

The impact of Equity Focused Health Impact Assessments on local planning for after hours care to better meet the needs of vulnerable populations:

An exploratory study

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February 2014

ACKNOWLEDGEMENTS

This research is a project of the Australian Primary Health Care Research Institute, which is supported by a grant from the Australian Government Department of Health. The information and opinions contained in it do not necessarily reflect the views or policy of the Australian Primary Health Care Research Institute or the Australian Government Department of Health.

We would like to acknowledge the support and contribution of the participating intervention and comparison Medicare Locals.

SUGGESTED CITATION

Harris E, Baum F, Wise M, Furler J, Lawless A, Harris P, Harris-Roxas B, Kemp L, Hurley C. The impact of Equity Focused Health Impact Assessments on local planning for after hours care to better meet the needs of vulnerable populations: An exploratory study. University of New South Wales Centre for Primary Health Care and Equity, 2013.

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Background

AN EXPLORATORY STUDY

This research project looked at the suitability and feasibility of conducting Equity Focused Health Impact Assessments (EFHIAs) on the After Hours Care Plans (AHCPs) of three Medicare Locals in three different states.

Given the potential benefits of adopting EFHIA in primary health care planning, this project sought to answer two exploratory research questions regarding the use of EFHIA in the development of Medicare Local AHCPs:

1. Is it effective and feasible to adopt EFHIA in local health planning in order to improve vulnerable groups' access to high quality after hours care and to improve equity in services?
2. Is EFHIA an effective mechanism for engaging health consumers and other members of vulnerable groups in local health planning?

The definitions that were used throughout this report are described in Appendix 2.

Equity Focused Health Impact Assessment

EFHIA is a structured assessment process that ensures that the distribution of health impacts is routinely considered in developing health plans [1]. Health Impact Assessment (HIA) is defined as 'a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population.' [2]. EFHIA includes a specific focus on equity at each stage of the process.

EFHIA has been identified internationally as a useful tool in assisting health services to address systematic differences, and provides a flexible, yet structured approach to routinely and consistently identifying and determining the possible impacts of policies and practices on different population groups. This enables the positive impacts of a policy to be strengthened and potentially negative impacts mitigated [3].

There is increasing interest in using EFHIA as an effective way of reducing health inequity. The World Health Organisation (WHO) Commission on the Social Determinants of Health recommends the use of Equity Impact Assessment for addressing the social determinants of health and reducing health inequity; and the UK requires all health policies to have an equality impact assessment before implementation.

EFHIA has particular relevance to primary health care planning, and given its focus on equity, may assist Medicare Locals in ensuring that their after hours care plans (AHCPs) meet the needs of their communities – and especially vulnerable groups within those communities.

POLICY CONTEXT

Health inequity and after hours health care in Australia

Although the Australian population has excellent and improving health there are some groups in the population who have significantly poorer health, which is related to increased health risks and lack of suitable living and working conditions. Many of these poor health outcomes are avoidable and may be partly addressed by improving access to health services.

International research shows that countries with strong universal primary health care systems have lower levels of health inequity [4]. Primary Health Care (PHC) therefore has an important role in reducing these levels of health inequity through the provision of high quality, universally available services. In order to address health inequity, and to give people the same level of care, it may be necessary to use targeted strategies to achieve universal health outcomes. This approach is known as ‘targeted universalism’ and provides some groups with extra or different kinds of services and programs [5], with the long term aim of integrating these groups into mainstream services. Such targeted services are for some of the people, some of the time with the long-term aim of ensuring that mainstream services’ routine practices extend to ensure use by currently under-served groups.

In Australia, the provision of after hours health services has been identified by the federal government as a key component in ensuring access to quality primary health care for all of the people, all of the time. Evidence suggests that a comprehensive, locally based, equity focused primary health care system for after hours care should ideally consist of a strong, high quality universal system that covers the whole population with a mix of locally tailored services for people who need additional support – for example, mental health, drug and alcohol and child protection, or palliative and dementia care services for those groups with the highest need.

Whilst there is limited evidence about specific after hours models or practices that measure health inequity in the various forms of after hours care, it is widely accepted that there are particular population groups who are more likely to access after hours services and other groups who experience significant difficulties in accessing them. In particular, populations that have high needs as well as difficulty accessing services include people living in remote and regional communities, Aboriginal and migrant populations, children and the elderly, individuals with mental health concerns, culturally and linguistically diverse (CALD) groups, and low income groups. These systematic differences in the use of after hours services are linked to systematic differences in health outcomes observed in the population, especially in rural areas [6]; but systematic differences are often difficult to identify and address in routine planning processes. Therefore, without dedicated attention to addressing the barriers to access, those who most need after hours services may be the least likely to access them.

Medicare Locals and After Hours Care Plans

In 2011, as part of the National Health Reform the Australian government established new local organisations, Medicare Locals, in order to better service the health needs of different communities. Medicare Locals are required to plan and fund a wide variety of health services in line with the health needs of their local community, including general practitioner (GP) after hours services, mental health services, immunisation, Aboriginal and Torres Strait Islander health, psychological services, women's and men's health, and pharmacy support and patient transport, amongst others.

The role of Medicare Locals is to plan, integrate and coordinate services and to address service gaps in order to represent and address the particular health needs of their community. Medicare Locals are still in their infancy, and all are at various stages in determining how best to plan for and fund the health needs of their communities. But if Medicare Locals are to appropriately cater to the health needs of their communities, then their planning processes need to incorporate considerations of equity and access from the outset.

In fact, Medicare Locals have a strong policy mandate to address issues of access and equity to ensure that their programs reach all members of the community, especially for those in greatest need. The National Primary Health Care Strategic Framework also provides a strong mandate for action in ensuring access to services for vulnerable groups. Strategic Outcome Two [7] of the framework aims to improve access and reduce inequity for individuals and their families by ‘delivering primary health care through an integrated service

system which provides high quality care across the country and actively addresses service gaps’.

A mandatory role and responsibility of each Medicare Local is to address the after hours care needs of their region; that is, to identify and address local after hours service gaps and to improve coordination and integration of after hours services. In order to carry out this responsibility, Medicare Locals are required to develop after hours care plans (AHCPs) [8] which aim to:

- > ensure that local after hours primary care services are well planned, coordinated and appropriate to community needs
- > ensure primary care services are accessible when needed in both the sociable and unsociable after hours periods, including for groups such as the residents of aged-care facilities, the house-bound aged and palliative care patients
- > assist the direction of patients to the most appropriate point of care for their condition, and
- > improve support for health professionals in the arrangement and/or provision of after hours care for patients.

Given the inequity currently experienced by vulnerable groups in accessing after hours services, there are strong policy imperatives for Medicare Locals to develop AHCPs that meet the needs of their communities by identifying gaps in local services and ensuring access to these services for vulnerable groups.

A possible strategy for minimising gaps in after hours service provision is the adoption of an Equity Focused Health Impact Assessment (EFHIA) in the development of AHCPs.

Methods

This exploratory study was undertaken in five overlapping stages:

- > a literature review
- > Equity Focused Health Impact Assessments (EFHIA) in relation to AHCPs in three Medicare Locals (‘intervention Medicare Locals’) in three different states
- > comparison of AHCPs in the three intervention sites and in three additional non-participating Medicare Locals in terms of their plans’ considerations of equity and access
- > key stakeholder interviews and
- > knowledge transfer to disseminate key findings.

STAGE 1: OVERVIEW OF THE LITERATURE

To inform the EFHIA process a targeted literature review was undertaken to provide a broad description of after hours care arrangements in Australia, offer background information on access and equity in general practice, draw attention to access and equity issues specifically associated with after hours care, and address differential effects of after hours care arrangements across the population (Appendix 2).

STAGE 2: CONDUCTING EFHIAs IN THREE MEDICARE LOCALS

The project developed and piloted a framework for assessing access and equity in three Medicare Locals' AHCPs.

There are two key consulting and planning stages in the development of AHCPs: stage one (which begins at the establishment of a Medicare Local and ends on 30 June 2013) and stage two (commencing 1 July 2013). During stage one, Medicare Locals are required to develop plans that identify immediate priority gaps for after hours care in the local area and that target specific activities or funding to service those priorities. Stage two plans must build on the approved stage one plans, but must develop a more comprehensive and long-term plan to ensure that after hours care reaches all consumers in the region. These stages are discussed in more detail in the definitions section of this report (Appendix 1).

The EFHIA was carried out on the completed stage one plans of three ('intervention Medicare Locals'), in order to inform the development of their stage two plans. After the EFHIA had been conducted and more comprehensive AHCPs developed for stage two, sections of the intervention Medicare Locals' stage one and stage two plans were compared to identify any changes in consideration of access and equity issues as a result of the EFHIA.

Recruitment

Intervention Medicare Locals were opportunistically selected with one or more of the investigators having a prior relationship with most of the Medicare Locals. All Medicare Locals approached by the project agreed to participate, however due to competing priorities and logistical issues a fourth EFHIA in Queensland was unable to proceed.

In each of the Medicare Locals the chief executive officer (CE) was approached to participate in the study. Following agreement the researchers met with the CE and the Medicare Local's after hours project officer. The project officers then worked with the investigators to conduct the EFHIA.

The expected roles of intervention Medicare Locals were to:

- > allocate a staff member to work with the project team
- > provide access to relevant documentation relating to AHCPs
- > organise local meetings and
- > review documentation relating to the EFHIA findings.

The three Medicare Locals were able to claim \$3,000 towards cost of their participation in the EFHIA.

Each of the assessment sites was allocated an experienced HIA practitioner to guide the process¹.

Undertaking the stepwise EFHIA process

EFHIAs were then conducted on the intervention Medicare Locals' completed stage one plans, as outlined in Table 1. EFHIA follows a stepwise process that includes screening and scoping, identification and assessment of evidence, developing recommendations and monitoring.

¹ NSW - EH; Victoria – PH; SA – FH and AL

In each EFHIA, a proposal was developed to determine what after hours activity as set out in the plan was going to be covered by the EFHIA and to establish the priority population to be serviced by the activity.

Table 1: Steps in an Equity Focused Health Impact Assessment

Step and purpose	Task	Endpoint
Screening: determines what the proposal is for the EFHIA and potential equity implications	<p>Overview of proposal: What is the proposal trying to achieve and how? What is the local problem? Define after hours care and how it is planned to address the local problem. Discuss initial distribution issues, who is likely to be affected Discuss opportunities for influence</p>	An agreed overview of the proposal and its potential equity implications
Scoping: plan the conduct of the EFHIA	<p>Determine which population groups to include. Discuss the equity dimensions on which to base the assessment (e.g. what does 'avoidability' mean for making recommendations?). Discuss evidence to include (including where to get distributional data and types of evidence). Identify steering / reference group Confirm that resources required for the EFHIA are adequate for the work involved (scope must fit resources). Develop terms of reference (including resolving disagreement).</p>	<p>A plan for the HIA</p> <p>Terms of reference</p>
Identification of impacts: collect information on impacts of various sources	<p>Review (or conduct, if required, given scoped population groups): Needs assessment (pop profile) Literature review Consultation data</p>	Overview of identified impacts from various sources
Assessment of impacts: assesses the activities in the AHCP proposal against evidence of impact to make draft equity recommendations	<p>Stakeholder workshop asking: What is the activity / initiative trying to achieve? Who might be disadvantaged by the initiative, and why? What is the evidence of inequality / inequity? What are the unanticipated impacts of the initiative? What would happen if the initiative was not implemented? What are the recommendations to improve the initiative and overall proposal? Map evidence of inequity against different sources, including the workshop, to inform and prioritise draft recommendations. (Impacts identified from two or more sources</p>	An assessment of the potential equity impacts of the proposal and draft recommendations

	are prioritised).	
Reporting and recommendations	Draft report (format flexible) and recommendations. Send to reference group or steering committee for sign off.	Final report

Comparing stage one and stage two of the AHCPs in the intervention Medicare Locals

Upon completion of the EFHIAs on the stage one plans, the intervention Medicare Locals' stage two plans were then assessed to determine whether participation in the EFHIA process had resulted in increased inclusion of dimensions of access and equity between stage one and stage two. The original intention was to compare stage one and stage two plans directly, however the template for stage two plans to be completed by the Department of Health and Ageing (DOHA) was substantially different to the template for the stage one plans, which made direct comparison difficult. Therefore it was necessary to identify a section in the stage two plan that covered similar issues to those in the stage one plan for purposes of comparison.

The sections of the plans that were assessed were:

- > Stage one plan: 'Step 1: Identification of approaches to address each priority area'.
- > Stage two plan: 'The health/ need service gaps that will be addressed and priority issues'.

Access and equity assessment criteria: assessing access and equity considerations in the plans

To allow for a consistent assessment of the dimensions of access and equity a framework was developed and expanded based on the work of Pechansky [9] and Starfield [10] (Table 2).

The dimensions from the two frameworks were integrated into one table for ease of coding and to reflect the researchers' thinking.

Table 2. Equity framework for assessment

	Dimensions of equity and access
Access to services	Availability
	Physical and geographic accessibility
	Affordability
	Appropriateness
	Acceptability
Quality in services	Continuity of care
	Coordinated care
	Comprehensive
Monitoring and reporting	Capability for understanding systematic differences in access and equity

Access was seen as having the following dimensions:

- > *Access to care*: awareness, availability (including workforce), accessibility (including, transport, hours of opening and physical access), affordability, appropriateness and acceptability.

- > *Quality of care*: continuity, comprehensive, coordinated.
- > *Equity of care*: systems in place to be able to describe systematic differences in who receives care and the quality of care across population groups.

The quality dimension was identified as present when it was specifically mentioned or when the concept was implied, for example, continuity of care was reflected in the requirement for services to provide speedy feedback to the patient's GP.

The equity dimension was seen as addressed when there was evidence provided or systems established to report on differential use or care.

Using these dimensions, the text from the two sections of the stage one and stage two plans was comprehensively analysed before coding results against the EFHIA framework (as set out in Table 2 above). The researchers recorded the number of times one of the dimensions of access or equity was mentioned in the stage one plan and then in the stage two plan of each intervention Medicare Local's AHCP (for example, access, cost, coordinated care). The concept was then coded and discussed with other investigators to identify potential differences between the two stages of the AHCPs.

STAGE 3: COMPARISON SITES

Comparison Medicare Locals were identified in the same three states as the intervention Medicare Locals, in order to compare sections of their stage one and stage two plans and identify any changes in their consideration of access and equity issues during the transition from stage one to stage two. This comparison was conducted in order to establish whether any changes in the consideration of access and equity in the AHCPs could be attributed to wider changes in the environment as opposed to being a result of the EFHIA.

The stage one and stage two plans of comparison Medicare Locals were assessed using the same methods as outlined in Stage 2 above.

STAGE 4: KEY STAKEHOLDER INTERVIEWS

Stakeholder interviews were conducted with participants from the intervention Medicare Locals, with research questions focusing on the feasibility and limitations of the EFHIA process in relation to the development of after hours plans. Nine interviews were conducted in total, with Medicare Local staff (n=3), inexperienced investigators (n=3) and experienced HIA practitioners (n=3) in order to evaluate the impact of the EFHIA on stage two AHCPs in the intervention Medicare Locals. Three of the investigators themselves were new to the EFHIA process and to dealing with Medicare Locals, so their views on the experience were also seen as relevant.

STAGE 5: KNOWLEDGE TRANSFER

Opportunities were sought to discuss the findings with key stakeholders and to present findings at conferences.

Results

STAGE 1: LITERATURE REVIEW

The aim of the review was to provide a broad description of after hours care arrangements in Australia, offer background information on access and equity in general practice, draw attention to access and equity issues specifically associated with after hours care, and address differential effects of after hours care arrangements across the population. (See Appendix 3).

In this section we report on those aspects of the literature review related to use of after hours services by population groups more likely to access services and by groups who experience significant difficulties accessing after hours care.

Whilst there are particular population groups who are more likely to access services and other groups who experience significant difficulties accessing after hours care, there is limited material about specific after hours models or practices that measure equity outcomes. Nonetheless, the literature found that populations that experience both high need and/or difficulty accessing primary health care services include the following groups.

Children

Children under the age of four years present most frequently and are the largest non-admitted population presenting to emergency departments in Australia [11], predominantly with trauma, gastrointestinal, skin symptoms or respiratory illnesses [12]. The literature indicates that primary health care presentations for children are higher than for any other section of the population [13] and decisions to consult medical care are affected by socioeconomic factors such as low income, single parent families, lack of health insurance [12, 14-17], parental illness attitudes [12, 18, 19], and concerns about illness severity [12]. Children are frequent users of primary health care services independent of socioeconomic status [20, 21], however access is reportedly less for children from CALD backgrounds [22-26]. Older children and teenagers tend to use after hours services less often than adults and the elderly [27].

Elderly

There is very limited evidence regarding after hours care specifically targeted to older people. Nevertheless, the general increase in the ageing population places additional strain and demand on all types of health services [28, 29]. Older people tend to express greater satisfaction and better access to health services than other population groups [30, 31] however they can also experience organisational, financial, geographic [32, 33] and personal barriers to access, such as mobility limitations [34, 35] and delayed seeking of medical support [35]. Caregiver health [36] and quality of life [37] have been consistently associated with access to medical care.

Though limited, the literature tends to suggest that the elderly are more likely to use after hours general practitioner co-operatives [38] and home visits [39, 40] rather than community health centres [30], telephone [35, 39] or web-based support [41]. They may also be more likely to receive chronic disease management interventions [30]. After hours telephone advice, though less utilised by older people, appears to have the potential to reduce calls for home visits [35, 39].

Examples of models specific to this population include an after hours model of care integrated within existing residential and service delivery structures and outreach services. The importance of integrating mental health services within primary care for the elderly was highlighted in the literature as an area requiring particular attention [42, 43].

Mental Health

Inequities in access to and utilisation of mental health support are consistently reported in the literature [44], especially for Aboriginal and Torres Strait Islander [45, 46], culturally and linguistically diverse (CALD) [47-51], rural [52-54] and low income populations [55]. Documented reasons for this inequity include increased experience of stigma [56, 57], limited access to culturally and literacy appropriate resources, and the social, psychological and material costs of engagement with services [58]. There are also documented inequities in access to support for specific mental health issues, in particular for personality disorders [59], bipolar disorder, psychosis [60], depression in the elderly [43], childhood mental illness [61] and behavioural disorders [62, 63].

CALD groups

Ethnicity, particularly for non-English speaking migrants, is associated with poorer access to primary health care [16, 64-67] and increased utilisation [49, 68, 69] of after hours care. The rates of non-English speaking clients attending hospital services may assist in deciding which groups to target regarding after hours or improved primary health care in general. While cultural competency is consistently identified as a useful strategy for enhancing healthcare utilisation [49, 70, 71], other barriers to access include language difficulties [23, 72, 73], patient and family expectations [69, 74-76], Medicare ineligibility [77], high care costs [47], impacts of trauma and relocation [64], cultural factors [64, 78, 79] and fragmented service provision [26].

Strategies to overcome barriers to access for CALD groups include the provision of free services [64], population-specific health providers [64, 79], routine use of interpreters rather than family/friends for language support [64, 73, 80], integrated healthcare support [26, 69] and health information systems which collect accurate ethnicity-related data [64, 80, 81].

Aboriginal and Torres Strait Islander people

In a review of the link between primary health care and health outcomes for the Aboriginal population, Griew and colleagues suggested that allocation of resources to primary health care could compensate for some of the negative health effects of socioeconomic disadvantage and inequality and improve health outcomes, especially in maternal and child health [82]. In Australia, comprehensive primary health care services for the Aboriginal population are shared between mainstream and Aboriginal Community Controlled Health Services (ACCHS). The ACCHS provide a range of community driven, culturally specific and tailored services including clinical care (medical, allied health, chronic disease management and emergency care), preventative health, policy and advocacy support [83].

Internationally there is a trend for indigenous populations to receive face-to-face rather than telephone-based after hours support [84-86]. The Australian BEACH Survey [87] collected information on the after hours arrangements of GPs in both metropolitan and rural areas. It identified that while rates varied by state and degree of remoteness, overall the rate of GPs' after hours visits or referral to another service for after hours care was higher for Indigenous patients than for other patients (46 and 32 per 100 consultations compared with 38 and 17 per 100, respectively). Despite this, Indigenous Australians use after hours emergency services at approximately the same rate (45% vs. 46%) as non-Indigenous Australians.

According to a report from the Australian Institute of Health and Welfare, the most common types of service provided outside of normal operating hours by Indigenous PHC services are transport (61%) and emotional and social wellbeing/mental health-related services (61%). Approximately 47% of services provide transfer/admission to hospital; 38% provide diagnosis and treatment of illness/disease; 37% provide treatment of injury; 31% provide hospital inpatient/outpatient care; 31% provide antenatal/maternal care; and 17% provide care in a police station lockup or prison [87].

Barriers to Aboriginal access to GPs and primary care have been identified, including: poor levels of cultural awareness by health staff [88]; discomfort with the physical environment of waiting areas [88]; impact of previous health care experiences and personal, social and historical context [89]; differences in GP responsiveness for different cultural groups [90]; lack of bulk-billing by GPs [91]; complexity of health care, social needs and co-morbid health conditions [91, 92]; workforce shortages of medical practitioners, nurses, allied health and dental health professionals in rural and remote areas [93]; lack of workforce training for non-Indigenous workers to provide effective and culturally appropriate services to Aboriginal people [93, 94]; practitioner focus on facilitating a comfortable physical environment and less on social aspects of relationships which are more valued by Aboriginal people [95]; and cost and accessibility to medicines and health care in rural and remote areas [96].

Strategies identified to overcome these barriers are listed in Appendix 2.

Rural and remote residents

Location and distance to health services have been identified as key factors differentiating rural from metropolitan health service delivery [97, 98]. For rural residents without access to a hospital emergency department there is greater tendency to rely on after hours services [99]. Access is problematic as a result of geography, closure of local facilities, lack of on-call allowances for rural GPs and inadequate hospital facilities for after hours services.

Wakerman et al [98] undertook a systematic review of PHC service delivery models for rural and remote areas in 2006. Similar to the findings from evaluations of the after hours primary medical care trials, this report identified that “there is no ‘one-coat-fits-all’ solution to meeting the diverse needs of residents of rural and remote Australia” (p.7).

Regardless of which model of care is provided, rural and remote community service delivery is complicated by difficulties associated with distance, staff recruitment and retention, economy of scale requirements, accessibility and cultural relevance [97, 98, 100-103]. Table 3 provides a summary of the issues that require consideration when designing service delivery models for after hours care in rural and remote areas as identified in the literature.

Table 3. After hours services: issues for rural and remote areas

Issue	Consideration
Workforce [103-114]	Recruitment strategy Availability Retention Professional development Support and supervision Student placement management Remuneration Career pathways Staff safety
Population [88, 115-117]	Culture and ethnicity mix Age and gender mix Distance from service Health and chronic disease profile Socioeconomic variations Ratio public vs. privately insured
System [98, 100, 103, 107, 112, 118-128]	Payment structures (e.g. fee for service, salaried) Financial resources and funding Economies of scale Government policy and priorities Information technology structures Interagency collaboration and referral systems

	Acute and emergency care availability/accessibility Staff skill profile Diversity and mix of allied health, nursing, medical and specialists Service delivery model variation Quality of technology/equipment Preventative services Cultural competency of staff
Community [34, 95, 98, 124, 129-133]	Community identity and cohesion Willingness to seek support Social support availability Access to technology Transport availability Home care support Financial and structural resources Cultural identity

Low income populations

There is consistent evidence that individuals from low income groups experience illness onset earlier in life, greater disease burden, difficulties with access to primary care, poor health service utilisation and high rates of hospital admissions [134-149]. There are also trends in which overall health status, post-hospitalisation outcomes and life expectancy seem to be poorer among this vulnerable population [135, 137, 142, 150-153]. This is typically due to the lack of resources that lead to families facing difficult living conditions, unemployment, poor diet, high rates of health risk behaviours, poor social support, and problems with access to transport [154-157]. It must be noted that socioeconomic status (SES) is relevant to a number of vulnerable population groups with low SES commonly recorded among Aboriginal people, ethnic minority groups, rural and remote residents and adults over the age of 65 [142].

Some research has shown a tendency for low income patients to rely on after hours services due to difficulties with access to GPs during usual hours [147]. Low socioeconomic groups are particularly affected by costs of health services with high percentages of low income adults going without health care due to the price of the service [158]. However, additional sources indicate that when it comes to GP visits there is little inequity, with similar rates of visits across income groups [159-161]; it seems that the distribution of specialist visits is where the main disparities lie.

In terms of after hours primary health care, there is limited information in the literature which specifically focuses on the relationship between socioeconomic status and after hours care. There is some suggestion that the move towards reliance on tele-health may be problematic for low income groups who are often less likely to have access to the required technology [27, 162] and, as mentioned above, some indication that after hours services are used by low income groups who have difficulty accessing a 'usual' health practitioner. However, Adler et al [153] described how though socioeconomic status is often considered as a covariate, i.e. one of the demographic factors that will influence an individual's use of health services, it is rarely a focus for a particular model of care. In general, models of after hours primary health care aim to improve access and this is one of the biggest challenges for low income groups. If access to primary health care is improved overall it seems likely that there will be a resulting decrease in hospital admissions and health practitioner visits [163]. Epstein [164] found some evidence of this when evaluating the impact of public ambulatory clinics on hospital visits in low income areas. Whilst some interventions do consider circumstances by offering free or low cost services, the best approach seems to be to offer low-cost, multi-disciplinary strategies which improve social support, provide education and seek to maintain health status among disadvantaged individuals.

STAGE 2: CONDUCT OF THE EFHIA

Engagement with Medicare Locals

Time constraints affecting the three Medicare Locals (ML1, ML2, ML3) and the different stages they were at in developing their stage one and stage two plans meant that the project had to adopt a flexible approach that was able to respond quickly to changing needs. Thus the actual process followed in each of the intervention sites was slightly different. However each EFHIA followed the same stepwise process.

Prior to the commencement of the EFHIA study, Medicare Locals had just completed an intense period of community, stakeholder and GP consultation. As a result the research team was not able to conduct separate consultation with the community due to the Medicare Locals' concerns of consultation overload.

Selecting activities to be assessed by the EFHIA

As part of the screening and scoping process each intervention Medicare Local selected more specific foci for the assessment. These generally reflected areas where the Medicare Locals had identified potential problems or areas that could be influenced by the EFHIAs (see Table 4).

For example, in ML1, the researchers conducted the EFHIA on the successful expression of interest (EOI) to expand the Medical Deputising Service (MDS). The ML1 Board decided to focus on the successful EOI for the MDS (with the tenderer's permission) as the Board felt this presented an opportunity to influence the contract that was being developed for the MDS.

In ML3, the EFHIA was undertaken in parallel with the detailed needs assessment for the stage two after hours plan, which facilitated discussions between the Medicare Local's CE, consultants undertaking the needs assessment and the researchers on emerging themes.

Table 4 provides an overview of the activity to be assessed by the EFHIA and lists the priority populations targeted by the activity in the Medicare Locals' AHCPs.

Table 4: Process and activity in each of the Medicare Locals

	ML1	ML2	ML3
Document assessed	Stage 1 Plan: The health need service gaps that will be addressed and priority issues	Stage 1 Plan, Step 1: Identification of approaches to address each priority area	Stage 1 Sub-Regional Plan
Priority activity areas identified for assessment	Successful Medical Deputising Service (MDS) EOI to extend existing MDS	Community awareness project Availability of services and full range of services for Residential Aged Care Facilities	After hours co-located clinics in local GPs, Health Direct, hospitals, MDS and Emergency Departments
Priority populations	Growth areas Migrants	Elderly New migrants Health workforce	Aboriginal people Migrants Low SES Communities
Screening & scoping	Agreement to proceed Focus of assessment	Agreement to proceed Focus of assessment	Agreement to proceed Focus of assessment

	decided	decided	decided
Identification	Literature review Population profile Steering Group	Literature review Key informant interview Stakeholder consultation Population profile Document review Steering group	Literature review Community Consultation report Stage two needs assessment Table of potential equity impacts Steering group
Assessment	Dimensions of equity identifying potential positive impacts plus potential equity issues	Each priority issue by using the six equity questions	Each priority using the six equity questions
Recommendations	Later discussed with successful tenderer	Presented to the Board for confirmation	Endorsed by CE
Evaluation	None planned	None planned	None planned

The full EFHIA reports (see Appendix 3, 4 and 5) present a more detailed description of the process followed and the findings. Recurring themes across the three EFHIA sites are outlined below in relation to the dimensions of equity that were being assessed (see Table 2 above).

Access to services

Awareness

All Medicare Locals had carried out initial needs assessments prior to developing their stage one after hours plans. A lack of community and service provider awareness of the range of after hours services available in the local area and how they could be accessed was a recurring theme in all three Medicare Local assessments. The Medicare Locals had decided to target community education programs in their stage one plans to address this issue.

ML2's stage one plan specifically focused on the issue of community awareness raising campaigns for the identified priority areas, with a particular focus on web-based information. Box 1 presents one section of ML2's EFHIA summary relating to the identified priority gap of community awareness.

By targeting consumer awareness the Medicare Local is addressing an identified need within their community. Poor health literacy is associated with poor health outcomes and is associated with social disadvantage; is prevalent among people from lower socioeconomic backgrounds, the elderly, culturally and linguistically diverse populations (CALD) and Indigenous Australians. Improving health literacy in those groups is likely to impact positively on health outcomes and health equity.

However, those in most need of improved health literacy are those least likely to be reached by standardised universal approaches. For example, in Australia there is a digital gradient which mirrors the social gradient in health. Those with lesser or no Internet access are likely to be the same people who have poorer health. There is a risk that a purely universal approach to improving consumer awareness will not reach those groups with the greatest need and may even increase health inequalities. ML2 will need to directly address these issues if they are to introduce or expand consumer awareness/health literacy approaches in

ways which do not inadvertently reduce access for some groups whilst increasing it for others. [165].

Box 1: ML2 EFHIA summary

In its stage one plan, ML3 considered a multi-layered approach to after hours care that includes community mobilisation, as well as the development of infrastructure for community awareness that could be used to promote a range of issues.

Availability

In ML1, the EOI that was assessed focused on how to expand the geographic coverage of the MDS in order to improve access for the whole population to general practitioners after hours. The EFHIA process subsequently identified a potential equity impact in the successful tender as a result of the EOI's reliance on patients having existing GPs to arrange follow up. The EFHIA pointed out that patients without a GP would be disadvantaged unless a particular effort was made to identify those people and to proactively arrange to link them to a GP clinic (Box 2).

Populations at greater risk of not having GP access are ATSI, CALD, newly arrived, low SES, and those in new growth areas. Given the higher rates of complex multi-morbidity chronic illness in disadvantaged population groups, they are likely to have a greater need for follow up and care coordination following contact with the after hours service. The service outlined in the EOI is closely linked to existing GP services to provide follow up to patients. Population groups without regular GPs are thus likely to be disadvantaged. Addressing this may require collection of additional data about how these groups are followed up, what their preferences may be and what potential there is to link them to existing GPs in the area.

Box 2: ML1 EFHIA report

A major focus in the Medicare Locals' stage one plans was on increasing the availability of after hours services and in maintaining existing levels of service. The Medicare Local in NSW for example saw maintaining current service delivery among general practitioners as a key issue once Practice Improvement Payments (PIP) payments ceased. Rural and remote areas, and outer metropolitan areas were also a specific focus of attention in the AHCPs reviewed. All three Medicare Locals were located in areas where rapid population growth was expected and where there already was a workforce shortage. These 'new' communities would not only have a shortage of after-hour services but also in-hour services and related infrastructure such as chemists, allied health providers and community health services.

The EFHIA identified frequent reference to the importance of sustainable models of in and after hours care in the Medicare Locals' AHCPs. Their stage one plans proposed a combination of strategies to address this, including funding existing services to cope with fixed costs but flexible demand. The lack of access to after hours pharmacies was identified as a recurring theme in all three intervention Medicare Locals' stage one plans.

Accessibility

Major issues identified in the plans in terms of making after hours services accessible were the hours of operation, availability of transport and time taken to reach the nearest service, especially in rural and semi-rural outer metropolitan areas. For people on the fringes of cities opening hours meant that by the time they reached home local general practices were generally closed. Extending hours was discussed in the plans as a way of addressing this. Some plans demonstrated interest in looking at innovative ways of providing transport or using existing community transport programs.

ML1 and ML2 stage one plans raised the use of new technologies as a potential strategy for addressing accessibility, however the EFHIA pointed out that this would need to be monitored to ensure different population groups are not disadvantaged.

Increasingly smart phone technology is being used to access services. [...] If this grows and the reliance of the service on this technology increases, it may disadvantage groups who have relatively lower access to these technologies. Monitoring the use of these different forms of access and the characteristics of the patients who access the service in different ways will help ensure that changes in the way services are accessed do not disadvantage particular population groups. *(ML1 EFHIA Report)*

Affordability

The cost of services was also a recurring theme in Medicare Local AHCPs. In ML1, for example, one of the conditions in the call for tenders for the MDS was that Medicare payments would only be required. In ML3, co-payment at after hours services in the local hospital was identified in the plan as a potential barrier to access.

The Medicare Locals found that while primary care services may have been bulk-billing – which ensured immediate financial barriers to access were removed – flow on costs at the pharmacy, pathology imaging etc. still presented financial barriers and potentially created inequities (as well as increasing demand on Emergency Departments where these services are free). Developing policies in relation to use of bulk-billing services for imaging and pathology was identified in the plans as a way of helping to minimise these financial barriers.

Finding an acceptable process for replacing the PIP payment for after hours care was taken up by all Medicare Locals. In ML3 it was proposed to pay GPs' registrations with the MDS in lieu of PIP payments. ML2 developed a level of service provision that would attract a determined level of payment. For example, to receive funding GP practices would need to be open specified hours.

Appropriate care

The need for culturally appropriate care was frequently cited in the plans in relation to the provision of after hours care, especially where provided by Medical Deputising Services. This appeared to be related to the number of overseas trained doctors providing care and their different approach to patient involvement in care.

Populations requiring interpreter services included CALD and newly arrived migrants. Access to interpreters was identified in the plans as important in ensuring quality and appropriate care. Monitoring use of interpreters and ensuring that all patients from CALD backgrounds had access to interpreters (available to medical practitioners by phone) were important evidence-based strategies to help ensure equity of access to appropriate quality care.

Acceptable care

Australian patients have high expectations of service delivery. In community consultations with ML3 carried out prior to developing their stage one plan, long waiting times in Emergency Departments and for MDS were identified as unacceptable and attracted high levels of political and community concern. Many patients also expected to be engaged in care by deputising services and reported dissatisfaction with care from practitioners who worked in more authoritarian ways. A number of reports from community consultations also expressed concern about cultural differences between patients and doctors involved in after hours care.

Quality in services

Continuity of care

There was limited mention in the plans of the importance of continuity of care except in relation to MDS where there was a strong expectation that GPs would be informed the following day of the presenting health problems, their management and possible follow-up. All three Medicare Locals saw informational continuity of care being promoted through the use of the Personally Controlled Electronic Health Record (PCEHR). It is not yet clear how access to and use of the PCEHR will be taken up by different population groups. The EFHIA suggested that potential inequities may arise if this is relied on to ensure continuity of care, especially in high need disadvantaged groups with a higher burden of complex chronic illness. Monitoring the use of the PCEHR and the demographic characteristics of patients who are using this and maintaining alternative strategies to ensure continuity would help reduce potential inequities.

Coordinated care

A major focus for coordination of care in the stage one plans was the relationship between after hours care providers and patients' usual GP. In this context use of the PCEHR was seen by the Medicare Locals as having an important role. There was also a focus on improving coordination between after hours services and acute hospital services, primarily Emergency Department through protocols and training.

Comprehensive care

The need to develop improved pathways of care for high need and vulnerable groups was identified in the stage one plans. This included patients in Residential Aged Care Facilities (RACF) where it may be possible to prevent admissions with an improved system of care, those with mental health or drug and alcohol problems and those requiring palliative care. It was recognised that these very vulnerable groups were often subject to fragmented care.

Stage one plans also recognised the need for after hours chemists, imaging and allied health services. ML3 identified the potential of expanding the hours of existing state government funded community health services as a way to access not only GPs but allied health and specialised services in D&A.

Monitoring and reporting

There is evidence from in-hours primary care that disadvantaged groups commonly receive differential quality of care (e.g. duration of consultations, prescribing rates and referral rates) [166-168]. Monitoring key quality indicators across different regions and population groups was identified as an important way of ensuring equity of access to quality care.

The EFHIA proposed that one important strategy that could be adopted to monitor equity of service provision is the collection and routine reporting of the characteristics of service users. This includes identifying the quality of care provided to vulnerable and disadvantaged population groups such as waiting times, clinical care processes, use of interpreters, and levels of use.

Summary

In the plans that were assessed, there was a strong emphasis on making services available to populations and communities that have no or limited after hours care. This was reflected in the Medicare Locals' concern to maintain existing after hours services provided by GPs following the withdrawal of PIP payments, to expand the coverage of MDS and to develop co-located afterhours services. However, beyond the issue of availability, there was limited focus on wider issues of access. The EFHIAs suggest that there are some significant emerging service gaps within after hours care that could require more focused attention

including in RACF, for patients with drug and alcohol or mental health problems and for palliative care.

STAGE 3: BEFORE AND AFTER COMPARISONS IN INTERVENTION AND COMPARISON SITES

In this section, two comparisons are made. The first is the comparison between the stage one and stage two after hours plans of the intervention Medicare Locals to assess whether there was an increased reference to the dimensions of access and equity following the EFHIA. The second comparison is between the AHCPs of the intervention sites, and the same plans in the comparison Medicare Locals. The purpose of this comparison was to assess the degree to which similar changes occurred in both sites (suggesting that changes may have been related to factors other than the EFHIA).

Medicare Local 1

In ML1, the stage one plan identified community awareness, availability of services and their appropriateness as key issues. The stage two plan also stressed the importance of continuity and co-ordination of care. Following completion of the EFHIA, there was only a small increase in issues raised and the emphasis shifted from access (e.g. affordable, appropriate) to quality (eg coordinated, comprehensive). In the comparison Medicare Local stage one plan there was a strong emphasis on increasing the availability of services, making available a comprehensive range of services that were accessible and affordable (including dental services), and ensuring services are appropriate to needs of homeless people, people with mental illness, palliative care patients and migrants. There was no substantial change in relation to these areas in the stage two plan.

Medicare Local 2

In ML2, the stage one plan identified the need for community awareness of services, availability of services and provision of a full range of RACF services. The EFHIA stressed the importance of building on and sustaining a strong universal system complemented by more targeted services. In the stage two plan two funding pools were identified. 'Pool 1' incentive replaced the after hours PIP payment to support GP after hours services. 'Pool 2' provided grants to providers of after hours care to meet identified gaps (including services for identified vulnerable and disadvantaged groups). The stage two plan of the comparison Medicare Local also proposed a similar pair of funding pools suggesting that these Medicare Locals have taken a complementary approach to their plans.

Medicare Local 3

Using the EFHIA framework there was evidence of a substantial increase in the number of times issues of access and equity were raised between the ML3 stage one and two plans. The stage one plan identified availability, acceptability and appropriateness as important issues to be addressed by the Medicare Local in their subsequent planning processes. The stage two plan, which covers the entire geographical catchment serviced by ML3, presented a much more concentrated focus on issues of access and equity. For example, the plan focused on identifying gaps to improve accessibility to after hours services in rural and semi-rural areas, and looked at the cost of services for patients, lack of transport and cultural appropriateness as a contributing factor to underuse of existing services.

In the comparison Medicare Local, the stage one plan addressed issues of availability of services and better co-ordination. In the stage two plan there was little change in access and equity dimensions addressed apart from the dimension of quality (which improved).

Summary

Table 5 provides a summary of the changes in the Medicare Locals and their comparison sites. The clearest change in incorporating issues of access and equity between stage one and two plans was in ML3. The change in ML2 did reflect the thinking outlined in the EFHIA

but a similar change was proposed in the comparison ML (possibly due to a state wide approach). There was little change in ML1.

Table 5: Summary of Change from stage one and two plans by Medicare Locals

	Intervention Medicare Local	Comparison Medicare Local
ML1	Slight increase in access and equity dimensions cited.	Vulnerable populations addressed in stage one plan. No substantial change in stage two.
ML2	Substantial change to establish funding pool which targeted vulnerable groups.	Similar change to establish targeted funding pool.
ML3	Substantial increase in number of access and equity dimensions cited.	Comprehensive stage one plan. However no substantial change in stage two.

STAGE 4: STAKEHOLDER INTERVIEWS

The following research questions were addressed through data from the interviews:

1. Is the use of Equity Focused Health Impact Assessment (EFHIA) a feasible and effective way to improve local planning for Medicare Locals/Local Health Districts (LHDs) to improve the access of vulnerable groups to after hours care?
2. In the emerging governance structures of Medicare Locals and LHDs, does EFHIA offer an effective mechanism to engage health service consumers and other members of vulnerable groups in local health planning?

Starting the EFHIA process

The investigators described their early involvement as somewhat messy and stop-start. This was attributed to the Medicare Locals still being in the process of starting up, the many demands on them, and some changes in staff for Melbourne and South West Sydney. In addition, all Medicare Locals had already commenced work on their after hours plans and it was necessary to add the EFHIA process on to what had already been done. The investigators also identified that the choice of Medicare Locals was pragmatic in that they all already had links with some of the investigators.

[...] The main issue was they were quite advanced in their After Hours Care Plan, had done their needs assessment. There was already quite a lot of interest in disadvantage and they had identified groups so the EFHIA steps had to be negotiated. I encouraged it because I didn't want to find another Medicare Local. (Inv1)

Engagement of Medicare Locals and Involvement of Medicare Local boards

In the original EFHIA process we had envisaged developing a steering committee of Medicare Local staff and members of the investigator team as part of the first step. Involvement of the Medicare Local board was also seen as important in the process. However, both investigators and Medicare Local staff reported that there had been only limited interaction and engagement of Medicare Local Boards in the EFHIA and a formal steering group had not been set up. The investigators and Medicare Local staff agreed that the numerous demands placed on the Medicare Locals and the developing nature of the services was a barrier to wider engagement in the EFHIA.

[...] Going to the Board was very rushed and we had very little time. Given this, it was remarkable they engaged at all. First time we went to the CEO he was on his own in empty offices – he was it and yet he was prepared to sit

down and talk to us about it. The next meeting, they'd just moved into new office space, they'd got new staff on and yet he sat down with us for about 2 hours – in the context we were doing it that showed high degree of interest and commitment and willingness to engage. (Inv3)

In the case of all of them, it was very difficult to move past staff to some sort of GP advisory group level. In SA we ended up having a couple of minutes there, in Victoria it was planned they would have something but I think it fell through. In each case we had to get approval from the board and the working group to do it so at that level there was engagement but not in the thinking process. (Inv5)

Effectiveness of the EFHIA processes and outcomes

Participants were asked to evaluate the effectiveness of the EFHIA in improving planning for the Medicare Locals. Although all of those interviewed felt that they had good knowledge of the concept of equity prior to the EFHIA, they described the assistance given to them by the investigators as helpful in forming their thinking around equity and exposing areas they had not considered previously. Another benefit of the process was that participating allowed the relatively new Medicare Local employees to extend or refine their knowledge of their local area with regard to its disadvantaged populations and the issues these populations faced in accessing after hours care. They also mentioned the role the EFHIA had in strengthening the final stage two AHCP submitted to the Commonwealth and that their experience could be used in other areas.

[...] Couldn't make changes to stage one plan but for stage two things like health literacy have been heavily impacted and we've used this plus other information we've gathered to say this is an important part of stage two. In terms of services it doesn't matter what you do if people don't know what to access, how to access, when to access, it won't make any large change and people will still not equitably receive service. So our stage two plan reflects this and a considerable amount of money is being spent in the area of communication and within that, work on health literacy. (ML1)

... It addressed a lot of equity issues that we had considered ourselves. I think it helped us to know that we were heading in the right directions and addressing the needs of disadvantaged groups [...] We attached the EFHIA plan as part of [the plan submitted to DOHA] along with the needs assessment. It has helped us in justifying decisions we have made in our discussions with service providers. (ML2)

The intentions were that we could use some of the learnings and some of the processes of the EFHIA in future planning processes ... potentially integrate some of the steps of the EFHIA process into the planning so it's not a distinct process it's just EFHIA as part of population health planning. (ML3)

The Investigators were more focused on the contrast between the research model and its real life application. Those interviewed considered that putting the EFHIA into practice required a more flexible and pragmatic response to the conditions in which the Medicare Locals were operating. Some investigators also mentioned outcomes in relation to learning about EFHIA or about the operations of Medicare Locals.

The process was a bit less systematic than we expected - it seemed a bit more flexible and bit less formal than we imagined so for us it was a 'learning by doing' thing. This project had to be flexible because we were coming into the Medicare Locals at different times and it had to be that way. (Inv3)

We wanted it to be more a learning experience for the Medicare Locals, that we would be doing it collaboratively with them, transferring skills into the

Medicare Locals on how to do these processes. I don't think that really happened except perhaps to a minor extent in (name) Medicare Local just because we got involved when they were still doing their needs assessment and that might have enabled us to have some influence on how they thought about it. (Inv5)

All agreed that there had been impact of the EFHIA on their after hours planning documents and participation had influenced their interactions with service providers. Most participants identified that the EFHIA process could be used to improve planning in other areas.

With equity it is difficult to get organisations to change the way they do business but this report helped them with another argument for their partners to change the way they do business. If that's the case then this is what we wanted to do with this work on equity focus. That to me was a win. (Inv6)

I enjoyed the process, got more than I expected out of it. When I started it was all new and I was very busy ... wondered how I was going to get through it all. But it helped get it all together, and was very pertinent for work and the new role of the Medicare Local. (ML2)

Capacity and feasibility of EFHIAs for Medicare Locals

Medicare Local staff and Investigators were asked questions relating to the capacity of Medicare Locals to undertake EFHIAs and the feasibility of them being able to take a larger role in any future EFHIAs. The Medicare Local staff felt it would be feasible if the EFHIA process was integrated into current planning processes and the Medicare Locals had the resources available in staff time and knowledge or access to outside assistance, to undertake them. However it was suggested that EFHIA may not be suitable or may get repetitive if carried out in every area of planning.

Our current staff do not have the time, capacity and the people to be able to go away and do that - the literature work and the analysis. I don't think we have the skills in the staff that we have to really have that equity focus and level of analysis. We could touch on it but don't obviously have the expertise that (name of investigator units) have. (ML3)

The Investigators found the the literature review both relevant and of great value, and mentioned the difficulty for Medicare Locals to obtain access to both the resources and the time to conduct such a review. One investigator suggested that many Medicare Locals lacked population planning and public health skills that were necessary to incorporate equity concerns in planning. Other investigators felt it was unlikely EFHIAs would be done by Medicare Locals unless it was part of a mandated process.

They could do small scale stuff with their current resources [...] but can't expect them to allocate core planning money to an equity focus. It is feasible at various scales depending on resources. The intellectual capacity is there and there's a willingness at various levels. (Inv1)

Engagement of vulnerable populations/consultation with vulnerable groups

The potential of the EFHIA process to engage vulnerable populations in local health planning was a primary research question for this project. However, in practice it was not possible for the investigators to engage with vulnerable groups in two of the three areas. In the third area, consultation on a range of health issues had already been carried out by the Medicare Local, making Medicare Local staff reluctant to repeat it during the EFHIA for fear of overburdening consumers. All three Medicare Locals intended to begin or continue consultation with consumers from disadvantaged groups but the timeline of the EFHIA had not coincided with this process. One Medicare Local felt it was inappropriate to consult with vulnerable groups without having a firm set of plans or issues to ask about. Another

Medicare Local described difficulty in linking with other services and their Local Health District as a barrier to engaging with consumers. All agreed that it was too early in the genesis of Medicare Locals to engage in consultation as envisaged by the EFHIA model. However, they also agreed that it may be a feasible means of engaging vulnerable groups once all the appropriate links are in place.

We're focused on getting services into the region. I know that we should be consulting with our community but at the moment I don't feel like we have everything tied down well enough to consult on. (ML1)

For the investigators, they were aware that consultation with consumers had not taken place as part of the EFHIA for the reasons already identified. This was accepted as part of the challenge of implementing a theoretical model in a real world context.

One of the other problems was getting contact with GPs, consumers and other stakeholders. They were very protective that they'd already consulted with those people to death and they had told them what they thought and here we were wanting to come back again. (Inv5)

Some investigators suggested that the EFHIA needed to use a more participatory approach with Medicare Locals and consumers and for it to be undertaken with sufficient time and resources.

Benefits of EFHIA

Participants in the evaluation identified both personal and organisational benefits from the EFHIA. The Medicare Local participants mentioned two main benefits from the EFHIA. The first was that taking part assisted them to settle into and learn a new role in a new organisation. The EFHIA also helped them in identifying needs in the community and the sorts of groups involved. The resulting thinking and the report from the EFHIA helped Medicare Local staff to strengthen the material they sent to the Commonwealth and to broaden their thinking about equity and how to address it.

It's a huge program, different service providers and areas/ demographics. [The] process helped in defining all of that. It gave us greater impetus when talking to service providers. Helped them to look outside the square ... At least it tells them this is an issue and it's been raised by the community and identified by this process. It's given us some background, it's not just lip-service. We have used it as evidence. (ML2)

The framework for conducting the needs assessment was pretty rigorous and we were conscious of the need for community engagement with different groups across the population so there was already that level of consciousness and engagement; it wasn't like there hadn't been any consideration but being able to draw on that expertise and the evidence around some of the social determinants, impacts of disadvantage, that kind of thing - that was valuable. Some of the things we weren't aware of like electronic communications, social media, probably made some assumptions there that didn't necessarily apply across the population. (ML3)

For investigators benefits of the EFHIA included making links with Medicare Locals and their staff, which could be used in the future, learning about the EFHIA process and after hours care issues. Some investigators also reflected on the benefits for Medicare Locals in putting equity issues on the agenda and having exposure to a clear stepwise process for the EFHIA.

Challenges for EFHIA

Many of the challenges confronted by the EFHIA were common to both investigators and Medicare Local staff. The issue of time was a particular challenge, including a lack of time to achieve both the EFHIA processes and meet the Commonwealth deadlines. There was also limited time for meetings between investigators and Medicare Local staff.

Timing was another issue with all three Medicare Locals at different stages of their development and of their after hours planning when the EFHIA was introduced. Also, the investigators had to meet deadlines set by the research grant that was funding the EFHIA project.

The main problems were finding the time to spend - face to face time with them - that was the most frustrating bit because they did seem very interested in engaging and the process but because we had only two limited visits, it felt like a bit of a lost opportunity. (Inv4)

Timing was difficult ... would have been great if the EFHIA had been in stage one ... the process of integrating it into stage two was challenging. This might have meant the greater engagement of the steering group. They could have had more input. (ML3)

Another concern for investigators in particular was the lack of certain resources to conduct the EFHIA. These resources included specialist knowledge of some areas and access to consumer groups and other stakeholders.

[...] to be sustainable it requires more commitment, resources (not just financial). Not sure even if it was held at a perfect time it would be all that easy to get active involvement ... It's been a struggle for investigators as well. ... My struggle was not so much with what we were trying to do but just getting it to happen. (Inv5)

For the Medicare Local staff, some of the processes of the EFHIA were unclear and needed refinement.

It would have helped to have seen ... particularly around the screening and scoping ... a bit more of a yes or no; an assessment tool, I got a bit lost in that process, it seemed a bit vague: are we screening, are we scoping? Where are we at? (ML3)

Suggested improvements

All participants were able to suggest improvements to the EFHIA process that could strengthen it. The Medicare Local staff and some of the investigators suggested that some clarification of the EFHIA processes would be of benefit to those who were unfamiliar with them.

Needs more clarity upfront, it took a couple of meetings; probably that was because I was new to the organisation as well. This was one of many things I was trying to get my head around in the first month or two - perhaps an explanation for dummies? That might have been provided in the month before I started? The key is to incorporate it into day-to-day business - not an extra job, it is the job. (ML1)

Participants agreed that the challenges identified around timing could be improved by a greater lead-in time for the process and commencing the EFHIA at the beginning of a planning cycle as had originally been intended. The clash between research requirements and real world settings was also mentioned as a factor that affected EFHIA outcomes.

Finally, there were some suggestions about how the EFHIA could be incorporated into routine work for Medicare Locals including making the process more participatory and

setting up designated resources to support Medicare Locals in doing EFHIA, either internally or externally.

[...] weave into the fabric - the Commonwealth has started down that path with what services should look like but go further and be very explicit about what you're doing. If it's written into the operational guidance that you must look at this then people will do this as a matter of course. (ML1)

Some participants also suggested that beyond structures, a wider commitment to equity was also necessary if the EFHIA was to become incorporated into Medicare Locals.

The EFHIA process worked. It's all to do with the timing and how it gets used and at the end of the day it's how the funder and the board put an emphasis on equity. And if they don't, an EFHIA isn't ... or it may have some impact in making them think we should think about that but if it's not a strong value in the organisation then you're probably not going to push them by doing an EFHIA. (Inv3)

Summary

The findings of the interviews suggest that overall the EFHIA process was considered by both the investigators and Medicare Local staff to have had positive outcomes. The two interview groups were able to implement a form of EFHIA for after hours care that resulted in benefits for both Medicare Locals and the researchers. The Medicare Local staff learned about the EFHIA processes, were able to use some of them to uncover issues that they had not considered and to confirm others that were already known in their areas. The investigators were able to test their model in a real world setting and adapt it to meet the challenges posed by short timeframes and participants who were on tight deadlines. The investigators also gained insight into and links with Medicare Locals.

The existing links between the Medicare Locals chosen and the investigators were important in facilitating the process. The ability to overcome some of the challenges and still implement the EFHIA may not have been as easy if these links and the commitment of the Medicare Locals CEOs had not been in place. Future EFHIAs would need time to develop such links, if they did not already exist. Medicare Local staff also suggested that the process for the EFHIA could be further clarified (including through a plain language guide) and that resources, both personal and financial would be needed if EFHIA is to become part of planning in Medicare Locals.

STAGE 5: KNOWLEDGE TRANSFER AND EXCHANGE

As part of the knowledge transfer and exchange process, presentations on the project have been given at local, national and international meetings. Meetings have also been held with DOHA officers in the Sydney and Canberra offices. These meetings and presentations have provided valuable feedback in the drafting of the report.

This has highlighted the potential for EFHIA to be used more widely in Medicare Local planning processes. At the time of writing, the project had not directly informed other policies or programs. However a number of other areas of Medicare Local work are potentially amenable to a more in-depth analysis of access and equity considerations as provided by an EFHIA. These include: constructing a service system for residential aged care facilities; improving access to allied health and psychological services; and integration into population health planning. However this would be dependent on building local capacity.

Discussion

This exploratory study tested the feasibility of using EFHIA as a means for assessing access and equity within Medicare Local plans. In this instance EFHIA was used to assess the after hours plans of Medicare Locals. However it is a process that could be applied to other areas of Medicare Local service planning.

Through the project we were able to:

- > successfully work with Medicare Locals to complete the three EFHIAs
- > demonstrate that
 - in at least one Medicare Local participation in the EFHIA significantly increased the focus on access and equity issues (this may partly be attributed to the researchers working closely with the needs assessment processes).
 - in another Medicare Local and as a result of the EFHIA, an equity approach was applied in strengthening and maintaining the existing after hours service and supplementing this with a pool of funds to support innovative approaches to addressing gaps including services for vulnerable and disadvantaged groups. This appeared to have been also adopted by the comparison Medicare Local as part of a statewide approach.
 - in the third, where the EFHIA was conducted on an EOI, there was no evidence of change.

Those interviewed expressed support for the process, reporting that it had influenced their plans and that they had learnt from it. They considered that the process could be applied to other areas of Medicare Local planning, however Medicare Locals would need support to initially undertake them and should take a strategic approach to selecting which programs or policies should be subject to an EFHIA.

There were few examples of initiatives to monitor the segments of the population that use or do not use services, a key equity dimension assessed.

There was broad based support by those involved who felt that it had been a useful learning experience. However there were some significant limitations:

- > The EFHIAs were conducted in only three Medicare Locals.
- > The tool for assessing the plans against the dimensions of access and equity in the plans was subjective and needed to be expanded to include awareness as a key dimension of access. A simple count of the number of times where mention of a dimension was made did not capture the level of sophistication expressed. Despite this the tool was easy to use and addressed the majority of issues raised.
- > Deciding what part of the plans would be assessed was difficult as the structure of each plan template was different and different types of plans were assessed. For example one was an EOI, one a stage one sub-regional plan and one a stage one Medicare Local wide plan.
- > The workforce distribution is a key driver of availability and needs to be considered more prominently in the EFHIAs in the future. In this study we considered it within the dimension of availability.

CHALLENGES/LIMITATIONS TO THE RESEARCH

Although we were able to work constructively with Medicare Locals to undertake the EFHIAs this was not without difficulty. The study was undertaken during a time when Medicare Locals were newly established. This meant that there was staff turnover in each of the study

sites, infrastructure was being developed (including changes of address and phone numbers) and pressure to deliver plans in very tight timeframes. All of the Medicare Locals had recently undertaken extensive community and general practitioners consultations and rather than repeat these consultations, these consultations were examined in secondary analysis. Within the constraints of their commitments and the study's timeframes it was not feasible to establish separate steering committees that represented a range of stakeholders. It was also difficult to actively engage the Medicare Local Boards in the process.

This implies that there needs to be ways to flexibly ensure the integrity of the EFHIA process as it is rolled out in a dynamically evolving system. This will need to involve a pre-screening stage to decide if there is sufficient capacity and commitment to successfully complete the project.

IMPLICATIONS FOR PRACTICE (MEDICARE LOCAL PLANNING)

There are a number of ways in which the use of EFHIA may be of direct and indirect assistance in Medicare Local planning processes. This study suggests that an EFHIA process conducted in collaboration or in parallel with needs assessment processes has the potential to directly increase the focus on access and equity.

Medicare Locals are expected to document the needs of their local communities and this means that there are significant variations in the ways gaps between need and service provision are identified and in the way possible solutions are developed. Joint state/ regional approaches are being taken by Medicare Locals to address common issues, such as community awareness programs or providing a system of care in Residential Aged Care Facilities. Thus it may be appropriate to undertake EFHIAs on jointly developed policies and plans at a city or state level as well as those of an individual Medicare Local.

Participating in EFHIA also has the potential to help Medicare Local staff to learn more about equity and vulnerable population groups in their communities and this may further improve planning processes [169]. Specifically there are opportunities to improve:

- > technical learning (how to use literature reviews, identify data sets that may provide information on the distribution of health within the population, integrate information from different sources, and evaluate patterns of health inequity in their area)
- > conceptual learning (approaches to addressing issues of access and equity, analysis forces driving patterns of health inequity) and
- > social learning (providing opportunities to work with other partners on time limited activities, appreciate fully the barriers to access from the perspective of people in disadvantaged groups, priority setting).

However, given technical skill limitations, routine undertaking of EFHIA may be difficult on all policies or plans. Thus it is suggested that EFHIA be more strategically used for those policies that focus on areas where there is evidence of barriers to access and equity.

IMPLICATIONS FOR POLICY

There are strong policy drivers for Medicare Locals to focus on improving access to and quality in PHC services. As a structured, stepwise and transparent process, EFHIA can assist local service planners to consider equity issues in their planning at multiple levels across diverse issues. For example, as part of policy development at national level, a process could be developed to equity-proof policies. This could involve undertaking a literature review that presents current knowledge of access and equity issues and population particularly affected. This could then inform targeted consultations and data

collection as part of the development process. Once there is enough substance in the policy it could be subject to a rapid equity filter.

This filter could use the six EFHIA questions [170]:

1. What is the initiative trying to do (aim, activities, anticipated health impacts, equity dimensions addressed)?
2. Is there evidence to support this (need, effectiveness)?
3. Is there evidence of inequity?
4. Who may be disadvantaged or advantaged by the initiative?
5. Are there likely to be unanticipated impacts?
6. Are there recommendations which could maximise positive impacts on health equity and minimise negative impacts?

A more comprehensive EFHIA may be needed if there are likely to be significant equity impacts, if a large number of people may be adversely impacted or if there are likely to be high, long term financial costs.

BUILDING CAPACITY

IF EFHIA is to become one of the tools used by Medicare Locals to improve access and equity as part of their planning processes, capacity will need to be built at national, state and local levels. This should involve organisational development as well as the development of a skilled workforce and provision of adequate resources. See Table 6 for an example of a capacity building approach to EFHIA (Appendix 7).

The engagement of universities in supporting the EFHIA process, data collection and evidence collection could assist in reducing duplication (e.g. a single rather than multiple literature reviews).

IMPLICATIONS FOR FURTHER RESEARCH

This study is small in scale and, while it was able to develop a system for assessing dimensions of access and equity this process needs to be refined and requires further testing. We were only able to demonstrate modest impacts. Because of the constraints in the ways consultation could be done we were unable to determine if the EFHIA process may allow participation of vulnerable and disadvantaged groups in a meaningful way (e.g. using action-research methodology). This should be the focus of further study.

Conclusion

Medicare Locals are still evolving as learning organisations. EFHIA provides one approach to integrating evidence into local planning. In answer to the first research question this study suggests that EFHIA is a feasible way to support Medicare Locals to consider equity of access by vulnerable groups as part of their planning for local after hours primary health care. There was also some evidence that it could be effective in helping to incorporate equity in the planning process and in the final plans.

The second question about engagement of health service consumers and vulnerable groups in planning remains unanswered. This was because it was inappropriate to undertake extensive consumer consultation and engagement immediately after this had been undertaken as part of the Medicare Locals' needs assessments. However secondary analysis of these needs assessment provided an opportunity to at least incorporate their perspectives in the EFHIA.

Three areas of recommendation emerge:

1. Methodologies to assist Medicare Locals to consider access and equity issues in their planning should be developed. This could include a range of approaches and tools such as EFHIA, equity lens or equity audits. Whatever is used will require both organisational and workforce capacity. This would be facilitated by an evidence check (rapid literature review) to identify strategic areas where access and equity issues are most important and effective ways to address them.
2. This study suggests that prior to commencing such a process, an initial 'pre-screening' review needs to determine:
 - a. the plans that are most appropriate to subject to an assessment (eg where there are likely to be access and equity issues)
 - b. whether the Medicare Local is able to commit resources and willing to act on the findings and
 - c. the stage of the needs assessment and planning process that will allow most effective input.
3. More research is needed to find and evaluate innovative ways to engage communities and other stakeholders in assessing the access and equity implications of Medicare Local plans in the context of many other competing consultations processes.

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