for the Review of Care and Health Applications (UK)
PACIC	Patient Assessment of Chronic Illness Care
PAM	Patient Activation Measure
UK	United Kingdom
WHO	World Health Organization

SELF-CARE EXPERT WORKING GROUPS

Expert Working Group 1 Funding models and health workforce roles to support self-care
Co-Chair: Prof Rosemary Calder, Professor of Health Policy, Mitchell Institute, Victoria University and Director, Australian Health Policy Collaboration. **Co-Chair:** Prof Shalom Benrimoj, Emeritus Professor of Pharmacy Practice, University of Sydney. **Rapporteur:** Mr Tyler Nichols, Policy and Research Analyst, Mitchell Institute, Victoria University. Prof Mark Morgan, Associate Dean, Faculty of Health Sciences & Medicine, Bond University and Chair, Expert Committee for Quality Care, Royal Australian College of General Practitioners. Ms Karen Booth, President, Australian Primary Health Care Nurses Association. Prof Jon Wardle, Director, National Centre for Naturopathic Medicine and Maurice Blackmore Chair of Naturopathic Medicine, Southern Cross University. Dr Ruth Dunkin, Adjunct Prof, Mitchell Institute, Victoria University. Ms Diane Walsh, Board Chair, Northern Territory Primary Health Network. Ms Tracey Johnson, CEO & Company Secretary, Inala Primary Care. Dr Kevin McNamara, Deputy Director, Research, Deakin Rural Health, Deakin University School of Medicine and Stream Leader, Economics of Pharmacy Research, Deakin University Centre for Population Health Research. Ms Kylie Woolcock, Policy Director, Australian Healthcare and Hospitals Association.

Expert Working Group 2 Cross-government policies and investment in self-care and preventive health Chair: Prof Rosemary Calder, Professor of Health Policy, Mitchell Institute, Victoria University and Director, Australian Health Policy Collaboration. **Rapporteur:** Ms Hazel Fetherston, Policy Fellow, Mitchell Institute, Victoria University. Prof Sharon Lawn, Professor, College of Medicine and Public Health, Flinders University and South Australian Mental Health Commissioner. Dr Paresh Dawda, Director, Prestantia Health and Member Expert Committee for Quality Care, Royal Australian College of General Practitioners. Dr Matt Fisher, Senior Research Fellow, Southgate Institute for Health, Society and Equity, Flinders University. Ms Carmel Williams, Manager, Health Determinants and Policy, Wellbeing SA, SA Department of Health and Wellbeing and Co-Head WHO Collaborating Centre - Advancing Health in All Policies implementation. Ms Lisa Gelbert, Senior Policy Officer, Consumer Health Forum. Mr Ben Harris, Director, Policy and Research, Private Health Australia.

Expert Working Group 3 Service design and health professional education and training Co-Chair: Prof Mark Morgan, Associate Dean, Faculty of Health Sciences & Medicine, Bond University and Chair, Expert Committee for Quality Care, Royal Australian College of General Practitioners. **Co-Chair:** Prof Karen Willis, Professor of Allied Health Research, La Trobe University and Chair, Academic and Research Collaborative in Health, Royal Melbourne Hospital. **Rapporteur:** Mr Tyler Nichols, Policy and Research Analyst, Mitchell Institute, Victoria University. Mr David Menzies, Chronic Disease Program Manager, South East Melbourne Primary Health Network. Mr John Bell, Self-care Consultant, Pharmaceutical Society of Australia and Specialist Practitioner/Teacher in Primary Health Care, University of Technology Sydney. Mr Russell McGowan, Consumer representative and Honorary Advisor, The International Society for Quality in Health Care. Dr John Litt, A/Prof of General Practice, Flinders Prevention, Promotion and Primary Health Care, School of Medicine, Flinders University (retired). A/Prof Sarah Dennis, Associate Professor of Allied Health, University of Sydney and South West Sydney Local Health District. Dr Vinay Lakra, President Elect, Royal Australian and New Zealand College of Psychiatrist and Director Clinical Services, The Royal Melbourne Hospital & North Western Mental Health. Prof Lynne Emmerton, Director of Learning and Teaching, School of Pharmacy, Curtin University.

Expert Working Group 4 Consumer engagement
Co-Chair: Prof Sharon Lawn, Professor, College of Medicine and Public Health, Flinders University and South Australian Mental Health Commissioner. **Co-Chair:** Dr Michelle Banfield, Research Fellow, Centre for Mental Health Research, Australian National University. **Rapporteur:** Ms Hazel Fetherston, Policy Fellow, Mitchell Institute, Victoria University. Ms Leanne Wells, CEO, Consumer Health Forum. Ms Ann Smith, Consumer representative. Ms Janne McMahon (OAM) Founder and Director, Lived Experience Australia. Mr Danny Vadasz, CEO, Health Issues Centre. Ms Penelope McMillan, Consumer representative. Ms Darlene Cox, Executive Director, Health Care Consumers' Association.

Expert Working Group 5 Health literacy Co-Chair: Dr Alison Beauchamp, Senior Lecturer, School of Rural Health, Monash University and Senior Research Fellow, University of Melbourne. **Co-Chair:** Dr Anita Trezona, Managing Director and Founder, Trezona Consulting Group. **Rapporteur:** Ms Bojana Klepac, Research Fellow, Mitchell Institute, Victoria University. Dr Maria Duggan, Adjunct A/Prof, Mitchell Institute, Victoria University. Dr Janney Wale, Consumer advocate. Dr Sundram Sivamalai, Professor of Rural Health, Emotional Well-Being Institute, Geneva and Board Director, Ethnic Communities' Council of Victoria. Prof Don Nutbeam, Professor of Public Health, University of Sydney, Principal Senior Advisor, Sax Institute. Dr Sarity Dodson, Global Lead, Development Effectiveness, Fred Hollows Foundation. Dr Linny Kimly Phuong, Fellow, Royal Children's Hospital; Honorary Fellow, Murdoch Children's Research Institute and Founder and Director, The Water Well Project. Ms Lidia Horvat, Manager, Safer Care Victoria. Ms Liz Meggetto, Executive Officer, Central West Gippsland Primary Care Partnership. Prof Kirsten McCaffery, Director, Sydney Health Literacy Lab; Principal Fellow, Sydney School of Public Health, University of Sydney.

Expert Working Group 6 Evidence based self-care interventions, measures and evaluation. Co-Chair: Prof Jenny Bowman, Professor of Psychology and Assistant Dean, Faculty of Science, University of Newcastle. **Co-Chair:** Ms Rachael Kearns, Research Officer, Centre for Primary Health Care and Equity, University of NSW. **Rapporteur:** Mr Tyler Nichols, Policy and Research Analyst, Mitchell Institute, Victoria University. A/Prof Ben Harris-Roxas, Director, South Eastern Sydney Research Collaboration Hub, University of NSW. Dr Tara Clinton-McHarg, Post-doctoral Research Fellow, University of Newcastle. Dr John Litt, A/Prof of General Practice, Flinders Prevention, Promotion and Primary Health Care, School of Medicine, Flinders University (retired). Dr Sarah Dineen-Griffin, Clinical Pharmacist and Chair, NSW Early Career Pharmacist Working Group, Pharmacological Society of Australia. Dr Stephen Carbone, Director, Prevention United. A/Prof Sarah Dennis, Associate Professor of Allied Health, University of Sydney and South West Sydney Local Health District. A/Prof Michael Greco, CEO, Care Opinion Australia.

Expert Working Group 7 Digital health and technology to support self-care. Co-Chair: Dr Oyuka Byambasuren, Postdoctoral Research Fellow, Institute for Evidence-Based Healthcare, Bond University. Co-Chair: Prof Rosemary Calder, Professor of Health Policy, Mitchell Institute, Victoria University and Director, Australian Health Policy Collaboration. **Rapporteur:** Ms Bojana Klepac, Research Fellow, Mitchell Institute for Education and Health Policy, Victoria University. Dr Annie Lau, Research Fellow, Australian Institute of Health Innovation, Centre for Health Infomatics, Macquarie University. A/Prof Belinda Lange, Research Lead for Technology, Caring Futures Institute, Flinders University. Prof Bodil Rasmussen, Chair in Nursing (Western Health) Deakin University. Prof Katherine Boydell, Professor of Mental Health, Black Dog Institute. Prof Britt Klein, Director: Biopsychosocial and eHealth Research and Innovation, Professorial Chair in Digital & Mental Health, Federation University. Prof Brian Oldenburg, Chair, Non-Communicable Disease Unit in the Melbourne School of Population and Global Health, University; Director, WHO Collaborating Centre for Implementation Research and Prevention and Control of NCDs. Dr Fiona Martin, Director, Digital Inclusion and Community Engagement, Australian Digital Health Agency.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