Healthy North Coast and the social determinants of health

Healthy North Coast

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Executive summary

This paper clarifies Healthy North Coast's (HNC) role in influencing the social determinants of health across the North Coast. It responds to a clear strategic imperative: social and structural conditions such as housing, income, transport, social connection, culture, health literacy and access to services directly affect whether people can access care early, stay well and avoid poorer health. As widely recognised drivers of health inequity and wellbeing, social determinants need to be considered across HNC's work; if they are not, HNC risks reducing the reach, relevance and impact of its planning, commissioning and partnership activity.

The PHN Program does not identify the social determinants as a discrete objective and includes limited national performance measures in this area. However, HNC has several important levers through which it can influence health equity. These include needs assessment, commissioning, primary care support, partnership development, advocacy, regional coordination and performance monitoring. By applying these levers strategically, HNC can help reduce the impact of social and structural barriers on access to care, health outcomes and equity across the region.

The paper argues that HNC should position the social determinants of health as a core component of its health equity approach, rather than as a standalone program area or an attempt to address every determinant directly. HNC is already contributing across a range of areas, including place-based planning, Aboriginal health and cultural determinants, access and health literacy, homelessness and housing-related vulnerability, social connection, care navigation, mental health and psychosocial supports, healthy ageing, refugee health, climate and health planning, community wellbeing and resilience, and cross-sector partnerships. The opportunity is to bring greater coherence to existing efforts by articulating, prioritising, governing and measuring this work within a clear strategic framework that builds on HNC's established practice in community-led, relational and adaptive approaches.

The proposed strategic approach is to focus HNC's effort where social determinants intersect with primary health care access, prevention, early intervention and continuity of care. This means:

- using the Health Needs Assessment and local intelligence to identify priority places, populations and barriers
- commissioning practical models that reduce those barriers, and
- convening partnerships where change requires action beyond the health system.

HNC should maintain universal system support across the North Coast, while directing more intensive commissioning, partnership and advocacy effort where inequity is greatest.

The recommended next step is to develop a succinct HNC position statement on the social determinants of health, supported by commissioning guidance, stronger place-based prioritisation, clearer partnership structures and measures that show whether HNC's activity is improving access, coordination and equity for priority populations and high-need communities. Given HNC's scale, mandate and resources, its contribution should be proportionate and focused on targeted, partnered initiatives rather than assuming responsibility for broad social change across the region.

Strategic imperative

The Healthy North Coast Strategic Plan 2023–2030 makes the clearest organisational link between HNC's equity agenda and the social determinants of health. Under the equity area of impact, the plan identifies improved social determinants of health as an intended outcome, supported by initiatives focused on priority populations, health inequity, Aboriginal partnership, access to care, health literacy and cross-sector collaboration. This creates a strategic imperative for HNC to treat social determinants not as a standalone program area, but as a core equity objective to be advanced through planning, commissioning, partnerships, advocacy and service system design.

This is imperative because the social determinants are widely recognised as primary drivers of health inequity, wellbeing and preventable demand on the health system. Social and economic factors represent the most influential and largest group of health factors, impacting 40% of health outcomes (Johnson, 2022). If HNC does not consider these conditions in the way it plans, commissions, partners and measures impact, it risks reducing the reach and effectiveness of its work, particularly for communities already experiencing disadvantage, poor access and compounding vulnerability.

Evidence shows that people living in rural and remote areas experience poorer social determinants and worse health outcomes on average when compared to populations living in metropolitan areas, with variation between and within regional communities (Flavel J, 2023). This supports a place-based approach that uses local intelligence rather than assuming need is evenly distributed across the North Coast.

The 2025–2028 Health Needs Assessment (HNA) shows how the social determinants are experienced across the North Coast through barriers to service access, low health literacy, socioeconomic disadvantage, social isolation and loneliness, cost-of-living pressures, housing availability and service fragmentation. These issues are not evenly distributed and are concentrated in communities experiencing entrenched disadvantage. Priorities from the 2025-2028 health needs assessment relevant to the social determinants of health included:

- improving health literacy and wayfinding, so people can access the right services at the right time and engage in preventive health behaviours
- prioritising communities living in areas of socioeconomic disadvantage, particularly in Kempsey, Nambucca Valley, Richmond Valley, Clarence Valley and Kyogle
- strengthening coordination between health and social care services, particularly where social isolation and loneliness, cost of living, housing availability and service fragmentation are affecting health and wellbeing.

Together, the strategic plan sets the organisational commitment and the HNA identifies where and why action is needed locally.

The social determinants of health

The social determinants of health are the conditions that influence people's health and their ability to access and benefit from healthcare. These include housing, income, education, transport, social connection, employment, culture and access to services. For HNC, these factors are important because they directly affect how people engage with health care, navigate the health system, manage their health and experience health outcomes, particularly those facing disadvantage or vulnerability. The World Health Organisation's (WHO) 2025 World Report on Social Determinants of Health Equity reinforces this position by emphasising that primary health care systems can influence social determinants when they are organised around population need, equity, local

intelligence and cross-sector collaboration. Detailed WHO recommendations relevant to this paper are outlined in Appendix A.

It is important to differentiate between the social determinants of health (population-level conditions) and health related social needs (individual-level experiences), as the levers of influence for HNC are different for both. Determinants shape health across populations, while social needs reflect how these conditions are experienced by individuals, requiring complementary system-level and service-level responses.

The Dahlgren-Whitehead model, outlined at Appendix B, provides useful supporting context for understanding the breadth of work addressing the social determinants at HNC.

HNC's current contribution to addressing the social determinants of health

HNC is already contributing to addressing the social determinants of health through a broad range of planning, commissioning, partnership and advocacy activities. Some initiatives directly address social conditions such as housing, homelessness, social isolation and service navigation. Others influence social determinants indirectly by improving access to care through free or lower cost services, strengthening culturally safe services, supporting health literacy, targeting investment to communities experiencing disadvantage and improving coordination across the service system. This is evidenced through examples such as the Healthy Ageing Strategy, Care Finder program, Primary Care Access initiatives, mental health and psychosocial supports, refugee health work, Community Wellbeing and Resilience grants, workforce initiatives, climate and health planning, and partnerships with Aboriginal Community Controlled Health Organisations (ACCHOs), Local Health Districts (LHDs), councils and community organisations.

The key strategic insight is that HNC already has a foundation to build from, but this work is not yet consistently described, prioritised, governed or measured as a coherent equity agenda. The opportunity is to shift from describing activity to clarifying HNC's role, levers and choices.

The Community Wellbeing and Resilience (CWR) Roadmap provides a useful example of this approach. The roadmap frames HNC's contribution through how investment is designed and delivered, and encompasses community-led, place-based, relational, trauma-informed, inclusive and learning-oriented practice. This is highly relevant to social determinants work because the way HNC commissions, convenes and learns can either strengthen or weaken the local conditions that support wellbeing, resilience and equity.

Table 1. HNC contribution to the social determinants of health

HNC lever	Current contribution to social determinants of health
Planning and intelligence	Uses the HNA, local intelligence, community voice and joint planning to identify priority populations, priority places and barriers linked to disadvantage, isolation, health literacy, access, service fragmentation and community resilience.
Commissioning	Funds services and models that improve access, navigation, outreach, social connection, culturally safe care, integrated support, early intervention and local adaptive capacity for people and communities experiencing disadvantage.

Partnerships	Works with ACCHOs, LHDs, councils, community organisations, housing and homelessness services, social care providers and local partners where health outcomes depend on action beyond the health system.
Advocacy and system influence	Uses submissions, policy engagement, regional coordination and partnership forums to advocate for change where local evidence shows that housing instability, transport barriers, cost-of-living pressures, workforce constraints, climate risk or service fragmentation are limiting health access and outcomes.
Monitoring and learning	Has an opportunity to better measure whether commissioned activity and partnerships are improving access, coordination, equity, community connection, local capacity and outcomes for priority populations and high-need communities.

Appendix B provides a broader social determinants framework that can be used to sense-check the breadth of HNC activity, but Table 1 is organised around HNC's own levers to keep the focus on practical influence and accountability.

This framing keeps the focus on HNC's own functions and choices. It avoids narrowing the analysis to a single social determinants' framework, while recognising that HNC activity spans individual, community, service, cultural, economic and environmental conditions that shape health outcomes. It also highlights that work addressing the social determinants is not only about program content, but about the quality of HNC's relationships, investment processes, local partnerships and learning systems.

Next steps for Healthy North Coast on the social determinants of health

HNC's strategic approach should be to influence the social determinants of health where they intersect with primary health care access, prevention, early intervention, continuity of care and equity. This keeps HNC within its PHN role while making explicit that social and structural barriers are central to whether commissioned services reach the people and communities most in need.

The next phase should move from documenting activity to setting a clearer organisational approach. This means defining HNC's role, prioritising where effort should be focused, embedding social determinants into commissioning and partnership practice, and building a stronger learning loop so activity can adapt as community conditions change.

A useful way to frame this role is to examine internal processes and external partnerships, advocacy efforts and coordination. HNC should consider how planning, commissioning, primary care support, partnership and evaluation practices can reduce inequity. In parallel, look for more opportunities where partnerships, advocacy and regional coordination require collective action beyond the primary care system.

Use planning and intelligence to focus effort

Existing plans and strategies, including the HNA, HNC strategic plan, joint regional planning, provider intelligence and community voices should be used together to identify where social and structural barriers are most affecting access, equity and outcomes.

HNC should be explicit about the social determinants it can influence directly, and those where its role is to reduce health impacts through commissioning, partnership, advocacy and service coordination. This includes low-barrier health services for people experiencing or at risk of

homelessness, improved navigation and health literacy, culturally safe care, transport and digital access solutions, and better coordination where social isolation, service fragmentation or workforce pressures affect care.

In practice, this means using disaggregated data and place-based intelligence to guide decisions about flexible funding, service design, partnership effort and advocacy. It also means regularly testing whether priorities remain current as community conditions change, and using data insights to forecast need where it may be under-reported.

Commission models that reduce barriers and build local capacity

Commissioning is HNC's main mechanism to translate the equity agenda into action. HNC can align commissioning with action to address the social determinants by funding models that improve access, coordination, navigation, outreach, culturally safe care, social connection, local capacity and early support.

Commissioning specifications should ask providers to demonstrate how they will reduce practical and structural barriers such as transport, cost, language, digital exclusion, stigma, cultural safety, service fragmentation and difficulty navigating care. This is particularly relevant for programs supporting Aboriginal health, mental health, refugee health, care navigation, older people, carers and people experiencing housing instability or homelessness.

The CWR Roadmap reinforces how HNC funds matters as much as what it funds. Relational investment, flexible processes, local ownership, trauma-informed practice and shared learning can strengthen local conditions that support wellbeing and resilience. HNC should build these approaches into commissioning where community capacity, trust and adaptation are central to impact.

Convene partnerships where change requires action beyond health

Multi-sector partnership should be treated as a strategic capability, not an optional add-on. HNC is well placed to act as a convener, facilitator, networker, funder and capacity builder with ACCHOs, LHDs, councils, housing and homelessness services, social services, education, emergency management and community organisations around shared priorities.

HNC will not need to lead every partnership agenda. In some areas, HNC may be best to lead where barriers relate directly to primary care access, commissioning, navigation or provider capability. In others, HNC's role will be to support, convene, contribute local evidence, fund enabling activity or advocate alongside partners who hold the primary mandate.

Partnerships should be both place-based and issue-based. Place-based partnerships can focus effort in high-need communities, while issue-based partnerships can target housing and homelessness, social connection, health literacy, climate resilience and access to care. Each partnership should have a clear purpose, agreed roles, practical workplans, community voice, shared accountability and mechanisms for reflection and adaptation.

Targeted and partnered investment principles

HNC should apply a targeted and partnered approach to work relating to the social determinants of health. This recognises that HNC is not solely responsible for changing broad social, economic or environmental conditions across the North Coast. Instead, HNC should focus its efforts where it has a practical point of influence through commissioning, primary care support, partnerships, advocacy, data, regional coordination or system design.

More intensive investment should be considered where three factors are clear: the specific condition, disease or health outcome in focus; the geographic location where need and opportunity are greatest; and the population or cohort experiencing inequitable access or poorer outcomes. Where these factors are not clearly defined, HNC's role should generally be limited to universal system support, evidence sharing, advocacy or participation in partner-led work.

Strategic actions

The actions below are staged to distinguish what HNC can do immediately to work that will require deeper planning, partnership development and monitoring over time.

Immediate actions

- Develop a succinct HNC social determinants of health position statement that clarifies the PHN's role, scope, priorities and practical points of influence, including where HNC should lead, support others to lead, advocate, or contribute through system influence.
- Confirm the priority social and structural barriers affecting access, equity and outcomes where HNC has a practical point of influence, using the HNA, local intelligence, community and provider experiences.
- Update commissioning guidance so new service specifications explicitly consider practical and structural barriers to access, equity and outcomes.

Medium-term actions

- Strengthen place-based prioritisation for high-need LGAs and communities, with a clear rationale for where HNC effort and investment should be focused.
- Expand integrated care, navigation, community connector and relational commissioning models that address both health and social needs.
- Formalise cross-sector partnership structures with agreed outcomes, roles, responsibilities.
- Deepen Aboriginal partnership and cultural determinants work across planning, commissioning, evaluation and governance.

Longer-term actions

- Build a stronger evidence base through routine monitoring, evaluation and learning, including measures that capture access, coordination, equity, community connection and local capacity.
- Embed adaptive management and shared learning processes so social determinants work can respond to changing community conditions rather than remain fixed to program cycles.

- Use HNC's regional role to advocate for broader system changes where local evidence shows that housing instability, transport barriers, cost-of-living pressures, workforce constraints, climate risk or service fragmentation are limiting health access and outcomes.

Measures of success

Success should be measured by whether HNC is embedding social determinants into the way it plans, commissions, partners and learns, and if this is improving access, coordination, equity and local conditions. Measures should go beyond service outputs to show whether HNC's activity is reaching priority populations, reducing practical and structural barriers, strengthening community connection and improving the ability of communities and services to adapt to changing need.

Table 2. Measures of success

Success domain	What HNC should look for
Strategic alignment	Clear organisational position, agreed scope, priority determinants and consistent consideration of SDOH in planning, commissioning, partnership and evaluation processes.
Access and equity	Improved reach to priority populations and high-need communities, reduced barriers to care, improved navigation and more culturally safe, inclusive and timely support.
Commissioning impact	Service specifications and provider reporting show how commissioned models address practical and structural barriers, build local capacity, strengthen social connection and support early intervention.
Partnership and system influence	Stronger cross-sector partnerships with agreed priorities, shared workplans, community voice, joint problem-solving and evidence of influence on issues that sit beyond the health system.
Learning and adaptation	Regular reflection, monitoring and evaluation show whether activities remain relevant, what is changing for communities, what barriers persist and how HNC is adapting its approach over time.

Conclusion

Social and structural conditions are primary drivers of health inequity and wellbeing, and they directly shape whether people can access care, engage early, remain connected and avoid poorer health. If these conditions are not considered in planning, commissioning and partnerships, HNC's impact will be narrower than its strategy intends.

The proposed approach keeps HNC within its PHN role while making better use of its existing levers. By using the HNA and local intelligence to focus effort, commissioning models that reduce practical and structural barriers, and convening partnerships where change requires action beyond health, HNC can strengthen its contribution to equity without taking responsibility for every determinant affecting the region.

The next step is to make this approach explicit through a succinct HNC position statement, updated commissioning guidance, clearer place-based priorities, formalised partnership structures and measures that capture contribution, learning and adaptation. This would allow HNC to move

from recognising social determinants as important to systematically embedding them in the way it plans, funds, partners and measures impact.

Appendix A: WHO evidence base relevant to primary health care and social determinants of health

The World Health Organisation's 2025 *World report on social determinants of health equity* provides the main external evidence base for this paper. The report confirms that health and wellbeing are shaped by much more than genes, health behaviours or access to healthcare. It defines the social determinants of health equity as the conditions in which people are born, grow, live, work and age, and people's access to power, money and resources. These conditions influence avoidable and unjust health gaps and can affect life expectancy, illness, wellbeing and access to opportunity.

The report is relevant to HNC because it reinforces the importance of acting through primary health care systems, local evidence, cross-sector partnerships and equity-focused governance. The report supports an approach where health organisations use their available levers to reduce the impact of social and structural barriers on access, prevention, early intervention and outcomes.

The report makes a number of recommendations relating to primary care. These recommendations are included below and present advocacy opportunities for HNC to improve the social determinants of health.

Recommendation 7.1: Achieve universal health coverage through progressive health financing and primary healthcare approaches

- *7.1.1 improve equitable access to a continuum of quality primary health services addressing both physical and mental health*
- *7.1.2 use pooled government resources to minimise out-of-pocket costs and finance health services*
- *7.1.3 increase the share of health and care sector funding to meet essential needs, to avoid marginalisation and discrimination*
- *7.1.4 facilitate equitable access to health technologies, from research and development through to manufacturing and delivery.*

The most cited barriers to achieving universal health coverage include: financing mechanisms and their effects, such as patients' out-of-pocket expenditure and impoverishment; governance issues, including policy inconsistency; inequity in income or service coverage; weak regulation and supervision mechanisms; and poverty.

Recommendation 7.2: Build and retain a health and care workforce capable of delivering equity

- *7.2.1 recognise and reward work in the care economy, including informal care, and demonstrate the role of the health and care sector as a healthy and equitable employer*
- *7.2.2 develop human capacity in health, social protection, educational, labour, local government and service organisations, to enhance intersectional efforts to address the social determinants of health equity.*

Medical professionals are well positioned advocate for a the social determinants of health approach, as those working in disadvantaged communities witness the impacts directly of poverty and inequalities on health outcomes. Members of the health workforce are generally trusted and well-respected voices in public and policy discourse, highlighting the importance of

professional bodies, publicly committing to reducing health inequities through action on the social determinants of health (World Health Organisation, 2025).

For this action to be implemented effectively in practice, it is essential to ensure a health workforce with an appropriate mix of disciplines, provide practitioners with training o the social determinants of health and health equity, and incorporate responsibilities into job descriptions. At the local level, the health workforce can advocate for healthier communities by making the case for action on issues such as housing, access to green spaces, or air pollution. To make such advocacy possible, they need to be supported in their roles and provided with adequate training and resourcing (World Health Organisation, 2025).

Recommendation 8.1: Strengthen focus on social determinants in health systems and policy platforms

- *8.1.1 integrate addressing the social determinants of health equity in all health strategies, policies, emergency preparedness and response plans, and public health laws*
- *8.1.2 establish coordination and accountability mechanisms for intersectional collaboration and community engagement for health at all levels of government.*

The report emphasises that the social determinants of health equity are not a discrete "programme" that can be rolled out by a single agency (World Health Organisation, 2025) . The social determinants of health need to be incorporated into daily health practice. For example, doctors can include a detailed social history of the patient in addition to their medical history (World Health Organisation, 2025)

Recent examples of this include in Spain, where the Ministry of Health has produced recommendations for regions (which are mostly responsible for health) to collect data on social determinants as part of the patient digital health record, including income, migratory status, social participation, social and family support, and area deprivation (World Health Organisation, 2025)

Emergency preparedness and response plans have in the past overlooked the social determinants, prioritising clinical care over promoting healthy populations. The COVID-19 pandemic illustrated how if the social determinants of health for groups are not addressed, including income security, there will be lower compliance with public health measures, and health inequities will worsen during and following a pandemic (World Health Organisation, 2025)

Recommendation 8.2: Monitor social determinants of health equity

- *8.2.1 strengthen statistical infrastructure and build capacity for the use of disaggregated data to measure progress on health equity*
- *8.2.2 utilise new technologies and novel data sources to fill data gaps and inform action on social determinants*

Monitoring the social determinants of health at macro, meso and micro levels is essential to identify and understand issues and needs, and to determine the best course of action to improve health equity. Unfortunately most countries lack systems for timely monitoring of health inequities or of the social determinants of health equity, and do not evaluate the impact of policies or interventions.

Key messages relevant to HNC

- Health inequities are produced and reproduced through social, economic, commercial, cultural and political conditions, not only through individual behaviour or clinical care.
- Primary health care systems can contribute to reducing inequity when they are organised around population need, culturally appropriate care, community engagement, prevention and local intelligence.
- Action on social determinants requires work beyond the health sector, including shared governance, intersectoral collaboration, community participation and accountability.
- Equity work needs better monitoring, including disaggregated data that shows who is benefiting, who is missing out and where inequities persist.
- Health organisations should embed social determinants into strategy, planning, service design, emergency preparedness and evaluation, rather than treating them as a separate or occasional area of work.

Implications for HNC

For HNC, the relevance of the WHO report is practical rather than theoretical. It supports this paper's position that social determinants should be embedded in how HNC plans, commissions, partners, advocates and measures impact. The report strengthens the case for HNC to focus on the points where social determinants intersect with its PHN role: access to primary care, prevention, early intervention, care navigation, culturally safe models, community connection, local capacity and integrated support.

The report also reinforces the need for HNC to work in ways that are proportionate to need. Region-wide system support remains important, but greater intensity of effort should be directed to the places and populations experiencing the greatest barriers and poorest outcomes.

Most relevant WHO recommendations for this paper

- improve equitable access to quality primary health care and reduce barriers that prevent people from getting support early
- strengthen culturally appropriate, person-centred models of care
- embed social determinants and health equity into health strategies, service planning and emergency preparedness
- build mechanisms for intersectoral collaboration, shared accountability and coordinated action
- use data and monitoring systems to identify inequities, guide investment and assess whether action is reaching priority populations
- support workforce capability and system capacity to understand and respond to social and structural barriers to health.

Appendix B: Dahlgren-Whitehead model of the social determinants of health

This appendix summarises the Dahlgren-Whitehead model as supporting context for the paper. The model is included because it provides a useful way to understand the breadth of social determinants that can shape health outcomes, while recognising that HNC's strategic approach should be organised around its own role, levers and practical points of influence.

Developed by Dahlgren and Whitehead in 1991, the “rainbow model” is a widely used conceptual model for understanding health inequities. It maps the relationship between individuals, their social and physical environments, and broader socioeconomic, cultural and environmental conditions. The model is used by public health agencies, including the Australian Institute of Health and Welfare, to explain how health outcomes are shaped by layered determinants rather than individual behaviour or healthcare alone.

The model presents health as being shaped by multiple layers of influence around the individual. These layers include individual characteristics, social and community networks, living and working conditions, and broader structural conditions. It is often described as a “rainbow” because it shows these layers surrounding the individual.

Figure 1. Dahlgren-Whitehead Rainbow Model



For HNC, the model is useful as a sense-checking tool because it shows that activity relevant to social determinants can sit at different levels. Table 3 details HNC activities that address the social determinants of health to each layer in Dahlgren-Whitehead framework.

Table 3. HNC activities aligned to the Dahlgren-Whitehead layers

Dahlgren-Whitehead layer	HNC activities	Partners and Reach	Funding
1. Age, Sex and Constitutional Factors	• Regional Health Needs Assessments identify age linked risks and population trends across the North Coast. • Healthy Ageing Strategy (2023–27) addresses ageing, chronic disease, frailty and physiological changes across the life course.	• Local Health Districts (LHDs) • General practice • Community groups	• PHN Core • Older Australians funding • Chronic disease streams

2. Individual Lifestyle Factors	• Healthy Ageing Strategy supports physical activity, healthy eating, falls prevention, and planning for ageing. • The Healthy me AI digital solution will aim to improve health literacy and self-management. • Medicare Mental Health and headspace communications activities promote help seeking.	• Older people & carers • GPs • Local councils	• Older Australians funding • Digital innovation funds • PHN Core
3. Social & Community Networks	• Healthy Towns / Healthy Towns Plus builds social connection, belonging and local resilience. • Healthy Me, Healthy Community was a social prescribing pilot in Port Macquarie from 2022-2024 promoting social connection for older people. • The Care Finder Program supports >1,200 isolated older people to access aged care, food, financial and housing supports. • The Aboriginal Health Partnership seeks to strengthen cultural determinants (country, language, identity). • The Community Wellbeing and Resilience Grants build community connectedness and wellbeing. • The Refugee Transition to General Practice project commissions social workers to connect newly settled refugees with comprehensive primary health care. • The Climate Change and Health Strategy will seek to strengthen place-based connection, mental wellbeing and cohesion in disaster affected communities (in development).	• Community organisations & neighbourhood centres • ACCHOs and Elders • LHD Health Promotion • Local governments	• PHN flexible funds • Healthy Ageing (Care Finders) • Philanthropic and climate resilience funds
4. Living and Working Conditions	• Housing & homelessness initiatives, including Homeless Peer Link Worker model and Homeless Hub Clinical Service. • Commissioned integrated primary mental health, psychosocial and aged care supports (hub and spoke, no wrong door e.g. Medicare Mental Health Centres, Safe Havens, brokerage funding, Healthy Hub Connect, Primary Care Impact Grants). • Workforce attraction & retention via the Welcome Experience (housing support, local connectors, partner employment). • The Primary Care Access program and the Urgent Care Clinics have made free general practice appointments to tens of thousands of North Coast residents.	• Mission Australia and psychosocial providers • General practices and ACCHOs • LHDs • Councils and emergency agencies • Commissioned providers	• PHN Core • Mental Health and Healthy Ageing streams • CPSP • Project grants • Philanthropic funds

	• GP workforce, QI programs and practice support to maintain service access in rural and disadvantaged areas. • The new Public and Population Health Steering Committee under the LHD MoU will consider environmental health issues and practical joint efforts to address.		
5. Wider Socioeconomic, Cultural and Environmental Conditions	• Health equity leadership through PHN Business Review, Productivity Commission inquiries, Rural Health Inquiry submissions and Reconstruction Authority reviews. • The Health Needs Assessment is used to prioritise flexible funding to priority populations and issues most in need. • Funding distribution models used in commissioning prioritise services where they are needed most in terms of socio-economic, rurality and health- based indicators (for example, higher staffing for high needs areas such as Clarence and Macleay Valleys). • The Climate Change and Health Strategy will address food/water security, environmental threats, heat, displacement, and long-term resilience. • The Aboriginal Health Partnership will embed cultural determinants in planning and commissioning (language revival, connection to Country).	• ACCHOs and cultural organisations • Councils and regional emergency bodies • Policy and funding agencies	• Indigenous health funding • PHN Core

The model should not be treated as a complete or sufficient framework for HNC's strategic approach. It has been critiqued for not making explicit the role of power, politics and commercial interests in producing inequities. It may also under-represent contemporary determinants such as the digital environment, cultural determinants and Indigenous worldviews.

For this reason, the model is best used as supporting context rather than as the organising framework for HNC's approach. Its main value is to help sense-check the breadth of determinants that may affect health outcomes. HNC's strategy should remain organised around its practical points of influence: where it can lead, where it can support others to lead, and where it can contribute through commissioning, advocacy, partnership or system influence.

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