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

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

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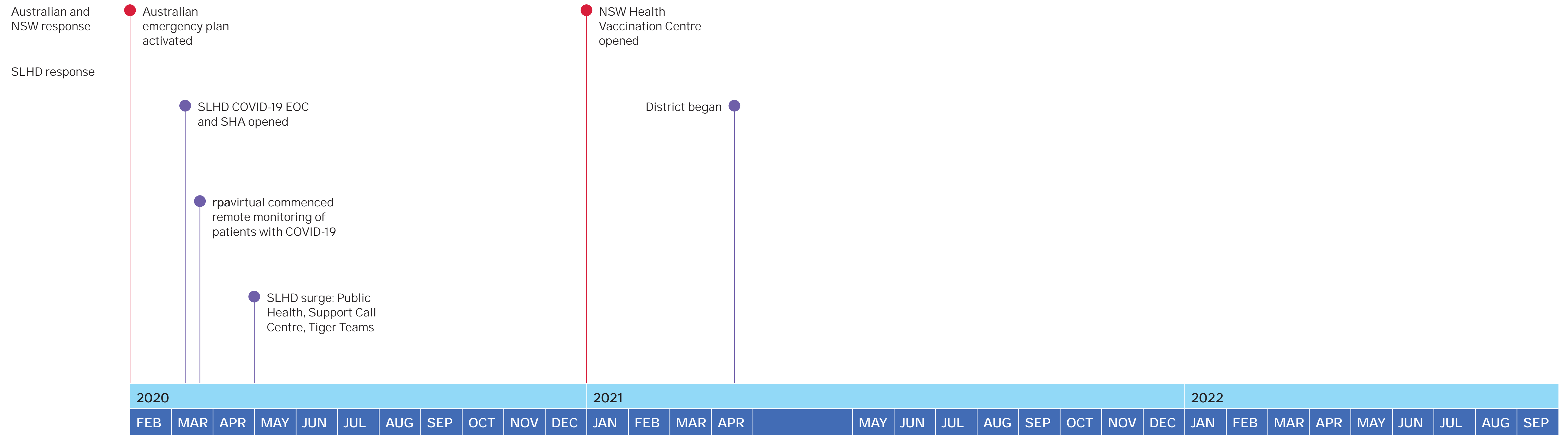
The EFHIA concluded at the point at which governments decided to reduce the special measures that had been put in place to manage and control the pandemic. At this point, the health sector (and all

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

Timeline of COVID-19 response and EFHIA activities



Key f ndings

In the following sections we summarise key f ndings 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.

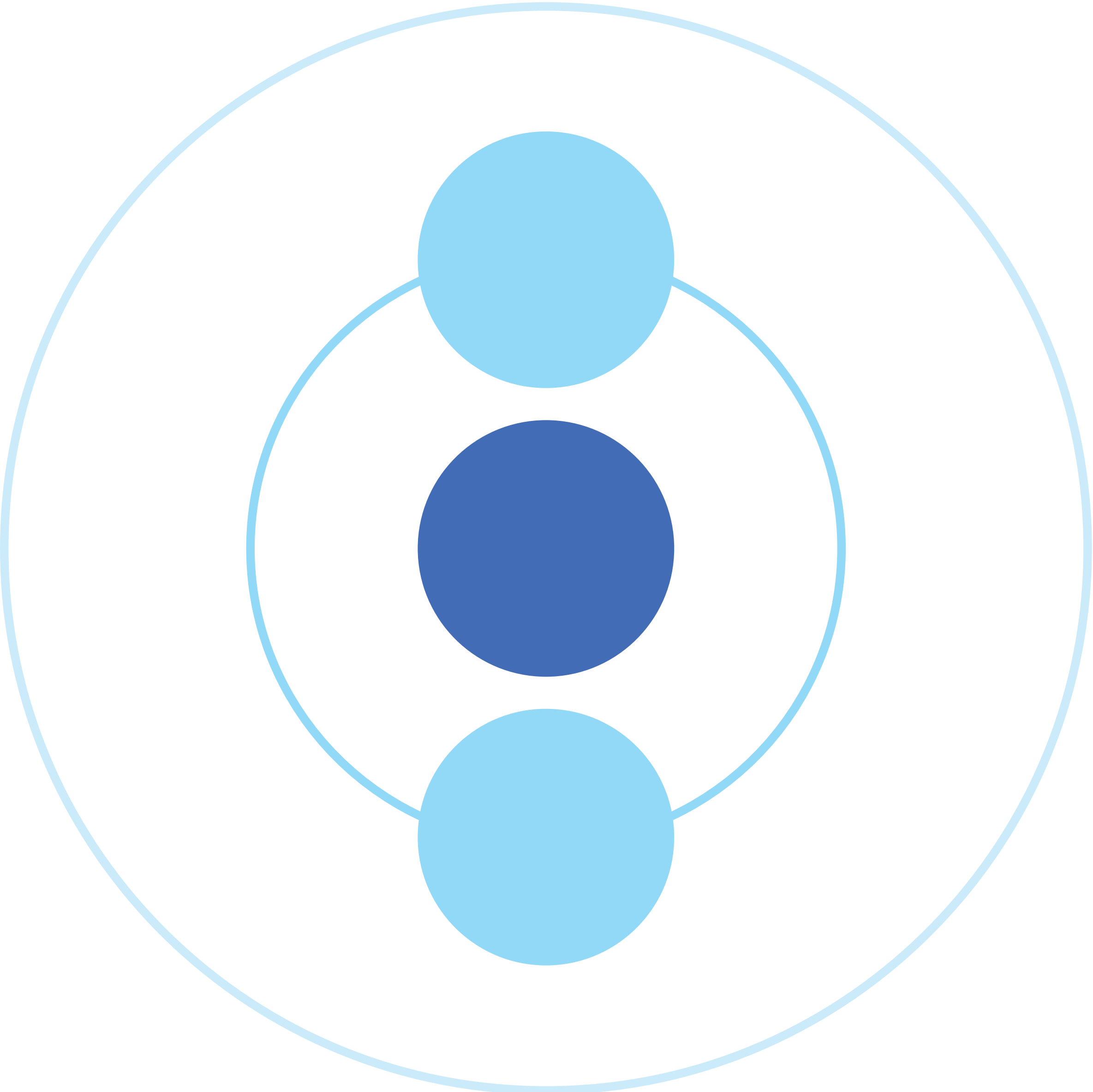
District response: health equity

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).
	Platforms supported responses across the diversity of population/client cohorts residing in SLHD and those cohorts that accessed SLHD on an intermittent basis.
Vulnerable communities focus areas for pandemic response.	Explicit targeted response and resourcing for identif ed vulnerable communities (populations and places).
Supportive environment for innovation and f exibility.	Being ready for risk and open to change, created opportunities for good ideas to rise and f exible targeted approaches to be identif ed and implemented.
	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 t e actualation.

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



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 f ndings 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 def nite, 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 def nite, 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 def nitely disproportionately affect those population groups that had higher exposure and vulnerability,

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
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- 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 diff culty 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 f nd 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 f exibility 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.

- Essential workers tend to be younger, women,

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 inf ux 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

Changes to health services

We identif ed f ve 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, def nitely 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 identif ed as experiencing signif cant 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 conitionsailability and 0 108.5 (si)-7.5 (d4.5 (8 (n-US)/MCID 1906 BDC BT0 Tw 10 0 0 10 m[(C)5.1 03.3071en-US -7.5 (l)4)-7.5 (bl3 BDC BT10 0 0 10 303.3071 586.7772

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 – Signif cantly 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

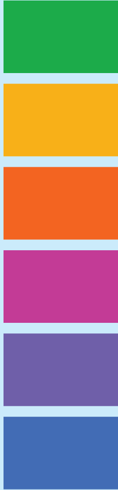
We have developed a set of equity-focused recommendations to mitigate negative health equity impacts and support and maximise potential positive health equity impacts identif ed in the impact assessment. To develop the recommendations, during key informant and stakeholder interviews participants were asked to suggest recommendations, evidence-based recommendations were identif ed 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 inf uence. 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 identif ed 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 inf uence 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:



Recommendation

Maintain a supportive environment for innovation and f exibility

Implication

Being ready for risk and open to change created opportunities for good ideas to arise and f exible targeted approaches to be identif ed 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

What we need to do more of

6

Recommendation

Continue and strengthen attention on addressing existing and ongoing 'wicked problems' amplif ed by COVID-19 (not just in communities but also within SLHD)

Implication

Addressing the existing inequalities that increase

What we need to do more of

Recommendation

Advocate for health equity and the determinants of health equity

Implication

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.

How (examples)

10

Recommendation

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

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

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 f exible work (including f exibility 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 inf uenced 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	

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

Relationships and trust already established that can be drawn on.

Increased capacity to act on the determinants of health equity outside of health care provision.

Lessons learned are shared.

How (examples)

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.

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.

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

14

Recommendation

Invest in and advocate for healthy urban environments

Implication

Increased capacity to act on the determinants of health equity outside of health care provision.

Taking action on health inequalities resulting from differences in material living conditions shaped by public policy.

How (examples)

a Support active and public transport infrastructure and reduce existing inequalities in access.

b Advocate for high quality/access to facilities/ greenspace in locationally disadvantaged neighbourhoods.

c Adopt strategies that put health equity and sustainability at the centre of planning.

d Support urban planning and infrastructure development to make neighbourhood places where we work.

e Advocate and collaborate to strengthen housing standards, affordable and social housing.

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.

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 aca9odnl SDg510.236 p0 0 k/anangActualText<FEFF0009>BT-8.36

Health Services (in addition to previous)

Recommendation

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

Implication

Platforms for equity-focused and place-based action could be mobilised/ramped-up when needed.

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

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
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19 Recommendation

Continue to build equity sensitive

Health Services (in addition to previous)

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 specif c issues and solutions.

c Continue and strengthen where possible, integrating f exibility 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

Health Services (in addition to previous)

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

Increased capacity to address determinants of health inequities.

Acting on the determinants of health equity outside of health care provision.

How (examples)

a Integrate clinical decision support systems that screen and document social determinants which inf uence 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.

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