Submission to the Senate Community Affairs Committee Inquiry into Australia's domestic response to the World Health Organisation's (WHO) Commission on the Social Determinants of Health report "Closing the gap within a generation"

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AML Alliance gratefully acknowledge the financial and other support from the Australian Government Department of Health and Ageing

The Australian Medicare Local Alliance (AML Alliance) is the peak national body representing the national network of 61 Medicare Local primary health care organisations (PHCOs). The AML Alliance and its member Medicare Locals were established by the Commonwealth Government in accordance with the National Health Reform Agreement (2011). Medicare Locals have been developed as regional PHCOs charged with (i) improving the patient journey through developing integrated and coordinated services; (ii) providing support to clinicians and service providers to improve patient care; (iii) identifying the health needs of their local areas and the development of locally focused and responsive services; (iv) facilitating the implementation of primary health care initiatives and programs; and (v) being efficient and accountable with strong governance and effective management.

As the peak national body, the AML Alliance is charged with assisting Medicare Locals to function effectively and efficiently, to achieve their objectives and to work as a cohesive network that can be responsive to evolving Commonwealth and community needs and priorities. It will do this primarily by acting as a lead change agent and through supporting Medicare Local performance.

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Key Recommendations

The Australian Medicare Local Alliance (AML Alliance) is pleased to make this submission to the Senate Community Affairs Committee Inquiry into Australia's domestic response to the World Health Organisation's (WHO) Commission on the Social Determinants of Health report "Closing the gap within a generation". The AML Alliance's submission refers specifically to items C & D of the Senate Committee's terms of reference.

PROGRAM DEVOLUTION TO MLS

AML Alliance recommends that the design and administration of key health and social health programs be devolved to Medicare Locals (MLs) and that flexible funding arrangements for MLs are accelerated to enable MLs to undertake or support the inter-sectoral and inter-agency work required to address the SDH at the local level.

WIDEN ANPHA'S ROLE AND MANDATE

AML Alliance recommends that the role and mandate of the Australian Preventive Health Agency (ANPHA) is widened to embrace a preventive approach that more fully includes and addresses the SDH.

DEVELOP MODELS OF CARE TO ADDRESS EQUITY IN ACCESS

AML Alliance recommends that existing national health infrastructure – particularly the National Health Performance Authority and Health Workforce Australia - continues to work to address equity in access to health services by highlighting areas of *unacceptable variation* and by working with MLs and other stakeholders to develop models of care that are affordable and accessible by all Australians, irrespective of their geography, cultural background or socioeconomic status.

ESTABLISHMENT OF A LEAD AGENCY TO COLLECT RELEVANT DATA

AML Alliance recommends that a lead national agency is charged with responsibility for the collection, analysis and dissemination of social determinants of health data and its linkage with other health data. AML Alliance also recommends that the use of equity assessment tools and health impact assessment tools be more widely promoted across all sectors.

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EARMARKED PUBLIC HEALTH RESEARCH FUNDING

AML Alliance recommends that, in addition to better organising and coordinating available SDH data, funding should be increased and ear-marked for future public health research, with priority given to the SDH and health equity in Australia.

EXPLORE AND DEVELOP EFFECTIVE INTER-GOVERNMENT MECHANISMS FOR ACTION ON SDH

The AML Alliance recommends that the Commonwealth consider what inter-government structures and mechanisms in the Australian context could facilitate a greater awareness of SDH and their impacts. This would need to be complemented with the development of relevant tools, frameworks and agreements to help support the design, implementation and evaluation of SDH policies across all sectors.

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Medicare Locals in the context of the social determinants of health (SDH)

The Australian Medicare Local Alliance (AML Alliance) supports a model of health care that emphasises prevention and promotes health and wellbeing and recognises that inequity arising from the social determinants of health is an important factor in the health outcomes of all Australians.

Health is much more than the absence of disease. There is good evidence that what, and how much, people eat, drink, smoke and how they expend energy are responses to their socio-political, socio-economic, socio-environmental and socio-cultural environments[1]. Although the adverse impacts on people of these environments may ultimately be dealt with in the health sector, the causes often lie elsewhere.

As the focus on prevention in Australia increases, the need to address these more fundamental causes is paramount. To do this requires policy responses from multiple portfolios, inter-sectoral engagement and a greater focus on primary health care (PHC).

Medicare Locals are helping to reorient the health system more towards primary health care (PHC).

At the regional level, Medicare Locals have been funded through the Commonwealth Department of Health and Ageing to deliver on the following objectives:

- improving the patient journey through facilitating access to integrated and coordinated services
- providing support to clinicians and other service providers
- undertaking population health planning to identify local health needs and to developing locally focused and responsive services to address priority needs
- facilitating the implementation and successful performance of a range of primary health care (PHC) initiatives and programs
- being efficient and accountable - having strong governance and effective management.

As local clinically and community-led organisations MLs are well placed to translate actions on SDH by taking the lead in establishing partnerships and initiatives to provide more connected, inter-agency responses to keeping people well.

The draft National PHC Strategic framework – if translated into effective actions through bilateral GP-PHC plans that incorporate integration between health and human services - offers an opportunity to recognise the role of PHC and MLs in addressing the SDH and addressing health inequality.

The establishment of the Australian National Preventative Health Agency (ANPHA), other supporting health infrastructure and a range of existing programs and services also offer opportunities to more systematically address the SDH.

[1] Sharon Friel, 2009. Health equity in Australia: A policy framework based on action on the social determinants of obesity, alcohol and tobacco. Paper prepared for the Australian National Preventative Health Taskforce http://www.preventativehealth.org.au/internet/preventativehealth/publishing.nsf/Content/0FBE203C1C547A82CA257529000231BF/$File/commpaper-hlth-equity-friel.pdf

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Response to the Senate Committee's Terms of Reference:

(C) Comments on the extent to which the Commonwealth is adopting a social determinants of health approach through:

(i) Relevant Commonwealth programs and services

ML and ML related programs

The following Commonwealth programs, implemented through MLs, or where MLs are a partnering agency, have a focus on addressing health inequity. These include:

- Closing the Gap (CTG)
- Access to Allied Psychological Services (ATAPS)
- headspace
- Rural Primary Health Services (RPHS)
- After Hours
- Partners in Recovery (PIR)

These services play an important role in helping to address issues of inequity to health services and encompass services that work closely with disadvantaged groups. However, many of these programs remain siloed and disconnected from each other. While areas such as aged care and mental health, which require national action, are still usefully funded through national program funding, there is real value to patients and communities in ensuring Commonwealth and other programs are both locally relevant and integrated - within and between sectors. MLs are established to lead this but will not reach their full potential if they are required to work in constructs that force them to implement models of care and system changes that are not locally relevant.

To achieve their full potential, MLs need to:

- be less reliant on program specific, 'siloed' funding
- have access to a combination of more flexible funding guidelines and further increases in flexible funding dispersed according to formulae that take into account relevant factors such as the socio-economic profile and service utilisation of populations
- have access to flexible funds for innovation.

AML Alliance recommends that flexible, less siloed funds as outlined above are developed for MLs to support them in playing a greater part in addressing SDH.

Closing the Gap (CTG)

MLs are helping to implement the health component of a number of Closing the Gap initiatives, where health is viewed and treated holistically such as through providing/coordinating community transport, financial advice and family planning services and which helps with health equity by providing a culturally relevant outreach workforce to assist Indigenous Australians access a range of health and other services.

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Access to Allied Psychological Services (ATAPS)

ATAPS enables GPs to refer consumers to registered mental health professionals (psychologists, counsellors and social workers) who deliver focussed psychological services. ATAPS helps address equity of access to services by providing access to many patients who would not otherwise be able to afford necessary psychological services.

headspace

Headspace, the National Youth Mental Health Foundation, provides a holistic approach to youth health by providing general health, mental health and counselling, education, employment, alcohol and other drug services through teams of multidisciplinary providers. The 'no wrong door' approach to care has ensured youth health needs are met comprehensively and seamlessly and provides a useful model of integrated, cross-sectoral service delivery that deals with some of the more underlying SDH that impact on young people's health.

Rural Primary Health Services (RPHS)

The RPHS program aims to enable better service coordination and responsiveness and improve access to priority PHC services for rural communities - which frequently experience significantly reduced access to health services than their urban counterparts. The program has been instrumental in enabling rural MLs to employ allied health professionals to improve access to these services for rural and remote communities, so helping health equity.

After Hours

The Australian Government's new After Hours program also has a health equity focus. Its primary aim is to provide all Australians, regardless of where they live, with accessible and effective after hours primary care services. It includes three main components:

- A new national after hours GP helpline which extends the existing national nurse triage line to provide medical information and advice services in the after hours period.
- Expanded after hours capacity for online triage and basic medical advice via videoconferencing.
- Devolved responsibility to Medicare Locals for the planning and funding of local face-to-face after hours services. Key principles underlying the Medicare Local services are that they are equitable and affordable to all Australians.

Partners in Recovery (PIR)

PIR aims to better support people with severe and persistent mental illness with complex needs and their carers and families. Key objectives of PIR include, better coordinated care, improving referral pathways and promoting a community based recovery model that brings together both the clinical and community support services needed by people experiencing severe and persistent mental illness with complex needs. PIR offers another model of integrated, inter-sectoral care that, like headspace, can help deal with both the clinical and social determinants of health.

Non ML-Programs

National Disability Insurance Scheme (NDIS)

AML Alliance also considers that the NDIS has the potential to help address SDH, and subsequently health inequality. Taking a "lifetime approach" where people with disability are supported from the time they acquire their disability (in early childhood for example), will provide the opportunity for intervention before disadvantage manifests and health begins to deteriorate. This can, and is envisioned, to include education and employment opportunities, as well as community participation and support initiatives.

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Social inclusion program

Although not explicitly stated, the Commonwealth's Social Inclusion Program appears to most closely identify with the social determinants of health (SDH) agenda. It specifically looks at the SDH by examining the social, economic and environmental factors that impact on health, such as employment, income, housing, education, disability, safety, community resources and social connectedness. Where the Social Inclusion Program appears to disconnect from the SDH agenda however is in its failure to explicitly recognise poor health as a result of disadvantage/social exclusion (and vice-versa). This connection is important in two main ways:

1. From a health policy and service design perspective it demonstrates the need to address these factors as part of a health system response, subsequently influencing health organisational mandate and resource allocation.
2. From a broader policy perspective it emphasises the importance of recognising the impact of a number of non-health areas on health, wellbeing (and consequently, productivity) and to work towards some form of health in all policies approach.
   This has been more fully addressed under point D ii)

(ii) The structures and activities of national health agencies

The goals of the current health reform are focused on the following major objectives:

- reorientation of the health system towards PHC, through Medicare Locals as well as better integration between primary and acute care
- enabling delivery of consumer – focused, quality, coordinated multidisciplinary care that is "wrapped" around the patient
- progression of a wellbeing and prevention agenda
- establishment of an equity/social determinants approach
- public accountability, sustainability and value for money.

This restructuring of the health system to a national-local structure, through MLs and the development of Local Hospital Networks (LHNs), has also included the development of a number of national agencies tasked with monitoring, reporting and overseeing policy development in the health sector.

AML Alliance believes the following national health agencies and structures could be more fully utilised to address the health equity and social determinants of health through their respective activities.

AML Alliance and MLs

AML Alliance recommends that the design and administration of key health and social health programs be devolved to Medicare Locals (MLs) and that flexible funding arrangements for MLs are accelerated to enable MLs to undertake or support the inter-sectoral and inter-agency work required to address the SDH at the local level.

Medicare Locals can play a key role in the SDH and reducing health inequities given they are identifying health needs and are charged with planning a better connected health care system within their regions. MLs will fulfil these roles working in partnership with other agencies - both health and non-health - whose services have a

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significant impact on the SDH. These include welfare and social service agencies, local government and town planners, education and employment facilities and the like.

For the SDH to be systematically tackled, there is a need for greater focus on the integration between primary health, social and community sectors. The discourse needs to be one of joined-up policy and program development across the various relevant parts of the health and human service systems. With the right policy levers, resourcing and mandate, MLs can assist in the cross-sector integration and collaboration needed to improve and sustain population health outcomes. This includes working to address the SDH that give rise to health inequity through the design and delivery of locally integrated health and social care programs and services.

There is scope for the Commonwealth to capitalise on the capacity of MLs to address health inequity and the SDH by accelerating the degree to which MLs hold regional funds for a range of program areas that connect with SDH and through which MLs can partner with and co-fund inter-sectoral approaches that promote health and prevent illness. For MLs to achieve this, they need to be regarded as meso structures working in the interests of their communities. They must:

- be given responsibility and funding for a range of programs that are currently disparately administered by state and local health/government
- be promoted within all government departments as agents through which health, human service and other related programs can be jointly planned, commissioned and coordinated.

Already, Medicare Locals are working with local community stakeholders to address SDH. Examples of this include:

- Working with local government and community groups to establish market-gardens in rural/remote areas where quality fresh food is often hard to source and/or is very expensive to purchase. This initiative provides better sources of nutrition at little relative cost, while also helping build social capital among community members, and teaching participants new vocational skills in areas of high unemployment – two factors known to contribute to health equity.

- Western Sydney ML's Closing the Gap program which has been linking with local community and social service providers to provide joined up, holistic care for a number of its Aboriginal and Torres Strait Islander population. In addition to receiving the necessary health care services, eligible Indigenous residents are also being provided with social services such as financial counselling and domestic and transport assistance. These 'non-health' services are proving to be vital to the health and wellbeing of recipients; all of which are often coordinated by a dedicated Aboriginal Health Worker, ensuring the individual's needs are being met with continuity and efficiency.

- South East Melbourne (SEM) ML which has linked more than 90 asylum seekers arriving in their area from detention centres to a health service and/or general practice appointment within 10 days of arrival. Prior to this intervention, asylum seekers were only accessing sporadic care through hospital emergency departments. The better linkage and coordination that SEM ML now provides for these asylum seekers means they are more likely to receive continued, coordinated care which is very important for such patients who often arrive with multiple physical and psychological conditions that need ongoing, multidisciplinary care.

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- MLs addressing disadvantaged groups in their after hours programs by setting up outreach after hours services to homeless people in metropolitan areas, working with culturally and linguistically diverse communities, including Indigenous Australians, to better educate them about, and increase their access to PHC which can link more directly with their usual PHC practice for better continuity of care. In one ML's region, this approach has increased access by Indigenous people to after hours services more than six-fold.

- Central Coast NSW (CC NSW) ML's work to facilitate access to mobile x-ray services for residential aged care facilities (RACFs) – another sector of society that often experiences reduced access to health care. This service is reducing the transfer of residents to hospitals, which often impact adversely on residents due to their frailty.

- Barwon Medicare Local which has helped form a coalition of local government, business and community organisations from across five municipalities (G21 Alliance) in Geelong Victoria to jointly plan, implement and evaluate services for the entire Geelong region. Collectively they identify and discuss how particular sectors and services impact on each other – particularly on health, and providing the chance to work together to ensure optimal community outcomes.

Australian National Preventive Health Agency (ANPHA)

AML Alliance recommends that the role and mandate of ANPHA is widened to embrace a preventive approach that more fully includes and addresses the SDH.

The Australian National Preventive Health Agency (ANPHA) strategic goals encompass:

- Healthy Public Policy – to guide comprehensive prevention and health promotion policies
- Health Risk Reduction - with an initial focus on obesity, tobacco and harmful alcohol consumption
- Knowledge Management/Information and Reporting – to build a greater evidence-base around prevention and health promotion and enhance evidence-informed policy and practice in this area
- Building broader and more comprehensive prevention and health promotion capacity

These are important contributions to the prevention agenda given the improvements to patient outcomes and health costs from earlier intervention and prevention approaches. However, there is a well-established association between socio-economic disadvantage and health – chronic and other disease and their associated risk factors are more common in lower socioeconomic groups[2]. Uptake of preventive health initiatives are also affected at the consumer level by many of the social determinants of health (such as education/health literacy, health beliefs and behaviour, the environment in which people live, affordability and access to services). To increase the impact of prevention approaches, ANPHA's role and mandate ideally needs to widen to allow for further work on addressing the SDH.

[2] AIHW Australia's Health 2012: http://www.aihw.gov.au/socio-economic-disadvantage-and-health/

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National Health Performance Authority (NHPA) and Health Workforce Australia (HWA)

AML Alliance recommends that existing national health infrastructure – particularly the National Health Performance Authority and Health Workforce Australia - continues to work to address equity in access to health services by highlighting areas of *unacceptable variation* in service access and by working with MLs and other stakeholders to develop models of care that are affordable and accessible by all Australians, irrespective of their geography, cultural background or socioeconomic status.

The role of the NHPA is to report on the activity and performance of both Local Hospital Networks (LHN) and MLs. The public reporting against key performance indicators (KPIs) of both LHN and ML activity will help to identify where there are differences in health across Australia. This in turn will highlight publicly where inequities exist and where action needs to be taken by MLs and others to address these. Public reporting is known to assist in raising performance[3] and so in itself will assist in addressing areas of health inequity.

HWA develops policy and programs across four main areas;

- workforce planning, policy and research,
- clinical training,
- innovation and reform of the health workforce and
- recruitment and retention of international health professionals.

The maldistribution of the health workforce across Australia is a well-recognised contributor to health inequity in terms of service access: life expectancy decreases with increasing rurality, yet MBS billing per person falls steadily with increasing rurality, largely due to the lack of health workforce available in these areas[4], [5]. One of HWA's three objectives under its 2012-2013 work plan is improving distribution to ensure the health workforce is placed in areas where it is needed. This includes projects and programs looking at rural workforce distribution as well as distribution and workforce models to help address access issues in places such as residential aged care facilities. In this way, this new national health agency is contributing to addressing aspects of health inequity.

[3] Martin N. Marshall, Paul G. Shekelle, HUW T.O. Davies and Peter C. Smith. Public Reporting on Quality in the United States and United Kingdom, *Health Affairs*, 22, no.3 (2003): 134-148

[4] AIHW, 2008: Rural, regional and remote health: indicators of health status and determinants of health. http://www.aihw.gov.au/publication-detail/?id=6442468076

[5] Department of Health and Ageing 2003. Submission to the Senate Select Enquiry Committee on Medicare, July 2003.

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(iii) Appropriate Commonwealth data gathering and analysis

Leadership for SDH data

AML Alliance recommends that a lead national agency is charged with responsibility for the collection, analysis and dissemination of social determinants of health data and its linkage with other health data. AML Alliance also recommends that the use of equity assessment tools and health impact assessment tools be more widely promoted across all sectors.

Leadership in the collection, organisation and dissemination of SDH data is required to be able to effectively plan, deliver and evaluate relevant services. A specific SDH data reference group could be established to consult with relevant stakeholders and provide advice to Commonwealth and state data agencies as a way of ensuring relevant and useful data collection, analysis and dissemination.

The Commonwealth already collects some SDH related data through the Australian Bureau of Statistics' (ABS) household surveys, which it uses to produce its Social Inclusion Program report "Social Inclusion in Australia: How Australia is faring". This includes data on disadvantage (short-term and entrenched), resources and community participation. However, as previously discussed, the Social Inclusion Program falls short of explicitly connecting the causal relationships between social factors and health outcomes, and subsequently fails to address the matter as a health issue in its reporting and analysis.

Other relevant data are also collected through other government agencies, such as the Australian Institute of Health and Welfare (AIHW) which collects data on public housing, homelessness, child health etc. States and Territories also collect valuable SDH related data.

The issue appears to be that existing data are not organised in a way that allows for sound inferences and subsequent policy decisions regarding social factors and health outcomes to be made, and that there is no one single body authorised with responsibility for this area. In addition, much of the relevant data also appears to be presented only at a national level, which is inadequate for local stakeholders such as Medicare Locals.

There is also a need to: better link PHC and other health data sets with those from other sectors, increase the use of equity assessment tools in both the health and non-health sectors and; promote the use of health impact assessments.

Funding for SDH data

AML Alliance recommends that, in addition to better organising and coordinating available SDH data, funding should be increased and ear-marked for future public health research, with priority given to the SDH and health equity in Australia.

Public health research has a history of underfunding in Australia relative to the amount of funding available for medical research. This imbalance is in contradiction to the Australian Government's broader health reform agenda. Moving away from Australia's hospital-focused medical model towards a population-level prevention

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and health promotion approach must be supported by an appropriate evidence base. Well supported and targeted research is needed to develop this. In addition to better organising and coordinating available SDH data, funding should be increased and ear-marked for future public health research, with priority given to the SDH in Australia. A central concern of public health research is finding ways to increase health equity, particularly through actions to address the gradient in health status across social groups and by improving the health of vulnerable groups.

(D) Scope for improving awareness of social determinants of health:

The AML Alliance recommends that the Commonwealth consider what inter-government structures and mechanisms in the Australian context could facilitate a greater awareness of SDH and their impacts. This would need to be complemented with the development of relevant tools, frameworks and agreements to help support the design, implementation and evaluation of SDH policies across all sectors.

(i) In the community

Efforts should be made to educate communities about the link between social, economic and environmental factors and health status. For example, promoting the links between social and relationship capital and mental health; drawing an explicit link between education, opportunity, employment, income and health; and educating communities on the need to have clean and accessible green spaces, bike paths, functioning parks, safe neighbourhoods etc. Communities must be informed and educated about these issues if they are to be empowered to help address them.

Medicare Locals are well positioned to assist in educating and empowering communities around their health and its determinants. Working with local stakeholders and the community to address local needs, Medicare Locals will continue to build the relationships and trust, and forge the networks and connections needed to drive health education and literacy. MLs are already starting to do this through their population based needs assessments which involve community engagement in determining priority areas for action through, for example, citizens' juries, focus groups and other consultation processes. Such forums already provide opportunity for MLs to raise awareness of SDH with their communities. In a number of cases, communities engaging with MLs in their population health planning and needs assessment processes have already identified SDH-oriented factors - such as safe places to walk, availability of healthy food at schools and workplaces, affordability of health services - as being critical to good health and as areas of action.

(ii) Within government programs

The disconnect between social factors and health status is evident in the Commonwealth's current funding arrangements. SDH are targeted to some extent through government employment programs, education, welfare, housing, transport and the like, but social services are funded and operated in silos separate from the health sector. A new, more integrated way of thinking about health and its determinants must occur if we are to begin allocating resources and developing programs appropriately.

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Governments must lead the shift in health policy and discourse to reflect what is now known about Australia's social gradient, and the factors driving it. A useful start would be for governments at all levels to examine the way they regulate, mandate and fund non-government organisations (NGOs) and the private sector who deliver many of the services that impact on population health and health equity. Sectoral integration in these parts of the system is important if Australia's social gradient is to be addressed efficiently and effectively.

The Commonwealth has an opportunity in the current health reform climate to begin supporting integration in the NGO sector. At the local level, the newly established Medicare Locals have been designed to break down silos and work across traditional sectoral boundaries in the interests of community health. To be successful in this - and to begin addressing health inequities - they must be adequately supported through resources, flexibility and mandate. With the right policy and financial levers, Medicare Locals can help shape social and community services and promote their impact on health outcomes at the local level. MLs will only be effective vehicles for this however if they are promoted as, resourced for and enabled to be, agents of multiple sectors.

The Commonwealth has already taken steps to implement a quasi SDH framework into its policy and program development cycles through the "Australian Public Service Social Inclusion policy design and delivery toolkit" – introduced by then Deputy Prime Minister and Minister for Social Inclusion, Julia Gillard, 2009. Although a step in the right direction, it is not in its current form adequate to sufficiently educate government departments and agencies on the SDH and the impact that government policies and programs have on health outcomes. It also needs a sound monitoring and evaluation framework to ensure policies and programs are achieving their desired effects once implemented.

The South Australian Government has a Health in All Policies (HiAP) program. This approach was designed and endorsed by the World Health Organisation as a way of achieving health equity, and promotes, at its core, a whole-of-government response to addressing the SDH. The central governance for SA's HiAP program sits with the Executive Committee of Cabinet Chief Executives Group, which reports to an Executive Committee of Cabinet. This group oversees the development, implementation and evaluation of the HiAP program across all of government, and has a memorandum of understanding with SA Health which performs many of the relevant functions.

This type of structure is an effective mechanism for achieving whole-of-government collaboration and action on the SDH. Progress made by the Norwegian Government in advancing its social determinants and health equity agenda supports this. A report produced by WHO Europe[6] examining the lessons learned and achievements gained in Norway – a global leader in this space - strongly endorses the need for ongoing parliamentary involvement in the process, and in particular, commitment, regular oversight and input from relevant Ministers.

(iii) Amongst health and community service providers

Information and education are key to creating greater awareness and understanding around the SDH for health and community service providers. There is an opportunity to build SDH elements into health and social care professional training and development throughout the professional lifespan, from the undergraduate level through to Continuous Professional Development (CPD) programs. This would complement the current reform agenda which promotes multidisciplinary, holistic, team-based care arrangements.

[6] WHO Europe. Setting the political agenda to tackle health inequity in Norway, 2009.

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Information and aides could be developed and targeted at specific professions to assist them in thinking about SDH, with emphasis on areas where they may be able to assist specifically. For non-health providers, educating them to think about the potential impacts their services may have on an individual's or community's health would be highly beneficial.

A core role for MLs is supporting health and other care professionals. Medicare Locals also have a role in linking with a range of community agencies such as urban planners, local councils, schools and the like. Over time, MLs will have the access, relationships and local knowledge needed to communicate with relevant groups, making them well positioned to raise awareness of, and disseminate, information about the SDH and their impact. Medicare Locals will also have an extensive network of local organisations and businesses that they can draw on to assist them in disseminating information about SDH.

The AML Alliance welcomes the opportunity to further discuss this submission with the Senate Community Affairs Committee, including the recommendations made in it.

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