



Sydney
Local Health District



UNSW
SYDNEY

Equity-focused health impact assessment of the COVID-19 pandemic in Sydney Local Health District

Summary report

Developed by the Health Equity Research and Development Unit 2023

Equity-focused health impact assessment of the COVID-19 pandemic in Sydney Local Health District

Summary report

Developed by the Health Equity Research and Development Unit 2023



Sydney
Local Health District



Acknowledgements

Title: Equity-focused health impact assessment (EFHIA) of the COVID-19 pandemic in Sydney Local Health District (SLHD): Summary Report.

Authors: Fiona Haigh, Esther Alloun, Christopher Standen, Miriam Olliek, Jude Page, Marilyn Wise

Research Team: Fiona Haigh, Esther Alloun, Christopher Standen, Miriam Olliek, Kerryn Drysdale, Jude Page, Marilyn Wise, Jennifer Green, Shoko Saito

About this document:

This document provides a summary of the EFHIA key findings. There is a separate Technical Report (172 pages) and Supplementary Material (120 pages) that describes the methods, data and analysis in detail.

ISBN: 978-0-6455478-1-8

Published: September 2023

Suggested citation:

Haigh F, Alloun E, Standen C, Olliek M, Page J, Wise M. (2023) An equity-focused health impact assessment of the COVID-19 Pandemic in Sydney Local Health District. Technical Report. Sydney, SLHD and UNSW.

About the Health Equity Research and Development Unit (HERDU):

HERDU is a partnership between SLHD and UNSW Sydney. HERDU's mission is to work in partnership with health services, organisations and communities to identify and reduce existing inequities in health and to prevent inequities in health from arising in the future.

HERDU: slhd-herdu@health.nsw.gov.au

Sydney Local Health District acknowledges the Gadigal and Wangal Peoples of the Eora Nation as the traditional owners of the land on which the District is located and works.

The Health Equity Research and Development Unit wish to thank all those who contributed to the equity-focused health impact assessment. Thank you to our community partners for sharing their experiences and insights. Thank you to key stakeholders who have provided us with insights and observations that were essential to the evidence used in the EFHIA.

We would like to acknowledge the contribution of the following expert reviewers to the EFHIA.

Peer expert reviewers of the EFHIA report and process

Elizabeth Harris AM
Adj Associate Professor Centre for Primary Health Care and Equity, University of New South Wales

Sarah Simpson
EquiACT, Adj. Lecturer, Centre for Primary Health Care and Equity, University of New South Wales

Liz Green
Consultant in Public Health, Director Welsh Health Impact Assessment Support Unit

Specialist section reviewers

Amy Rogers
Manager Child Health Information Link, Child and Family Community Health Services, SLHD

Rachel Walker
Acting General Manager, Community Health Services, SLHD

James Everingham
Disability Inclusion and Strategy Manager, SLHD

Walter Towney
Director Performance Reporting and Clinical Services Support, RPA Virtual Hospital, SLHD

Kim Brauer
Carers Program Manager, SLHD

Tamsin McVeigh
Acting Deputy Director, Clinical Governance and Risk Unit, SLHD

Dr Jason Cheng
General Manager Sydney Dental Hospital and Oral Health Services

Kate McBride
Executive Director, Institute of Academic Surgery, SLHD

Barbara Luisi
Director, Diversity Programs and Strategy Hub, Population Health, SLHD

Jessica Crause
Acting Operations Manager, Workforce and Corporate Operations, SLHD

Dr Andrew McDonald
Acting Director, Mental Health Services, SLHD

Joseph Jewitt
Acting General Manager, Concord Repatriation General Hospital, SLHD

Dr Shih-Chi Kao
Director, Priority Populations Program, Population Health, SLHD

Vesna Dragoje
Director, Sydney Health Care Interpreter Service

Julie Finch
Chronic Care Program Manager, SLHD

Miranda Shaw
General Manager, RPA Virtual Hospital

Lisa Parcsi
Director, Integration and Partnerships

Steering Committee

Dr Teresa Anderson
Chief Executive, SLHD

Lou-Anne Blunden
Co-Chair, Executive Director Clinical Services Integration and Population Health

A/Prof Fiona Haigh
Co-Chair, Director HERDU

Kerry-Anne Hartman
SLHD Board Member

Richard Acheson
SLHD Board Member

Dr John Cullen
Clinical Director Aged Care, Rehabilitation and Chronic Care

Dr Andrew McDonald
Director Mental Health Services SLHD

Dr Pam Garrett
Director, Planning, SLHD

George Long
Director, Aboriginal Health, SLHD

Dr Leena Gupta
Director Public Health, SLHD

Renee Moreton
General Manager, Population Health

Dr Jason Cheng
General Manager Sydney Dental Hospital and Oral Health Services

Gregory Nolan
Acting General Manager Balmain Hospital

Judy Pearson
General Manager, Drug Health Services

Miranda Shaw
General Manager, RPA Virtual

Michael Morris
General Manager, Canterbury Hospital

James Everingham
Disability Inclusion and Strategy Manager, SLHD

Barbara Luisi
Director Diversity Programs and Strategy, Population Health, SLHD

Christopher Standen
Health Equity Research and Development Unit

Feroza Yasmin
Consumer Representative

Miriam Olliek
Health Equity Research and Development Unit

Suzanne Baker
Community Participation and Volunteer Manager, Canterbury Hospital

Jude Page
Health Equity Research and Development Unit

Eddie Heng
Graduate Health Management Trainee

Dianna Jagers
General Manager Community Health

Rachel Walker
Acting General Manager Community Health, SLHD

Kiel Harvey
General Manager, Royal Prince Alfred Hospital

Sven Nilsson
Disaster Manager, SLHD

Sydney Local Health District has a long-standing commitment to achieving health equity.

We are immensely proud of the way our staff and our community continue to support our equity-focused COVID-19 response. While the COVID-19 pandemic has affected us all, we have seen that some groups have experienced greater risks to health than others. The pandemic has prompted us to reflect on and adjust to new ways of working and living.

This equity-focused health impact assessment (EFHIA) was conducted by the Health Equity Research Development Unit (HERDU), a Sydney Local Health District service in partnership with the University of New South Wales Centre for Primary Health Care and Equity. HERDU work in partnership with health services, organisations and communities to identify and reduce existing inequities in health and to prevent inequities in health from arising in the future.

HERDU has carried out this EFHIA to support the District's pandemic response. This includes recovery from the COVID-19 pandemic and building resilience to future pandemics, as well as similar emergency situations.

The District has been at the forefront of the state's response to COVID-19, with staff caring for critically ill patients in intensive care and hospital wards, working at testing clinics, surveillance sites and Special Health Accommodation, and building systems, sites and communication to support this important work.



Dr Teresa Anderson AM
Chief Executive
Sydney Local Health District



Hon. John Ajaka
Chair
Sydney Local Health District

Since 2021 our staff have been part of the biggest vaccination campaign in history, giving more than 1.6 million COVID vaccinations in our Vaccination Centres and in our community through our mobile vaccination program.

The COVID-19 pandemic has required us to pivot our existing engagement strategies and work in new ways to not only maintain our connection with our community and our networks, but also to work with our community groups and leaders and their networks to keep people safe from COVID-19. We are very proud of our strong partnerships and collaborations with our communities, together with other human service agencies.

We have begun to harness the strengths and incredible innovations from our COVID-19 response, to introduce new ideas into our organisation, change practice, and make plans for the future. This EFHIA report provides 22 equity-focused recommendations which will support future health equity action within the District and more widely.

We thank all those who contributed to the EFHIA. Thank you to our community partners for sharing your experiences, insights and observations – we are stronger together.

AOR	Adjusted odds ratio
CI	Confidence interval
CALD	Culturally and linguistically diverse
EFHIA	Equity-focused health impact assessment
HERDU	Health Equity Research and Development Unit
HIA	Health impact assessment
IPV	Intimate partner violence
IRSD	Index of Relative Socio-economic Disadvantage
RACF	Residential Aged Care Facilities
SA2	Statistical Area Level 2
SA4	Statistical Area Level 4
SES	Socioeconomic status
SHA	Special Health Accommodation
SLHD	Sydney Local Health District
WFH	Work(ing) from home

Acknowledgements	4
Foreword	6
Abbreviations	7
Introduction	8
Recommendations	9
What we did	10
Focus areas	11
Key findings	14
District response: health equity	15
What worked well	15
What we need to do more of	16
What we could do differently (hindsight for next time)	17
How COVID-19 impacted on health equity	19
What did we learn?	20
Risk and consequences of infection	20
Changes to work	22
Working from home (WFH) and flexible work	22
Economic and employment impacts	22
Essential and frontline workers	22
SLHD staff	26
Changes to health services	28
Recommendations	31

Introduction

The COVID-19 pandemic has had significant impacts on the health and wellbeing of Sydney Local District (SLHD) staff, consumers, communities and patients and their families. As we emerge from COVID-19 we can use the lessons learnt from our experiences to take deliberate action to support health equity within the SLHD and more widely.

The ways in which the COVID-19 pandemic has affected the District community, reflects the broader mechanisms by which health inequities are created and sustained. We saw people living in the more socioeconomically disadvantaged areas of the District were more likely to be infected, hospitalised and die from COVID-19. SLHD recognised at an early stage, the potential for people living in situations of vulnerability to be disproportionately affected by not only by the pandemic, but also the associated response.

Actions taken to reduce the transmission of COVID-19 undoubtedly saved lives. However, they also had negative impacts on health. For example, the temporary stopping of services and the suspension of some home visits, limited early detection, triage and treatment of child development and wellbeing issues. Pandemic responses that may have improved health outcomes overall, may also have created, perpetuated and, in some cases, amplified health inequities.

A need was identified for a more systematic overview of the potential longer-term equity impacts resulting from COVID-19 and the actions taken in response to the pandemic. A proposal to carry out an equity-focused health impact assessment (EFHIA) of the COVID-19 pandemic in SLHD was approved by the District's Chief Executive (July 2020).

The Health Equity Research Development Unit (HERDU) is a partnership between SLHD and UNSW Sydney. HERDU's mission is to work in partnership with health services, organisations and communities to identify and reduce existing inequities in health and to prevent inequities in health from arising in the future. HERDU has carried out this EFHIA to assist SLHD (and other responsible agencies) to address health equity in their ongoing responses to the pandemic and in their future planning. This includes considering recovery from the current pandemic and building resilience to future pandemics, as well as similar emergency situations.

The EFHIA took as its starting point, the time at which the first evidence emerged that the COVID-19 virus had reached Australia, and focused on the health and health equity impacts of the virus and of the NSW government and SLHD responses (in particular) over the following two years. These responses were focused, primarily, on preventing deaths and on containing the spread of the virus.

Although there were state-specific variations in the implementation of responses in Australia, there was universal government acceptance of the need for nation-wide actions by all sectors – and, in particular, by the health sector.

The EFHIA identified multiple health and health equity impacts arising from the pandemic and the District responses. Some of the impacts were positive (as in actions that mitigated or prevented health inequities from occurring). Some of the impacts were neutral (as in there was no increase in inequities in health that had been measurable before the onset and response to the pandemic). Some of the impacts were, however, negative (inequities in health were exacerbated by the pandemic and by the District responses to it).

In preparing recommendations for the District to guide actions to reduce or eliminate health inequities associated with the COVID-19 pandemic, it has been necessary to consider the policy, organisational and political contexts within which recommended actions are to be implemented. This is necessary because many of the factors that affected and influenced the health and health equity impacts of the virus (and the District responses) were highly dependent upon the priority, urgency and scale of the actions taken to prevent deaths and infection. The recommendations will be enacted in very different social, political, policy and organisational environments.

For example, the District (and all health services) were directed to give urgent priority to managing and preventing the pandemic, and in doing so, to pause, delay or ration the delivery of health care necessary for people with a range of other health problems. Health employees were reassigned to roles directly associated with managing the pandemic, facilities were repurposed, new organisational arrangements to ensure timely, appropriate, acceptable communication with marginalised communities were implemented, and attention was given to ensuring that vital services were universally accessible.

The EFHIA concluded at the point at which governments decided to reduce the special measures that had been put in place to manage and control the pandemic. At this point, the health sector (and all other sectors) were expected to return to 'business as usual', i.e., to pre-COVID agendas and activities, in addition to continuing to manage the detection and prevention of the spread of COVID, and care for people infected with new strains of the virus. The changed political, policy and organisational environments are now needing to cope with the ongoing consequences of the pandemic, including, for example, a shortage of staffing for aged care, disability care and home care. Health staff, who have been physically and mentally exhausted by the efforts required to manage the pandemic, now need to manage the continuing threats posed by the rapidly evolving strains of COVID. The mental health consequences of the pandemic and the society-wide and particular responses, are likely to require greater investment in health care, while the accessibility of emerging treatments for long-COVID, as well as the accessibility of all health care (including that provided by GPs), will have implications for health equity into the future.

This EFHIA report concludes with 22 equity-focused recommendations directed at what worked well, what we need to do more of and what we could do differently to support health equity within the District and more widely.

The counterfactual scenario of not investing in health equity is that we rely on equity champions to drive the equity agenda. This risks equity being seen as 'good but not necessary', while the cost of not acting continues, potentially growing unfair and avoidable differences in health outcomes for SLHD communities and staff. For long-term positive health equity impacts to occur, equity-focused actions and ways of working need to be sustained and embedded into 'business as usual'. This includes linking actions to address identified equity impacts to key strategic drivers, such as NSW Future Health Strategy, SLHD Strategic Plan, SLHD Chief Executive Priorities and SLHD Equity Framework.

Recommendations

We recommend SLHD:

- 1 Establishes a Health Equity Action Committee to:
 - a review EFHIA recommendations and develop actions
 - b develop and oversee implementation and monitoring process
 - c report progress to Board and Chief Executive.
- 2 Incorporate learnings from the EFHIA into policies and practice.

What we did

A health impact assessment (HIA) is a structured process for considering potential positive and negative health impacts of an action (such as the COVID-19 response). The goal of undertaking an HIA is to provide a set of evidence-informed recommendations and considerations to assist with planning and implementation. This enables the potential positive impacts of the intervention to be strengthened and any negative impacts to be mitigated.

An equity-focused HIA (EFHIA) has a specific focus on equity at each stage of the process. Health equity is concerned with creating equal opportunities for health and bringing health disparities down to the lowest level possible. Inequities arise when there are systemic differences in health status, that is, health determinants/risks or access to health care between groups that are avoidable and unfair.

The scope of the HIA was determined by the project Steering Committee, consisting of 28 core members (SLHD, community and consumer representatives), with additional consultation of community stakeholders. To inform the scoping process, 23 interviews and focus groups were carried out, as well as a rapid scoping review of the emerging literature on COVID-19 and health equity.

We collected evidence to identify and assess potential health impacts and disparities. HIAs can rely on a wide range of evidence, and for this EFHIA we:

- 1 Developed a community profile using publicly available health and socioeconomic data (e.g., from the Census)
- 2 identified and assessed potential health impacts and disparities by:
 - a assessing how the risks and consequences of COVID-19 infection varied across populations in SLHD, using data from NSW Health's Notifiable Information Management System (NCIMS).
 - b carrying out literature reviews, focusing on evidence reviews and peer-reviewed literature (approximately 600 documents):
 - i Changes to health services due to COVID-19 and health equity
 - ii Changes to the way we work due to COVID-19 and health equity
 - iii Virtual care and health equity
 - iv COVID-19, perinatal service delivery and health equity
 - v Grey literature, including SLHD reports and documents from peak bodies, non-Government organisations and universities, and reports identified by key informants.
 - c Primary data were collected from community members and key stakeholders (n = 64) to understand issues specific to the local context and how they and their communities' health and wellbeing were potentially affected across the three focus areas, and to identify potential actions to mitigate health equity impacts.

In the assessment stage, we synthesised and critically assessed the evidence gathered in the identification stage to describe key health equity impacts. As much as possible, we triangulated data from interviews, focus groups and literature, as well as local data.

To develop impact statements, we used evidence of health equity impacts that had already occurred during the pandemic, combined with knowledge and evidence of the key determinants and pathways for how health inequities occur, so as to develop predictions of ongoing and future impacts. Impacts were characterised according to direction of impact, likelihood, severity, level and timeframe.

During key informant and stakeholder interviews, participants were asked to suggest recommendations to mitigate negative health equity impacts and maximise positive impacts. Evidence-based recommendations were identified from literature review articles and the general evidence base around acting on health equity. Recommendations were collated and assessed in relation to: link to causal pathway, equity-focus, feasibility and link to SLHD potential areas of influence. A proposed set of recommendations was developed and circulated to the EFHIA Steering Committee, participants in the EFHIA and other key stakeholders, for comment and further prioritisation. A revised set of recommendations was then developed.

A Technical EFHIA Report (242 pages), describing the EFHIA process and synthesising the evidence, has been developed. The technical report will act as a reference document. Sections of the technical report were sent to topic experts within the District to validate (gaps, accuracy, general comments). The complete report was then sent to two HIA experts for peer review. Their comments were integrated into the report and a draft technical report describing the process, evidence and impact characterisation was sent to the Steering Committee for comment and validation. The Technical Report has been updated in response to feedback received.

The following timeline outlines the stages and activities involved in the EFHIA, alongside key milestones in the District COVID-19 response. Our data collection ended in December 2021, and our analysis does not include more recent changes and developments.

Focus areas

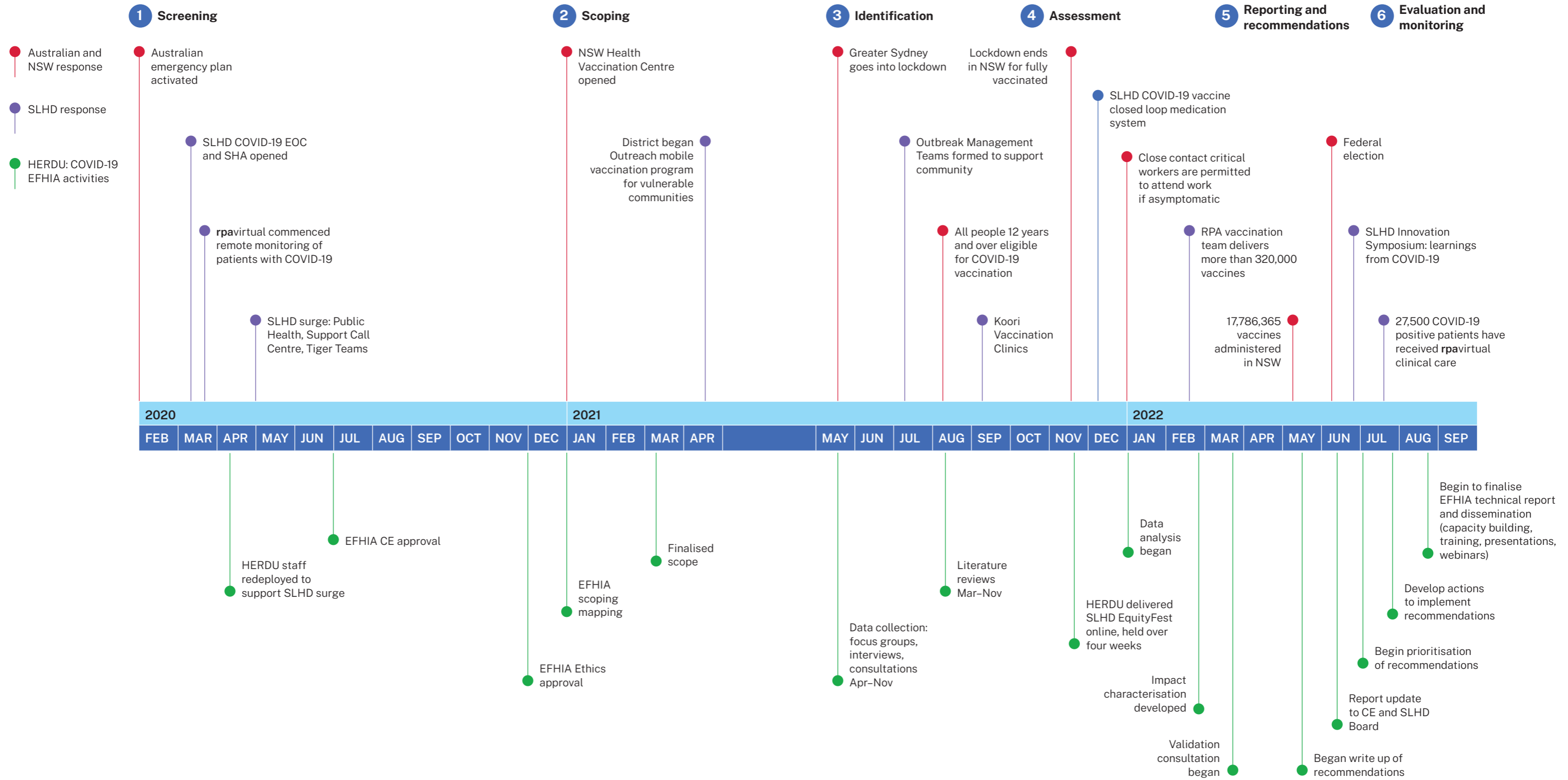
The Steering Committee selected three areas of focus for the EFHIA:

- 1 Risks and consequences of COVID-19 infection
- 2 Changes to health services
- 3 Changes to work – for SLHD staff and in SLHD communities

It was decided that the EFHIA should focus on:

- a Five priority populations: health workers, older adults, younger people, people from culturally and linguistically diverse (CALD) backgrounds and women
- b The SLHD geographic area
- c Both short and long-term impacts of COVID-19 and future pandemics.

Timeline of COVID-19 response and EFHIA activities



Key findings

In the following sections we summarise key findings from the EFHIA. We start by providing an overview of what worked well, what we could do more of and what we could do differently. We then describe the key health equity impacts and populations disproportionately affected in relation to three focus areas:

- 1 Risk and consequences of COVID-19 infection
- 2 Changes to work
- 3 Changes to health services.

District response: health equity

What worked well

What worked well	Implication
High-quality hospital-based services supported by out of hospital and virtual services for those infected with COVID-19.	The system, when vulnerable people reached it, saved their lives.
	rpavirtual clinical assessment and care for patients with COVID-19 isolating at home or in the special health accommodation (SHA) saved lives.
	This care prevented the onward transmission to the community and/or in our health facilities as well as allowing our acute hospitals to manage demand.
SLHD Equity infrastructure.	Equity was integral to SLHD response from the start.
	SLHD was able to draw on data and on pre-existing initiatives, experiences and relationships to respond quickly to what was known would be the likelihood of the inequitable impact of the virus on our population, and to what was known would be necessary in the responses.
	Platforms for equity-focused and place-based action could be directly mobilised.
	The response built on long-term development of relationships and trust with partners (in good times and bad).
Vulnerable communities focus areas for pandemic response.	Explicit targeted response and resourcing for identified vulnerable communities (populations and places).
	Being ready for risk and open to change, created opportunities for good ideas to rise and flexible targeted approaches to be identified and implemented.
Supportive environment for innovation and flexibility.	Signals that expertise in developing clinical/community responses that met the needs of the community were best achieved with consultation.
	Innovation is ongoing, not just reserved for crisis.

“We’ve actually individualised care and tried to meet the diverse needs of families to the best we can in a really challenging time, and I’m pretty proud of the way it worked out”

“So we developed in partnership with a whole range of stakeholders, how we would respond... we developed really clear pathways around how to have providers respond to that. We developed pathways for testing so that those that were vulnerable who couldn’t necessarily access a testing centre per se or a clinic, we would go to them after hours, contacts, that kind of thing. We developed fortnightly Community of Practice with our local disability providers so that we were speaking regularly and engaging. It took a lot of work” the diverse needs of families to the best we can in a really challenging time, and I’m pretty proud of the way it worked out”

What we need to do more of

What we need to do more of	Implication
Continue to build and invest in sustainable equity infrastructure.	Sustainable embedded equity infrastructure that addresses the determinants of health equity and can be drawn on/ramped up as needed.
	Translating existing infrastructure to reach a wider SLHD population, building capacity, capability and resilience.
	Establishing and maintaining a flexible mindset that questions, exposes and innovates.
Continue and strengthen attention on addressing existing and ongoing 'wicked problems' amplified by COVID-19 (not just in communities but also within SLHD).	Addressing the existing inequalities that increase vulnerability to and are exacerbated by pandemics and other major challenges.
	Leaders within health services being supported to make what might be difficult decisions around resource allocation in response to what emerging/ unknown needs are still to surface.
Expand leadership and governance ('with' rather than 'of').	Increased capacity to address determinants of health inequities.
	Broadening leadership and governance.
	Increased recognition of the value of diversity and understanding of the ability of the workforce and community to contribute ideas and work towards solutions.
Advocate for health equity and the determinants of health equity.	Acting on the determinants of health equity outside of health care provision.
	Improved understanding of the intersection of determinants of health and wellbeing that exist in our communities, the drivers of those differences, and the role of Health Services
Walk the talk of equity by looking inwards.	Supporting staff and addressing drivers of inequities within services and structures.
	Bounce back better.

"We need to take people on our journey so it's not a top down approach, that's there's that groundswell about what we could do differently. Genuine partnership is not easy to obtain" (i14)

"And the freedom that came with COVID. If you had an idea in COVID, people ran with it. 'Great. Yes. Do that'. The home visiting side of things for vaccinations. 'Yes. Of course, we thought of that, let's do that'. So people felt really empowered" (i18).

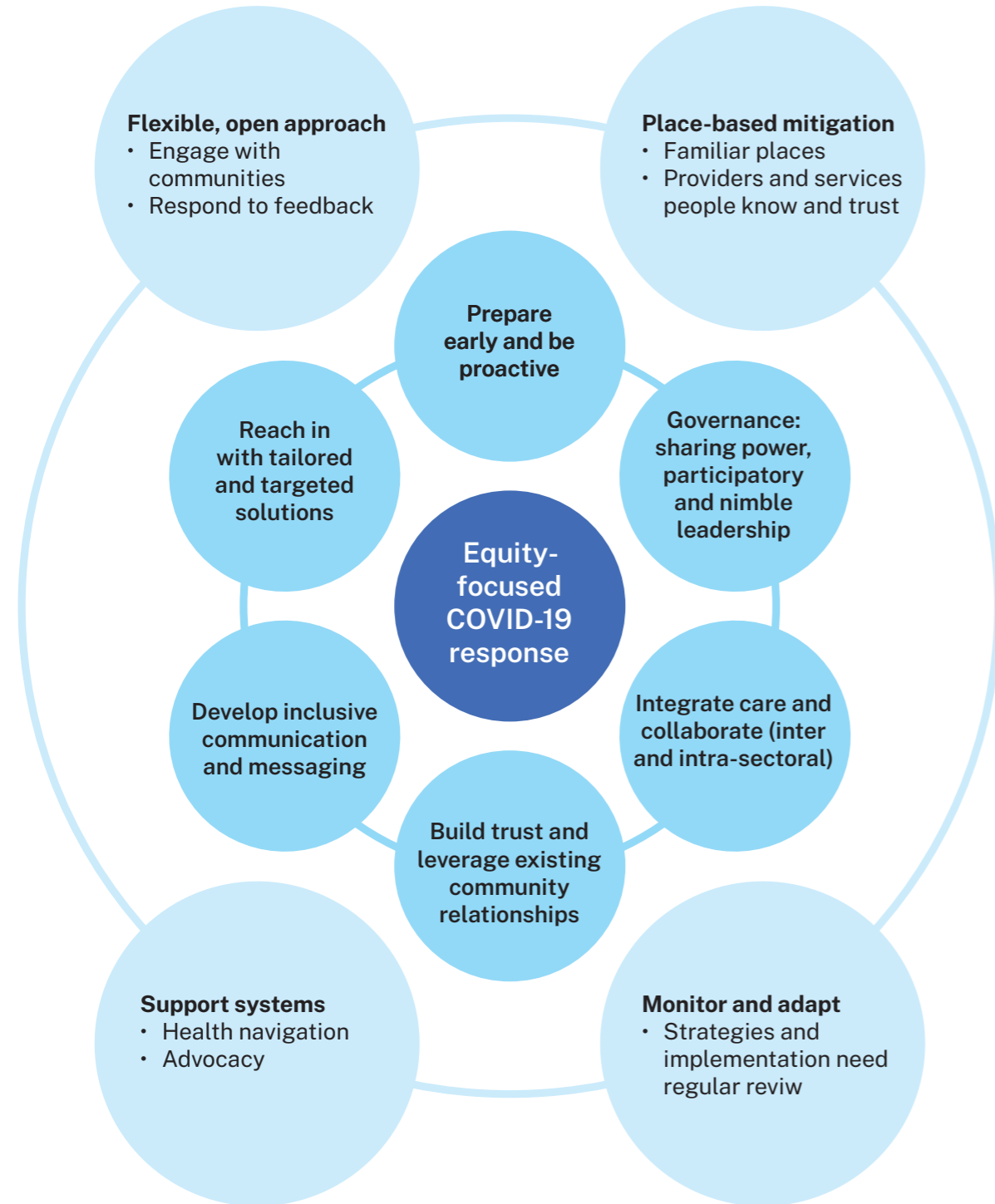
What we could do differently (hindsight for next time)

What we could do differently	Implication
Strengthen consideration of equity impacts and trade-offs when responding to emergency.	Capacity to consider medium to long-term health (equity) impacts.
	Capacity to consider unintended impacts.
	Improved utilisation of resources.
Increase prioritisation of maintaining services that are addressing health equity determinants and outcomes.	Equity-focused approach ensuring existing inequities are not worsened, nor are new inequities created, while attempting to reduce risk of exposure.
	Capacity to consider medium to long-term health (equity) impacts.
	Capacity to consider unintended impacts
Address inequities in workforce culture and systems.	Address the double (work and personal) pandemic burden on health workforce.
	Address health equity within SLHD workforce.

"There's an inequity in the amount of attention that has been given to the things that we need to do on a day-to-day basis and I think actually the community has felt it because they can't access care in as timely a way. Non-COVID related care" (i13)

"It takes energy to run services and provide that emotional, physical labour and care for people [...] During the pandemic it's not that it doesn't happen, but it's more difficult. And so, it's just more complicated to find all the energy to build that back up, before you have to then go and provide it again" (i7)

We used the analysis and evidence from this EFHIA and literature to establish emerging factors of success for an equity-focused response to COVID-19



How COVID-19 impacted on health equity

The figure below describes the conceptual framework informing our understanding of how the pandemic and associated response impacts on health equity.

The starting point for understanding how COVID-19, changes to work and changes health services impacted on health equity, is the existing health inequalities within the population of SLHD.

Individual, populations and communities have different levels of vulnerability according to their access to health determinants (social stratification).

This affects:

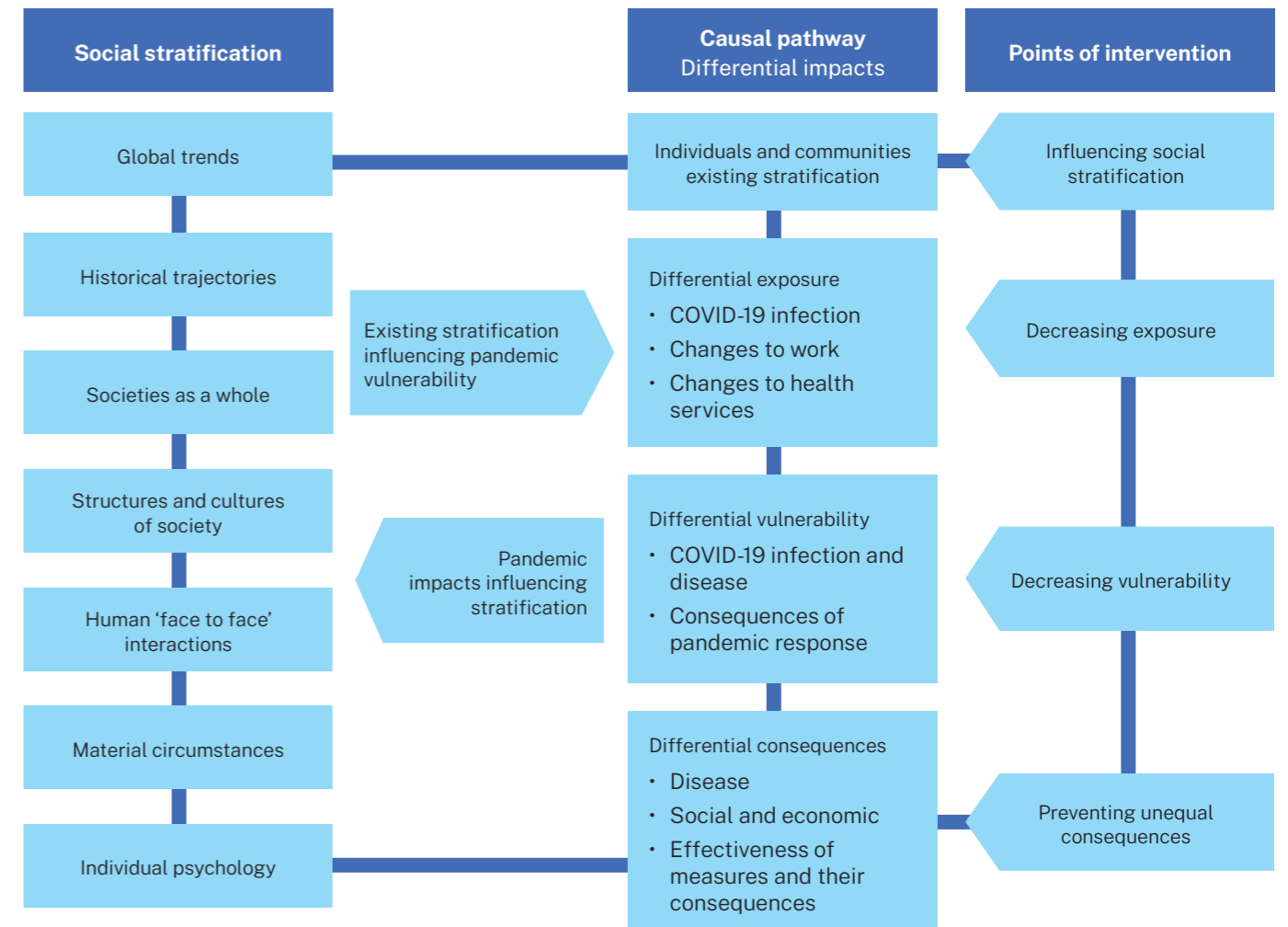
- 1 Who is exposed (to COVID-19, to changes to work and to changes to health services)
- 2 Differences in vulnerability once exposed
- 3 Differences in consequences directly from COVID-19 infection and indirectly through control measures.

Differences in health outcomes can occur at multiple stages and can occur directly through COVID-19 morbidity and mortality or indirectly through social and economic pathways that lead to changes in health outcomes (causal pathways).

These unequal experiences of the pandemic fed back into social stratification.

The multi-level and dimensional causes of health inequities means that there are also multiple places (points of intervention) to take action. Ranging from addressing the existing causes of health inequalities (social stratification) that increase certain populations vulnerability, to addressing the unequal and inequitable health outcomes resulting from the pandemic and associated control measures.

Conceptual framework for understanding health equity pathways and potential points of intervention



Source: Adapted from Diederichsen et al 2012 and Katikireddi et al 2021

What did we learn?

Risk and consequences of infection

People living in the more socioeconomically disadvantaged areas of the District were more likely to be infected, to be hospitalised and to die from COVID-19. However, once a person did become infected, there is no evidence that they were any more likely to die, other things being equal, than someone living in a less disadvantaged area. Further, while Aboriginal and/or Torres Strait Islander people infected with COVID-19 were more likely to end up in hospital, there is no evidence that they were any more likely to die, other things being equal, than non-Aboriginal and Torres Strait Islander cases. This is despite the COVID-19 vaccination rate among Aboriginal and Torres Strait Islander people lagging that among the general population (Woodley, 2022) (our modelling did not control for vaccination status because the data were not available).

These findings suggest that, in SLHD at least, the COVID-19 care provided to Aboriginal and Torres Strait Islander cases, and to cases from disadvantaged areas, was at least as good (in terms of preventing death) as that provided to non-Aboriginal and Torres Strait Islander cases and those from less disadvantaged areas. Alongside hospital-based care, clinical care for patients with COVID-19 isolating at home or in SHA saved lives in some cases. This care also prevented the onward transmission to the community and/or in our health facilities, as well as allowing our acute hospitals to manage demand.

COVID-19 infection exacerbates existing inequalities within and between groups and geographic areas, causing definite, major, short to medium-term negative, and probable major, long-term negative, impacts on health equity. In addition to physical health impacts, including mortality, COVID-19 infection causes definite, moderate to major mental, social and personal harm through loss of income and/or employment, educational impacts, loneliness and social connection, stigmatisation, fear and anxiety, depression and grief. Long-COVID will definitely disproportionately affect those population groups that had higher exposure and vulnerability, and lower adaptive capacity.

The pattern of COVID-19 infections, hospitalisations and fatalities in the District, has generally mirrored that of the nation:

- Aboriginal and/or Torres Strait Islander cases were more than 60% more likely to be hospitalised than non-Aboriginal or Torres Strait Islander cases (adjusted odds ratio (AOR) 1.64, 95% confidence interval (CI) 1.37–1.96). There was not a statistically significant relationship between Indigenous status and likelihood of death.
- Likelihood of hospitalisation increased with age, with a case aged 50–69 more than two times as likely to be hospitalised as a case aged 20–49 (AOR 2.63, 95% CI 2.37–2.92), and a case aged 70+ about 12 times as likely to be hospitalised (AOR 11.60, 95% CI 10.43–12.92). Likelihood of death from COVID-19 increased with age: a case aged 50–69 was more than 60 times as likely to die as a case aged 20–49 (AOR 63.56, 95% CI 19.73–204.81) and a case aged 70+ was more than 550 times as likely to die (AOR 562.74, 95% CI 179.13–1,767.82).
- Increasing IRSD score (i.e., decreasing socioeconomic disadvantage) was associated with a decrease in the likelihood of hospitalisation (AOR 0.997, 95% CI 0.996–0.977): a case living in Punchbowl (IRSD score 862) was twice as likely to be hospitalised as a case living in Balmain (IRSD score 1,091), other things being equal. There was not a statistically significant relationship between IRSD score and likelihood of death.
- There was not a statistically significant relationship between gender and hospitalisation likelihood. Male cases were more likely to die than female ones (AOR 1.53, 95% CI 1.13–2.06).

Populations already experiencing inequities (marginalised, minoritised) experience disproportionate negative health impacts from exposure to and infection with COVID-19 in the short to medium-term. These impacts are likely to continue into the medium and long term unless measures are taken to address the determinants of pre-existing health inequities, to protect marginalised and vulnerable populations from exposure to COVID-19 infection, and to provide accessible, appropriate care when infected. We identified the following population groups as being differentially affected by risks and consequences of COVID-19 infection:

Population groups particularly affected by risk and consequences of infection

- Those with higher risk of exposure, due to living in locationally disadvantaged areas, crowded housing, boarding houses, group homes, residential aged care facilities (RACFs) or prisons or working in frontline/essential occupations.
- Those with higher risk of serious illness, including older adults, people with pre-existing conditions (including diabetes, obesity, cancer, respiratory disease, disability), unvaccinated people and Aboriginal and Torres Strait Islander people.
- Those with limited capacity to take protective actions through lack of knowledge, means or choice (e.g., low-income households, people with low health literacy, people with poor digital literacy/access, some Culturally and Linguistically Diverse (CALD) people, essential workers, precarious (unprotected/insecure) workers, and people living in group homes/ RACFs/ prisons/ overcrowded housing).
- Those with poorer access to available, acceptable, appropriate and high-quality care (including people living in lower socioeconomic areas, low-income households, people with low health literacy, CALD people, Aboriginal and Torres Strait Islander people);
- Those living in socioeconomically disadvantaged areas, who have poorer access to health and other services, are more likely to experience stigma and have higher risk of morbidity/ mortality.
- Unvaccinated people, who were more likely to experience stigma, job loss (especially in industries/sectors where vaccination was mandated), serious COVID-19 symptoms and outcomes, social isolation, disengagement and lower trust in institutions and governments.

Changes to work

Working from home (WFH) and flexible work

Lower socioeconomic areas with less social infrastructure, transport and open space, and with relatively high amounts of residents working in essential/frontline roles, living in small, poor quality or crowded housing and more likely to experience digital disadvantage, were and are less likely to benefit from working from home (WFH) and flexible work and potentially experience widening inequities. In SLHD these areas include Riverwood, Punchbowl, Wiley Park, Lakemba, Redfern, Waterloo and Glebe. Again, here the impacts of the pandemic compounded pre-existing social and structural inequalities shaped by planning and infrastructure policies, work legislation, social protection and education opportunities.

Increased availability of WFH and flexible work options could, however, particularly help lone parents, people with caring responsibilities, people living with disability and locational disadvantaged communities, if they were able to access WFH employment opportunities. Employers, such as the District who adapt and adopt WFH and flexible work with appropriate resourcing and support, may improve inclusiveness, participation and job satisfaction for some marginalised populations.

If working from home and flexible work arrangements are maintained, then there is likely to be short, medium and long-term positive impacts on air pollution levels and noise. However, there was some evidence that this positive impact may be partially offset by less people using public transport due to fear of exposure. If there is long-term shift towards reduced commuting and increased active transport (cycling and walking), then this could have a positive impact on wellbeing. However, there is potential risk to availability of public transport if usage drops. Additionally, changes to transport could possibly impact on climate change.

Economic and employment impacts

Certain population groups already experiencing marginalisation are overrepresented in the precarious and unemployed workforce (i.e., women, young people, migrants and CALD minorities). Economic policy interventions, such as 'JobKeeper' and increases to income support, probably impacted positively on health equity in the short-term. However, the temporary nature of economic policy interventions presents a missed opportunity to address underlying determinants of health equity in the long-term. Precarious workers and unemployed people are particularly vulnerable to negative impacts resulting from the pandemic and associated response.

Essential and frontline workers

Essential and frontline workers are more likely to live in areas of locational disadvantage (less social infrastructure, open space and transport choice) and with higher numbers of people living in households. They are also more likely to be part of a casualised, low paid workforce. At the system level, the impacts of the pandemic reveals and worsens existing social and spatial inequities created by multisectoral public policy in housing, planning and infrastructure. Essential and frontline workers are particularly vulnerable to negative impacts of COVID-19 through increased risk of infection, related stress and anxiety, stigma and discrimination, and work intensification and risk. Essential and frontline workers may also have experienced positive health and wellbeing impacts through keeping or gaining employment, feelings of participation and inclusion and, in some cases, the perception of having a valued role.

Population groups particularly affected by changes to work

- People living with disability, some CALD communities, young and old workers, women, and people with low levels of education are overrepresented in low paid jobs. Casual employment has relatively higher levels of older and younger people, and people with lower education attainment, particularly high in accommodation and food services. People on low income are:
 - More likely to work in roles that do not allow for WFH. However, if able to WFH, would:
 - Benefit most from reduced transport costs
 - Be harmed most by any shift in costs related to a home office.
 - Low paid and casual workers are more likely to become unemployed or have hours reduced and more likely to be or become casual workers.
- Newly precarious (unprotected/insecure) or unemployed people are:
 - Less likely to have the knowledge and skills to navigate systems such as Centrelink
 - Less experienced and familiar with ways of coping with financial stress and poverty.
- Population groups most affected by job losses, including:
 - Young and older people
 - Women
 - Migrants and CALD minorities
 - LGBTIQ+ and gender diverse people
 - Unemployed or under-employed people who could not access income supports (recent examples included casual employees, university workers, gig/zero-hour contract workers, temporary migrants, international students and refugees and asylum seekers) and who are:
 - More likely to experience financial stress, housing and food insecurity
 - More likely to feel stigmatised and to have reduced trust in government.
- Women are less likely than men to have access to WFH and flexible work opportunities and are more likely to experience negative impacts associated with WFH:
 - Women overall are more likely to be negatively affected by trying to balance caring and working roles. This was particularly likely when WFH formed part of mandated lockdowns including school closures.
 - WFH had a probably negative impact on amount and proportion of unpaid work undertaken by women.
 - Working from home possibly increased risk of family violence occurring and decreased likelihood of detection and support being provided.
 - For some women, WFH and flexible work may have positively affected caring roles through enabling access to employment opportunities and/or the ability to balance caring and work roles.
 - Women experience higher levels of precarious work than men.
 - Women are more likely to have fewer financial resources.
 - Older women are particularly vulnerable to housing insecurity.
 - Women are more likely to experience violence in relation to financial insecurity, in particular women with long-term health conditions and Aboriginal and Torres Strait Islander women.

Population groups particularly affected by changes to work (continued)

- Digitally disadvantaged people, with limited digital access, literacy or ability to afford data and equipment (ability, affordability, access), are less likely to be able to access WFH and more likely to experience additional stress and anxiety during transition to online work:
 - People with low levels of income, education and employment, new migrants and refugees, people with mobile only access (e.g., people experiencing homelessness, including boarding house and other shared housing residents), social housing residents, those living in some regional areas, people aged over 65, Indigenous people and people with a disability, are at particular risk of digital exclusion.
 - High income households, younger people and tertiary educated people are less likely to be digitally disadvantaged.
 - When WFH is combined with school closures, digitally disadvantaged families are more likely to experience barriers to education.
- People who live in cramped or overcrowded living conditions are more likely to have:
 - Experience increased stress at the individual and family level
 - Experience difficulty working or studying
 - Be unable to WFH
 - Be at risk of injury or OHD/musculoskeletal problems if not able to access an appropriate work set up.
- People who live alone and people with already limited social and other connections:
 - Are more likely to experience isolation and loneliness.
- Organisations lacking in digital infrastructure or capacity:
 - Have reduced access to or capacity to implement WFH
 - Face increased stress during transition (short-term).
- Older people:
 - Are more likely to experience negative psychological effects from isolation
 - Are more likely to be digitally disadvantaged.
- Carers, particularly women:
 - Potential positive impact through potential improved access to employment opportunities
 - Potential negative impact through disruption and crossover between caring and working roles
 - More likely to lose employment if unable to find care (particularly in the case of school closures and restrictions on care provided in the home)
 - More likely to experience negative impacts on psychological wellbeing and relationship stress.
- People with pre-existing mental health conditions:
 - More likely to experience negative psychological effects from isolation.
- Single parent families:
 - Greater flexibility and potential for an improved work/life balance and increasing future employment options as remote/WFH became/ become more established
 - Are at risk of isolation and potential greater imbalance in caring and working roles.

Population groups particularly affected by changes to work (continued)

- Essential workers tend to be younger, women, migrants (people on temporary visas, refugees, undocumented people) and from CALD communities. Major areas of essential and frontline workers included the service industry, frontline health care workers, emergency services, teachers, indoor production and warehousing, transportation of goods and construction sites:
 - These were already marginalised populations that tend to have less capacity to take and access protective measures
 - Are overrepresented in the casual and low paid workforce
 - Are more likely to be employed in areas with poor or unsafe work conditions with limited protections or power
 - As essential workers are more likely to live in areas with high COVID-19 transmission, they were more likely to experience additional Public Health Restrictions as well as over policing
 - Essential workers often experienced an intersection of vulnerabilities/marginalisation (e.g., migrant, precarious worker, female).
- Locationally disadvantaged, low socioeconomic neighbourhoods:
 - These areas may have experienced higher levels of COVID-19 infection through work related transmission combined with living conditions and an urban environment that had limited protective measures
 - In the medium to long-term, these areas may have relatively high populations experiencing long-COVID
 - Are more likely to be affected by grief and trauma from COVID-19 deaths
 - Are more likely to have experienced additional restrictive Public Health measures (Local Government Areas [LGAs] of concern) potentially resulting in economic impacts from fines, stigma and discrimination, and trauma and stress
 - Have high populations of refugees, migrants, Aboriginal and Torres Strait Islander people and CALD communities with a history of trauma, over policing, racism and stigma, who may have been particularly vulnerable to negative impacts related to enforcement of Public Health measures restricting movement.

SLHD staff

Health workers are disproportionately burdened by pandemic fatigue owing to the dual role that they occupy: as both on the frontline of the COVID-19 prevention and treatment response, and as community members. The pandemic imposed a dramatic shift in the ways people in the health sector do their work, with the pandemic response forcing the development of new work processes to manage risk exposure (infection control, training and personal protective equipment [PPE]), major changes in service delivery, staff redeployment and the diversion of resources to prepare for and/or deal with the influx of COVID-19 cases. These rapid transformations have had differential impacts on staff and their health and wellbeing. Health is a major employer (12.5% of the NSW workforce is health and social assistance), so actions taken to address health equity impacts on staff can have a significant impact.

Throughout our discussions with key informants, there were two main areas of concern that emerged as impacting staff's health and health equity, with mixed outcomes. First, maintaining staff safety while ensuring continuity of care and service delivery; this also required the development of innovative work processes. Second, coping with increased workloads, pandemic fatigue and ongoing uncertainty/unpredictability. As the pandemic has continued with no clear end in sight, these complex challenges have impacted individual and collective resilience and have become significant issues.

Stress, fatigue, chronic uncertainty and anxiety associated with working within Health Services during a pandemic, varies in relation to roles, working context and individual characteristics. Changes to working roles, such as redeployment, intensification of work and changes to work content, can have varying impacts depending on people's personal circumstances. Pandemic related impacts on health service staff also have systems level impacts, with potential increased absences, turnover of staff and difficulties in recruitment. This in turn may affect organisational culture and further exacerbate potential negative staff impacts, while also affecting service delivery. There are potentially positive system level impacts through an increased culture of providing opportunities to influence and control work environment, developing skills and experience, and participation in decision making. The positive impacts on staff wellbeing and perceived benefits in terms of better decision making and implementation of actions through increased flexibility, less hierarchical and more responsive

decision making, was a strong theme in our analysis, alongside a concern that, as the pandemic eases, the work culture and environment will return to 'business as usual'.

While the impacts of long-COVID are currently unclear, it is possible that long-COVID will also affect health service staff and staffing.

We identified the following population groups as being particularly affected by changes to work:

SLHD staff particularly affected by changes to work

- Staff with less control and autonomy:
 - Experience higher levels of stress (when exposed to similar experiences) at work during the pandemic, compared to staff who have more control and autonomy (e.g., nurses and support staff versus doctors and paramedics)
 - Are less likely to be engaged in decision making and planning processes and more likely to feel a lack of control and participation/influence in the workplace
 - Experience relatively higher levels of fatigue and burn out
 - More likely to experience negative impacts of redeployment if redeployment continues to provide low levels of control, autonomy or opportunities to learn and develop new skills and experiences. However, if redeployment provides opportunities for growth, autonomy, new experiences, etc., then this may have a positive impact on staff
 - More likely to experience the double burden of uncertainty, unpredictability, and reduced agency/control in work as well as in personal spheres.
- Women are more likely to experience the double burden of stress and burden in relation to managing a family and caring responsibilities as well as work pressures.
- Lower paid workers, such as cleaning staff, junior admin roles, aged care workers and lower-level roles:
 - Lower levels of autonomy and less likely to be engaged in decision making and planning processes
 - More likely to come from at higher risk groups for COVID-19 infection
 - Less likely to have access to flexible or WFH options, and less likely to have digital access and literacy, a quiet space to work, etc., if able to WFH
 - Are More likely to have limited capacity to isolate at home, and lower income workers are more likely to live in overcrowded or share housing and less likely to be able to afford alternative accommodation.
- Staff from already marginalised population groups are more likely to experience intersecting vulnerabilities and have more limited capacity to take protective action, including:
 - Support with childcare and caring obligations
 - Living in overcrowded housing
 - Living in locationally disadvantaged neighbourhoods (LGAs of concern, long commuting distances, impacted on by travel restrictions, etc.)
 - Stigma and discrimination outside of work.
- Peer health workers/Community Health Workers/Cultural support workers:
 - Likely to have higher levels of exposure to COVID-19
 - More likely to experience a dual burden in relation to personal and working life (high-risk environments, affected by movement restrictions)
 - More likely to be working directly with vulnerable communities with high needs and are often also part of these communities themselves
 - Sometimes experiences mixed unclear guidance due to non-hospital-based roles.
- Staff in high contact roles, such as nurses and aged care staff:
 - Likely to have higher levels of exposure to COVID-19
 - More likely to work outside of the hospital environment (e.g., within communities, home visits)
 - More likely to experience a dual burden in relation to personal and working life (high-risk environments, affected by movement restrictions)
 - Were likely to be working directly with vulnerable communities with high needs and are often also part of these communities themselves
 - Sometimes experience mixed unclear guidance due to non-hospital-based roles.
- Workers with limited capacity to isolate at home (e.g., those with families/caring responsibility, workers in share houses, lower income workers) are more likely to live in overcrowded or share housing.

Changes to health services

We identified five main areas of health equity impacts resulting from COVID-19 related changes to health services:

- 1 prioritisation of the COVID-19 response
- 2 temporarily stopping services
- 3 changes in patient behaviours
- 4 changing the way services are delivered
- 5 impacts on staff.

New vulnerabilities and inequities for certain groups have emerged because of COVID-19 restrictions and changes in care. There have also been positive impacts, such as increased access and improved coordination, through the wider use of virtual care. In addition, there are positive health equity impacts resulting from an equity-focused service response.

Overall, the prioritisation of responding to the COVID-19 pandemic has reduced the harm caused by COVID-19 infection. COVID-19 infection disproportionately impacts on population groups already experiencing inequities. Therefore, actions taken to reduce the risk of infection and to provide adequate health care to those infected, definitely impacts positively on health and possibly impacts positively on health equity, given the heightened risk for already marginalised groups. However, evidence showing continued disproportionate deaths in lower socioeconomic and other groups, suggests that measures to reduce transmission and to provide health care is not enough in themselves to stop disproportionate morbidity and mortality resulting from COVID-19 infection.

To respond to COVID-19, health and other sectors, had to stop doing other activities. Because of the weight of the crisis and the potential exposure of the whole population regardless of who they were, there was a social license during that time to move resources from one place to another. Prioritisation of the COVID-19 response (in particular, stopping services to reduce the risk of exposure to COVID-19 or because of redeployment of staff to the COVID-19 response) has probable short-term unintended negative impacts on health equity. Prioritising COVID-19 management by diverting resources and staff, generates inequities in accessing other care. In focusing on critical COVID-19 related care, health care rationing and diversion away from clinical care, the pandemic has had major impacts on health services, creating unmet needs. Primary and community-based services, the child youth and family health sector, specialised care in community health, chronic and complex care, mental health,

non-communicable diseases services and elective surgery, were all identified as experiencing significant disruption during the peak times of pandemic. Changes to delivery of services that particularly responded to the needs of populations already experiencing health inequities (such as child and family health services, mental health services and psychosocial support, substance use disorders, HIV and sexual health, management of chronic conditions and dental care), probably increases health inequities in the short, medium and possibly long-term. The short-term positive impacts of the COVID-19 response may possibly lead to unintended longer-term negative health equity impacts.

Changes to the way services are delivered, in particular, increased use of virtual care, has a possible positive impact on health equity through increasing availability and access to health services for some groups. Virtual care can also negatively impact on health equity if those same groups face barriers to access (accessible, available or appropriate care).

Visitation and other infection control measures mitigate risks from COVID-19, but also have probable unintended negative impacts, with implications for equity, through adding barriers for already vulnerable and disadvantaged patients who face difficulties in access to and experience of services.

SLHD directly responded to the COVID-19 pandemic with a range of equity-focused targeted responses to address the emerging health equity impacts of the pandemic. Overall, these responses had a definite positive impact on health equity, as evidenced by the relatively high vaccination rates in vulnerable and marginalised communities, with social housing residents in the District have the highest two-dose vaccination rate in NSW.

We identified the following population groups as being particularly affected by changes to health services:

Populations particularly affected by changes to health services

- Those who experience poorer access to available, acceptable, appropriate and high-quality care, including:
 - People living in low socioeconomic areas
 - People with low income
 - People with low health literacy
 - CALD community members
 - Aboriginal and Torres Strait Islander people
 - LGBTIQ+ people
 - People living with disabilities
 - People with bloodborne diseases
 - People without access to Medicare
 - People experiencing homelessness.
- People who are high users of health services, such as:
 - People with chronic and complex health problems
 - People living with disabilities
 - Older people.
- Users of community-based services.
- Children and young people:
 - Experiencing high burden of pandemic in terms of disrupted education, social isolation/connection due to lock downs, household stress (parental stress, income/employment changes, housing, abuse/neglect) and changes to access to community services and resources
 - Temporary loss of access to school-based health services and early detection within school and other environments
 - Missed developmental checks
 - Major impacts on child and family health services
 - Already vulnerable groups already experiencing poorer health and poorer health care access disproportionately affected (children with disabilities, lower SES, CALD communities, refugees and asylum seekers, digitally disadvantaged)
 - Increased burden on young carers.
- Older people:
 - At greater risk of adverse events from COVID-19 infection
 - Many services used by older persons were disrupted (e.g., home visits and assessments, respite care, health promotion activities)
 - Service disruption can lead to: changes in physical health and activity (leading to functional decline); social isolation, loneliness, wellbeing (loss of support services, community networks or visitation rights in group homes); psychological consequences from disrupted routines and activities; increased family and caregiver burden, potentially leading to long term impacts/decline
 - Some evidence of avoidance of health services
 - More likely to be digitally disadvantaged
 - Decline in physical activity sometimes resulting in overall decline
 - Greater risk of social isolation and loneliness
 - Disproportionately affected by visitor restrictions
 - Older people with cognitive decline (e.g., Alzheimer and dementia) less able to understand changes to services and restrictions.
- CALD community members:
 - Already experiencing barriers to health care access and utilisation
 - Higher levels of low health literacy
 - More likely to have difficulties understanding information and changes to services (if not provided in appropriate format and language).
- Digitally disadvantaged:
 - Less likely to be able to access and utilise virtual health services
 - More likely to use telephone rather than online (e.g., zoom) services
 - Already experiencing barriers to health care
 - Financial burden through cost of data, need for equipment.

Populations particularly affected by changes to health services (continued)

- Carers
 - Already experiencing health inequities
 - Stress and anxiety from not being able to visit and provide care when visitor restrictions in place
 - Significantly impacted by stopping of respite services
 - Increased caring burden through service being stopped
 - Lock down and changes to health services often meant losing access to formal and informal peer support, although some examples of successful online transition.
 - Economic and employment impacts from increased caring burden.
- Women:
 - More likely to have caring role and be affected by changes to health services
 - For some, shift to virtual care may affect access, appropriateness and quality of health services (e.g., in situations of interpersonal violence or high-risk pregnancy).

Recommendations

We have developed a set of equity-focused recommendations to mitigate negative health equity impacts and support and maximise potential positive health equity impacts identified in the impact assessment. To develop the recommendations, during key informant and stakeholder interviews participants were asked to suggest recommendations, evidence-based recommendations were identified from literature review articles and we drew on the health equity evidence base. Recommendations were collated and assessed in relation to: link to causal pathway, equity-focus, feasibility and link to SLHD potential areas of influence. Recommendations were circulated to participants and key stakeholders for feedback, comment and prioritisation.

These recommendations identify actions that we can do now and over the medium and long term to build back more equitably and to prepare for future pandemics and other major challenges such as climate change. These include actions to address existing determinants of inequities that lead to different levels of vulnerability within and between populations and places, and actions to address the unequal consequences of COVID-19 and the pandemic response.

These actions focus on the role of the District as commissioners of this report. However, the health equity problems that we have identified in the EFHIA cannot be resolved by the health sector and system working alone. Health equity impacts are often caused by decisions made by organisations and people from beyond the health sector. The public health response cannot be separated from public policy. Actions taken by the District are often guided by State and Federal level policy. Some of the following recommendations the District can directly act on, many will require collaboration and partnership with other actors and communities, and some recommendations may appear outside of the direct influence of the District. SLHD can act as a health equity champion and advocate for changes in other areas beyond direct control.

In short, the recommendations have been formulated to be taken up by the health sector (SLHD) as it is operating in 2022 and beyond -incorporating actions to reduce and prevent inequities in health.

The recommendations are separated into six sections:

- 1-4** Maintain what worked well
- 5-9** What we need to do more of
- 10-12** What we could do differently
- 13-15** Risks and consequences of COVID-19 infection (in addition to above)
- 16** Changes to work (in addition to above)
- 17-22** Recommendations: Health services (in addition to above)

Maintain what worked well

1 Recommendation
 Maintain high-quality hospital-based services supported by out-of-hospital services for those infected with COVID-19

Implication

The system, when vulnerable people reached it, saved their lives.
 Clinical care for patients with COVID-19 isolating at home or in SHA saved lives in some cases.
 This care also prevented the onward transmission to the community and/or in health facilities, as well as allowing acute hospitals to manage demand.

How (examples)

- a The COVID-19 care provided to Aboriginal and Torres Strait Islander cases in hospital, and to cases from disadvantaged areas, was at least as good (in terms of preventing death) as that provided to non-Aboriginal and Torres Strait Islander cases and those from less disadvantaged areas.
- b virtual clinical assessment and care for patients with COVID-19 isolating at home or in the SHA.
- c virtual in-home community nursing services maintained for all patients as an important hospital avoidance and care maintenance strategy.

NSW Future Health Strategy	2.4 strengthen equitable outcomes and access (additional: 2.5, 6.3)
SLHD Strategic Plan	Focus area 1: Equitable care for our community
CE Priorities	16. Vulnerable communities
SLHD Equity Framework	1. Individual health care. 5. Fairer system

Maintain what worked well

2 Recommendation
 Maintain and enhance existing SLHD Equity infrastructure

Implication

Equity was integral to SLHD response from the start. SLHD was able to draw on data and on pre-existing initiatives, experiences and relationships to respond quickly to what we knew would be the likelihood of the inequitable impact of the virus on our population, and to what we knew would be necessary in the responses.
 Platforms for equity-focused and place-based action could be directly mobilised.
 Long term building of relationships and trust with partners in good times and bad.
 Platforms that support responses across the diversity of population/client cohorts residing in SLHD, and those cohorts that access SLHD on an intermittent basis.
 Expertise within District that could be drawn on (e.g. involvement of trauma Informed Clinicians within Outbreak Management Teams)

How (examples)

- a Equity is embedded in the SLHD system Leadership and governance, Values; Drivers (e.g. SLHD Equity Framework, SLHD Strategic Plan); History of action on health equity; Existing expertise and knowledge (e.g. within leadership and expertise of CSI&PH executive).
- b Equity platforms including-Substantial Aboriginal workforce and leadership; Cultural support workers; Expertise and intelligence (HERDU, Public Health Unit/The Observatory, Diversity Hub); Place based interventions (e.g., Can get Health in Canterbury, Healthy Homes and Neighbourhoods, Waterloo Link Worker); Place based services (e.g., Community Health Centres).
- c Existing relationships (and sometimes trust) to build on: within/into communities, with partners.
- d Educate e.g., SLHD employees about these equity-focused resources.

NSW Future Health Strategy	2.4 strengthen equitable outcomes and access (additional: 2.5, 6.3)
SLHD Strategic Plan	Focus area 1: Equitable care for our community
CE Priorities	16. Vulnerable communities. 6. Clinical Engagement. 4. Quality and Safety Performance.
SLHD Equity Framework	1. Individual health care

Maintain what worked well

3 Recommendation
 Maintain vulnerable community focus areas within emergency and crisis responses

Implication

Explicit targeted response and resourcing for identified vulnerable communities (populations and places).

How (examples)

- a Systematically identify both place (e.g., Wiley Park, Campsie, Lakemba, Waterloo, Riverwood) and population based vulnerable communities. This includes approaches to identify new, emerging, ‘hard to hear’ communities.
- b Collaborative planning and action with partners, including: the disability sector and disability group homes; residential aged care facilities (RACF); vulnerable people and housing (social housing residents, boarding houses, people experiencing homelessness); Aboriginal and Torres Strait Islander response.
- c Align initiatives with sharing leadership within and across services as part of pandemic responses, bringing diverse perspectives and valuing the input of. e.g., SLHD staff, who have varying levels of experience and roles within the District. Cultural Support Workers.

NSW Future Health Strategy	Vision: investment in ‘wellness’ 3: ‘people are healthy and well’ (additional: 3.4, 3.2, 5.1, 5.2)
SLHD Strategic Plan	Focus area 1: focus on prevention (additional: priority 8)
CE Priorities	16. Vulnerable communities. 15. Collaborative Care Program.
SLHD Equity Framework	3. Prevention and health promotion

Maintain what worked well

4 Recommendation
 Maintain a supportive environment for innovation and flexibility

Implication

Being ready for risk and open to change created opportunities for good ideas to arise and flexible targeted approaches to be identified and implemented. People who don’t make mistakes are those that don’t do anything.

Signals that expertise in developing clinical/ community responses that meet the needs of the community, are best achieved with consultation.

Innovation is ongoing, not just reserved for a crisis.

How (examples)

- a Maintain a system and personnel who are encouraged to be proactive, design, work and plan cooperatively.
- b Strengthening engagement with front-line workers from across professions and with varying levels of experience.
- c Identifying champions or key staff at any level in the District who have expertise, experience and relationships/networks, so that they can be easily called upon
- d Support for innovative infrastructure such as rpavirtual, Special Health Accommodation, vaccination hubs and mobile vaccination clinics.
- e Communities of practice set up to share knowledge and problem solve.

NSW Future Health Strategy	Vision: investment in ‘wellness’ 3: ‘people are healthy and well’ (additional: 3.4, 3.2, 5.1, 5.2)
SLHD Strategic Plan	Focus area 1: focus on prevention (additional: priority 8)
CE Priorities	11. ICT and Virtual Health. 13. Research. 18. Experience the human experience.
SLHD Equity Framework	3. prevention and health promotion

5 Recommendation
Continue to build and invest in sustainable equity infrastructure

Implication	How (examples)
Sustainable embedded equity infrastructure that addresses the determinants of health equity and can be drawn on/ramped-up as needed.	a Introduce KPIs/reporting around equity, and identify opportunities for how principles of equity are built into all service plans.
Translating existing infrastructure to reach a wider SLHD population, building capacity, capability and resilience.	b Strengthen and embed pre-existing platforms (see Rec 2).
Establish and maintain a flexible mindset that questions, exposes and innovates.	c Proactively identify new platforms (where the equity gaps are, such as newly vulnerable, those not accessing services, etc.).
	d Consult with users as to where, what and how.
	e. Maintain sustainable dedicated equity capacity and expertise. Engage staff whose opinions/ experiences/ideas could be leveraged off to extend equity programs that are already proven.
	f Continue to support and build consistent approaches to place based work.
	g Create sustainable long-term funding for equity infrastructure. Invest time, trust and tenacity in systems, tools, resourcing and capacity building.

NSW Future Health Strategy	2.4 strengthen equitable outcomes and access (additional: 3.1, 5.2)
SLHD Strategic Plan	Focus area 1: Equitable care for our community
CE Priorities	16. Vulnerable communities
SLHD Equity Framework	5. fairer, more inclusive system

6 Recommendation
Continue and strengthen attention on addressing existing and ongoing ‘wicked problems’ amplified by COVID-19 (not just in communities but also within SLHD)

Implication	How (examples)
Addressing the existing inequalities that increase vulnerability to and are exacerbated by pandemics and other major challenges.	a Targeted work service provision, such as waiting times for services targeting the most vulnerable and marginalised (e.g., oral health and child and family health services).
Leaders within health services are supported to make what might be difficult decisions around resource allocation in response to what emerging/unknown needs that are still to surface.	b Develop processes to identify and respond to unknown/unmet/unengaged/emerging needs.
A broad approach influencing the system and building pathways for consumers and services to better meet the needs of vulnerable communities.	c Addressing challenges, we don’t easily measure or see (racism/stigma/feeling valued).
	d Proactive planning for emerging challenges, such as long-COVID and climate change.
	e Strong partnership with human service agencies and other stakeholders.
	f Resourcing portfolios that work across silos

NSW Future Health Strategy	5. research and innovation informs service delivery (additional: 2.4, 2.5, 3.1, 5.1, 5.2, 6)
SLHD Strategic Plan	Focus area 6: Research, evidence and consumer experience drive service improvement.
CE Priorities	5. COVID response, recovery and reform. 13. Research.
SLHD Equity Framework	1. Individual health care. 2. how we operate

What we need to do more of

7 Recommendation
Expand leadership and governance ('with' rather than 'of')

Implication	How (examples)
Increased capacity to address determinants of health inequities.	<ul style="list-style-type: none"> a Build governance and leadership within -including Aboriginal leadership, consumer and community engagement, (Diverse) workforce governance and leadership with -including governmental partners (intersectoral), community-based organizations and advocacy groups; place and population based organisations. b Continue to support collaborative governance mechanisms (e.g., Healthy Strong Communities, Healthy Families Healthy Children, Healthy Homes and Neighbourhoods, Primary Care Partnership Committee, Aboriginal Health Group with AMS/ SVHN/SESLHD, Aboriginal Social Determinants of Health Committee). c Seek genuine and shared partnerships within communities. Investing in building capacity, trust and relationships with those experiencing inequities (e.g., through Peer Educator Program).
Broadening leadership and governance.	
Increased recognition of the value of diversity and understanding of the ability of the workforce and community to contribute ideas and work towards solutions.	

NSW Future Health Strategy	Core Values. (additional: 4.2, 3.7)
SLHD Strategic Plan	Priority Area 2. Focus Area 1 and 3 and 5.
CE Priorities	5. COVID response, recovery and reform.
SLHD Equity Framework	2. How we operate as an organisation. 5. Fairer system

What we need to do more of

8 Recommendation
Advocate for health equity and the determinants of health equity

Implication	How (examples)
Acting on the determinants of health equity outside of health care provision.	<ul style="list-style-type: none"> a Health Impact Assessments (HIAs)/equity checks/ research on significant equity issues that go beyond provision of health services but affect health of SLHD. b Building on existing equity resources, strengthening existing, and seeking new, partners from social care and other areas. c Advocating for SLHD communities and accessing funding to support these communities. d Strengthening data accessibility and linkage.
Improved understanding of the intersection of determinants of health and wellbeing that exist in our communities, the drivers of those differences and the role of Health Services.	

NSW Future Health Strategy	CORE values. (additional: 4.2, 3.7, 4)
SLHD Strategic Plan	Priority Area 2. Focus Area 1 and 3 and 5.
CE Priorities	6. Vulnerable Communities. 5. COVID response, recovery and reform.
SLHD Equity Framework	2. How we operate. 5. fairer system

What we need to do more of

9 Recommendation Walk the talk of equity by looking inwards

Implication

Bounce back better.
Addressing health inequalities resulting from differences in material living conditions shaped by public policy.

How (examples)

- a Acting as a Health Equity Leader (e.g., employment practices, carbon neutrality, procurement processes).
- b Workforce culture, practice systems and ways of working.
- c Identify ways of maintaining positive aspects of workplace change during COVID-19 (shared decision making, opportunities for growth, innovative and faster ways of working).

NSW Future Health Strategy	Core Values. (additional: 4.2, 3.7)
SLHD Strategic Plan	Priority Area 2. Focus Area 1 and 3 and 5.
CE Priorities	5. COVID response, recovery and reform.
SLHD Equity Framework	2. How we operate as an organisation. 5. Fairer system

What we could do differently

10 Recommendation Strengthen consideration of equity impacts and trade-offs when responding to an emergency

Implication

Capacity to consider medium-to long-term health (equity) impacts.
Capacity to consider unintended impacts.
Improved utilisation of resources.

How (examples)

- a Tools, processes and directives to systematically consider equity impacts, long-term impacts and trade-offs when responding to emergency situations.
- b A clear(er) process for deployment plans and tools to support decision making that includes guidance from e.g., Communities of Practice.
- c Stratify potential redeployments in the event of an emergency so that those who provide care to the most vulnerable/disadvantaged populations are redeployed behind those who provide more mainstream care

NSW Future Health Strategy	Values: respect. 3.5 (additional: 1.2, 2.1, 2.2, 2.3, 3.5, 4.2, 4.4, 4.5)
SLHD Strategic Plan	Focus Area 1 and 3 and 5.
CE Priorities	5. COVID response, recovery and reform.
SLHD Equity Framework	2. How we operate as an organisation. 3. work with communities

11 Recommendation
 Increased prioritisation of maintaining and enhancing services that are addressing health equity determinants and outcomes

Implication

Equity-focussed approach ensuring existing inequities are not worsened, nor are new inequities created, while attempting to reduce risk of exposure.
 Our health system is there for every one of us (not just the most visible or apparently urgent).

How (examples)

- a Flexible approaches that allow for maintaining services to vulnerable populations where possible.
- b Tools, processes and directives to systematically consider equity impacts, long-term impacts and trade-offs when responding to emergency situations. While taking into account scarcity of resourcing and external (e.g., State level) guidance.

NSW Future Health Strategy	Values: respect. 3.5 (additional: 1.2, 2.1, 2.2, 2.3, 3.5, 4.2, 4.4, 4.5)
SLHD Strategic Plan	Priority 3: inclusive healthcare responsive to Aboriginal communities. Focus Area 3 and 5.
CE Priorities	18. Experience the human experience. 5. COVID response, recovery and reform.
SLHD Equity Framework	1. Individual health care. 4. Take action on SDH. 2.How we operate

12 Recommendation
 Address inequities in workforce culture and systems

Implication

Address the double (work and personal) pandemic burden on health workforce.
 Address health equity within SLHD workforce.

How (examples)

- a. Maximise opportunities for positive impacts of WFH and flexible work (including flexibility of work location) for all staff, and particularly those staff impacted by movement and other restrictions.
- b. Providing opportunities for staff (of different levels and roles) to contribute to decisions and be empowered to take actions.
- c. Investigate approaches to address the double (work and personal) pandemic burden on the health workforce. For example:
 - Build resilience by engaging a multisystem approach; that is, consider the intersections between individual, workplace and societal levels, and recognise the capacities and support the needs of a diverse and structured workforce.
 - Recognise that longer-term demotivational fatigue may have a bigger impact on staff wellbeing than short-term fatigue, and design strategies to address longer-term demotivational fatigue.

- Long-term motivational strategies should recognise the impact of upheaval and the unpredictable nature of the pandemic, and should seek to engage people in developing strategies to respond to these challenges by drawing on a strength-based practice to enhance existing workplace and SLHD assets.
- Workplace allocation and/or deployment should be based on principles of equity and diversity, as individuals' circumstances are influenced by broader societal challenges as well as their own capacities and relationships.
- Supporting ownership and agency within units to set up services in response to the ongoing nature of the pandemic moving beyond reacting to circumstances as they arise; involve staff in planning for permanent service delivery structures that are agile and proactive in respect to the pandemic, and foster a shift away from 'disaster response' and towards long term stability.
- Communication strategies should be targeted and tested and include both individual and broader contextual factors in order to be more effective and to adhere to the principles of transparency, fairness, consistency, coordination and predictability.

NSW Future Health Strategy	Values: respect. 3.5 Close the gap (additional: 1.2, 2.1, 2.2, 2.3, 3.5, 4.2, 4.4, 4.5)
SLHD Strategic Plan	Priority 3: inclusive healthcare responsive to Aboriginal communities. Focus Area 3 and 5.
CE Priorities	18. Experience the human experience
SLHD Equity Framework	1. Individual health care. 4. Take action on SDH. 2.How we operate

Risks and consequences of COVID-19 infection
(in addition to previous)

13 Recommendation
Build on existing and/or establish new partnerships with organisations that work with frontline, essential and precarious workers

Implication	How (examples)
Relationships and trust already established that can be drawn on.	<p>a Build capacity and strategies to reach workers with effective culturally and linguistically tailored programs and practices for reducing exposure, testing, contact tracing, isolating and care strategies.</p> <p>b Advocate for measures to enhance capacity and remove barriers to preventive action, such as paid sick leave, increases in minimum wage, income support and welfare measures.</p>
Increased capacity to act on the determinants of health equity outside of health care provision.	
Lessons learned are shared.	

NSW Future Health Strategy	2 (additional: 1.1, 4.2, 4.3, 3.7, 5.2)
SLHD Strategic Plan	Focus area 1: Equitable care and a healthy built environment
CE Priorities	5. COVID response, recovery and reform. 13. Research. 16. Vulnerable communities
SLHD Equity Framework	1. Individual health care. 2. How we operate. 4. Action on SDH. 5. Fairer system

Risks and consequences of COVID-19 infection
(in addition to previous)

14 Recommendation
Invest in and advocate for healthy urban environments

Implication	How (examples)
Increased capacity to act on the determinants of health equity outside of health care provision.	<p>a Support active and public transport infrastructure and reduce existing inequalities in access.</p> <p>b Advocate for high quality/access to facilities/greenspace in locationally disadvantaged neighbourhoods.</p> <p>c Adopt strategies that put health equity and sustainability at the centre of planning.</p> <p>d Support urban planning and infrastructure development to make neighbourhood places where we work.</p> <p>e Advocate and collaborate to strengthen housing standards, affordable and social housing.</p> <p>f Collaborate and partner with communities and community-based organisations to support and build capacity to take action and advocate for equitable provision of greenspace, facilities and affordable and higher standards of housing.</p>
Taking action on health inequalities resulting from differences in material living conditions shaped by public policy.	

NSW Future Health Strategy	2 (additional: 1.1, 4.2, 4.3, 3.7, 5.2)
SLHD Strategic Plan	Focus area 1: Equitable care and a healthy built environment
CE Priorities	5. COVID response, recovery and reform. 13. Research. 16. Vulnerable communities
SLHD Equity Framework	1. Individual health care. 2. How we operate. 4. Action on SDH. 5. Fairer system

Risks and consequences of COVID-19 infection
(in addition to previous)

15 Recommendation
Continue to address data gaps

Implication	How (examples)
Increased knowledge of populations groups likely to experience inequitable impacts.	<p>a. Include:</p> <ul style="list-style-type: none"> number, characteristics and spatial distribution of people in precarious employment. people living in congregate housing e.g. boarding houses, temples, backpacker hostels, pub accommodation <p>b. More inclusive recording of the gender in NCIMS: Currently only four options: Male, Female, Transgender, Not stated/inadequately described.</p> <p>c. Review eligibility, demand and access, especially in pockets of socioeconomic disadvantage and 'new' areas of intersectional disadvantage that came to the fore during the pandemic.</p> <p>d. Develop a set of equity indicators for SLHD</p>

NSW Future Health Strategy	2 (additional: 1.1, 4.2, 4.3, 3.7, 5.2)
SLHD Strategic Plan	Focus area 1: Equitable care and a healthy built environment
CE Priorities	5. COVID response, recovery and reform. 13. Research. 16. Vulnerable communities
SLHD Equity Framework	1. Individual health care. 2. How we operate. 4. Action on SDH. 5. Fairer system

Changes to work (in addition to previous)

16 Recommendation
Advocate for and implement actions to address the equity impacts of Work from Home (WFH) and digital access

Implication	How (examples)
<p>Taking action on health inequalities resulting from differences in material living conditions that are shaped by economic and political structures.</p> <p>Acting on the determinants of health equity outside of health care provision.</p> <p>Platforms for equity-focused action that can be directly mobilised.</p>	<p>a Actions that challenge gender norms and address the unequal caring and unpaid work burden experienced by women.</p> <p>b Intimate Partner Violence policies and procedures that incorporate WFH guidance and responses.</p> <p>c Actions to address the digital divide (ability, affordability and access).</p> <p>d Advocate for reducing transport costs for people who cannot WFH.</p> <p>e Within SLHD, support staff transitioning into online work, identify individual and role/area of work specific digital barriers to online working.</p> <p>f Encourage and support partner organisations to adopt supportive flexible work practices.</p> <p>g Draw attention to the health implications of inequities.</p>

NSW Future Health Strategy	4. (additional, 2, 3, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 5.4).
SLHD Strategic Plan	Priority 2: strengthening and valuing diverse workforce. (additional: Focus area 5)
CE Priorities	6. Clinical engagement (additional: 5, 7)
SLHD Equity Framework	2. How we operate. 5. fairer system

17 Recommendation
Continue to develop and strengthen models of care that are patient-centred and involve proactive outreach and care coordination

Implication	How (examples)
Platforms for equity-focused and place-based action can be directly mobilised.	<ul style="list-style-type: none"> a Continue investing in integrated care, care coordination and collaborative practices between services. b Continue supporting and identifying new opportunities for outreach services. c Continue to develop hybrid approaches to virtual care and in-person care, considering access, acceptability, quality and appropriateness of services. d Continue to build staff capacity in business-as-usual times in areas that support equity-focused responses, such as virtual care, mental health and queer, Trans and gender-diverse people's health and needs.

NSW Future Health Strategy	3. (additional: 3.7, 2.4,2.5)
SLHD Strategic Plan	Focus area 3 (services) (additional: Focus area 4: ICT to support care)
CE Priorities	5. COVID response, recovery and reform. 7. Mental health services. 11. ICT and virtual health
SLHD Equity Framework	1. Individual health care. 4. Action on SDH. 5. Fairer system 2.

18 Recommendation
Develop a strategy to address longer term equity impacts from the pandemic and the response

Implication	How (examples)
Platforms for equity-focused and place-based action could be mobilised/ramped-up when needed.	a Develop plans and resourcing for longer term health equity impacts such as:
Explicit targeted response and resourcing for identified vulnerable communities (populations and places).	<ul style="list-style-type: none"> i Unmet need and delayed seeking of care ii Delayed diagnosis and treatment, particularly for vulnerable children and young people iii People lost to/disengaged from the system.
Health services that are available, acceptable, appropriate and of high quality for populations already experiencing health inequities and also populations more likely to be vulnerable to future impacts.	b Using an adaptive, flexible approach that allows for context specific service provision.

NSW Future Health Strategy	3. (additional: 3.7, 2.4,2.5)
SLHD Strategic Plan	Focus area 3 (services) (additional: Focus area 4: ICT to support care)
CE Priorities	5. COVID response, recovery and reform. 7. Mental health services. 11. ICT and virtual health
SLHD Equity Framework	1. Individual health care. 4. Action on SDH. 5. Fairer system

19 Recommendation
Continue to build equity sensitive health services

Implication

Health services that are available, acceptable, appropriate and of high quality for populations already experiencing health inequities and also populations more likely to be vulnerable to future impacts.

How (examples)

- a Cultural competency and safety (of staff and/or what and how services are delivered).
- b Physically locating and/or delivering services in communities.
- c Identifying and mitigating barriers to accessing services.
- d Engaging communities and patients in the planning of services.
- e Strengthened preventative hospital avoidance and health creation services and activities as well as treatment.

NSW Future Health Strategy	3. (additional: 3.7, 2.4,2.5)
SLHD Strategic Plan	Focus area 3 (services) (additional: Focus area 4: ICT to support care)
CE Priorities	5. COVID response, recovery and reform. 7. Mental health services. 11. ICT and virtual health
SLHD Equity Framework	1. Individual health care. 4. Action on SDH. 5. Fairer system

20 Recommendation
Adapt COVID-19 response guidance and policies to different settings

Implication

Bounce back better.
Strengthened capacity across system to respond.
Building on lessons learnt during the pandemic – how quickly and creatively staff responded with innovation and courage, and how some of the traditional barriers to change and collaboration were ignored.

How (examples)

- a Adapt guidance for COVID management at each alert level (red, amber, green) to different settings of care (e.g., Hospital settings, community settings, home visits).
- b When developing risk management policy in community-based services:
 - i Ensure clear and transparent decision making and communication to enhance staff and patients understanding of decision-making processes and outcomes.
 - ii Identify opportunities for staff to engage in decision making and planning processes, in particular, in identifying context specific issues and solutions.
- c Continue and strengthen where possible, integrating flexibility and innovation into harm and risk reduction strategies to allow for adaption of services to maintain (and resume) access, particularly for vulnerable population groups and places.

NSW Future Health Strategy	3. (additional: 3.7, 2.4,2.5)
SLHD Strategic Plan	Focus area 3 (services) (additional: Focus area 4: ICT to support care)
CE Priorities	5. COVID response, recovery and reform. 7. Mental health services. 11. ICT and virtual health
SLHD Equity Framework	1. Individual health care. 4. Action on SDH. 5. Fairer system

21 Recommendation
 Further strengthen expertise and capacity in relation to groups identified as experiencing negative health equity impacts during the pandemic

Implication	How (examples)
Increased capacity to address determinants of health inequities.	a Continue to support population and place specific roles within SLHD and population specific capacity and expertise.
Acting on the determinants of health equity outside of health care provision.	b Continue to support roles that incorporate lived experience, such as cultural support workers, community health workers, bilingual community educators and peer workers.
Health services that are available, acceptable, appropriate and of high quality for populations already experiencing health inequities and also populations more likely to be vulnerable to future impacts.	c Support peer-led, co-designed and collaborative approaches.
	d Identify ways to strengthen engagement of population groups identified as experiencing negative health equity impacts (the who and how).
	e Continue to encourage and facilitate community participation in promoting health, wellbeing and resilience.

NSW Future Health Strategy	3. (additional: 3.7, 2.4,2.5)
SLHD Strategic Plan	Focus area 3 (services) (additional: Focus area 4: ICT to support care)
CE Priorities	5. COVID response, recovery and reform. 7. Mental health services. 11. ICT and virtual health
SLHD Equity Framework	1. Individual health care. 4. Action on SDH. 5. Fairer system

22 Recommendation
 Identify and implement approaches so that staff and service design can be informed by the social and structural context that impacts on clients of these services

Implication	How (examples)
Increased capacity to address determinants of health inequities.	a Integrate clinical decision support systems that screen and document social determinants which influence an individual's health and use of health care, prompting practitioners to take action, such as facilitation of referrals to institutional and community support services.
Acting on the determinants of health equity outside of health care provision.	b Identify options to integrate social determinant screening instruments into electronic health records.
	c Build knowledge and capacity within the health system and patients, about rights and expectations in relation to health service provision.

NSW Future Health Strategy	3. (additional: 3.7, 2.4,2.5)
SLHD Strategic Plan	Focus area 3 (services) (additional: Focus area 4: ICT to support care)
CE Priorities	5. COVID response, recovery and reform. 7. Mental health services. 11. ICT and virtual health
SLHD Equity Framework	1. Individual health care. 4. Action on SDH. 5. Fairer system





Sydney
Local Health District



UNSW
SYDNEY