South Eastern Sydney Local Health District

EQUITY STRATEGY

Working together to improve equity in health and wellbeing, with a focus on those who need it the most.

NSW GOVERNMENT | **Health** South Eastern Sydney Local Health District

ENDORSED DECEMBER 2015

"Health outcomes are not equal for people throughout the world, both across and within countries. Many of these disparities — due to underlying social determinants — are avoidable and unacceptable.
It does not have to be this way and it is not right that it should be like this. Where systematic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair."

The World Health Organization[1]

STRATEGY AT A GLANCE

Where systematic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair. In South Eastern Sydney Local Health District (SESLHD) our vision is working together to improve equity in health and wellbeing, with a focus on those who need it the most. Our goal is to reduce inequities in health and wellbeing within a generation. *The SESLHD Equity Strategy* provides a framework for that to be achieved.

SESLHD EQUITY STRATEGY GOAL

Reduce inequities in health and wellbeing within a generation

OUR FOCUS

PEOPLE who are most disadvantaged

PLACES where they live or can be reached

OUR STRATEGIC DIRECTIONS

- Transform our health services to systematically improve equity
- Invest to provide more care in the community and more prevention and wellness programs
- Refocus our work to better address the social determinants of health and wellbeing

OUR APPROACH

Engage patients and communities as equal partners in addressing health inequities

Take a population health system approach, balancing short- and long-term goals

Be an innovative, learning organisation

ORGANISATIONAL DEVELOPMENT: capability, alignment, health, change and learning

COMMITMENT from the Board and down through the whole organisation

INTELLIGENCE to guide decisions and actions

TOOLS to support best practice

FOUNDATIONS : BUILDING OUR CAPACITY TO ACT

FOREWORD

The avoidable death rate is 58 per 100,000 population in the Rose Bay area. Travel just 5km west to the Darlinghurst area, or 30km south west to the Riverwood area and the rates are more than double (165 and 128 per 100,000 respectively). Or go 40km south to the Kurnell area and the rates are 50% higher (90 per 100,000).

Based on ABS population and death registration data for 2009-2012

We know that there are inequities in our world, our country and our District, and that these differences have direct and tangible consequences for the health and wellbeing of individuals and communities. There are differences in our socioeconomic positions, and the social and physical environments in which we live. There are differences in the vulnerabilities of individuals and groups, in their health beliefs, their risks and their health and wellbeing outcomes.

And we know that these differences are unfair.

We will directly challenge this. We will be bold in our ambitions for the communities we serve. We will engage with our communities. We will take a positive, long-term approach, seeing our service users, families, carers and communities not as consumers but as assets and partners in developing resilient, healthy communities. It is a task that is not to be underestimated, and will require a long-term and systematic commitment working with our partners, but it is one that we must and will achieve. Everyone has a role to play in transforming our health system into one that routinely and directly acts to recognise, understand and address inequities.

As a whole District, we aim to develop a culture in which our workforce is inspired and empowered to test new approaches to close the gaps in avoidable deaths and avoidable hospitalisation rates between our most disadvantaged people and places, as compared to the rest of the South Eastern Sydney population. We will address what matters the most, for those who need it the most, to improve their health and wellbeing.

Michael Still MBA
SESLHD Board Chair
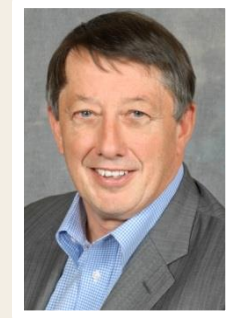
Gerry Marr
SESLHD Chief Executive

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"Equity should be a consideration in everything we do for our communities."

Dr James Mackie
Medical Executive Director
Senior Staff Specialist Renal Medicine

"If we are to best meet the needs of our local communities, there is an imperative for us to have a deep understanding of the role that health inequities play in people's lives. Although the health of our District as a whole compares favourably with other parts of NSW, when we dig beneath the surface there are substantial differences in different groups' access to services and health outcomes."

Julie Dixon
Director, Directorate of Population Health, Planning and Equity
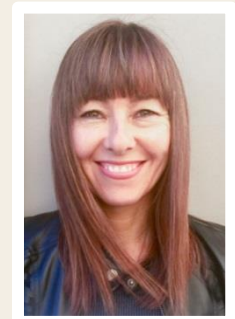
OUR COMMITMENT TO EQUITY

Equity is about fairness. When we look at gaps in measures of health and wellbeing between individuals, groups or communities, we must ask: Are there differences? Is there a pattern to this? And why? Three key features of **health inequities**[2, 3] are that these differences are:

■ **Systematic** — The differences are not random – there is a pattern across the population. Groups of people, or places where people live, can be predictors of health and wellbeing.

■ **Avoidable** — Health inequities are not the result of biology, but of society. Just as they are socially produced, they can be socially remedied.

■ **Unfair** — Discussions of health inequity include an underlying principle of social justice. It follows that a key principle of equity in health care is making sure that people get fair access to the same opportunities.

These differences are evident across our communities, and not just in one small group that experiences extreme disadvantage[2]. Right across our communities, those with higher social status are healthier than those below them[4]. This stepwise connection between decreasing social position and decreasing health is known as the *social gradient*[5]. If we are to reduce inequities in health and wellbeing, must do more to level this gradient out[2].
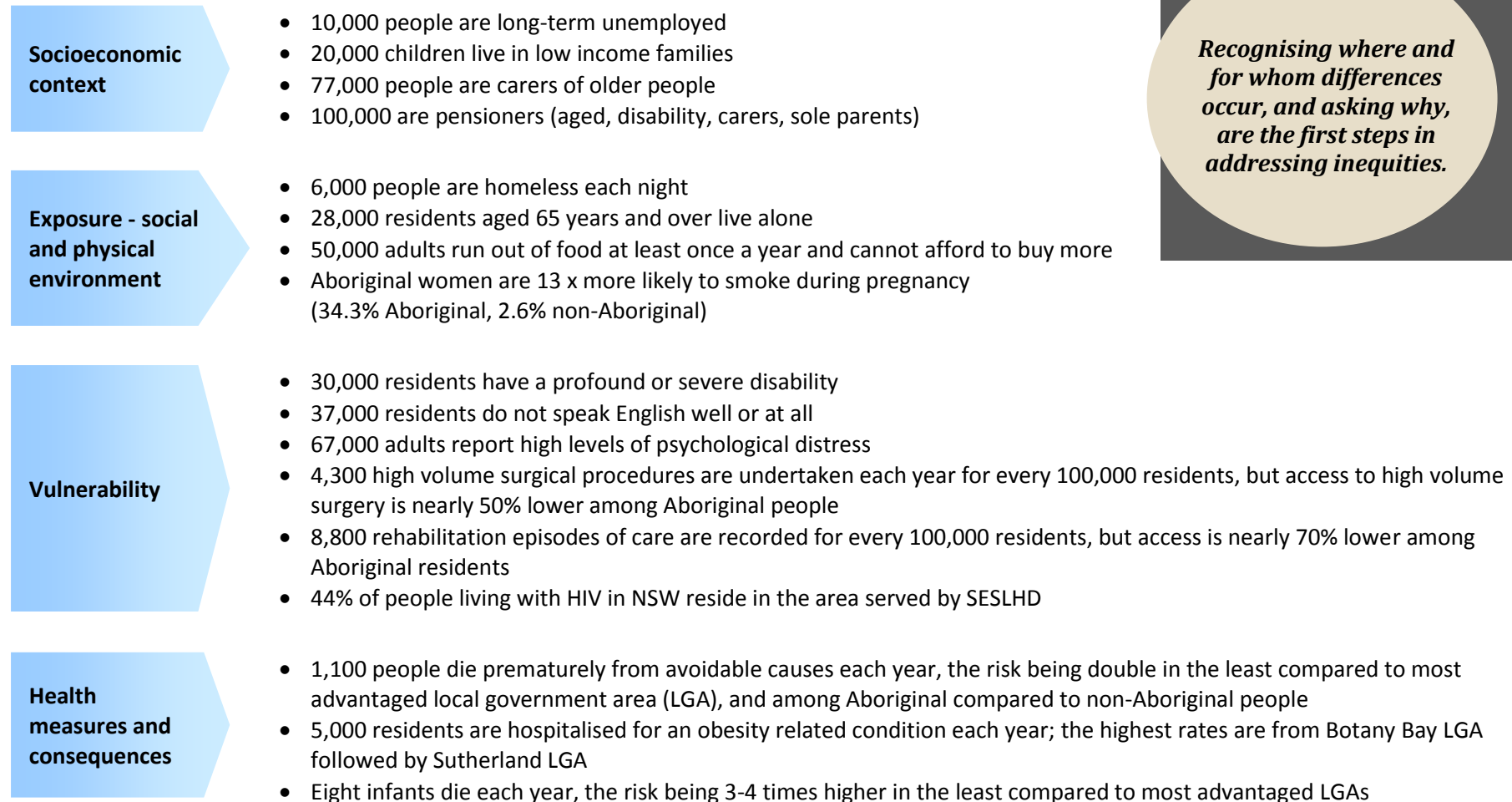
The *SESLHD Road Map to the Delivery of Excellence 2014-2017*[6] recognises equity in health and wellbeing as a priority for action across the entire organisation.

Health equity means that everyone has a fair opportunity to live a long, healthy life.

What are the differences experienced across our District?

Despite most people within our District enjoying very good health, some do not. Recognising differences is an essential first step addressing inequities[7]. In SESLHD, some known differences that contribute to inequities include:

Socioeconomic context

- 10,000 people are long-term unemployed
- 20,000 children live in low income families
- 77,000 people are carers of older people
- 100,000 are pensioners (aged, disability, carers, sole parents)

Recognising where and for whom differences occur, and asking why, are the first steps in addressing inequities.

Exposure - social and physical environment

- 6,000 people are homeless each night
- 28,000 residents aged 65 years and over live alone
- 50,000 adults run out of food at least once a year and cannot afford to buy more
- Aboriginal women are 13 x more likely to smoke during pregnancy (34.3% Aboriginal, 2.6% non-Aboriginal)

Vulnerability

- 30,000 residents have a profound or severe disability
- 37,000 residents do not speak English well or at all
- 67,000 adults report high levels of psychological distress
- 4,300 high volume surgical procedures are undertaken each year for every 100,000 residents, but access to high volume surgery is nearly 50% lower among Aboriginal people
- 8,800 rehabilitation episodes of care are recorded for every 100,000 residents, but access is nearly 70% lower among Aboriginal residents
- 44% of people living with HIV in NSW reside in the area served by SESLHD

Health measures and consequences

- 1,100 people die prematurely from avoidable causes each year, the risk being double in the least compared to most advantaged local government area (LGA), and among Aboriginal compared to non-Aboriginal people
- 5,000 residents are hospitalised for an obesity related condition each year; the highest rates are from Botany Bay LGA followed by Sutherland LGA
- Eight infants die each year, the risk being 3-4 times higher in the least compared to most advantaged LGAs

We are concerned by unfair differences.

We can see the effects of disadvantage across our entire health system[8]:

- **More preventable presentations to emergency departments**
- **More complications associated with their admissions to hospital**
- **Longer lengths of stay**
- **More avoidable long-term conditions**
- **Poorer self-management leading to compounded poor outcomes**
- **Over-representation of disadvantaged people in virtually every measure of health and wellbeing.**

These effects start in the early years of life that build the foundations for future life and learning. Children living in the lowest socioeconomic status areas are almost twice as likely to die as infants, nearly three times as likely to die due to injury, 30% more likely to be born with low birthweight, 60% more likely to have dental decay, and 70% more likely to be overweight or obese. Disadvantaged children are more likely to have health and behavioural problems, experience housing and food insecurity, and are more likely to be developmentally vulnerable at school entry[9].

Disadvantage in childhood goes on to have a compounding impact across the entire life course, affecting achievements at school, shaping employment prospects, economic and social situation, and lifelong health and wellbeing[9-11].

The impact of this builds over time, with consequences both for the individual and for the health system in terms of economic costs. Health inequities are health system cost drivers, and therefore have an impact across the whole community. International data suggest that[12]:

People in the lowest quintile of income groups use about twice as much health care services as those in the highest quintile[i].

An additional 400,000 Australians of working age would assess their health as "good" if health equity was achieved between individuals living in the lowest versus the highest income quintile households[13]. How might this change in health status impact on the use and cost of Australia's health system?

In Australia, calculations regarding the cost of inaction on the social determinants of health have suggested that[13]:

- Over 500,000 hospital episodes could be prevented if the health gap between the bottom and top income quintile households could be closed, with savings of nearly $2.3 billion per year.
- A further $273 million per annum could be saved through reduced doctor and medical related services, and savings of $185 million in prescribed medicines.

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[i] *Quintiles* is a statistical term referring to the division of a population into five equal groups.

Understanding the determinants of health and wellbeing

All other things being equal, genetics and biology have clear influences on health. But health and wellbeing are far more complex than this, because society *isn't* equal. Where we are on the social gradient is a direct predictor of our health and wellbeing. The figure below describes the determinants of health, and those towards the bottom of the page are known as *social determinants*. Influenced by a range of factors inside and outside the health system, these social determinants are strongly linked to disadvantage and subsequent health inequities[7, 14-16]. They are a product of our society and, as such, can and must be remedied by our society. This applies from how a person is treated in a clinical appointment to their social status and opportunities at the broader social level. As we did before, asking: **What are the differences that people experience?** provides valuable insight to this.

<table>
<tr>
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Health, good or bad, starts long before "illness". It starts in our homes, our schools, and our jobs. Where you live, what you have and what you do all have an impact on your health. The opportunity for health begins in our families and our neighbourhoods.

</td>
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HEALTH & WELLBEING OVER TIME
Life expectancy.   Illness and injury.
Skills to manage long-term health issues.
Mental health – strength – wellbeing.

Influences of genetics and biology

SHORT-TERM HEALTH EFFECTS
Weight – blood pressure – glucose tolerance.
Early signs of long-term health issues. Whether immunised.

LIFESTYLES & BEHAVIOURS
Smoking – food – exercise.   Alcohol – drug use.
Cancer screening – immunisation.   Using health services – asking for help.

SOCIOECONOMIC FACTORS
Education – employment – income – family – housing – support.

WHERE AND HOW WE LIVE
Our society – culture – racism.   Being part of a community, feeling strong and confident.
Living somewhere that makes it easy to be active.   Having good access to affordable, healthy food.   Good government policies and support.

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What are the differences in...

Health consequences?

Health measures?

Vulnerability?

Exposure – social and physical environment?

Socioeconomic context?

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What can we do about it?

A determinants approach to health and wellbeing requires a broad scope of action, as suggested by the scope and scale of the figure on the previous page. Below, we explore this further and ask what issues we should be considering across the scope of determinants, from the most immediate and pressing clinical issues of health and wellbeing (top of diagram) to the social determinants that influence them (bottom of diagram) – and everything in between.

The determinants of health

- HEALTH & WELLBEING OVER TIME
- SHORT-TERM HEALTH EFFECTS
- LIFESTYLES & BEHAVIOURS
- SOCIOECONOMIC FACTORS
- WHERE AND HOW WE LIVE

What should we be thinking about?

Greater community involvement in designing services — Volunteers — More attention to social determinants when treating patients — **Better self-care** — **Clinical services** — Health literacy — Understand patient health behaviours — Health professionals that recognise and act to address inequities — **Equity of access** — **Empowering patients and carers** — Equity lens in planning

Strong partnerships — Build our volunteers program — **Health and wellbeing improvement** — More services in communities — More attention to social determinants when designing prevention programs — Equity lens in planning — **Prevention** — Engage communities — **Targeted Localised Integrated** — Intervene in early years of life, build life-long healthy habits

Multi-sectoral interventions in disadvantaged communities — **People & communities are assets** — How can we work together better? — Strong partnerships — Local needs = local actions — **Engage communities** — Urban planning — Environments to support better health and wellbeing — **Build resilience** — Intervene in early years of life – vision and actions for the long term

What could we do?

- Transform our health services to systematically improve equity
- Invest to provide more care in the community and more prevention and wellness programs
- Refocus our work to better address the social determinants of health and wellbeing

What do we need to change?

Consultation with our communities, staff and other service providers and organisations across our District has told us that there are some clear changes we all must make to the way we routinely work.

In every clinical interaction, we need to look at the whole person: their physical, social and emotional wellbeing.

We need to look at the whole person to understand what bearing their unique circumstances may have on the specific clinical issues that they are presenting with. Our clinical teams need to explore and understand each person's socioeconomic situation, social and physical environment, personal vulnerabilities, risks and behaviours – as well as their skills, strengths and other assets. For example, we could ask: how has this affected them up to this point? How will it affect their care today, and their recovery and longer term outcomes tomorrow?

We must better recognise the complex overlap and convergence between different aspects of disadvantage.

Are our service models designed to recognise and respond to complex needs? The newly arrived migrant with poor English who cannot get a job… the Aboriginal man that experiences severe mental illness and is homeless…. the pensioner who lives alone and has no one to look out for her…. the woman who has experienced domestic violence, moved into public housing and struggles to support herself and her children. Accessibility of services, transport, access to interpreters and trauma-informed care are just some of the many strategies required.

We must do more to address service access issues.

As well as better meeting the needs of individuals that we do see, we must also consider the potential needs of those that we don't. We need to ask: Who doesn't turn up to appointments – and why not? Who discharges against medical advice and then requires readmission later – and was there something that our services might have done differently to avoid this? And who isn't coming into contact with our services at all in the first place – and why not? The unrecognised needs of today may well become the avoidable hospitalisations and avoidable deaths of tomorrow.

We will build stronger intersectoral partnerships to tackle social determinants at the individual and community level.

This is not something that we can or should do alone. Effective and enduring partnerships with a strong focus on two-way communication and shared problem-solving are crucial for our District to improve the health and wellbeing of individuals and communities. Partnerships with others such as primary care will be vital in clinical settings, and at the broader community level we will forge partnerships with patients, their families and carers, volunteers, community members and the many other organisations that represent or serve them.

WHAT WE WILL DO

Our Equity Strategy Framework

We recognise that it takes more than a well-intentioned list of strategic directions and priorities for investment to achieve change. **HOW will we achieve it?** To that end, we have developed an *Equity Strategy Framework* that outlines methods to determine our focus for action and how we will approach this undertaking. And we must invest in the organisational foundations required to achieve sustainable change. These key concepts are explored in the following sections of this Strategy, which also includes more detailed explanations and examples of the three core strategic directions for action.

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From the Framework: Our Focus

People who are most disadvantaged

People who are most disadvantaged tend to die younger, get sicker, experience more risk factors and use preventive health services less than those who are most advantaged[15, 17]. **Marginalised** people and communities experience discrimination and exclusion (social, political, economic) because of unequal power relationships across economic, political, social and cultural dimensions. **Vulnerable** people and communities are at higher risk for poor health as a result of barriers they experience to social, economic, political and environmental resources, as well as limitations due to illness or disability.

A wide range of groups across our communities experience disadvantage. Not every person in every group has the same experience, but groups most likely to experience inequities in health and wellbeing include:

- People from low socioeconomic backgrounds, including people who are homeless, long-term unemployed, or living in public housing or households in rental stress
- Aboriginal people
- People living in single parent households with dependent children
- Socially isolated, disengaged people (eg older people and young people not working or studying)
- People who experience mental illness, particularly moderate to severe mental illness
- People living with a disability
- People from some culturally and linguistically diverse backgrounds, particularly refugees
- People who are gay, lesbian, bisexual, transgender, questioning, queer and in-between

There is often overlap between disadvantaged groups. For example, people with moderate or severe mental illness are at higher risk of homelessness, long-term unemployment and incarceration. They typically have increased risk behaviours, such as alcohol misuse, smoking and HIV risk behaviours. As well as contributing to premature death, the increased risks and associated illnesses make difficult situations faced by people with mental illness even more challenging[18-20]. Many more examples of overlap are apparent in the following pages.

Data are provided in the following pages for different groups that experience disadvantage across our communities. These are just some of the many groups that will require our attention. Where available, local data are included. Greater detail can be found in additional documents that will be produced to support this Strategy.

People from low socioeconomic groups

People from the lowest socioeconomic groups tend to have relatively poor health[17]. People with higher incomes and education tend to be:

- Healthier
- Able to afford better, healthier food
- Able to afford better, safer and healthier housing
- Able to participate in healthy activities
- Able to access and afford better health care
- More informed about healthy choices and behaviours[17].

Being from a relatively low socioeconomic group is a predictor of many measures of health risk, such as smoking[21], as well as short-term and long-term measures of health such as obesity, oral health and cancer survival[17].

SESLHD is home to a large number of people who experience socioeconomic disadvantage. This is a broad concept with many facets including economic resources, employment, education, housing, marital and family make-up and English proficiency. Collectively these represent people's access to material and social resources, and their ability to participate in society[22]. For example, Botany Bay, Randwick and Sydney LGAs have a higher proportion of public housing than the NSW average. In Botany Bay LGA 11% of all dwellings are public housing, with up to 70% in some suburbs[23]. More on the relative disadvantage in different areas is discussed in the next section (*Our focus: Places*).

People who are homeless

People who are homeless typically have complex health and psychosocial needs, and face significant barriers to accessing health services[24]. In this as in other groups, the issues are complex and overlapping – for example, Aboriginal people are over-represented, and children and young people make up 37% of the total NSW homeless population[25].

About 20% of NSW's identified homeless population live in SESLHD, equating to around 5,600 people. This includes persons living in 'severely' crowded dwellings (around 26% of the total homeless population of SESLHD), persons in supported accommodation for the homeless (around 14%), persons staying in boarding houses (around 40%), persons staying temporarily with other households (around 10%), persons in improvised dwellings, tents or sleepers out (around 8%) and persons in other temporary lodging (around 1%)[26].

The largest proportion of people who are homeless in our District are in Sydney Inner City, representing 60% of our homeless population. Contributing factors to homelessness across NSW[25] include:

- 31% Domestic violence and relationship issues (time out from family, family breakdown, violence and assault)
- 28% Accommodation issues (housing crisis, inadequate or inappropriate dwellings)
- 22% Financial difficulties (housing stress, unemployment)
- 7% Health reasons (mental health issues, substance abuse issues)
- 12% Other (transition from care/custody, lack of support, discrimination)

Aboriginal people

Around 6,300 Aboriginal people live in our District, equating to just under 1% of our total population. The highest proportions of Aboriginal residents live in the Botany Bay (1.9%) and Randwick (1.7%) LGAs. Despite there being some improvements over the last decade, Aboriginal persons continue to experience significant health inequities[27]. This includes lower life expectancies (8.6 years less for Aboriginal males and 7.4 years less for Aboriginal females), 1.5 times higher mortality rates and 1.3 times higher infant mortality rates[27] when compared to non-Aboriginal persons.

The inequities in health and wellbeing experienced by Aboriginal people are evident in a wide range of variables. For example, Aboriginal people experience substantially higher:

- Prevalence of risk factors such as smoking, smoking during pregnancy, overweight and obesity[28].
- Prevalence of health consequences such as long-term conditions and multiple morbidities[27].
- Rates of hospitalisation due to unintentional injury, interpersonal and domestic violence, and self-harm[28].

One of the greatest concerns that we must urgently address is that Aboriginal people, whose risk is already higher than others, often then have poorer outcomes when accessing our services. Aboriginal people are more likely to discharge against medical advice then have unplanned readmissions within 28 days, and similarly leave the emergency department before completing treatment, then re-present to the same emergency department within 48 hours[27]. What are the causes of this, and what can be done by our services to address them?

People that experience mental illness

The life expectancy gap between people with mental illness and the general population is substantial – as much as 16 years less for males and 12 years for females – and it appears to be rising[29]. Whilst suicide prevention is an obvious priority issue, we frequently overlook the excess mortality for people with mental illness from almost all other causes of death including cardiovascular and respiratory disease[30] and cancer[31]. Reducing preventable physical illness must be a greater priority for action[30]. For example, people with mental illness typically have increased risk behaviours, such as alcohol and substance use, and risk behaviours related to blood borne viruses such as hepatitis C[32]. Around a third of Australians with mental illness smoke cigarettes – more than double the rate seen across the community[33]. For those with severe mental illness, the smoking rates can be much higher, as high as 70-80%[33, 34].

As noted earlier, it is important to recognise the overlap with other factors related to disadvantage. For example:

- Homelessness is a major issue for people with mental illness. People with mental health issues have been found to represent a large proportion of "rough sleepers". Homelessness in turn exacerbates existing mental illness, and can contribute to the onset of other mental health issues such as anxiety and depression[20].
- Mental illness is a significant issue for Aboriginal peoples, with recent NSW data indicating 1.7 x higher rates of psychological distress in Aboriginal adults, 2.2 x higher rates of hospitalisations due to intentional self-harm and 1.4 x higher rates of suicide[28].

Vulnerable children and young people

Investments in the early years of life are a strong focus of this Strategy, as the developmental periods in early childhood and again in adolescence are critical. Many of the risk factors for poor adult health (such as physical inactivity, poor diet and tobacco smoking) are adopted in adolescence and are influenced by adverse childhood experiences such as living with parental mental illness, substance misuse, domestic violence and intergenerational trauma. This highlights an important opportunity for prevention, early intervention and clinical care[9-11].

- Children aged up to 17 make up 19% of the SESLHD population[35], with 6% overall aged 0-4 years (the early years). As a raw figure, the highest number of children aged 0-4 years live in the Randwick and Sutherland Shire-West areas; as a proportion of the population, this is highest in Sutherland Shire-West, Waverley, Botany Bay and Rockdale[36].
- Kogarah, Sydney (Inner & East), Rockdale LGA and Botany Bay LGA have the highest rates of children with one or more developmental vulnerabilities, and also with two or more vulnerabilities[37].
- There is a higher proportion of Aboriginal children in the community under the age of 15 compared to non-Aboriginal children, presenting opportunities for interventions with potential long-term benefits[27].
- Aboriginal children are disproportionately represented in the child protection system. In SESLHD they are 4.5 times more likely to be reported as being at risk than non-Aboriginal children[35].
- In SESLHD there are 935 children and young people who are in out of home care and who have significant support and health needs due to past experiences of abuse and neglect[35].

Vulnerable older people, particularly those who are socially isolated and/or frail

Between 2011 and 2022, the SESLHD resident population is expected to increase 14%, from 850,000 to 970,000 people. However the older age groups – the main users of acute, subacute and aged care – are expected to grow much faster than the rest of the population.

The fastest growing age group will be the 70-84 years age group, which will increase from about 65,000 to 87,000 people (a 35% increase). The next fastest growing age group will be those aged 85 years and over, which will increase from about 18,000 to 23,000 people (a 27% increase). This will drive a growing demand for services, particularly in areas such as Sutherland where demographic shifts will be significant.

There is a clear need to design and deliver services to meet the unique needs of vulnerable older people.

- People aged 85 years or older tend to be the main users of both acute care and aged care.
- As many as 80% of people aged 65 years or older have three or more long-term health conditions[38].
- Frail older people are at particularly high risk of injuries from falls, which are a high cause of emergency department presentations and can have profoundly debilitating long-term effects[39].
- Many older people face additional burdens such as social isolation and financial hardship[17]. An estimated 28,000 SESLHD residents aged 65 years and over live alone, equating to 1 in 4 older people. And of those that do not, many are the primary carers of their ageing partners.

Vulnerable people from culturally and linguistically diverse backgrounds

Some migrants (especially those from a refugee or refugee-like background) do not have good health on arrival, and many more may develop longer-term health and wellbeing issues once they are here. Inequities can arise or be related to one or more of the following[40]:

- Language and cultural barriers in accessing health care
- A poor understanding of our health system
- A poor understanding of early intervention and preventive care
- A poor understanding of concepts related to self-management
- Differing beliefs about health and illness
- Preference for use of traditional or alternative medicines
- Lack of trust and perceived discrimination
- A lack of cultural competency of the health system itself
- Concerns that their health issues could affect their immigration status

These barriers mean that many people from migrant and refugee backgrounds do not participate in preventive health care, and often present to services late in the course of their illness or condition. For example, women from culturally and linguistically diverse backgrounds often present late in pregnancy, and do not benefit from appropriate prenatal care[41]. People from culturally and linguistically diverse backgrounds experiencing mental illness often present in emergency situations and are more likely to be hospitalised on an involuntary basis[42]. Some migrant women experiencing domestic violence may fear that they will not be able to remain in Australia if they leave a violent relationship, and are therefore less likely to seek help[43].

Other groups that experience disadvantage

Approximately 25,000 SESLHD residents have a **profound or severe disability** – around 1 in 30 people. People with disability are more likely to have lower socioeconomic status, fewer educational qualifications, be out of work, and experience discrimination. People with a disability often require more and complex health resources and services. The prevalence of disability varies across SESLHD, with around 1 in 20 people in Botany Bay and Rockdale LGAs having a profound or severe disability, compared to 1 in 40 in the Sydney and Waverley LGAs.

Carers are playing an increasingly important role in our communities. Primary carers often report poorer physical, mental and emotional health and wellbeing that they attribute to these responsibilities[44, 45]. Just over one-third of primary carers have a disability themselves, and are more likely to live in poor economic circumstances[45].

Whilst women generally experience better measures of health than men, **disadvantaged women** have many unique needs. Women are more likely than men to be responsible for a sole-parent household when young, to care for others during their middle age, and to live alone when elderly[44]. Many women experience harassment, violence and discrimination, which affect their health and wellbeing[44].

Domestic violence occurs in all parts of our community but impacts disproportionately on vulnerable groups including Aboriginal people, migrants, people with disabilities and those who identify as lesbian, gay, bisexual or transgender. There is a strong association between domestic violence and poor health outcomes[43].

From the Framework: Our Focus

Places where they live or can be reached

There are certain geographic areas in our District that experience greater disadvantage than others. This provides insight to where our greatest focus should occur: we are committed to universal health care but to planning and delivering it in a manner that is proportionate to need. **We know that health issues such as multiple morbidities and long-term conditions are more prevalent in disadvantaged areas. We must focus our greatest investments where they are needed the most.**

The Socio-Economic Indexes for Areas (SEIFA) are produced by the Australian Bureau of Statistics to describe various aspects of advantage and disadvantage, in terms of people's access to material and social resources, and their ability to participate in society. The Index of Relative Disadvantage factors in issues such as income, employment, occupation, education, housing and English proficiency. The figure at right shows the SEIFA categorisation of Statistical Local Areas (SLAs) in SESLHD. **The most disadvantaged SLAs are Sydney (Inner), Botany Bay and Rockdale** – although there is wide variation in disadvantage within SLAs, so it also requires closer examination of smaller areas. For example, the southern part of Randwick SLA and north western part of Hurstville SLA are highly disadvantaged according to a number of indicators. More detailed analyses including at the postcode and suburb level will be made available.

Some of these areas cross borders with neighbouring Districts, so effective partnerships will be essential. A settings approach (eg working in schools or through public housing) is another means by which place can be a useful planning consideration.

Relative disadvantage across SESLHD
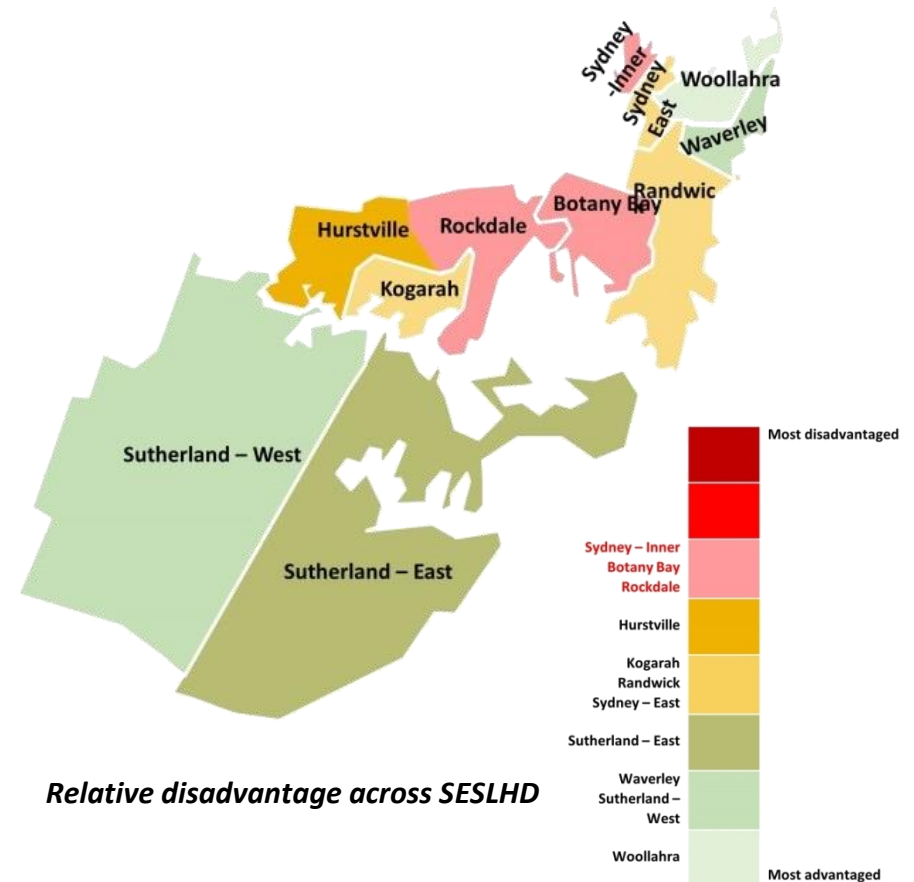
"We know that marginalised people such as refugees often present late to health services, when it can be hard to provide effective treatments. Clinicians need to take responsibility to help overcome barriers for disadvantaged people to access our services. We can do this by looking at models of care that reach out to these groups in our community."

Dr Amany Zekry
Clinical Stream Director Medicine
and A/Professor of Medicine, University of New South Wales
Head of Gastroenterology and Hepatology, St George Hospital
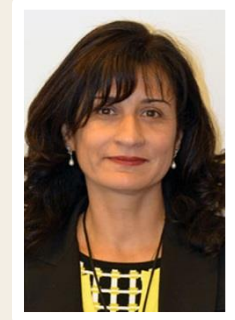
"To care for our community together we need to consider equally the physical, emotional, social, economic and spiritual needs of every person. As health professionals we can walk alongside the person and help them achieve their goals, and improve their wellbeing."

Julia Capper
Acting Director, SESLHD Allied Health
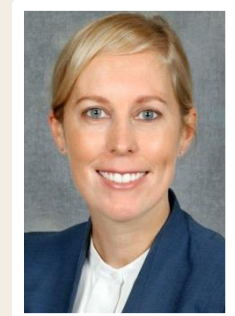
"We need to recognise that primary and preventive care are an important part of healthcare that may not be provided elsewhere, so we need to bridge the gap."

Dr Jeffrey Post
Senior Specialist, Department of Infectious Diseases and The Albion Centre
Director of Physician Education, Prince of Wales Hospital
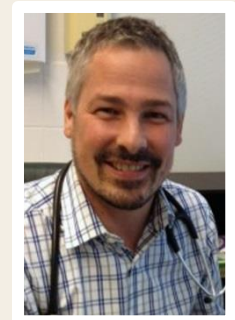
▶ Strategic Direction 1: Transform our health services to systematically improve equity

The *SESLHD Road Map to Excellence 2014-2017[6]* articulates the Triple Aim framework, an approach to optimising health system performance that considers (1) the health of our population, (2) their experience of care and (3) the per capita cost to provide it[46]. Equity of access and outcomes are integral to this. We must ask:

- Do services reach and meet the needs of those who need them the most?
- Do we act on the social determinants of health that affect the health and wellbeing of our service users, their families and carers?
- How are service users, families, carers and the community being engaged to be more involved in and in control of their health care?
- What information do services collect to monitor and respond to this?

This collective set of actions to reshape our health services will reflect in particular the organisational development and commitment foundations described later in this Strategy. These include the values and attitudes of our workforce, such as seeing service users as equal partners in the planning, design and delivery of services. Our services must be accessible and address the unique needs of our disadvantaged population groups. We will interrogate data to identify unwarranted variations in healthcare and outcomes between population groups such as increased medical errors, longer length of stay, avoidable hospitalisations and readmissions as well as over and underutilisation of procedures. And we will partner with other organisations, communities and volunteers to identify ways to improve health and wellbeing outcomes for those that need it the most.

Concepts such as co-production and community engagement (see OUR APPROACH from page 28) are equally important here, and are integral to understanding disadvantage and the context of the individual service user. By recognising and leveraging community assets, frontline service providers can develop solutions better tailored to service user need, increasing their impact. Service users and communities experience improved service outcomes and become partners in the delivery of their own care, building their capacity and resilience for the future. And ultimately this is more effective care, immediately and preventatively[47].

Priorities for investment

1.1   **Support services to routinely recognise, understand and better address inequities, including a greater focus on the influence of social determinants.**

1.2   **Identify and address unwarranted clinical variations amongst population cohorts.**

1.3   **Empower service users to be equal partners in care and increase the focus on and effectiveness of self-care.**

1.4   **Identify and develop strategies to better identify and support people with specific needs, such as (but not limited to) social isolation, trauma history, cultural needs, the different needs of younger and older people, and socioeconomic disadvantage.**

1.5   **Invest in digital information and communication technologies that can increase access to services and programs in innovative ways.**

What does this look like?

We need to ask ourselves:

What people do we see?
- Are certain groups overrepresented?
- Who doesn't turn up to appointments?
- Who doesn't access our services at all?
- Why not?

Does everyone benefit from care equitably?
- How do you know that for sure?
- KPIs by disadvantaged group, deep data dives

Do we understand their disadvantage?
- What do we know, what do we ask?
- How does this impact on their behaviour and health?

And we need to ask our service users:
"What matters to you?"
Not just "What is the matter?"

What are some examples of practical actions that clinical teams can apply?

- Provide rapid pathways and access to vulnerable groups
- Identify social and mental wellbeing needs as well as physical
- Identify population cohorts such as those living with heart disease and examine if there is variation in access and outcomes
- Ask if patients are Aboriginal
- Send text message reminders of appointment bookings
- Structured follow-up: ringing and rebook as soon as possible
- Setting aside an emergency slot each day for people who are in a crisis who need see us quickly (which reduces the burden on the emergency department)
- Use of interpreters and bilingual staff
- Outreach services +/- provision of transport
- Flexible clinic opening times
- Patient advocacy for housing , welfare and medical services
- Gender-sensitive care, especially for women
- Case management and home visiting
- Integration across health and non-health providers
- Culturally-sensitive care models
- Cultural competency training of staff
- Trauma-informed care, which is a strengths-based framework grounded in an understanding of and responsiveness to the impact of trauma, creating opportunities for survivors to rebuild a sense of control and empowerment[48]

▶ **Strategic Direction 2: Invest to provide more care in the community and more prevention and wellness programs**

- How can we routinely integrate preventive care into clinical practice, and actively seek to close health gaps?
- What investments must we make in prevention and wellness programs?
- How can we engage communities more effectively recognise and build upon their assets, identify what matters most to them, and co-create solutions with them?

Partnerships beyond the Local Health District structure are also important in this scope. For example, primary care services are often the first point of contact with the health system. Our partnerships with primary health providers and organisations must be strengthened and include a strong focus on addressing inequities, particularly as those who experience disadvantage are often the least likely to seek out early intervention and preventive care, thus compounding their disadvantage in the long term[49].

"There is now a strong consensus on the need for an expanded primary care role and general practice in particular. This is at the heart of any vision we have for shifting the balance of care, particularly the management of long-term conditions and the growing burden of disease in our population and promoting prevention, early detection and early intervention. It is a prerequisite to tackling the challenges facing unscheduled care, preventable disease burden and dealing with inequalities of health care delivery."

SESLHD Road Map to the Delivery of Excellence 2014-2017[6]

Greater investments in the early years of life are particularly important. We know that a good start in life is strongly associated with long-term benefits, not only in physical health but mental and emotional wellbeing. This must begin with pregnancy planning, maternal and antenatal health care and extend through infancy and childhood[49]. Yet these community, prevention and wellness programs are frequently under-utilised by the most disadvantaged people in our communities.

It will be particularly important in the context of this broad Strategic Direction to avoid fragmentation and take a targeted, localised and integrated approach to the delivery of services and programs. This will ensure that they are better targeted and tailored to specific local needs[50].

Priorities for investment

2.1   Make greater investments in the early years of life.

2.2   Build strong key partnerships such as those with primary care services.

2.3   Take a targeted, localised and, where appropriate integrated approach to the delivery of community based services, prevention and wellness programs.

2.4   Tackle risk factors such as obesity to help people remain in good health, with a focus on social and environmental determinants.

2.5   Invest in strategies to improve the health of individuals with long-term conditions, particularly frail/older people.

HepCheck 123

People subject to homelessness have higher rates of hepatitis C than the general population. Despite numerous specialist health, homelessness and community-based services working across Inner City Sydney, there are a number of issues that impact on the provision of hepatitis related health care to this vulnerable population. In response to this, HepCheck 123 is a program coordinated by the HARP (HIV and Related Programs) Unit that:

- Provides a simple hepatitis health road map for clients engaged with the program.
- Delivers specialist hepatitis clinical assessment in homelessness settings.
- Facilitates the client journey from primary prevention to specialist treatment, depending on need.
- Is implementing a workforce development program to build the capacity of homeless sector staff to engage and support clients in addressing their hepatitis health needs.
- Has established a dedicated website to facilitate cross sector communication, training and other educational resources, and securely host service information.
- Implements cross sector health promotion activities, including program branding and social marketing.

Malabar Community Midwifery Link Service

In partnership with local communities the Malabar Community Midwifery Link Service (MCMLS) provides culturally appropriate, community based, integrated maternity and child and family health service for women who give birth at the Royal Hospital for Women (RHW). The care of Aboriginal families is a priority area for the MCMLS and follows a continuum, starting in early pregnancy through to early childhood.

The MCMLS operates in partnership with the Sydney Children's Hospital Network Randwick and includes a Clinical Midwife Consultant, four Clinical Midwife Specialists, an Aboriginal Health Education Officer (AHEO), a Social Worker, a Child and Family Health Nurse (CFHN), a Community Paediatric Advanced Trainee, and a Speech Pathologist. The CFHN, Community Paediatric Advanced Trainee and Speech Pathologist and link closely with the RHW midwives, AHEO and Social Worker.

Our goal is that each pregnant woman, with the support of an Aboriginal Health Worker, establishes a trusting relationship with the team to receive individualised continuity of care throughout the woman's pregnancy, labour, birth and the early weeks following birth, and to support a seamless and smooth transition into child and family health services. The midwives provide a 24 hour on call service for the labour and birth. The focus is on flexible and accessible service delivery through the hospitals, home visits, outreach clinics with rapid access to the full range of tertiary services as required. The service also provides proactive preventive care, such as encouraging families to become smoke-free through the "Quit for New Life" program.

▶ **Strategic Direction 3: Refocus our work to better address the social determinants of health and wellbeing**

Communities (geographic or demographic) are a major setting for action to address the social determinants of health. Community strength and capacity are essential, and resilience is a key factor in how people respond to adversity. Actions could include[1, 49, 51, 52]:

- Identify specific populations or communities to work with (see OUR FOCUS starting on page 13 for potential people and places).
- Engage them fully and from the very beginning.
- Undertake a comprehensive needs assessment and mapping of community assets that includes strong community input.
- Develop a suite of localised actions, with a particular focus on social determinants such as employment, education, housing and urban planning to help create environments that support good health. These will require strong inter-sectoral partnerships.
- Recognise that many of these actions will take significant time.

This also reflects the commitment to engagement described earlier in OUR APPROACH (from page 28). Key features of this include[47]:

- Building community resilience and community capacity. This is necessary for effectiveness, but is also an outcome in itself.
- Building strong networks across communities and the many organisations that work within them.
- Taking an asset-based approach that nurtures the strengths and resources of service users, families, carers and communities.

Although work in community settings is a key focus here, **clinicians** also play an important role in identifying how and where the determinants of health impact upon the health and wellbeing of service users. Recognising the importance of factors such as loneliness and social isolation, psychological stressors and anxiety, and financial insecurity are essential clinical considerations. This can also then be fed into planning for prevention strategies at the community level.

Ensuring that equity of care is a component of the quality improvement cycle can also improve their immediate clinical care. We can identify the assets of service users – their positive abilities and strengths – to identify and provide solutions which promote their self-esteem and efficacy for better health outcomes and less reliance on acute services.

Priorities for investment

3.1 Engage communities to identify and co-produce more local actions that build community capacity and resilience.

3.2 Build environments that enable safe, active and socially inclusive lifestyles for good population health and wellbeing.

3.3 Build stronger intersectoral working partnerships. The scope of this undertaking is more than we can achieve alone.

3.4 Embed the principles of addressing social determinants throughout our entire organisation, not only in broad community programs but also in routine clinical practice. "What matters to you?" needs to be as important as "What is the matter with you?"

Working with La Perouse Panthers Knockout Committee

Establishing strong partnerships is certainly not a new concept for the District. By building on existing partnerships and drawing upon the local successes to inspire further collaborations across the system is key to improving health outcomes for all.

"We are using the knockout, which is a huge part of our community, as an avenue to build relationships with service providers and external organizations like the HARP unit."

Corrine from Community Organisations and member of the knockout committee

"The HARP Unit has been great…it's helped us a lot. We've helped them and they've helped us explain and make the community aware of what is happening with HIV and safe sex and just make them aware of where they are today. But now (with) the younger lot coming through, the world has changed and I think the HARP unit along with us can move on and explain it to these younger people in our community."

Donny Houghton, Caretaker of Yarra Oval for La Perouse Football Club

A new local investment: Connecting Communities for health and wellbeing

The new Connecting Communities initiative in the Rockdale area is an exciting move towards community-driven projects with long-term thinking to address social determinants. The Rockdale City Council has signed on to be a key partner in this intersectoral collaboration. The aims of this partnership are:

1. To fund local projects/activities identified by community groups/organisations that address the needs of and positively influence individual and community health and wellbeing.
2. To contribute to tackling health inequalities and promoting equity between population groups by targeting resources where they are most needed; focusing on early interventions; and adopting strength/asset based approaches.
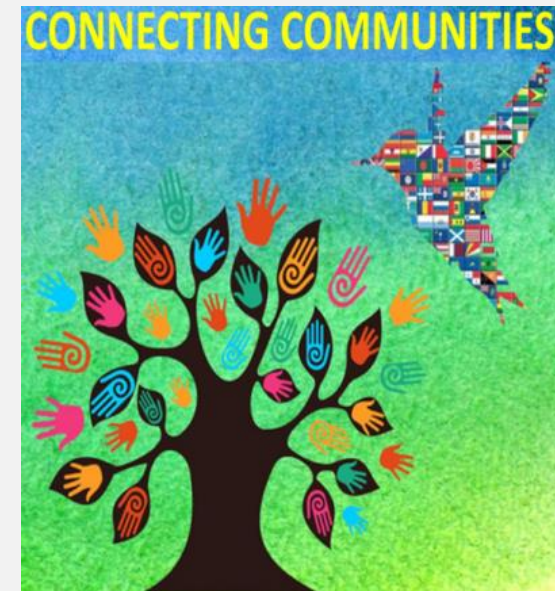
"I cannot express how happy I am that there is a service like this. With the issues that I have relating to my mental health, I wouldn't have been able to have made it this far without your help. I can't remember the last time I have smiled, and when I came in I was in so much pain ‑ mate, I was so sore ... but now I can go and get the plate and I'm going to be smiling all over the place. Thank you so much. I am so grateful."

David Thorpe
Patient of the SESLHD Oral Special Needs Dental Service based at Mission Australia

"I took Lachlan to hospital and we weren't even asked "Are you Aboriginal?" I want to be asked. My son needed an operation and I would have liked help from an Aboriginal worker to help me understand the procedure and how I can explain it to my boy. It was a sensitive time and I wanted support, I'm on my own and it would have meant a lot to have someone Aboriginal there with me."

Nicole, mother of 2 year old Lachlan
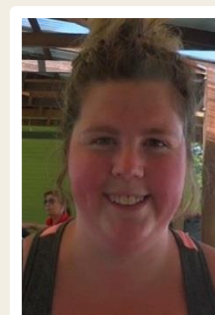
From the Framework: Our Approach

We will engage people and communities as equal partners in addressing health inequities

Engaging people and communities is a common principle across the health sector. But are we really doing it well enough? We need to move beyond providing services and programs *to* or even *for* service users and communities – we must genuinely work *with* them (see right, adapted from[47]). This is relevant in every individual clinical interaction through to large, community-based strategies and programs.

We know that this approach is important to address inequities, and this lies at the heart of the commitment made in this Strategy[53-55]. We are committed to the concept of **co-production**, which refers to a shift in the power dynamic between service provider and consumer. Co-production places equal value on professional training and lived experience[47]. To that end, the **asset-based approach** directly seeks out, acknowledges and draws upon the assets that individuals and communities can bring to these endeavours[56]. This isn't just about addressing needs. It is about recognising and building upon the assets of individuals and communities, such as their lived experiences, skills and social networks.

In action, this means that we will:

- Transform the way we plan and manage our health system to better involve service users and communities in the design and delivery of all health services.
- Build stronger networks across communities and the many organisations that work within them.
- Conduct more meaningful community consultation, become better at listening and truly hearing what is said, and directly act upon what service users and communities tell us.
- Embed these principles across our entire health system, from individual clinical interactions to larger community-based programs and services.
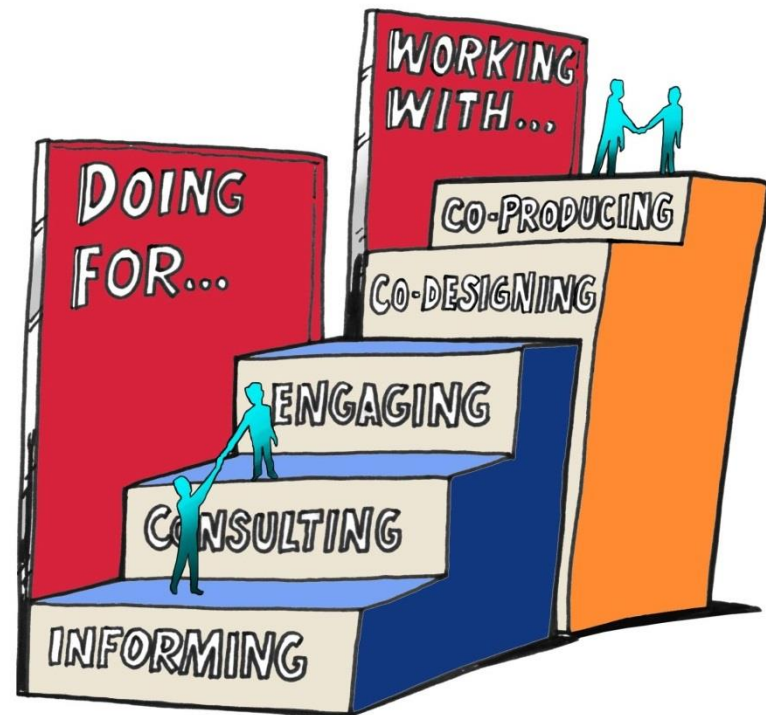
From the Framework: Our Approach

We will take a population health system approach, balancing short- and long-term goals

Populations — Unit of intervention — Individuals

Integrated care models
Co-ordination of care services for defined groups of people (eg older people and those with complex needs)

Population health systems
Improving health outcomes across whole populations, including the distribution of health outcomes

Improving population health requires multiple interventions across **systems**

Individual care management
Care for patients presenting with illness or for those at high risk of requiring care services

Making every contact count
Active health promotion when individuals come into contact with health and care services

Focus of intervention
Care services — Health improvement

Our approach requires coordinated multiple interventions across systems. Our recently-published *SESLHD Integrated Care Strategy 2015* describes important goals for our District: to create an agile, joined up system, based on patient-centred care, and a health intelligence structure to enable targeted action through delivery of innovative proactive models of care[57].

This *SESLHD Equity Strategy* aligns and builds upon this in important ways. Integrated care is part of a broader shift away from fragmentation of individual care towards *population health systems* – health systems that take a more coordinated approach to improving the health and wellbeing of whole populations[58]. Ultimately, this requires **multiple interventions across systems** (see left)[58]. It also requires a balance between short- and long-term goals, with recognition that the substantial pay-off from many (but not all) population health interventions but may take longer to achieve.

What might this look like? A recent example from within SESLHD was investigation of diabetes, where people with diabetes or likely to develop it are seen as the "population" in the context of the diagram above. A **deep data dive** was undertaken to better understand the current diabetes landscape, variations across the District and opportunities for improvement. Diabetes prevalence, type, management, health service utilisation, health outcomes, projections and population groups were analysed. Geographic variations pinpointed those areas in greatest need (Botany Bay and Rockdale). Through this process, the District can develop a targeted approach and tailor services to the identified population groups. Multiple interventions across systems are now underway.

From the Framework: Our Approach

We will be an innovative, learning organisation.

SESLHD is strongly committed to evidence-based best practice. We will make responsible decisions and be accountable for our use of public health funds.

Yet evidence can only take us so far. There are gaps in what we understand, gaps in what we know works – and far too often those gaps relate to the people who experience the most significant inequities. Many of our evidence-based services and programs have consistently left the most vulnerable in our communities behind. To truly improve equity in health and wellbeing, we must build on the evidence by being more innovative.

We will ask:

- **What are we trying to accomplish?**
- **How will we know that a change is an improvement?**
- **What change can we make that will result in an improvement?**

We will build cultural change to foster innovation

- A culture where staff feel comfortable asking, raising concerns, giving and receiving feedback and being innovative.
- Working towards collaboration. Asking 'What else?', 'Tell me more?'
- Accountability
- Strong teamwork and communication

We will introduce more learning elements into our organisation

- Transparency
- Learning from errors and through debriefing. Regular feedback to staff.
- Evaluation and measurement (including the figure shown at right).

Acknowledgement: Adapted from the Institute for Healthcare Improvement

Make further changes or adjustments and monitor

Assess the problem, analyse the causes and decide a course of action

Act | Plan

Study | Do

Measure the impact

Make changes that address the causes
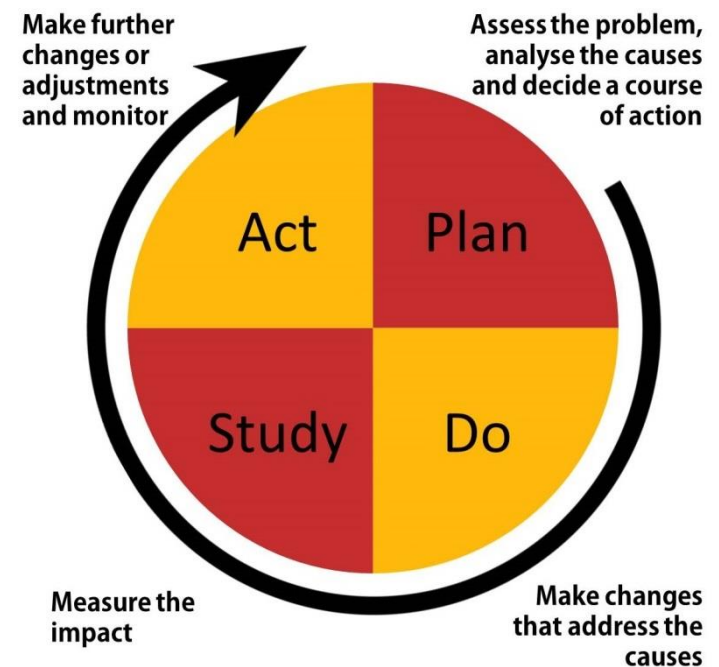
"Across the District, we must use a population-level lens to plan our services and programs. At the local community level, we must engage with communities and other service providers to identify needs, assets and strengths at the individual, family and community level. And across all our services our programs, we must deliver interventions that are tailored, proactive, flexible and person-centred."

Danielle McHugh
SESLHD Equity Coordinator
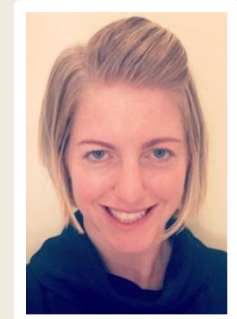
"We conducted a study with the Chinese population and found that only one-quarter of patients were aware of the free interpreter service, and that these non-English speaking patients felt obliged to use their family for language assistance when visiting medical staff and while in hospital. Nursing staff have a key role in acting as patient advocates. In acting as patient advocates nurses can ensure that patients who do not speak English well have the opportunity to access an interpreter to receive timely and accurate information and education. "

Janine Bothe
Clinical Nurse Consultant- Surgery, St George Hospital
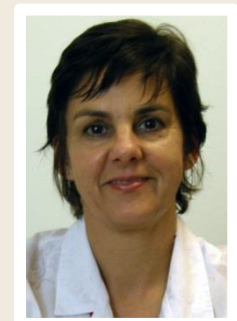
From the Framework: Our Foundations

Organisational Development

The "foundations" within our Equity Strategy Framework refer to things that are essential to building the capacity of our District to better understand, recognise and respond to inequities. These are necessary to the achievement of this Strategy, and begin with organisational change, including a strong focus on our building the capacity of our workforce (including our volunteers) to better recognise, understand and respond to inequities.

What can we do as an organisation to improve our culture, systems and workforce to better achieve the vision of this Strategy?

Broad reaching and sustainable cultural and organisational change will build a better foundation for implementation of this Strategy. This will require ongoing attention. Elements to be considered include:

- *Organisational Capability* now and in the future, people, technology, knowledge, partnerships etc.
- *Organisational Alignment* between our purpose, values, vision, strategies, systems and processes.
- *Organisational Health* including good communication, decisions taken at right level and organisational resilience.
- *Organisational Change* being adapted to the external environment, internal ownership of change etc.
- *Organisational Learning* with a focus on innovation, experimentation, sense making etc.

What we will do

"Capacity building" concepts can be vague, and can easily dissolve into soft strategies with little long-term benefit. To avoid this, we will identify concrete actions grounded in evidence-based frameworks[eg 59] to achieve sustainable organisational change.

This includes strategies related to our structure and systems:

- Including equity objectives, values and actions in organisational policies, procedures and quality systems.
- Allocating specific resources to equity actions, and equity criteria in funding allocation.
- Recognising and rewarding equity best practice.

And strategies related to people and partnerships:

- Workforce development strategies such as integration of equity concepts into mandatory training, job descriptions and performance management.
- A stronger focus on equity issues such as cultural competence.
- Strong leadership across the organisation, from visible executive leadership (see also next section) to champions within services, and ensuring that those people are supported.
- Effective and sustainable partnerships with the community and other organisations.
- Communication looking both inside and outside our organisation for better information-sharing and shared problem-solving.

Commitment

Many of the actions described in this Strategy will be challenging to deliver. With the many urgent pressures upon the public health system, some might argue that resources should be directed to hospital waiting times rather than the social determinants of health. But we would argue that the two are inextricably linked, and that improved equity will have benefits across the whole health system in the long term.

But while there will be some short-term achievements, the likely timeframe for many desired changes will also lie beyond the scope of a single plan or election cycle. Our resources and attention must be diligently directed to "important" issues, not just the "urgent" ones.

It also essential to commit to actions to improve equity across the whole spectrum of determinants. This is relevant in every setting, from emergency departments to population health services. All of this will require a clear commitment from every part of our health service.

"We will be bold in our ambitions for the community we serve. We will engage with our communities and measure what matters to them. We will see our patients and communities as assets and as partners in developing resilient, healthy communities."

Gerry Marr
Chief Executive, SESLHD

What we will do

Commitment is part of the organisational development described on the previous page, but it extends beyond the relatively introspective nature of that. We also require a strong, public declaration.

- The SESLHD Board and district's peak committees will make clear and public statements of commitment, and ongoing reference to equity in public comments, media releases and other communication to the communities that we serve.
- The Board and Executive Team will ensure that all Key Performance Indicators at the District and individual service/program level reflect our equity goal.

This will be further echoed internally:

- All service planners, practitioners and managers across the organisation will use this Strategy and supporting documents to provide an equity lens and complete an Equity Impact Assessment on their draft plans.
- All clinical streams and committees will focus on relevant priorities, actions and indicators of equity.
- We will conduct and report sub-group analyses of Service Agreement KPIs to ensure that services are delivered equitably.
- Healthcare facilities and directorates will include equity considerations in their structures, committees, individual job descriptions and performance management processes.

From the Framework: Our Foundations

Intelligence to guide decisions and actions

Understanding the issues is key to planning effective action. The Directorate of Planning, Population Health and Equity (PPHE) will take a lead role in supporting this important foundation of action. There are two key aspects to this:

1. Collecting the appropriate data
2. Analysing and disseminating that intelligence.

The District will build a health intelligence system that identifies our most disadvantaged individuals and communities, assesses the health gradient across different levels of disadvantage, and, as far as possible, points to actions required to address inequities. Data systems must also be improved to capture and accurately record data relevant to vulnerable and disadvantaged groups, such as Aboriginality, county of birth and language spoken, use of interpreters, refugee status and homelessness.

The PPHE and Business Intelligence and Efficiency Unit will interrogate data and make results available to District services, teams and community partners to assist the targeting, development, delivery and evaluation of locally-relevant action. We will share intelligence with our partners, such as St Vincent's and Sydney Children's Hospitals, the local Primary Health Network, Aboriginal Community-Controlled Health Organisations, non-government organisations, government agencies and interagency groups.

What we will do

Improvements to data collection will explore:

- The availability of data (ie what is collected).
- The quality of these data and how readily they can be accessed and used by services to inform service design and delivery.

Analyses will include:

- Community asset mapping
- A `HotPop&Spot' series ("deep data dive"/"needs assessment") focussing on the needs/gaps and assets/strengths of our vulnerable and marginalised people (`HotPop') and places (`HotSpot').

Planning strategies will incorporate this through:

- Equity Focussed Health Impact Assessments (EFHIA), particularly `Rapid EFHIA', as a means of enhancing consideration of health equity in the development of our policies, programs and services.
- Development of key equity indicators (including access and outcomes) for routine reporting at all levels of the organisation.

Our workforce will be supported through:

- Workforce development opportunities to build staff capacity to interrogate and interpret relevant data.

From the Framework: Our Foundations

🛠 Tools to support best practice

Equity is a major national and international issue, and there are already many resources already available to support best practice. Additional localised resources will be developed as necessary to meet our needs. These will be disseminated via a dedicated intranet site.

Samples of key resources to be made available include:

Reducing inequities experienced by a range of disadvantaged groups
- Social determinants approaches to public health: from concept to practice (WHO)
- Equity, social determinants and public health programmes (WHO)
- Community builders NSW (NSW Government)
- The Social Determinants of Health Alliance

Reducing inequities experienced by Aboriginal people
- What works? A review of actions addressing the social and economic determinants of Indigenous health (Closing the Gap)
- The health of Aboriginal people of NSW: Report of the Chief Health Officer 2012

Reducing inequities experienced by people with mental illness
- Equity, social determinants and public health programmes. Chapter 7: Mental disorders – equity and social determinants (WHO)
- Living Well: Putting people at the centre of mental health reform in NSW (NSW Mental Health Commission)

Reducing inequities experienced by people from culturally and linguistically diverse backgrounds
- NSW Health Policy and Implementation Plan for Healthy Culturally Diverse Communities 2012-2016 (NSW Ministry of Health)
- Inquiry into the responsiveness of Australian Government services to Australia's culturally and linguistically diverse population (Australian Human Rights Commission)

What we will do

We will identify and/or develop and disseminate:

- Evidence reviews
- Examples of best practice
- Published literature
- Planning tools
- Health impact assessment tools with an equity lens
- Other tools include patient activation and decision aids to give patients a greater involvement in decision making
- Education and training opportunities
- Current initiatives from within SESLHD, to foster better understanding of what others are doing and opportunities for collaboration and shared learning
- Case studies, both from within SESLHD and beyond in the state, national and international context.

We will also:

- Work closely with inter-agencies such as Family and Community Services (FACS), Department of Justice, Police, Education, local businesses, not-for-profit agencies and other sectors in collaborative efforts to enhance the social determinants of health
- Support the coproduction and design of initiatives that improve access and patient journeys for vulnerable communities.

HOW WE WILL DELIVER THIS STRATEGY

Governance

The Directorate of Planning, Population Health and Equity will oversee implementation of this Strategy on behalf of the District Executive Committee. The SESLHD Equity Coordinator will be responsible for providing leadership and coordinated support and implementing equity action to achieve the District's aim of improving access and outcomes for vulnerable communities, and reducing health inequalities.

In consultation with Directorates, committees and services across the District, a governance structure will be created to drive the delivery of this Strategy. This will most likely include a **Leadership Group** of champions from across the organisation, key partners and representatives of service users and communities. Governance will also link appropriately to lead committees and collaborative structures across our District, including (but not limited to):

- SESLHD Board and Board Committees
- SESLHD Community Partnerships Committee
- SESLHD Community and Consumer Council
- SESLHD Clinical and Quality Council and healthcare facility and mental health community advisory committees
- SESLHD District Executive Team
- SESLHD Multicultural Health Advisory Committee

Partnerships

As already described, the scope of this Strategy goes beyond the health sector. To effectively address and influence social determinants of health, strong and lasting partnerships will be essential. This will include, but not be limited to:

- Service System Group (multi-agency partnership group)
- Communities
- Workplaces
- Education sector
- Government – relevant federal and state agencies, and local governments across the District
- Neighbouring local health districts
- Media
- Non-government organisations, including social welfare
- Patient, carer, consumer and community groups
- Primary health care groups and providers
- Private businesses
- Professional associations
- Transport sectors
- Universities and research organisations

Linkages to key documents

This *SESLHD Equity Strategy* will be implemented in close alignment with other key plans and documents.

Delivery Plan

A delivery plan will be developed to highlight key actions and investments for the District. This will not be an exhaustive process, as it is our intention to maximise our investments in direct actions. A consultation process across the District will be undertaken to collect and then collate key actions into the plan. This will be made available across the District to encourage partnerships and action alignment where appropriate.

HOW WE WILL MEASURE OUR PROGRESS

This Strategy is ambitious and has a long-term goal. Inequities are complex, with many different measures of health and wellbeing to consider across many different (and overlapping) populations and places across our District. Whilst the evaluation will therefore be equally complex, the headline indicators of our goal will be as follows.

Our goal

Reduce inequities in health and wellbeing within a generation.

Headline indicators of progress

Reduce inequities between the most and least advantaged PEOPLE and PLACES in our communities:

- Reduce the gaps in avoidable death rates and avoidable hospitalisation rates between disadvantaged groups and the rest of the South Eastern Sydney population
- "Level out" the gradient in avoidable death rates and avoidable hospitalisation rates across the social hierarchy, including between geographic areas within South Eastern Sydney

People: that is disadvantaged, marginalised or vulnerable people, compared to the rest of the population, eg Aboriginal people, people that are homeless, refugees, people that experience moderate or severe mental illness

Places: that is locations where people live (and learn, earn and play) eg statistical local areas of residence

Key themes will include:

Co-produced outcomes
This means services should enable service users and other stakeholders to identify desirable outcomes to be planned for, and collaborate with them and others to achieve those outcomes.

Diverse outcomes
Combining a core of quantifiable and comparable outcomes with others that cannot be aggregated; accepting as legitimate a wider 'narrative' for value than, for example, clinical effectiveness or meeting service targets and objectives. Clinical and personal health outcomes may also need defining more holistically through focusing on the outcomes for the person rather than, or in addition to, the success of a treatment or intervention.

Impact from people, communities and services
Leading to an approach that emphasises overall 'impacts' achieved by people, communities and services combined.

Longer-term and person-centred impact
More driven by what is important to the person – for example, wellbeing, independence, social capital, feeling confident and supported to manage their life, health and care.

We will consult with others to develop methods and measures to further evaluate this Strategy. This will include experts from across our District teams. We will also seek advice from associated universities and our human services colleagues and partners. And we will seek input from the community, with whom we will work in equal partnership to deliver this Strategy.

As noted earlier:

"We will engage with our communities and measure what matters to them."

Gerry Marr
Chief Executive, SESLHD

Some outcomes may be apparent in the short-term, such as demonstrable improvements in access to services. Others may take many years, such as outcomes from investments in the early years of life.

Notwithstanding the consultation required to develop this further, some of the key concepts we will consider throughout this process include the following.

Strategic Direction 1: Transform our health services to systematically improve equity

Factors that will be considered in the evaluation will include (but will not be limited to):

- Evidence that our health services systematically look at the whole person: their physical, social and emotional wellbeing.
- Evidence that we recognise the complex overlap and convergence between different aspects of disadvantage, and deliver flexible and tailored care to address this, including consideration of service access, transport, access to interpreters and trauma-informed care.
- Exploring clinical variations for population cohorts of people who experience disadvantage (eg Aboriginal people, people with mental illness, people from low socio-economic backgrounds) with consideration of such measures as:
  - Avoidable mortality rates
  - Proportions accessing care on time – eg surgery, emergency
  - Uptake or utilisation rates for specific interventions, programs and services – eg coronary revascularisation procedures, cataract surgery, mobile health
  - Proportions rating care as good or very good
  - Patient activation, outcomes and experience measures
  - Lengths of stay, readmission rates, emergency department presentations
- Collecting qualitative feedback from patients, carers and staff regarding the patient experience.
- Evidence of co-production of our health services, including use of clinical tools to assess shared decision making (eg *collaborRATE*[60]).

Strategic Direction 2: Invest to provide more care in the community and more prevention and wellness programs

Factors that will be considered in the evaluation will include (but will not be limited to):

- Further exploration of variations for population cohorts of people who experience disadvantage, such as:
    - Aboriginal people
    - People with mental illness
    - People from low socio-economic backgrounds)
- … with consideration of measures relevant to community, prevention and wellness programs and services, such as:
    - Measures of health literacy
    - Prevalence of and hospitalisations attributable to smoking, alcohol, obesity
    - Notifications of sexually transmissible and blood borne virus infections
    - Proportions accessing prevention and care on time – eg antenatal care, immunisation
    - Uptake and utilisation rates for specific interventions, programs or services (eg diabetes screening, health coaching)
- Demonstrable equity of access to care in the community and prevention and wellness programs.
- Evidence of co-production of our community, prevention and wellness services and programs.

Strategic Direction 3: Refocus our work to better address the social determinants of health and wellbeing

Factors that will be considered in the evaluation will include "health assets" (eg as described by the Public Health Wales Observatory[61]) that include but are not limited to:

- People: health, education, financial well-being, resilience, knowledge, self-efficacy.
- Community: services, family cohesion, neighbourhood satisfaction
- Structure: employment, open environment, built environment, transport, personal security and safety.

On a practical level, these could include measures related to:

- Community strengths: people feeling safe walking alone after dark, providing support to relatives, able to get support in crisis.
- Participation: education and training, employment, volunteering.
- Vulnerabilities: Developmentally vulnerable children, adults reporting high psychological distress, families experiencing housing (rent or mortgage) stress, food insecurity, crime and violence.

We recognise that the scope of this is large and that we cannot undertake comprehensive evaluation methods to measure all of these things. However we can look for opportunities to consider these issues within the scope of our existing and planned work, collect targeted data when feasible, as well as seeking opportunities to access data from partners, other organisations and academic institutions that can provide insight to these issues.

Evaluating our partnerships across all these actions

In alignment with the *SESLHD Community Partnerships Strategy*, we will seek to demonstrate evidence of effective engagement of the community, including patients, their families and carers ("consumers" or people that use or could use our services), volunteers, individual community members and those from other organisations that represent or serve them. This will include evidence that:

- People were engaged and did participate in the process, particularly those that are not typically reached well by our traditional planning and consultation processes, and ensuring that people from different backgrounds are involved, including vulnerable and marginalised populations in particular.
- We improved our understanding of and attention to their input.
- Real influence and change occurred as a result of community participation and partnerships, including:
  - Evidence of co-production in terms of practical examples of community-driven changes to policy, service design and delivery.
  - Feedback from communities regarding process and outcomes.
  - Evidence that that vulnerable and marginalised populations in particular have been heard.
  - Feedback from staff regarding processes and outcomes.

The SESLHD Community Partnerships Strategy

Effective and enduring community partnerships are crucial for our District to achieve an effective and sustainable health system for the future. We should not and cannot design and deliver our health services without them. Across our entire organisation, community partnerships are those that we forge with patients, their families and carers, volunteers, community members and other organisations that represent or serve them.

The SESLHD Community Partnerships Strategy was developed to ensure that people are engaged and do participate, that they are listened to and heard, and that there will be real influence and change as a result. Through this, we aspire to see improvements in the empowerment and resilience of the communities that we serve, and their increased satisfaction with the services that we provide.

As there are strong parallels with this Equity Strategy, notably the focus on community engagement, co-production and equity, we will ensure that the planning, delivery and evaluation of both is carefully coordinated.

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APPENDICES

Appendix A: The consultation process

Extensive consultation was undertaken to develop this Strategy, including discussions with our SESLHD staff, patients, their families and carers ("consumers" or people that use or could use our services), volunteers, individual community members and representatives of other organisations across our District. The consultation process included presentations to committees and teams, face-to-face forums and workshops as well as opportunities to submit individual feedback (anonymous if desired) through online survey tools (Survey Monkey).

An Aboriginal Health Impact Statement was completed (see Appendix B).

The endorsement process included submissions to the SESLHD Clinical and Quality Council, SESLHD District Executive Team and the SESLHD Board.

Appendix B: Aboriginal Health Impact Statement

Aboriginal Health Impact Statement Declaration

Introduction

This Aboriginal Health Impact Statement has been produced to accompany the SESLHD Equity Strategy. This Impact Statement is based on the NSW Aboriginal Health Impact Statement and Guidelines and aims to document the health needs and interests of Aboriginal people have been imbedded into the development, implementation and evaluation of the Plan.

Declaration

Title of Initiative   The SESLHD Equity Strategy

☑   The health needs and interests of Aboriginal people have been considered and appropriately addressed in the development of this initiative.

☑   Appropriate engagement and collaboration with Aboriginal people has occurred in the development and implementation of this initiative

☐   Complete checklist is attached.

Name of Manager: Gail Daylight
Title: Manager
Unit Name: Aboriginal Health
Local Health District: South Eastern Sydney

Signature: _Daylight_____   Date: 24/11/2015

Aboriginal Health Impact Statement Checklist

DEVELOPMENT OF THE POLICY, PROGRAM OR STRATEGY

1. Has there been appropriate representation of Aboriginal stakeholders in the development of the policy, program or strategy?	**Yes**

At both the service and management levels.

2. Have Aboriginal stakeholders been involved from the early stages of policy, program or strategy development? Please provide a brief description	**Yes**

Discussions were held with SESLHD's Manager, Aboriginal Health at the commencement of the consultation period to identify key issues for Aboriginal and Torres Strait Islander people in relation to the Equity Strategy. It is intended that ongoing advice will be sought through the subsequent delivery planning process from the Manager as required. Numerous statistics and information have been included in the plan regarding current outcomes, issues and critical needs of the Aboriginal population with respect to reducing inequities.

3. Have consultation/negotiation processes occurred with Aboriginal stakeholders?	**Yes**

4. Have these processes been effective? Explain	**Yes**

There has been ongoing dialogue between the Aboriginal health unit and the Department of Planning, Population Health and Equity regarding the needs of Aboriginal and/or Torres Strait Islander people. This dialogue has been very valuable and led to community consultations with existing services such as Bulbuwil (Healthy Living) Aboriginal Lifestyle Support Program and the La Perouse Aboriginal Community Health Centre.

5. Have links been made with relevant existing mainstream and/or Aboriginal-specific policies, programs and/or strategies? Explain	**Yes**

Yes. Clear links have been made to *NSW Aboriginal Health Plan 2013-2023*. The Strategy has also been informed by evidence published in *The Health of Aboriginal People of NSW: Report of the Chief Health Officer* (NSW Ministry of Health, 2012) and local statistics where available.

CONTENTS OF THE POLICY, PROGRAM OR STRATEGY

6. Does the policy, program or strategy clearly identify the effects it will have on Aboriginal health outcomes and health services? Comments

Yes

The SESLHD Equity Strategy describes the approach that our whole system will undertake to reduce health inequities across our communities, and Aboriginal peoples are a clear priority for action in that context. The Strategy describes how we will transform our health services to systematically improve equity, invest to provide more care in the community and more prevention and wellness programs, and refocus our work to better address the social determinants of health and wellbeing.

7. Have these effects been adequately addressed in the policy, program or strategy? Explain

Yes

The Strategy includes a focus on engaging patients and communities as equal partners in addressing health inequities (a key concept in self-determination), taking a population health system approach, balancing short- and long-term goals, and being an innovative, learning organisation. This latter point is particularly relevant for Aboriginal peoples. We need to recognise that the way things have been done in the past have not always been effective nor appropriate for Aboriginal peoples, so we must be open to change.

8. Are the identified effects on Aboriginal health outcomes and health services sufficiently different for Aboriginal people (compared to the general population) to warrant the development of a separate policy, program or strategy? Explain

No

It is important that this particular Strategy be for our whole system and our whole population, as it describes a comprehensive and long-term approach. However this does not preclude the future development of more specific corresponding plans for Aboriginal peoples. It has been written in a way that can inform and guide such work, and for example this is already occurring in the development of a new plan for services to be delivered by the Prince of Wales Aboriginal Community Health Team.

IMPLEMENTATION AND EVALUATION OF THE POLICY, PROGRAM OR STRATEGY

9. Will implementation of the policy, program or strategy be supported by an adequate allocation of resources specifically for its Aboriginal health aspects? Describe

Yes

At this point, it is a broad Strategy without specific funding allocations for specific services or program. Once endorsed by the Board, the next step will be the development of a delivery plan to guide implementation. It is at this point that specific resource allocation will be determined, and as Aboriginal peoples are identified as a priority for action, this is the point at which that will occur in consultation with the SESLHD Aboriginal Health Unit and local communities.

10. Will the initiative build the capacity of Aboriginal people/organisations through participation? In what way will capacity be built? *Yes*

This is a strong theme of the Strategy. We will engage people and communities as equal partners in addressing health inequities. The Strategy describes a strong commitment to co-production, which places equal value on professional training of health workers and lived experiences of community members. To that end, the asset based approach is also a key element that directly seeks out, acknowledges and draws upon the assets that individuals and communities can bring to these endeavours.

11. Will the policy, program or strategy be implemented in partnership with Aboriginal stakeholders? Briefly describe the intended implementation process *Yes*

Strategy implementation will be overseen by a Leadership Group of senior champions from across the organisation, key partners and representatives of service users and communities. This will include Aboriginal representation. Further community consultation and engagement is also a key factor of the Strategy.

12. Does an evaluation plan exist for this policy, program or strategy? *No*

13. Has it been developed in conjunction with Aboriginal stakeholders? Briefly describe Aboriginal stakeholder involvement in the evaluation plan *NA*

Evaluation of the Strategy will be complex due to the nature of the work, but is an important component. Details of the evaluation will be developed in the near future. Aboriginal stakeholders will have input to the intent and design of that process.