Sydney Local Health District

UNSW SYDNEY

Health Equity Research and Development Unit

We welcome the opportunity to provide a submission and support the whole of government approach taken by the Inquiry. We also acknowledge the extent of Australia's achievements in responding to the pandemic. Measures like housing for people who were homeless and providing income support being two examples. As recent data from Australian Institute of Health and Welfare (AIHW) shows, Australia has performed well internationally

WHO WE ARE

This equity-focused health impact assessment (EFHIA) was conducted by the Health Equity Research Development Unit (HERDU), a Sydney Local Health District (SLHD) service in partnership with the University of New South Wales (UNSW) Centre for Primary Health Care and Equity (CPHCE).

HERDU is an Academic unit embedded within the District. Its primary function focuses on strengthening health equity within the District and NSW. 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 were commissioned by the District to carry out an EFHIA on the COVID-19 pandemic response (see Technical Report Attachment). A Health Impact Assessment (HIA) is a structured process for considering potential positive and negative health impacts of a proposed policy, plan or other intervention. The goal of undertaking an HIA is to provide a set of evidence-informed recommendations to enhance potential positive impacts of the intervention to be strengthened and any negative impacts to be mitigated.

Our research identified current and potential future health equity impacts of the COVID-19 pandemic, focusing on three main areas: 1. risks and consequences of infection, 2. changes to work and 3. changes to health services. The research focussed on a specific geographic area and the response of one local health district (Sydney Local Health District), however, the findings and lessons learned have broader applicability.

A Technical EFHIA Report (242 pages) describing the EFHIA process and synthesising the evidence, has been developed. Details of the research methods are described in pages 21-29 of the report. This EFHIA report concludes with 22 equity-focused recommendations (page 121-151). The findings are intended to inform health and other responsible agencies to consider equity in their response to the pandemic, to prevent the reinforcement and expansion of existing health inequities and to prevent new ones from developing. This includes considering recovery from the current COVID-19 pandemic and building resilience to future pandemics, as well as similar emergency situations.

The EFHIA took as it's 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. The EFHIA focused most intensively on the role of the health sector and most of the impacts identified were directly linked to actions taken by the health sector. It is also important to acknowledge that the actions of sectors other than health are vital to the health of the population.

KEY FINDINGS

Equity focussed response from the health sector contributed to saving lives for disadvantaged groups

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) (page 40-47 and page 106-107). 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 Special Health Accommodation (health hotels) 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 acute hospitals to manage demand.

SLHD directly responded to the COVID-19 pandemic with a **range of equity-focused targeted responses (page 91-103) 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. Social housing residents in the District have the highest two-dose vaccination rate in NSW.

Known social determinants associated with health outcomes and inequities, such as housing, employment, immigration and Indigenous status, have long been recognised by SLHD as priority areas where opportunities for good health and access to appropriate services need to be enhanced; in other words, equity is embedded in the health system and in the work culture in SLHD. The equity-focused response from SLHD centred around intentional engagement with, and prioritisation of, socially vulnerable populations and people in high-risk settings for COVID-19 transmission.

We found that actions taken to reduce the transmission of COVID-19 undoubtedly saved lives. However, they also had some negative impacts on health.

Trade-offs: service disruption and unintended impacts (page 65-82 and 121-128)

More generally, in focusing on critical COVID-19 related care; health care rationing and diversion away from clinical care, impacted 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 the 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), increased health inequities in the short, medium and possibly long-term. 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. The short-term positive impacts of the COVID-19 response may possibly lead to unintended longer-term negative health equity impacts, calling for increased capacity in considering health (equity) impacts and unintended impacts.

Impact on staff (page 82-83 and 115-120)

We found that health staff shouldered a double, work and personal, burden during the pandemic. Workplace allocation and deployment changed rapidly, were not always communicated clearly, or fully considered people's circumstances. However, effective responses from health staff were supported by an environment that allowed flexibility, making room for innovation and delegating power to people on the frontline with appropriate resourcing.

WHAT WORKED WELL

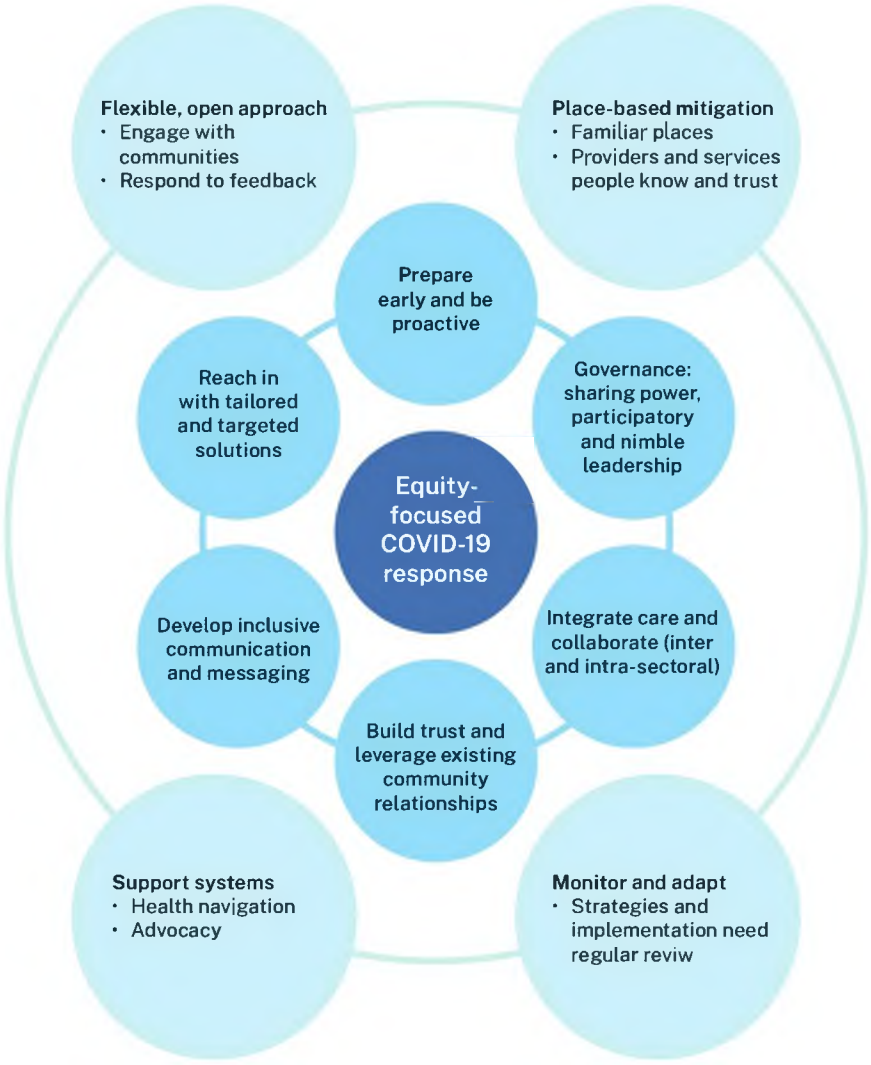
High-quality hospital-based services supported by out of hospital and virtual services	• The system, when vulnerable people reached it, saved their lives • This care prevented the onward transmission to the community and/or in health facilities as well as allowing acute hospitals to manage demand.
Investing in equity Putting equity at the centre of policy and practice	• Equity was integral to SLHD response from the start. • SLHD was able to draw on data and on pre-existing initiatives (e.g. health navigators, bilingual community educators, in-house health equity research unit), experiences, and relationships (e.g. with AMS, NGOs, government agencies) to respond quickly to what was known would be the likelihood of the inequitable impact of the virus on the population • In-house platforms for equity-focused and place based action could be directly mobilised. e.g. 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). • The response built on long-term development of relationships and trust with partners (in good times and bad).
Vulnerable communities focus for pandemic response	• Explicit targeted response and resourcing for identified vulnerable communities (populations and places). • SLHD focussed on four priority areas and vulnerable populations: (1) the disability sector and disability group homes; (2) residential aged care facilities (RACE); (3) vulnerable people and housing (social housing residents, boarding houses, people experiencing homelessness); and (4) Aboriginal and Torres Strait Islander response • See pages 91-103 of the Technical Report

RECCOMENDATIONS (page 129-151)

Strengthen consideration of equity impacts, trade-offs and long term impacts when making decisions to stop or limit services during emergencies	• 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 • Our health system is there for every one of us (not just the most visible or apparently urgent).
Maintain vulnerable community focus areas within emergency and crisis responses	• Explicit targeted response and resourcing for identified vulnerable communities (populations and places). • Systematically identify both place and population based vulnerable communities. This includes approaches to identify new, emerging, 'hard to hear' communities. • Collaborative planning and action with partners,. • Align initiatives with sharing leadership within and across services as part of pandemic responses, bringing diverse perspectives to problem solving.
Continue to build and invest in sustainable equity infrastructure and equity sensitive health services	• 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 population, building capacity, capability and resilience. • Proactively identify new platforms (where the equity gaps are, such as newly vulnerable, those not accessing services, etc.).
Continue and strengthen attention on addressing the existing inequalities that increase vulnerability to and are exacerbated by pandemics and other major challenges.	• Proactive planning for emerging challenges, such as long-COVID and climate change. • Strong partnership with human service agencies and other stakeholders. • Resourcing portfolios that work across silos • Develop processes to identify and respond to unknown/unmet/unengaged/emerging needs • 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
Expand leadership and governance ('with' rather than 'of')	• Increase capacity to address determinants of health inequities. • 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.

The analysis and evidence from the EFHIA and literature was used to establish emerging factors of success for an equity-focused response to COVID-19. These are identified in Figure 27 of the EFHIA below.

Figure 27 Emerging success factors



Sydney Local Health 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.

The COVID-19 pandemic has required the District to pivot its existing engagement strategies and work in new ways to not only maintain the connections with the community and networks, but also to work with the community groups and leaders and their networks to keep people safe from COVID-19.

The District has begun to harness the strengths and incredible innovations from the COVID-19 response, to introduce new ideas into the organisation, change practice, and make plans for the future.

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