HEALTH & EQUITY PROFILES

Project Report
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Centre for Health Equity Training, Research and Evaluation
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EXECUTIVE SUMMARY

The need for Area Health Services (AHS) to develop an informed understanding of patterns of health inequity within their area was highlighted during the development of the NSW Health and Equity Statement. Improved information should enable AHS to identify and address the needs of priority populations and groups in their local area. As part of the AHS Performance Agreement (Public Health Protection and Health Promotion Section) all Areas are required to develop Inequity Profiles to underpin the local three year Public Health Plans. In 2002 the Centre for Health Equity Training Research and Evaluation (CHETRE) was contracted to:

- review the development of Health and Equity Profiles by Area Health Services; and
- identify areas for future development.

Teleconferences and a one-day workshop were held with AHS staff involved in the development of the profile, to review progress and the issues related to the development of the profiles. Area Health Services also made copies of their inequity profile (or a draft) available at the workshop.

Fifteen of the AHS provided copies of the inequity profiles at the workshop with only two AHS not having made any attempt. The majority of the profiles, however, are minimalist in their approach, focusing on describing health inequities with limited or no analysis of the implications for the AHS of these health inequities.

The teleconferences and workshop elicited a range of issues for consideration by AHS and the NSW Health Department including:

- the need for a shared understanding about the concepts of equity and equality;
- moving beyond looking at patterns of inequity within AHS to addressing equity of access and equity of resource allocation;
- strategic placement of the profiles to inform planning and service development;
- the scope and focus of the profiles – how "health" is defined, focusing on the geographic distribution of health or the distribution of the underlying determinants of health, and a concern that the process of simply describing health inequities would not provide new information;
- the need for ongoing technical support and guidance, an interest in looking at ways in which existing data sets could be better used to provide relevant data and developing measures for health and wellness – moving beyond measuring "illness";
- the need for a communication strategy to support the profiles so that all groups are involved in the development and have a clear understanding of the purpose and use of the profiles;
- leadership and collaboration – the release of the NSW Health and Equity Statement was seen as crucial in providing high level commitment for AHS to address health inequity; and
- moving from describing to acting – if the profiles are to be useful they need to be linked with action.

This project report outlines future directions for building on the significant progress achieved to date in the development of the health and equity profiles. The release of the NSW Health and Equity Statement provides an impetus for the further development of these profiles and it is recommended that:

1. The profiles are called Health and Equity Profiles.

2. NSW Health develop a statement to provide guidance to AHS on:
   - The purpose of the profiles and ways in which they can be linked to planning and service development processes;
   - The scopes of the profiles;
   - "Core" indicators to be included in the profiles and suggestions on additional indicators to enhance the profiles; and
   - Definitions of major concepts including health, inequity and inequality

3. NSW Health provide technical support to AHS in the development of the profiles by:
   - Negotiating a set of "core" indicators to be included in the profiles and how they should be presented;
   - Providing technical support and data analysis, especially to rural areas, in the "core" indicator areas.
   - Providing profiles on health issues for groups that may be "invisible" to geographically based local analysis, for example homeless people, refugees, and prisoners.
   - Exploring the potential expansion of existing data sets such as HOIST and CATI surveys to include equity related data.
   - Exploring ways of measuring positive health within individuals and communities.

4. As part of the roll out of the Health and Equity Statement NSW Health provide:
   - Access to evidence of effective interventions to address health inequality at the local level;
   - Develop a communication strategy for the health sector and the wider community on the importance of addressing health inequalities and the action that is necessary to reduce health inequality.

1. BACKGROUND

1.1 Development of Inequity Profiles

During the development of the NSW Health and Equity Statement there was extensive discussion on the need for Area Health Services (AHS) to develop an informed understanding of patterns of health inequity within their area. This was seen as an important adjunct to the information contained in the NSW Chief Health Officer's Report and would enable AHS to identify and address the needs of priority populations and groups in their local area.

The requirement for AHS to develop Inequity Profiles was included in the Performance Agreement (Public Health Protection and Health Promotion Section) with AHS CEOs to underpin the local three year Public Health Plans.

In order to support AHS NSW Health convened a Committee to provide advice to AHS on minimum requirements to fulfill obligations under the performance agreement. The advice of this Committee was released on 8th March, 2002 and the relevant data were analysed centrally and made available via the HOIST system to all AHS.

The minimum data set provided the following information for each Local Government Area (LGA) within an AHS:

- Premature deaths
- Preventable deaths (Primary, Secondary and Tertiary)
- Asthma
- Psychological stress
- Smoking
- Falls in older people
- Teenage mothers
- Childhood immunisation rates

1.2 Aims & methods of the project

The aim of the project was to:

- review the development of Health and Equity Profiles by Area Health Services; and
- identify areas for future development.

The project involved:

1. **Collection of profiles**
   All AHS were asked if they would be willing to make copies of their profiles available to other workshop participants.

2. Teleconferences with AHS Staff

Teleconferences with staff from all Area Health Services in NSW to discuss:

- the approaches that had been used by Area Health Services in the development of their profiles;
- the types of data that had been included in the profile;
- ways in which the profiles would be used within the AHS;
- the strengths and weaknesses in the approaches that had been used;
- key issues to be addressed in the workshop.

(See Appendix 1 for participants and Appendix 2 for Questions covered in the teleconferences).

3. Workshop

A one-day workshop was held to discuss progress that had been made and issues related to the development and use of the profiles.

(See Appendix 3 for Workshop Program and Appendix 4 for Workshop Participants).

2. PROGRESS IN DEVELOPING THE PROFILES

2.1 Developing Health and Equity Profiles

Fifteen of the 17 Area Health Services have developed or are in the process of developing Profiles and the majority of AHS made these profiles available for distribution to other AHS (See Appendix 5).

- The majority of profiles were minimalist in their approach and had built their profile around the data that had been provided by NSW Health.
- A number of AHS had built their profile into existing planning or reporting processes such as Epidemiology Profiles for their Areas or as background rationale in the development of their Public Health Plans.
- At least two AHS saw the profile as directly feeding into action to be undertaken as part of Health People 2000.
- At least three AHS had taken a broad intersectoral approach to the development of their profile and had consulted with and/or engaged other government departments, local government and community groups.

The range of profiles can be seen in the accompanying documentation.

The profiles were generally descriptive with little discussion or analysis on the meanings of the findings. It was not clear to those developing profiles on the extent to which these profiles were plans of action to address health inequality or were to inform the development of action plans.

Key methodological and service delivery issues related to the development of the profiles are addressed later in this report. (See Section 3)

2.2 Purpose of the profiles

Through the processes of the teleconference and the workshop a number of purposes for the Profiles were identified:

- The existence of the profiles and the incorporation of their development into CEO performance agreements was seen as making explicit the commitment of NSW Health to addressing health inequity.
- The data that is presented in the majority of the Profiles provides a clear and easy to understand evidence of patterns of health inequity in an AHS.
- The Profiles have the potential to identify specific locations and population groups within an AHS that may be experiencing poorer health.

- As well as allowing better understanding of the patterns of health inequity within an AHS the Profiles were also seen as being able to provide information:
  - On patterns of health service use and resource allocation within AHS to inform planning and health service development.
- The profiles also provide baseline data against which progress can be monitored.

3. WHAT ARE THE ISSUES THAT WE NEED TO ADDRESS TO IMPROVE THE PROFILES?

3.1 Equity or Equality

The fundamental concepts of equity and equality are difficult conceptually and often contested because decisions are based on values and assumptions about the nature of problems to be addressed. This is often compounded because people use the words interchangeably, often with differing meanings. Clarifying the fundamental concepts to be covered in the Profiles was seen as an important step in their further development.

For the purposes of this project the following definitions have been taken from the NSW Health and Equity Statement:

"Equity is about equal access to services for equal need, equal utilisation for equal need and equal quality of care or services for all, with a focus on health outcomes. An equity approach recognises that not every one has the same level of health or level of resources to deal with their health problems and it may therefore be important to deal with people differently in order to work towards equal outcomes."

"Equity in health implies that ideally everyone should have a fair opportunity to attain their full potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided. Based on this definition the aim of policy for equity and health is not to eliminate all health differences so that everyone has the same level of health, but rather to reduce or eliminate those, which result from factors which are considered to be both avoidable and unfair. Equity is therefore concerned with creating opportunities for health and with bringing health differentials down to the lowest levels possible."[1]

This definition illustrates that three factors are important in deciding if health in unequal or
inequitable:

- The health of the groups involved is not equal ***but in addition****;*
- A value decision is made as to whether the differences are seen as unfair or unjust; and
- The differences are seen as avoidable – we can do something about them.

Having a clear understanding of the issues to be addressed in the Profiles is further compounded by the many ways in which the health of people can be seen as vulnerable or disadvantaged. People may be seen as disadvantaged by:

- Particular health problems or health risks, such as people who have mental health problems or people with diabetes; or

[1] Whitehead M. The concepts and principles of equity and health. Europe: World Health Organisation, Regional Office, 1990.

- Stages in their life cycle or specific life events, such as birth of a baby, young people or older people.

However most people when talking about health inequality are referring to differences related to the socioeconomic differences between groups.

3.2 Equity of what?

One of the key issues to emerge from the workshop was the interest by AHS in not only looking at the patterns of health inequity within their areas but also issues related to access to services and the distribution of resources.

Equity of resource allocation

Several AHS were interested in examining the distribution of health resources within and between Area Health Services. For example there were concerns that despite attempts to link the Resource Distribution Formula (RDF) with the health and demography of local areas there was no requirement for AHS to distribute these resources in an equitable way internally. There was also no easy way of determining the equitable distribution of resources between types of illnesses (heart disease versus psychiatric illness) or service types (community care versus acute care services).

Equity of access

Many participants identified the need for Profiles to provide data on the access to services by vulnerable populations and groups within their Area and to identify differences in the quality and outcomes of service provision related to socioeconomic status. For example, access to smoking cessation programs or nicotine replacement treatments by low socioeconomic groups.

Equity of outcome

From a population health perspective there was strong interest in establishing the patterns of health inequity at a population level. This was seen as being reflected in a number of indicators such as mortality and preventable mortality, morbidity, burden of disease, health risk factors and measures of well-being. This was seen as important in identifying specific population groups who had poorer health as well as geographic locations.

3.3 Inequity or Health and Equity profiles?

The original brief for the development of the profiles spoke about health inequity profiles. This title was seen as having two main drawbacks by those consulted on the Teleconferences and in the Workshop. Firstly, it was perceived, as a negative concept that could be seen as further stigmatising groups whose health was poor. Secondly, it did not convey a sense of purpose in developing the profiles. Renaming the profiles as "Health and Equity Profiles" was seen as conveying a more action oriented purpose for the gathering and presentation of the data.

However it was also recognised that AHS should have the freedom to decide what the profiles would be called locally to ensure that they fitted into the wider planning and policy processes.

3.4 Strategic placement of the profiles to inform planning and service development

The requirement for AHS to develop Inequity Profiles developed independently from the development of Public Health Plans although there was a clear understanding that the Public Health Plans needed to be informed by data on patterns of health inequity in their areas. In many AHS the connection between the development of the Health Inequity profiles and Public Health Plans has not been explicitly made. In addition although the development of the Inequity Profiles was included in the Strategies Document that supports the Health and Equity Statement it was not included as a recommendation in the Statement itself. The participants in the workshop and teleconferences saw the lack of clear links to major policy or planning initiatives as increasing the likelihood that the Profiles would be marginalised in their ability to influence planning and service development.

Despite these limitations there were a number of examples given at the workshop on the ways in which the profiles were already being used to influence policy and service development within AHS.

Payment for Antenatal Classes in Wentworth

Recently there has been discussion on the possibility of charging couples to attend Antenatal Classes. Initially the discussion has been that this would act as a major deterrent for people on low-incomes attending classes and therefore the current no cost policy should remain. However a review of those who were currently attending the classes revealed that they were mainly from high socioeconomic areas and that few people from the most disadvantaged suburbs in the area were attending classes. A decision was made to charge for classes but to use the income to make services more accessible and appropriate to those who were not currently attending, for example by out reach programs.

3.5 Scope and focus of the profiles

There were a number of substantial issues raised about the scope and focus of the profiles. These included:

Defining health

There was debate on whether the profiles should be used to describe patterns of illness and disease within AHS or whether they should be based on a social view of health that placed the patterns of poor health in the physical, social and economic environments in which people live.

This decision has a profound impact on the structure of the profiles and the data that is seen as needed to be included as illustrated in the following box. There was general support for the profiles taking a broad social view of health.

Illness in Anyplace

In this profile the focus is on presenting data on mortality/ preventable mortality and morbidity, levels of risk factors and health service use. Differences in health status is presented by age, gender, place of residence, country of birth and where available education level, income and employment status.

Health in Anyplace

In this profile similar health data is presented but in addition there is interest in contextualising the data to include underlying rates of unemployment, education and other socioeconomic. Ideally it would be useful to have measures of resilience and capacity of individuals and communities.

Focus on the geographic distribution of health or the health of specific populations

The available technology has now made it easier to demonstrate geographic patterns of poor health and the distribution of the underlying determinants of health (such as levels of unemployment, income and education). However there may be specific populations within an AHS whose needs may not be recognised through analysis of geographically distributed data. For example, the needs of Aboriginal and Torres Strait Islander Peoples, refugees and recently arrived migrants, or people who have recently been released from prison.

It was seen as important that the Profiles present comprehensive data on a broad range of health inequalities and not only those that were geographically distributed. This raised the issue of what data was available locally for many of these groups and the need to rely on health data from other groups with a similar background that could be supplemented by qualitative data. The need to supplement quantitative data was seen as important in moving from describing patterns of health difference to understanding why this was happening and what could be done. The provision of background profiles on health issues for specific population subgroups (such as homeless people and prisoners) would reduce the duplication of effort by each AHS.

Data or data plus action

It was not clear to many of those who participated in the consultation processes on the extent to which the Inequity Profiles were primarily to be used to provide evidence of patterns of health inequity in AHS or were there to provide a blueprint for action. There was some disquiet that the process of describing health inequities would not provide new information and only serve to reinforce the idea that by somehow describing the problems they would be addressed. This again highlighted the importance of linking the Profiles to existing planning and policy development processes.

3.6 Supporting the development of the profiles

Technical support and guidance

There was strong consensus among those at the workshop that the Epidemiology Branch in NSW Health has a vital role in providing technical support to AHS on the range of data that is available and guidance on how it should be presented, for example at what levels and when should data be aggregated – collector district, suburb, postcode or LGA. The provision of the premature mortality data to AHS as part of the development of the Inequity Profiles was seen as a good example of how centrally provided data could assist areas.

The extent to which there should be a minimum data set that should be provided in all Profiles was discussed and there was general agreement that it would be useful if clear minimum data expectations were identified for general reporting. Area Health Services would then be free to supplement this data in ways that they found most useful.

Guidance was also sought on the best way to present data. For example, how should comparative population data be estimated – for example comparison of the top and bottom twenty percent of the population or the bottom twenty percent compared to the population average, etc.

Expanded use of existing data sets

There was interest in looking at ways in which existing data sets could be better used to provide relevant data in the preparation of the Profiles. This was seen as being facilitated in two ways:

- Incorporating data sets from other sectors on the HOIST data set, such as transport use or planning data sets from other government departments; and
- Enhancing routine data sets, such as the health survey data collection, with specific questions on equity related issues. This could be done at state and AHS levels.

Measuring health and illness

In the longer term it was recognised that work needed to be done on identifying measures of health and wellness at individual and community level that places the creation of health in a social context. This was important for two reasons. Firstly in the debates that are made over the need to take a more health-oriented/preventive focus the outcomes of interventions that are less closely related to conventional health interventions (such as resilience or self management) need to be robustly measured. Secondly continuing to focus on illness reduces the likelihood of engaging other government and non-government organisations and community groups in taking action to reduce health inequality, especially in creating the conditions that will lead to prevention and reduced exposure to social and economic environments that affect health.

3.7 Communication strategies

Developing a communication strategy to support the profiles was seen as important. There were many groups who needed to be involved in the development of the profiles and who needed to have a clear understanding of the purpose and use of the profiles. There were also a large number of potential users of the profiles (including planners, service providers, other sectors, local government and local communities) who needed to understand the nature of the data presented and the implications for policy and practice.

Many of those were consulted saw that there were a number of potential risks that needed to be managed if the profiles were to be effectively used:

- There was a risk that the profiles would only reinforce the stigmatisation of local communities or groups with poor health;
- AHS Boards and Senior Managers may not want the data freely available as it may put demands on them to provide additional services for which there were no resources available;
- The community may not see the health differentials as resulting from structural factors but from individual behaviour, for example levels of teenage pregnancy or smoking rates. There may be little sympathy for giving priority to addressing these issues rather than more general health concerns.

3.8 Leadership and collaboration

The release of the NSW Health and Equity Statement was seen as crucial in providing high level commitment for AHS to take action to address health inequity. The fact that the majority of AHS had made some attempt to develop their Profile demonstrates an underlying willingness to act on this issue. However without a clear mandate, resourcing and ongoing support from NSW Health there was a perception that issues of equity would continue to be marginalised by acute service delivery demands.

The willingness of the majority of AHS to share their profiles with each other was seen as demonstrating high levels of trust between those involved and a willingness to work together on this issue. There would appear to be significant advantages in encouraging AHS to work collaboratively on the development of profiles.

3.9 Moving from describing to action

As mentioned earlier there was a strong sense in which people felt that enough time had been invested in describing the problems of health inequity in NSW and there now needed to be a commitment to action. Continuing to describe the problem with no commitment to action was seen as reinforcing a sense of powerlessness that nothing could be done. If the profiles were to be seen as useful they needed to be linked with action.

A key component of any further work to develop the Profiles was to provide AHS staff with skills and support in identifying evidence of effective intervention and ensuring that these interventions were incorporated in planning and service development proposals.

4. MOVING FORWARD

4.1 Clear definition of the scope and purpose of the profiles

Most AHS now have a profile that explores issues of health inequality in their communities. Many of these profiles are minimalist and will need to be more fully developed to be useful for planning and service development purposes.

This process will be greatly assisted by:

- Guidance from NSW Health on the purpose of the statements;
- Defining major conceptual terms addressed in the profiles such as health, inequality, and inequity; and
- Outlining in more detail the potential scope of the Profiles to look at issues related to resource allocation, access to services as well as health outcomes.

4.2 Strategic Placement of the Profiles within planning processes.

There was general agreement that the profiles should be formally linked to the NSW Health and Equity Statement as this will provide a mandate for their development and use. As well thought needs to be given to how the information in the plans will be used to inform planning and service development at state and AHS levels. Currently the profiles range from being stand alone documents to being part of Epidemiology Profiles, Public Health Plans as well as being used to guide service or disease specific service development plans. There was no clear consensus on the best way in which integration of the profiles into planning and service development processes should occur.

4.3 Provision of support and technical advice

Several areas were identified where support and technical advice would be useful. The first of these was to provide opportunities for staff from AHS to meet together and share their experiences in developing the profiles and include:

- Identifying opportunities within existing networks (such as the Directors of Health Service Development) to promote the equity profiles;
- The creation of an electronic list to facilitate collaboration and the exchange of information between AHSs and the Department about issues relating to the equity profiles.

One of the outcomes from increased opportunities to meet would be enhanced system capacity through exchange of knowledge and experience.

Secondly technical advice and support from the Epidemiology Branch within NSW Health was sought to assist in:

- Negotiating a set of "core" indicators to be included in the profiles and how they should be presented;
- Providing technical support and data analysis , especially to rural areas, in the "core" indicator areas.
- Providing profiles on health issues for groups that may be "invisible" to geographically based local analysis such as homeless people, refugees, and prisoners.
- Exploring the potential expansion of existing data sets such as HOIST and CATI surveys to include equity related data.
- Exploring ways of measuring positive health within individuals and communities.

4.4 Shift from description to action

The Health and Equity Statement provides an opportunity to shift from describing the patterns of health inequality in NSW to taking action that will reduce health inequality. The profiles therefore need to be linked at the local level to action that is effective. This will require focussed attention on building the capacity of AHS to tackle health inequalities including:

- provision and creation of evidence of effective interventions
- providing staff with skills and resources to undertake these interventions
- developing organisational infrastructure, such as information systems to facilitate this work.

4.5 Engagement of key stakeholders and the community

There are many people who need to be engaged in taking action to address health inequality and who will be "users" of the profiles. At AHS level this includes:

- AHS Board
- Clinical Councils
- Senior AHS Executives
- Local workers who may need to reorient their current practice
- Other government and non-government organisations and community groups

As well local communities also need to be informed about patterns of health inequality that exist in their area and the implications this may have for the way in which local health resources are invested.

An effective communication strategy is required to inform these groups of the need to address health inequalities and to address their concerns. Given that any decision(s) on defining health inequalities is value based, and often contested, it is important not to assume that there will be an open discussion on the nature of health inequality, its causes and possible interventions.

5. CONCLUSION & RECOMMENDATIONS

There has been significant progress by AHS in the development of their health inequity profiles. The release of the NSW Health and Equity Statement provides an impetus for the further development of these profiles and it is recommended that:

5.1 The profiles are called Health and Equity Profiles.

5.2 NSW Health develop a statement to provide guidance to AHS on:

- The purpose of the profiles and ways in which they can be linked to planning and service development processes;
- The scopes of the profiles;
- “Core” indicators to be included in the profiles and suggestions on additional indicators to enhance the profiles; and
- Definitions of major concepts including health, inequity and inequality

5.3 NSW Health provide technical support to AHS in the development of the profiles by:

- Negotiating a set of “core” indicators to be included in the profiles and how they should be presented;
- Providing technical support and data analysis, especially to rural areas, in the “core” indicator areas.
- Providing profiles on health issues for groups that may be “invisible” to geographically based local analysis, for example homeless people, refugees, and prisoners.
- Exploring the potential expansion of existing data sets such as HOIST and CATI surveys to include equity related data.
- Exploring ways of measuring positive health within individuals and communities.

5.4 As part of the roll out of the Health and Equity Statement NSW Health provide:

- Access to evidence of effective interventions to address health inequality at the local level;
- Develop a communication strategy for the health sector and the wider community on the importance of addressing health inequalities and the action that is necessary to reduce health inequality.

These recommendations have been developed on the basis that responsibility for implementation is shared across the NSW Department of Health between the relevant public health (epidemiology, health protection and health promotion), policy, planning and information system areas.

APPENDICES

APPENDIX 1: PROFILE INTERVIEWS – PARTICIPANTS

Participant			Area
1.	Sarah Thackway	Population Health	Illawarra AHS
2.	Darren Mayne	Population Health	Illawarra AHS
3.	Therese Jones	Public Health Unit	Mid Western AHS
4.	Jeannine Liddle	Public Health Unit	Mid Western AHS
5.	Kim Gilchrist	Public Health Unit	Greater Murray AHS
6.	Tony Kolbe	Public Health Unit	Greater Murray AHS
7.	Peter Sainsbury	Population Health	Central Sydney AHS
8.	Alexandra Raulli	Population Health	Macquarie AHS
9.	Karin Fisher	Population Health	New England AHS
10.	Peter Massey	Population Health	New England AHS
11.	Victor Carey	Public Health Unit	Northern Sydney AHS
12.	Peter Lewis	Public Health Unit	Central Coast AHS
13.	Margaret Lesjak	Public Health Unit	Southern AHS
14.	Glenn Close	EIRE	Western Sydney AHS
15.	Sallie Newell	Population Health & Research	Northern Rivers AHS
16.	Therese Dunn	Population Health & Research	Northern Rivers AHS
17.	Bin Jalaludin	Population Health	South Western Sydney AHS
18.	Seeham Girgis	Population Health	South Western Sydney AHS
19.	Kris Hort	Population Health	Wentworth AHS
20.	Christine Dwyer	Population Health	Wentworth AHS
21.	Ann Ryan	Population Health & Planning	Mid North Coast AHS
22.	Paul Corben	Population Health & Planning	Mid North Coast AHS
23.	Cath Kennedy	Population Health	Far West AHS
24.	Hugh Bourke	Population Health	Far West AHS
25.	Yona Cass	Health Promotion	South Eastern Sydney AHS
26.	Mindi Xie	Public Health Unit	South Eastern Sydney AHS
27.	Craig Dalton	Public Health Unit	Hunter AHS
28.	Megan Cahill	Population Health & Planning	Hunter AHS
29.	Jenny White	Population Health & Planning	Hunter AHS

APPENDIX 2: PROFILE INTERVIEW QUESTIONS

Five interviews were conducted with all of the Area Health Services via teleconference – representatives from three to four Areas participated in four of the interviews and a fifth teleconference was conducted separately with one AHS. The interviews were conducted by the CHETRE project team (Liz Harris & Sarah Simpson) and Hannah Baird, Centre for Health Promotion, also participated in some of the interviews.

The following questions were e-mailed to all interview participants in advance of the interview.

1. Please briefly outline:
   - The approach used* to develop your inequity profile. For example, was there a consultation process with key stakeholders?
   - The types of data in your Area inequity profile. For example, does it include the minimum data set (preventable avoidable mortality) only or a range of other performance indicators as well?

2. How will the inequity profile be used within your Area? For example, as a basis for developing interventions to reduce health inequalities and/or as a basis for the public health plan and/or will it be integrated into all Area planning?

3. Please identify one-two of the strengths in the approach used in developing your inequity profile.

4. Please identify one-two of the limitations in the approach used in developing your inequity profile.

5. Please identify one key issue that you would like to see addressed as part of the inequity profiles workshop in May 2003.

* For those Areas who are in the process of developing their inequity profile, your responses to these questions should be based on what the Area intends to do. For example, in question 1, please outline the types of data that your Area plans to use in the inequity profile.

APPENDIX 3: PROFILES WORKSHOP - PROGRAM

Workshop Aims:

1. To showcase the inequity profiles developed and/or being developed by Areas.
2. To highlight some of the key issues from the development phase eg. the limitations of existing data.
3. To identify the issues and some of the challenges in moving from describing to acting.

9.30-10am	1. **Welcome** (Liz Harris, Director, Centre for Health Equity Training Research & Evaluation & Sarah Simpson, CHETRE) • **Introductions** (Liz Harris) • **Preliminary findings/feedback from inequity profile interviews** (Sarah Simpson)
10-10.30am	2. **What are the inequity profiles for and why are they important?** (Bill Bellew, Director, Centre for Health Promotion, NSW Health)
10.30-11am	3. **Equity: Inequality. Same or different?** (Liz Harris) – conceptual issues.
11-11.30am	**Morning Tea**
11.30am-1pm	4. **What do the existing inequity profiles look like?** (Hannah Baird, Centre for Health Promotion, facilitator) • **Illawarra AHS** (Sarah Thackway, Director, Public Health, Manager, Population Health, 15-20mins) • **Northern Rivers AHS** (Uta Dietrich, Manager, Health Promotion Unit, 15-20mins) • **Wentworth AHS** (Kris Hort, Director, Population Health Unit, 15-20mins) • **Questions & group discussion** (Hannah Baird, 30 mins)
1-2pm	**Lunch**
2-2.45pm	5. **Using inequity profiles in practice** (Sarah Simpson, facilitator) – panel discussion from 4 different perspectives (5 mins each)

	• **How would a CEO of an Area use the profile? Potential gains & risks** • **How would the Chairperson of an Area Board use the profile? Potential gains & risks** • **How would the Director-General of NSW Health use the profile? Potential gains & risks** • **How would the Director, Centre for Health Promotion use the profile? Potential gains & risks** • **Group discussion** (10 mins)
2.45-3.15pm	6. **Inequity profiles: what should they look like?** (Liz Harris) – small groupwork eg. • **data limitations** • **level of aggregation** • **location or specific populations**
3.15-3.45pm	**Afternoon Tea**
3.45-4pm	7. **Feedback from small groupwork in session 6** (Liz Harris)
4-4.30pm	8. **Communication: how much does the community need to know?** (Liz Harris - group discussion)
4.30-4.50pm	9. **Moving forward** (Bill Bellew)
4.50-5pm	10. **Evaluation**
5pm	**Close**

APPENDIX 4: PROFILES WORKSHOP - PARTICIPANTS

	Name	Organisation
1.	Alexandra Raulli	Macquarie AHS
2.	Jo Mitchell	South Eastern Sydney AHS
3.	Jeannine Liddle	Mid Western AHS
4.	Therese Jones	Mid Western AHS
5.	Peter Sainsbury	Central Sydney AHS
6.	Ros Poulos	Central Sydney AHS
7.	Chris Rissel	Central Sydney AHS
8.	Sarah Thackway	Illawarra AHS
9.	Darren Mayne	Illawarra AHS
10.	Hugh Burke	Far West AHS
11.	Margaret Lesjak	Southern AHS
12.	Pete Whitecross	Northern Sydney AHS
13.	David Small	Northern Sydney AHS
14.	Kim Gilchrist	Greater Murray AHS
15.	Tony Buttigieg	Central Coast AHS
16.	Peter Lewis	Central Coast AHS
17.	Shani Prosser	Corrections Health AHS
18.	Justine Waters	Northern Rivers AHS
19.	Uta Dietrich	Northern Rivers AHS
20.	Kris Hort	Wentworth AHS
21.	Karen Lenihan	Wentworth AHS
22.	Seeham Girgis	South Western Sydney AHS
23.	Karin Fisher	New England AHS
24.	Ann Ryan	Mid North Coast AHS
25.	Jennifer White	Hunter AHS
26.	Helen Moore	Centre for Epidemiology, NSW Department of Health
27.	Janet Anderson	Primary Health & Community Care Branch, NSW Department of Health
28.	Philip Vita	Review of Healthy People 2005
29.	Chris Mills	Consultant, Review of Healthy People 2005

	Name	Organisation
30.	Bill Bellew	Centre for Health Promotion, NSW Department of Health
31.	Elizabeth Harris	CHETRE
32.	Hannah Baird	Centre for Health Promotion, NSW Department of Health
33.	Sarah Simpson	CHETRE

APPENDIX 5: SUMMARY OF PROFILE STATUS BY AHS

Area Health Service	Developing or developed profile	Minimum Data Set only (incl^g where done as part of Area Epi profile)	MDS plus (including intersectoral component)	Provided copy for workshop
Central Coast AHS	Developed	✓		Yes
Central Sydney AHS[1]	No	NA	NA	NA
Far West AHS[2]	No	NA	NA	Advice provided
Greater Murray AHS	Developed	✓		Yes
Hunter AHS	Developed		✓	Yes
Illawarra AHS	Developed		✓	Yes
Macquarie AHS	Developing	✓		Yes
Mid North Coast AHS	Developed	✓		Outline provided
Mid Western AHS	Developed	✓		Yes
New England AHS	Developed		✓	Yes
Northern Rivers AHS	Developed		✓	Yes
Northern Sydney AHS	Developed	✓		Yes
Southern AHS	Developed		✓	Yes
South Eastern Sydney AHS	Developed	✓		Yes
South Western Sydney AHS	Developed	✓		No
Wentworth AHS	Developed		✓	Yes
Western Sydney AHS	Developed	✓		Yes

The information contained in this summary reflects the status of the profile as at 30 May 2003. Since this time, several Areas have undertaken further work on the development of their profile.

[1] Central Sydney AHS indicated at the time of interview (mid May 2003) and the workshop that they had not developed the profile and no intention to commence development.

[2] Far West AHS provided written advice to the workshop that they have done very little in progressing the inequity profile given concerns that it will tell the Area what they already know and not necessarily result in any actual changes/action to address the inequities highlighted in such a profile.