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

A snapshot of WA health system initiatives to improve health equity and access to care for people living in low socioeconomic conditions

Contents

Acknowledgement of Country and People

WA Health acknowledges the Aboriginal people of the many traditional lands and language groups of Western Australia. It acknowledges the wisdom of Aboriginal Elders both past and present and pays respect to Aboriginal communities of today.

1. Background and purpose

The *Sustainable Health Review (SHR) Final Report* sets out 8 enduring strategies and 30 recommendations to drive a cultural and behavioural shift across the health system to support the delivery of patient-first, innovative and financially sustainable care.[1] The first enduring strategy is to 'commit and collaborate to address major public health issues'. Recommendation 3c, which sits within the first enduring strategy, calls for a reduction in 'inequity in health outcomes and access to care with a focus on people living in low socioeconomic conditions'.[1]

The SHR takes a social determinants approach and emphasises reducing inequity and inequality across the state by addressing the multiple and complex sources of health inequity, including child and family safety, disability support, education and housing.[1] A fairer, more equitable health system that takes into account the social determinants of health and contributes to reducing inequity for people living in low socioeconomic (SE) conditions will also contribute to the long term sustainability of the health system. Opportunities to improve health equity for people living in low SE conditions exist in settings for community-based primary health care, as well as the health system.

The implementation plan for this recommendation includes a requirement to produce a snapshot of existing and planned initiatives across the health system that seek to enhance communications, policies, programs and services in order to promote health literacy and health equity for people living in low SE conditions. The best practice initiatives deliver sustainable, enduring contributions to the improvement of health outcomes, health literacy and access to care for people living in low SE conditions.

WA health system annual reports and websites were reviewed to identify and develop a profile for the selected initiatives.

Aspects of all 8 SHR enduring strategies will contribute to reducing inequity for people living in low SE conditions. This bulletin also maps the linkages between enduring strategy 1 and the other 7 enduring strategies of the SHR.

Health equity refers to the absence of unfair, avoidable differences among groups of people, defined socially, demographically, geographically, economically, or by other dimensions of inequality.

Health literacy refers to how people access, understand and use health information in ways that benefit their health.

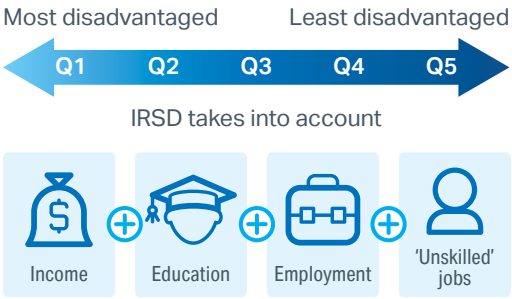
2. Snapshot of socioeconomic disadvantage and health in WA

What is socioeconomic status?

Socioeconomic status (SES) is a measure of the SE position of individuals and communities relative to the rest of the population.

How is it measured?

The Index of Relative Socioeconomic Disadvantage (IRSD) classifies individuals into 5 categories (or 'quintiles'):



Why does it matter?

SES provides insight into the factors that may influence an individual's or community's ability to access and use information, resources and services to maintain their health. Taking these factors into account will lead to a more equitable health system and better health outcomes for all.

Who is disadvantaged in WA?

WA population
2.7 million

1 in 7
live in low SE areas

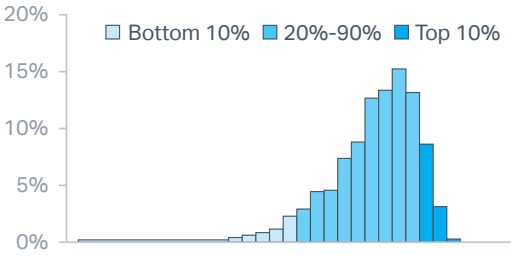
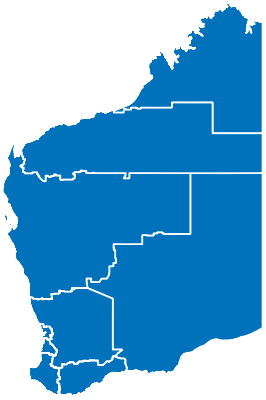


Figure 1: Population distribution across the Index of Relative Socioeconomic Disadvantage (IRSD) by SA1 in WA (Source: ABS 2018)



1 in 2
country WA
residents live in low SE areas

1 in 50
metro WA
residents live in low SE areas

Figure 2: The Index of Relative Socioeconomic Disadvantage by LGA in WA (Source: ABS 2018)

Socioeconomic disadvantage is a risk factor for chronic disease

The rate of ill health, disability and death is

1.5x higher

among the lowest SE areas, compared to the highest SE areas

Compared to people living in higher SE areas, people living in low SE areas are:

- **3.3x** likely to smoke daily
- **1.3x** likely to be physically inactive
- **1.6x** likely to live with obesity

If all Australians had the same health outcomes as the highest SE communities, burden from ill health, disability and death would decline by

20%

Influences of access to services among people experiencing disadvantage:

- Systemic factors
- Organisational factors
- Personal and family factors

3. Influencing the social determinants of health through collaboration and partnerships

WA Health works in partnership with a range of stakeholders across all levels of government and the non-government sector to design, deliver and promote initiatives that improve the social determinants of health in WA. WA Health achieves this through:

- active engagement with formal and informal cross-sector forums and networks, and contribution to strategic planning and policy development where these may influence health outcomes.
- working closely with local governments to support their local health planning.
- partnering with peak bodies, including not-for-profit agencies, that represent the interests and concerns of, and provide services to priority populations.

WA Health participates in the Supporting Communities Forum, an initiative to build a collaborative partnership between the State Government and the community services sector, to improve economic growth, employment and community wellbeing, particularly for vulnerable populations in WA.[2]

The Chronic Disease Prevention Directorate has completed an extensive mapping project which identifies intersecting policies, strategies and initiatives for chronic disease prevention across the WA public sector. The project has shown that many Government agencies have functions and policies which contribute to healthy and safe settings, people and communities, food and drinks, and recreation.

Health Service Providers are in a particularly strong position to develop and grow partnerships at the local community level.

Case study 1:
North Metropolitan Health Service's Priority Communities Program and interagency Social Inclusion Network

Social connectedness is an important determinant of health. Social inclusion, including having strong interpersonal relationships, can benefit physical and mental health by providing networks to provide support, help coping with hardship, and gain access to employment and other opportunities for civic participation.[3]

More than half (54 per cent) of Australians aged 15 years and older with a long-term health condition or disability report experiencing some level of social exclusion, compared with a quarter of the general population.[4] People living in lower SE conditions tend to report feeling social exclusion at higher rates than people living in higher SE conditions.[5]

The North Metropolitan Health Service (NMHS) delivers the Priority Communities Program, which includes supporting the delivery of targeted health promotion activities in 2 locations in Perth's northern suburbs.[6] These areas have been identified as having populations with poorer health outcomes compared to the general population.[6] As part of this program, the NMHS hosts the interagency Social Inclusion Network.[6]

The network is a cross-sector partnership of more than 30 organisations, including state and local government, the non-government sector, schools, communities of CaLD backgrounds, Aboriginal organisations and service providers.[6]

The collaborative partnerships formed through the network enable community development and individual capability building, and support the delivery of interventions which foster harmonious, inclusive and healthy communities.[6] The network facilitates several community-based programs, including the Balga Boodja Walking Trail, tailored food literacy programs, weekly community walking groups, and the 'With One Voice' Mirrabooka community choir.[6]

4. Health equity in the community

4.1. Promoting equitable and sustainable improvements in health through public health and prevention

Public health measures are most effective and equitable when delivered across the whole population, while providing targeted interventions for priority populations who may be disadvantaged and at an increased risk of exposure to health risk factors.[7] This can be achieved by making sure that the messaging, focus and intensity of an intervention are responsive and proportionate to the needs of these populations.[7]

The *State Public Health Plan for Western Australia 2019–2024* provides strategic directions for prevention, health promotion and health protection for the state and identifies people living in low SE conditions as a key priority population.[8] WA Health funds delivery of a range of preventive health programs across priority areas, including chronic disease and injury prevention, and health protection through environmental health measures and communicable disease control.

Funded service providers must ensure equitable access to the programs they deliver for all people regardless of their social, economic or cultural background. To increase the impact of initiatives among priority populations, including disadvantaged and at-risk groups, service providers use strategies that include:

- ensuring reach and relevance of health messaging and interventions for priority populations.
- ensuring communications and interventions are clearly understood and easily accessible by priority populations, and that they support improved health literacy.
- ensuring professional development, training and resources are available to build the capability of stakeholders and partners in delivering communications and interventions.
- incorporating geographically targeted and tailored settings-based approaches.

Case study 2:
Make smoking history

In WA, the prevalence of daily smoking among people living in the lowest SE areas is more than double (13 per cent) the rate among people living in the highest SE areas (5 per cent).[9] People living in low SE conditions may face more barriers that make it harder for them to reduce their smoking and quit, such as ongoing exposure to smoking in their social networks, perceptions of stigma when accessing quit services, and costs of accessing smoking cessation products and treatment.[10]

The Make Smoking History (MSH) Priority Settings Program believes nobody should live in poverty, be socially excluded or die early because of tobacco. The program aims to reduce tobacco-related inequities experienced by people accessing community, health and corrective services, and to raise awareness of the social injustice caused by tobacco smoking.

The MSH Priority Settings program works with community, health and corrective services to identify tailored strategies to change policies, practices and systems to provide everyone at these services (clients and staff) with access to comprehensive and non-judgemental cessation support in a trusted environment, and to increase access to supportive smoke-free areas.[11] Working with community, health and corrective services ensures that policies, practices, and systems are sustainable, integrated into existing service delivery, easy to access for staff and clients, and make a positive impact.[11]

MSH also uses public education campaigns, advocacy and research to raise awareness of the harms and social injustice caused by smoking and the benefits of quitting.[11] MSH is delivered by Cancer Council WA and jointly funded by the WA Department of Health, Healthway and Cancer Council WA.[11]

4.2. Ensuring equitable access to health services in the community

A collaborative of WA social welfare agencies and The University of Western Australia has worked with local families experiencing entrenched disadvantage to identify context-specific barriers and enablers to accessing health services in the community.[12] Barriers to access may include:

- a lack of available services
- insufficient funding and workforce capacity for services to meet demand
- restrictive eligibility and access criteria including caps on frequency of access
- accessibility and affordability of transport
- onerous administrative requirements to qualify for access
- limited opening hours and appointment availability
- individual financial circumstances and competing priorities.[12]

WA Health recognises the need for universal access to basic health services, with targeted strategies to provide additional intervention and support to make services more accessible to priority populations who are disadvantaged or at higher risk. Work that aligns with SHR enduring strategies 1, 2, 3, 4 and 6 contributes to this goal. Priorities include:

- consultation and partnerships with relevant government and non-government stakeholders, including consumers, to ensure that policies, programs and services are contemporary, holistic, and appropriately meet the needs of priority populations.
- embedding specific mechanisms to reduce the impact of barriers to access in service design for priority populations who may be disproportionately affected, such as waiving certain requirements.
- providing outreach services to target hard-to-reach populations, such as those who may be geographically isolated, and those who are unable to independently access services, for example school children, those in aged care, residents of mental health facilities, and people living in custody.

Case Study 3: Dental health services

Poor oral health is more common in low SE communities than in the general population.[13, 14] This can have a detrimental effect on a person's health and wellbeing by impairing their appearance, speech and self-esteem, which can in turn limit participation at school, in the workplace, at home and in other social settings.[13] Poor oral health can result from other risk factors that are linked with living in low SE conditions, including poor nutrition, smoking, alcohol and other drug use, poor oral hygiene and infrequent dental care.[13, 14] Common barriers to good oral hygiene and access to dental care include cost, a lack of available care, stigma, and lower levels of health literacy.[13, 14]

The *State Oral Health Plan 2015–2020* includes an objective to improve oral health outcomes and reduce the impact of poor oral health in socioeconomically disadvantaged groups.[14] The North Metropolitan Health Service (NMHS) delivers high quality, efficient oral health services to eligible populations through the statewide Dental Health Service (DHS). The DHS provides general and specialist dental care for financially, socially and geographically disadvantaged people in WA.[15]

The DHS delivers the School Dental Service, a public health program which provides free general dental care to students attending WA Department of Education-recognised schools aged 5 to 16 years, or up until the end of Year 11, ensuring school students are captured by the service regardless of cultural, social or economic background.[15] The DHS also provides Special Dental Services to harder-to-reach priority populations, including residents of metropolitan aged care residential facilities, prisoners in metropolitan and major rural Department of Corrective Services facilities, eligible clients of the Department of Communities, and through visiting services to eligible patients at Royal Perth Hospital and Graylands Hospital.[15]

The DHS offers subsidy schemes to provide assistance to eligible clients to access general and special orthodontic care, including in country locations.

4.3. Empowering people through access to community-based support, information and assistance with system navigation

The challenges of navigating complex health and social care systems to access services can be harder for people living in low SE conditions, particularly when they are unwell. When there are gaps in services provided in the community, people are more likely to present at hospitals.[1] Receiving appropriate care and support in the community has the potential to prevent an average of 500 emergency department (ED) presentations and 140 hospital admissions daily in WA.[16] A key barrier to accessing services in the community for people experiencing SE disadvantage, particularly as their needs increase in complexity, is a lack of coordination and collaboration between sectors and organisations.[12, 17] Implementing priorities under SHR enduring strategies 1, 2, 3, 4 and 6 will contribute to addressing these issues.

WA Health has implemented a number of initiatives to improve the quality, safety and value of community-based care. This is in addition to measures introduced to reform the management of outpatients in the community following contact with the hospital system to avoid recurring presentations and unplanned readmissions. For example, the Outpatient Reform Program aims to modernise referral services, ensure appropriate pathways to care, adopt standardised and contemporary waitlist management, maximise digital consultations for outpatient services, and enhance transparent public reporting for outpatients. The new Health Navigator Pilot program is connecting vulnerable children in out-of-home care, their parents, carers and support workers with health services in Mirrabooka and the South West.

WA Health also recognises the importance of working with community-based organisations beyond the health sector to ensure people who may be experiencing social, economic or other forms of hardship, alongside managing their health conditions, are provided with the support they need. WA Health achieves this through:

- cross-sector partnerships, particularly with not-for-profit organisations, to enable access to comprehensive, ongoing support in the community.
- models to improve community care for people with a range of chronic conditions.
- improved communication, relationships and coordination between primary care and hospitals to ensure appropriate access.
- connecting patients and carers with services that will build their capability to appropriately self-manage their health conditions and cope with other forms of hardship.
- innovative solutions to provide continuity of high-value care beyond the health system.

Case study 4: Community link booth at Fiona Stanley Hospital

Recommendation 4 of the SHR Final Report is for WA Health to 'commit to new approaches to support citizen and community partnership in the design, delivery and evaluation of sustainable health and social care services and reported outcomes', and includes a priority to introduce 'community-based and online approaches to better link people to support and navigation assistance, including a pilot of Community Booths'.[1]

WA's first Community Link Booth was established at Fiona Stanley Hospital in 2019, with support from the South Metropolitan Health Service's Fiona Stanley Fremantle Hospitals Group, the Health Consumer's Council of WA, and ConnectGroups, the peak body of

self-help and support groups in WA.[18] The Community Link Booth connects patients, families and carers with community-based services and organisations, which provide emotional, social and physical support, information and navigation assistance to help them to manage their conditions in the community following their discharge from hospital.[18]

Access to the service is through the booth at the main entrance to the hospital, or from the wards. Two teams of volunteers operate the service, one based at the hospital and the other at ConnectGroups providing referrals.[18] The service complements and supports the work of clinical staff to assist patients after discharge, promotes the development of self-management skills for patients and carers, and helps to reduce the high rate of preventable hospitalisations in WA.[18]

5. Equity of access to services in the health system

5.1. Health services for diverse populations and people with complex needs

Diverse populations, people living in low SE conditions, and people who are experiencing other forms of disadvantage, may be affected by a complex range of issues that can negatively influence their health. An equitable health system prioritises delivering care according to need, and recognises that some people need more, or a different kind of support, to achieve a state of health and wellbeing that is similar to the general population.

WA Health implements strategies to foster an equitable health system by ensuring staff have access to appropriate training and professional development. WA Health also recognises that mainstream services designed for the general population may not holistically address these issues when accessed as the sole form of health care. To fill this gap, WA Health also delivers specialist services and alternative models of care, including services provided by multidisciplinary teams, which are dedicated to meeting the needs of diverse populations and people living in low SE conditions.

Enduring Strategies 2, 3, 4 and 7 include implementation priorities that contribute towards ensuring equity of access to services in the health system:

- Implementing a systemwide approach to identifying and supporting frequent users of health services to improve care pathways and reduce presentations.
- Establishing a medical respite centre model for homeless people in Perth.
- Expanding hospital substitution programs including ‘Hospital In The Home’ and technology-assisted independent living.
- A ‘Home First’ model to reduce delays to/from home and enhance support for early assessment and access to health and support services for people in their own home.

Case Study 5:
Royal Perth Hospital Homeless Team

People experiencing homelessness have a higher prevalence of health risk factors, and are more likely to have difficulty in accessing and using resources, such as information and services, to maintain their health.[19, 20] As a consequence, they have a higher prevalence of disability and disease than the general population, and have increased complex service needs that are more likely to lead to recurring contact with the health system.[19]

In Perth, people experiencing homelessness tend to frequent the CBD due the high concentration of support services that cater to their needs within the area. This, in part, explains the high number of patients experiencing homelessness being seen at Royal Perth Hospital (RPH).[19] In 2016, the East Metropolitan Health Service (EMHS) established a Homeless Team at RPH.[19] The Homeless Team is a partnership between RPH and Homeless Health Care, a specialist health service for people experiencing homelessness across Perth.[19]

The Homeless Team helps patients identified within RPH as homeless by improving discharge planning and aftercare, and referring patients to community services to aid access to accommodation and other supports, including long-term GP care.[19] The Team also aims to reduce use of hospital services and support long-term improvements in health and welfare by addressing the social determinants of health.[19]

The Home2Health Research Team (University of Western Australia) works with the Homeless Team to evaluate the health and economic impact of the services they provide. The research team has evaluated the impact of the Homeless Team's first 2-and-a-half years of service delivery, during which they provided support to 1,000 patients. The evaluation found that following contact with the Homeless Team, there were fewer ED presentations and inpatient admissions at EMHS hospitals, equivalent to a cost saving of $4.6 million for the WA health system.[19]

5.2. Innovative solutions to meeting the health needs of priority populations

The *WA Health Digital Health Strategy 2020–2030* sets out a vision for the transformation of health care through digital innovation and technology and identifies the expansion of telehealth and virtual care services as a vital initiative to achieve this vision.[21] Most of the SHR enduring strategies will contribute to developing new and improved ways to provide care in clinical or community settings.

WA Health has prioritised several areas for focus and investment to drive innovation, including:

- pursuit of a priority-driven research agenda to allocate funding to projects to help improve sustainability and to preparing the WA health system for emerging threats.
- digital innovation, including better use of ICT to support business intelligence and analytics, and patient care.
- better capture and use of data to ensure that –
  - WA Health has timely access to more comprehensive, robust data for inform decision-making and planning for policy, programs and services, and monitoring of patients
  - patients have access to and control over their health data.

SHR has identified that Telehealth and virtual care services have also been identified as key enablers of person-centred, equitable, seamless access to health care.[1] Telehealth and virtual care can help resolve issues quickly without compromising patient safety, and produce significant cost-savings for the health system. Telehealth and virtual care has played a vital role in overcoming barriers of time, cost and distance for patients seeking care, particularly those living in rural and remote regions.

Case study 6: WA Country Health Service Command Centre

WA Health faces unique challenges in delivering services across a vast, sparsely populated land area in a cost-constrained environment.[22] This means that country WA residents, who are also more likely to live in low SE areas, face additional barriers to accessing health services. These include needing to travel further, being away longer from work and family, and bearing higher costs for their care.[22]

Telehealth and virtual care services have many reported benefits for patients and the health system overall. These include easier and improved access to health care, fewer unnecessary visits, less stress and inconvenience for patients, better use of patient and clinician time, more consistent and coordinated follow-up care for patients, the ability to include family members and carers within the consult, and improved information exchange between multidisciplinary teams.

The WA Country Health Service Command Centre provides a digitally-enabled, flexible and dedicated specialist clinical workforce to support country hospitals and nursing posts in real time.[23] The Command Centre provides the following services:

- Emergency Telehealth Service with 24/7 virtual access to emergency specialists.
- Inpatient Telehealth Service providing virtual ward rounds when a local GP is unavailable.
- Mental Health Emergency Telehealth Service providing virtual access to mental health specialists.
- Acute Specialist Telehealth Service with virtual access to medical specialists.
- Acute Patient Transfer Coordination overseeing safe, timely and efficient patient transfer between regional and metropolitan hospitals.
- Advanced Patient Monitoring System using advanced technology and real-time information to support patient care.

Continuing to expand telehealth and virtual care services across the system, including upgrading infrastructure and increasing the workforce capacity needed to deliver these initiatives, will further support equitable access to care for people living in country areas, particularly those living in low SE conditions.

6. Building a health system that meets community needs

The main drivers of increased demand for health services include population growth and ageing. Demand for health services is accelerating, particularly in regional and remote communities. Advances in technology have improved access to care in these areas, but there is a need to ensure that local services, including vital supporting infrastructure, are developing in response to and in anticipation of new and changing demands. For example, 4-wheel-drive, long distance ambulances have been purchased for the Kimberley with specialist communications and safety technology as part of *The Country Ambulance Strategy – Driving equity in Country WA*.

Case study 7: Southern Inland Health Initiative

The Southern Inland Health Initiative (SIHI) has been a transformative investment to improve health services and infrastructure in southern inland regions of country WA.[24] SIHI catchment areas were identified based on local and future health service needs, with a focus on disadvantaged groups and communities which had experienced demonstrable barriers to accessing health services.[24]

SIHI funding was distributed across 6 work streams:

- District Medical Workforce Investment Program to boost medical resources and workforce.
- District Hospitals and Health Services Investment Program to provide major capital upgrades.
- Primary Health Care Demonstration Program to develop comprehensive primary care centres.
- Small Hospital and Nursing Post Refurbishment Program to modernise hospital and nursing posts.
- Telehealth Investment Program to expand the WA Statewide Telehealth Service.
- Residential Aged Care and Dementia Investment Program to improve aged and dementia care.

The SIHI has laid a foundation for innovation, enabled WACHS to advance its technological readiness, and contributed to economic efficiencies and improvements in health outcomes and access to care for regional communities.[24] An evaluation of the SIHI demonstrated that it achieved:

- a 58 per cent increase in the number of GPs in SIHI towns.
- a 16 per cent increase in the 7-year GP retention rate in SIHI towns.
- an expansion of the telehealth network, with more than 900 videoconferencing endpoints distributed across the State, and the establishment of the Emergency Telehealth Service.

- 18,224 country outpatient appointments delivered via telehealth in 2017 (30 per cent increase on 2016), saving patients from travelling 27.3 million kilometres.
- a 32 per cent reduction in non-urgent ED attendances at SIHI hospitals.
- a 26 per cent reduction in people returning to EDs for further treatment within 48 hours.
- Decreased length of stay in hospitals, with an estimated 19,000 inpatient bed days saved.
- $300 million worth of improvements to more than 30 hospitals and health services across the region, enhancing facilities to meet the contemporary health needs of communities.

7. Interdependencies across the SHR

Through its 8 enduring strategies and 30 recommendations, the SHR Final Report seeks to drive a cultural shift from a predominantly reactive, acute, hospital-based system to one with a strong focus on prevention, equity, early child health, end of life care, and seamless access to services at home and in the community through the use of technology and innovation.[1]

Recommendation 3 is a cross-cutting recommendation which promotes equity for priority populations – Aboriginal people (recommendation 3a), Culturally and Linguistically Diverse populations (recommendation 3b), and people living in lower SE conditions (recommendation 3c). Delivering all parts of recommendation 3 depends on a whole-of-system response to addressing their access and service delivery needs to enable health equity for all Western Australians. Delivering all parts of recommendation 3 depends on a whole-of-system response to addressing access and service delivery needs for all Western Australians'.

The figure in the appendix shows how the enduring strategies and their recommendations interconnect with recommendation 3c.

8. Future directions for mapping progress against recommendation 3c

This publication showcases major themes in this work, and captures examples of important initiatives in case studies from across the WA health system. WA Health is implementing major initiatives to support access and equity issues, through innovative programs, as well as 'business as usual'. However, it is not possible to document the full extent of health system efforts to improve health outcomes for people living in lower SE conditions in a report of this nature, or to identify current gaps and opportunities for future service delivery by this process.

The project team for recommendation 3c is investigating other ways to support and map the health system's approach to ensuring that the needs of people living in lower SE conditions (and potentially other priority populations) are met. In July 2023 the WA health system executive supported developing a new mandatory health equity impact statement and declaration policy. The proposed policy will ensure that the intent of Recommendation 3c (and 3b, which is to reduce inequity in health outcomes and access to care for people of CaLD backgrounds) is embedded in the development and implementation of WA health system policies, programs and initiatives. This will make it possible to capture the scale of this work, help chart the health system's progress towards meeting the intent of these recommendations, and assist with identifying opportunities for improvement.

Recommendation 3c also calls for the health system to improve data collection scope and methodology will improve data quality to enable more efficient and reliable geospatial analysis. The Department of Health and Health Service Providers will implement this complex piece of work, which is expected to extend over the SHR's 10-year lifespan. In the meantime, the Department's Epidemiology Directorate can provide maps showing levels of socioeconomic disadvantage using Socio-Economic Indexes for Areas (SEIFA) by SA1 (SA1s are the smallest geographic areas used by the ABS, for which Census data are made available, with an average population of 400 people). These maps can be provided for a variety of geographical areas, including health service areas, health regions, health districts and local government areas.

In late 2023, the Epidemiology Directorate will be able to provide some health indicators such as health risk factors, health service utilisation and health outcomes by SEIFA for some of these geographical areas (e.g. health service areas, health regions, health districts). This can help the health system to identify communities that may be affected by a relatively greater level of socioeconomic disadvantage than others, and to consider this in their planning. The Epidemiology Directorate will explore options for analysing and reporting on these health indicators using SEIFA. Updated estimates of SEIFA based on the 2021 Census are expected to be released by the Australian Bureau of Statistics in mid-2023. Project scoping is expected to start in mid-late 2023.

Appendix: Mapping interdependencies across the SHR

Strategy 1: Commit and collaborate to address major public health issues.

Strategy 2: Improve mental health outcomes.

Strategy 3: Great beginnings and a dignified end of life.

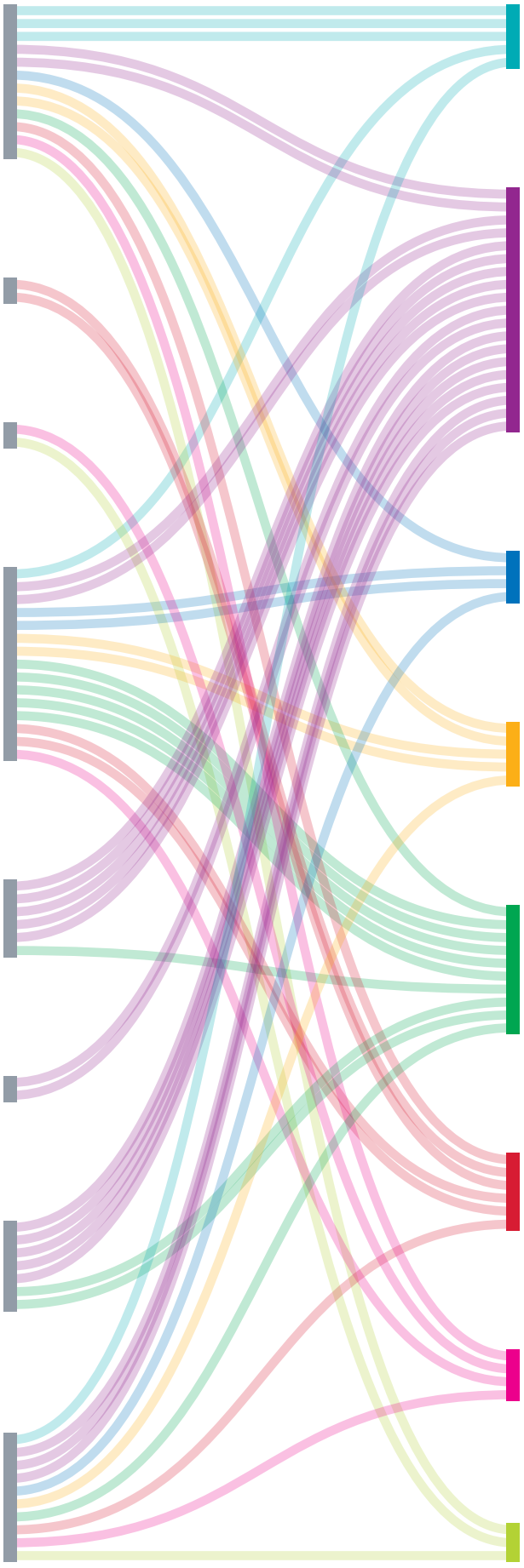
Strategy 4: Person-centred, equitable, seamless access.

Strategy 5: Drive safety, quality and value through transparency, funding and planning.

Strategy 6: Invest in digital healthcare and use data wisely.

Strategy 7: Culture and workforce to support new models of care.

Strategy 8: Innovate for sustainability.



People living in low SE conditions are disproportionately affected by a range of public health issues amenable to prevention.

People living in low SE conditions tend to face challenges in accessing health care. Improving system planning, funding, digital and analytical capability, workforce capacity and partnerships can help to address these barriers.

People may have one or more characteristics that may increase their risk of disadvantage, exposure to risk factors and poor health outcomes. Targeted interventions to embed equity in policies, programs services is needed.

People living in low SE conditions have health and social needs that require innovative, person-centred, responsive solutions.

People living in low SE conditions tend to have higher needs for care in the community, experience additional barriers to accessing appropriate care, and are more likely to interact with the hospital system to fill this gap.

People living in low SE conditions are disproportionately affected by mental health and AOD use.

People living in low SE conditions are more likely to have complex chronic conditions which complicate end-of-life care.

Living in low SE conditions is often linked with other adverse social determinants of health, and poorer developmental and health outcomes in children.

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