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

Technical report

Developed by the Health Equity Research and Development Unit 2023

Foreword

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

We are immensely proud of the way our staff and our community continue to support our equity-focused COVID-19 response. While the COVID-19 pandemic has affected us all, we have seen that some groups have experienced greater risks to health than others. ” ê HÃ%åê$ ß ÃR HK,$HZêå `R Z, Kê•êßZ ,% Ã%å adjust to new ways of working and living.

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

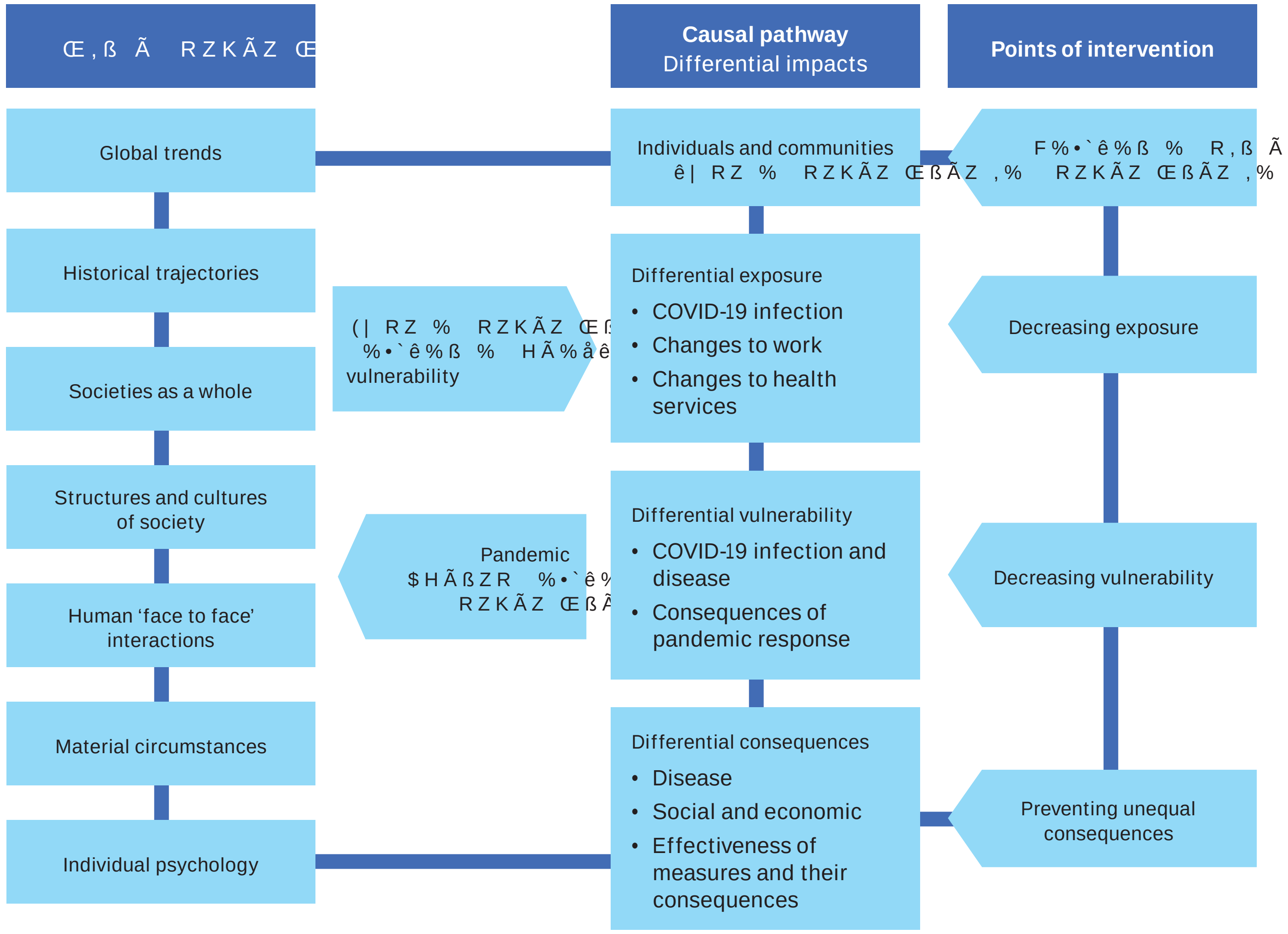
HERDU has carried out this EFHIA to support the District's pandemic response. This includes recovery from the COVID-19 pandemic and building resilience to future pandemics, as well as similar emergency situations.

The District has been at the forefront of the state's response to COVID-19, with staff caring for critically ill patients in intensive care and hospital wards, working at testing clinics, surveillance sites and Special Health Accommodation, and H.5 (e)alol(lol(IS)/MC[(w)17 2r(tienSdi≠i(xis)20.6 (ti)-7.5 (ng4303 ЗDC BT-0.015 Tw 10

Note on language and terminology

In line with NSW LGBTIQ+ Health strategy,

Figure 1 Conceptual framework for understanding health equity pathways and potential points of intervention



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

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

The Health Equity Research and Development Unit (HERDU) was tasked with carrying out rapid evidence reviews and equity checks to inform SLHD's COVID-19
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a more systematic overview of the potential longer-term equity impacts resulting from COVID-19 and the actions taken in response to the pandemic. An HIA screening process supported the rationale for carrying out an EFHIA to inform medium-to long-term planning and response (see Supplementary Material). A proposal to carry out this EFHIA was approved by SLHD's Chief Executive (July 2021).

HIA is a structured process for considering positive and negative health impacts of a proposed policy, plan or other intervention before it is implemented or while it is underway (in the case of a 'concurrent HIA'). The goal of undertaking an HIA is to provide a set of evidence-informed recommendations and considerations to assist with planning and implementation of the intervention. This enables the potential positive impacts of the intervention to be strengthened and any negative impacts to be mitigated.

HIA provides a process through which evidence (of different kinds), interests, values and meanings are

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

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available health and socioeconomic data (e.g., from the Census)

- Identify and assess potential health impacts and disparities by:
  - objectively assessing how the risks and consequences of COVID-19 infection varied across populations in SLHD, using data ÿK,$ _Œ° BêÃ Z R _,Z ŒÃÞ ê F%ÿ,K$ÃZ % Management System (NCIMS)
  - conducting literature reviews of the focus areas
  - collecting and analysing evidence from community members and key stakeholders, through focus groups and interviews.

Ethics approval for the project was granted on 11 December 2020, by the SLHD Research Ethics and =,vêK%Ã%ßê fÿŒßê ó,K,Z,ß, _,â µ“‘ ‘ ‘•‘ ‘“‘ ETH02564).

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HK,Œ ê ,ÿ ŒXB# R H,H` ÃZ ,% wÃRZ,êÑ ê,ŒKåÃ concentrating on the priority populations selected during the scoping stage. For each priority population, absolute numbers and proportions were obtained using the ABS Census Table Builder Pro application (Australian Bureau of Statistics, 2020).

Spatial distributions of the priority populations, as well as socioeconomic advantage and disadvantage, were mapped using ArcGIS geospatial software (Esri Inc., 2019). Where available, data were also collected ÃÞ,`Z Ãåå Z ,%Ã K R ÿÃßZ,KR åê%Z Œêå Z K,` Z ê interviews, focus groups and literature reviews.

2.4.2 Assessment of risks and consequences of COVID-19 infection in SLHD

Differences in the risk of COVID-19 infection, hospitalisation and fatality across population groups and geographic areas in SLHD, were quantitatively ÃRRêRRêå Þ} Ã%Ã }R % Ã %ê RZ ,ÿ ß,%ŒK$êå Ã%å probable COVID-19 cases recorded in NCIMS (NSW Health) up to and including 21 February 2022.

To begin with, the number of cases, hospitalisations and fatalities per 100,000 persons were mapped by suburb and using ArcGIS geospatial software (Esri Inc., 2019).

Next, the relationships between a suburb's level of socioeconomic disadvantage (as measured using the Index of Relative Socioeconomic Disadvantage [IRSD] (Australian Bureau of Statistics, 2016b) and its COVID-19 case, hospitalisation and fatality rates, were visualised using scatterplots and tested using the Pearson correlation method. This analysis was performed using Python version 3.9.7 (Python Software Foundation, 2022).

Finally, logistic regression was used to ascertain the effect of socioeconomic disadvantage (IRSD score), gender, Indigenous status and age on (a) the likelihood of a case being hospitalised and (b) the likelihood of a case dying from COVID-19. In both models, the Box-Tidwell procedure was used %êÃK Kê ÃZ ,%R H ÞêZwêê% F…Œ# R ß,Kê and the logit transformation of the dependent variable. This analysis was performed using SPSS Statistics version 26 software (IBM, 2019).

In addition to the rapid scoping review of COVID-19 and health equity conducted during the scoping stage (see 2.3. Scoping, above), we carried out four literature reviews, focusing on evidence reviews and peer-reviewed literature:

1. Changes to health services due to COVID-19 and health equity
2. Changes to the way we work due to COVID-19 and health equity
3. Virtual care and health equity[1]
4. COVID-19, perinatal service delivery and health equity[2]

We also utilised grey literature, including SLHD reports and documents, reports from peak bodies, non-government organisations (NGOs) and `% vêKR Z êR Ã%å KêH,KZR åê%Z Œêå Þ} ê} %ÿ,K$Ã%ZRâ Throughout the EFHIA process, grey literature was collected and included in a Zotero library of approximately 630 documents.

2.5.1 Changes to health services due to COVID-19 and health equity

To better understand the impacts of changes to health services due to COVID-19 on health outcomes and equity, we conducted a systematic review of the literature. Our aim was to capture recent literature documenting the consequences of pandemic-induced changes in health care (across access, availability, quality and appropriateness), with a particular focus on health workers, older adults, younger people (including children and their families), people from CALD backgrounds and women. We searched for peer-reviewed articles published since December 2019 in the PubMed, EMBASE, Web of Science and CINAHL databases. Our search strategy followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. A set of search terms was developed using the PICO (population, intervention, context, outcome) framework and tested multiple times across the different databases to ensure that relevant articles with enough depth and breadth of information were being captured. ” ê Œ%Ã RêÃKß wÃR ß,%å`ßZêå ,% ™ _,vê$ÞêK “‘“’â The database search results were imported into Endnote, where duplicates were removed, before a single library was moved into Covidence systematic review software for title/abstract and full text screening.

Over 2,680 articles were screened at the title/abstract stage, with a sample double screened by two researchers (EA and CS). Because of the large volume of literature, inclusion criteria were tightened to focus only on high-income countries (as it was thought these would be most relevant to the SLHD context), and to exclude articles on virtual care, as it had already been the topic of a full literature

2.5.3 Virtual care and healal2504qu5 (ual it)-2.07713Se

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In NSW, Local Health Districts (LHDs) are established

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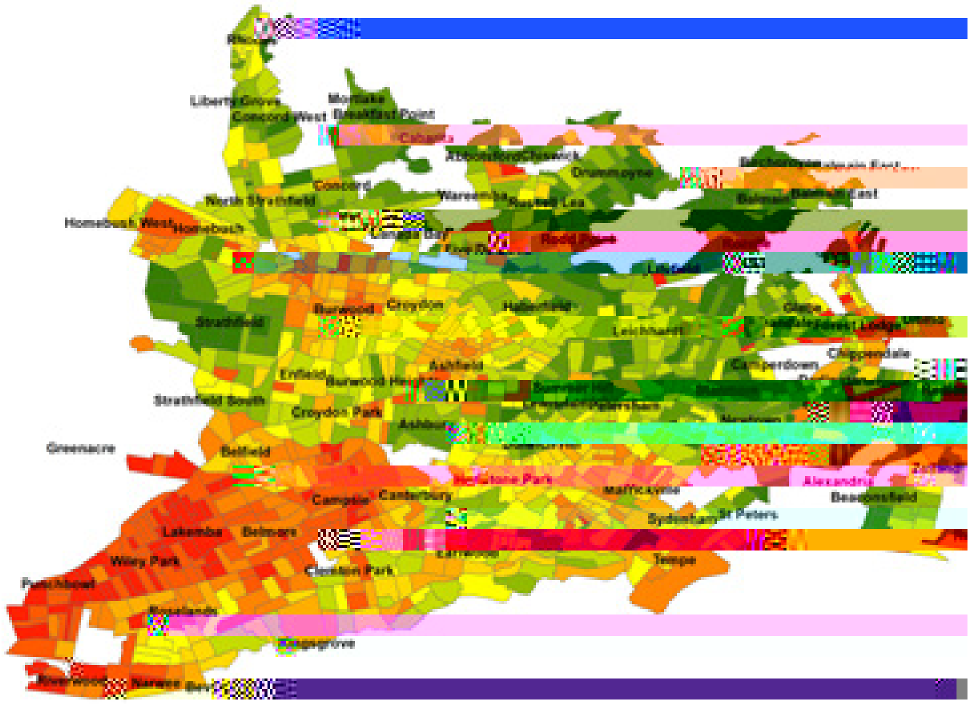

IRSAD decile

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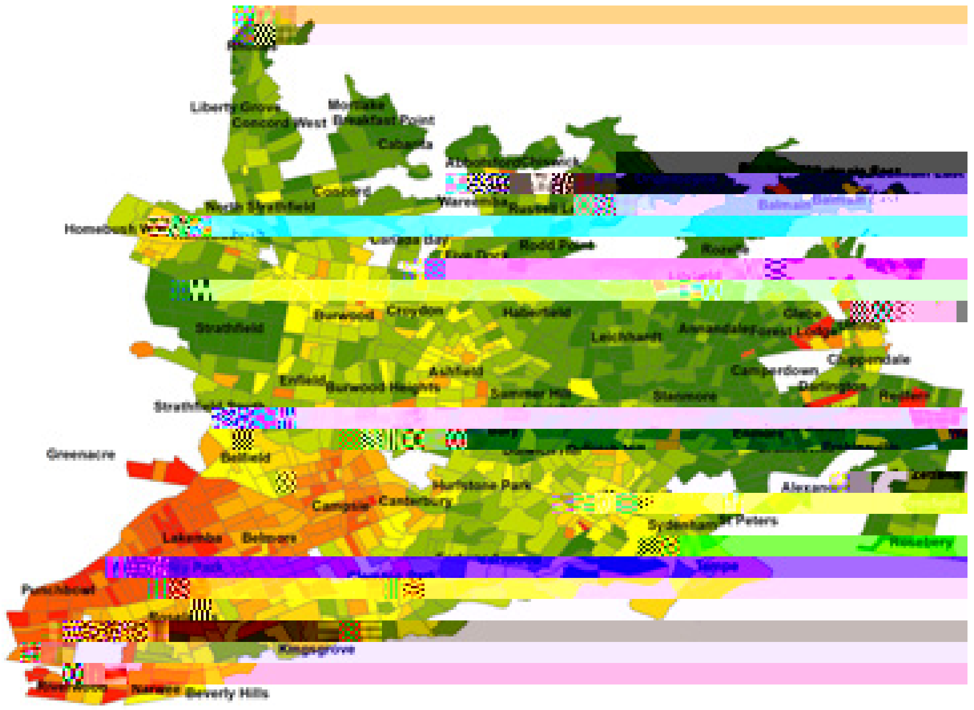

3.2.2 Access to public open space

There are large disparities in access to public open space, with people living in the western part of the SLHD generally having poorer access (Figure 11 and Figure 12, below).

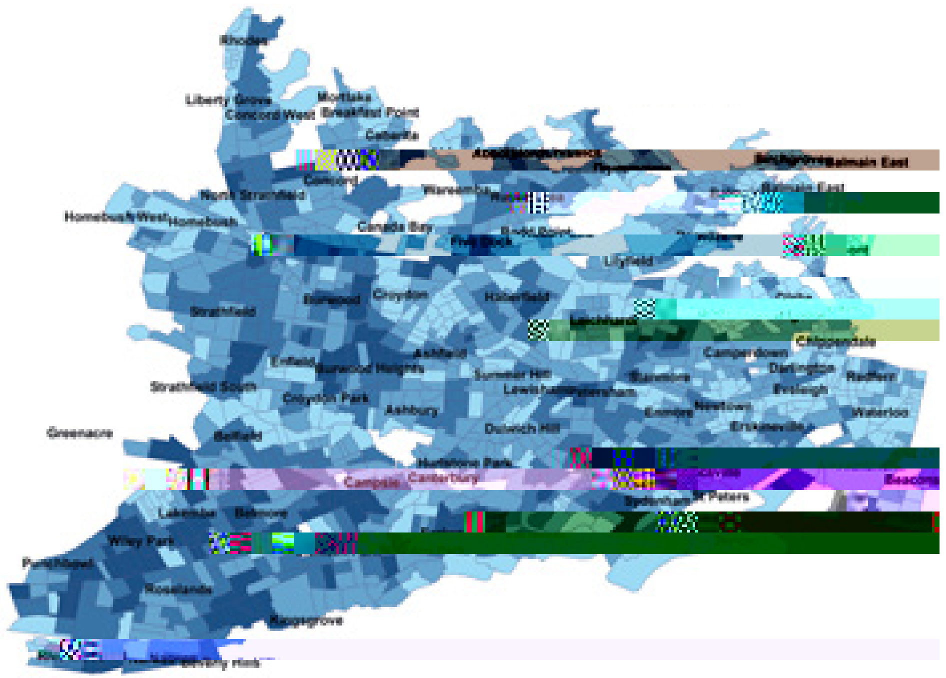

Figure 11 Average distance to closest public open space – by SA1

0–130.1

130.100001–249.1

124.100001–415.3

415.300001–875.5

Source: RMIT University, n.d.

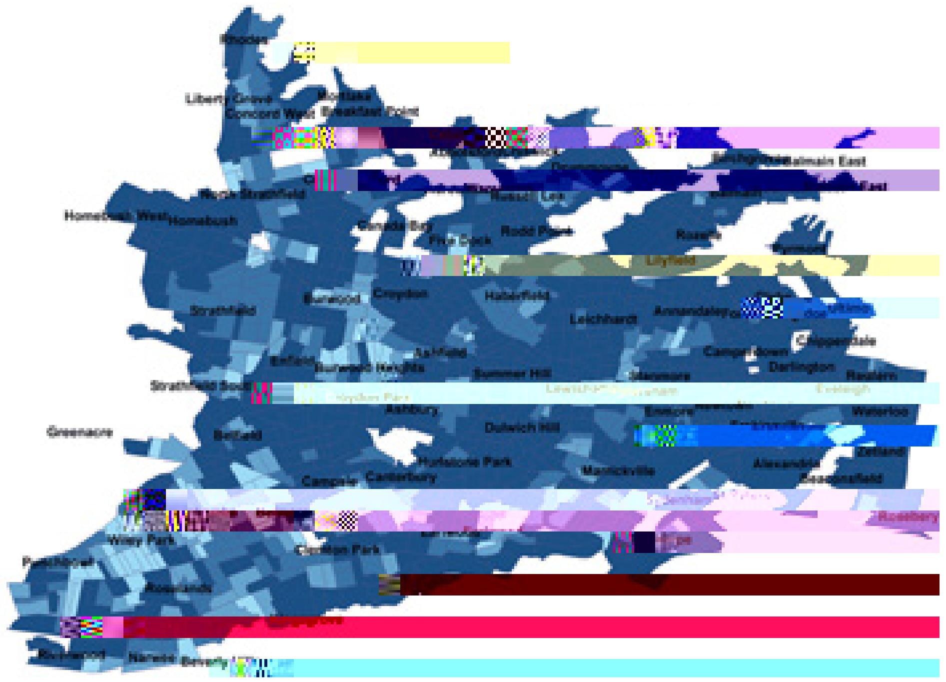

Figure 12 Percentage of dwellings within 400 metres or less of public open space – by SA1

0–26.9

26.900001–59.1

50.100001–86.7

86.700001–100

Source: RMIT University, n.d.

Access to large public open spaces (larger than 1.5 hectares) is generally poor throughout the SLHD, however, there are some exceptions, such as areas near the Cooks and Parramatta rivers (Figure 13 and Figure 14, below).

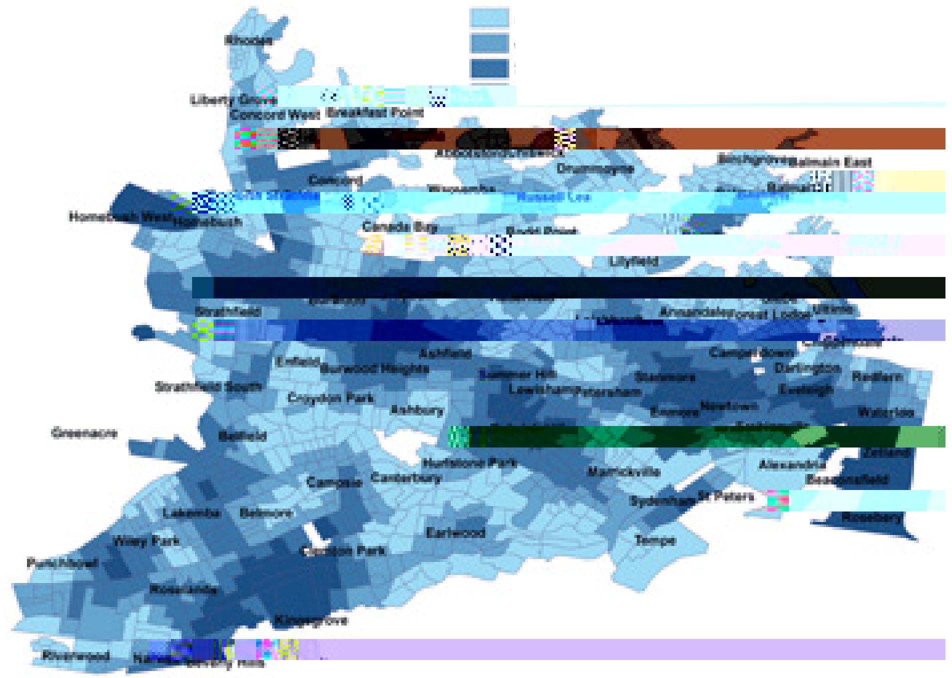

Figure 13 Average distance to closest public open space larger than 1.5 hectares – by SA1

0–405.4

405.400001–786.2

786.200001–1244.1

1244.100001–2530.1

Source: RMIT University, n.d.

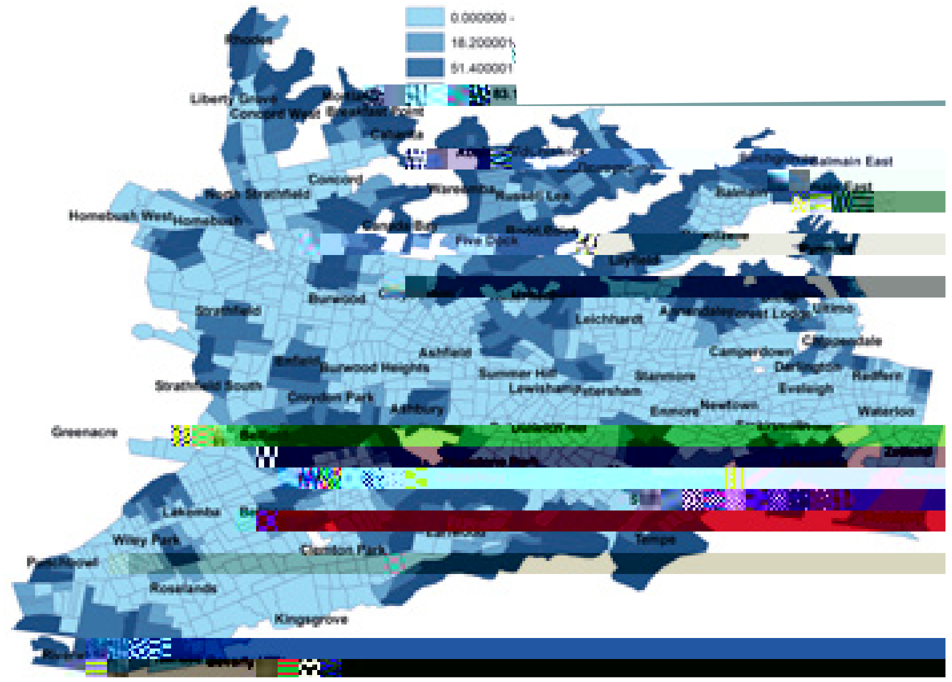

Figure 14 Percentage of dwellings within 400 metres or less distance of public open space larger than 1.5 hectares – by SA1

0–18.2

18.200001–51.4

51.400001–83.1

83.100001–100

Source: RMIT University, n.d.

1.533133–2.774791
2.774792–4.016448
4.016449–5.258106
5.258107–6.499763
6.499764–7.741421

5.088894–6.263775
6.263776–7.438657
7.438658–8.613538
8.613539–9.788419

4 Evidence summary

This section summarises the evidence in relation to the three focus areas: risks and consequences of COVID-19 infection, changes to work and changes to health services.

exposed to and infected by COVID-19, and also more likely to experience serious health consequences, including hospitalisation and death (Baena-Díez et al.,
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& Kawachi, 2021).

In Australia, in the time period up to 31 October 2021, the number of people who died due to COVID-19 was over four times higher for people living in the most disadvantaged neighbourhoods compared to those living in the least disadvantaged neighbourhoods (ABS, 2022b).

Although the number of infected people was much higher in younger age groups (see Table 4), older people experienced a much higher incidence of mortality (ABS, 2022b). The risk of serious illness from COVID-19 increased with age, especially for those over 70 years old. Residents in aged care facilities were
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deaths occurring (Australian Government Department of Health, 2022). For example, during 2020, 7% of all COVID-19 cases in Australia and 75% of all deaths, f all

Figure 19a Reported COVID-19 cases, per 100,000 persons to 21 February 2022, by suburb

8,516–12,380

12,390–15,420

15,430–20,160

20,170–26,270

Source: NCIMS, NSW Health

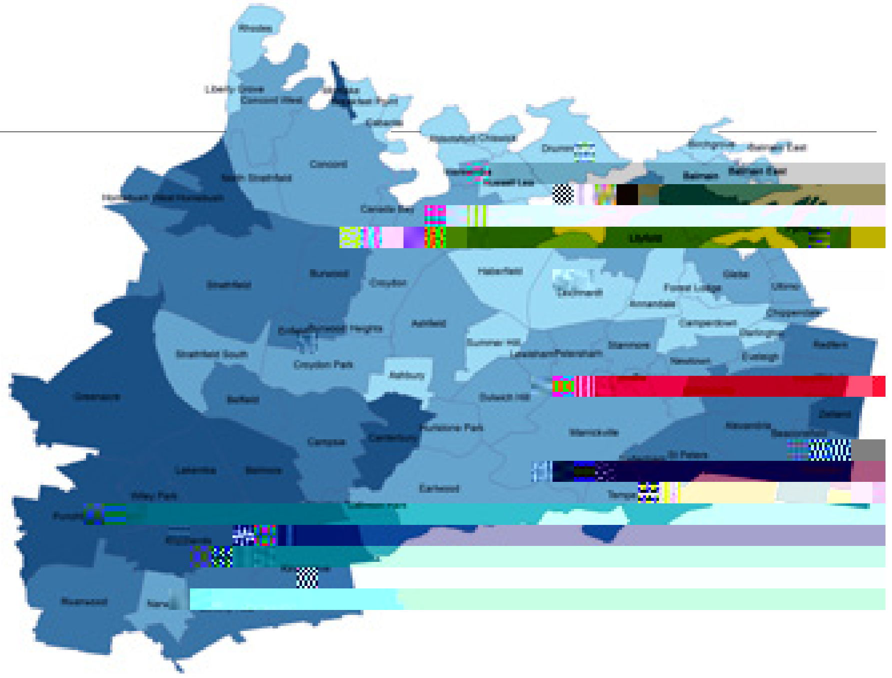


Figure 19b Reported COVID-19 hospitalisations per 100,000 persons to 21 February 2022, by suburb

121.126780–389,888884

389.888885–843.30885

843.30886–1,080.63003

1,080.63004–1,613.63096

Source: NCIMS, NSW Health

Figure 19c Reported COVID-19 fatalities per 100,000 persons to 21 February 2022, by suburb

0–12.4781629

12.4781630–45.4098247

45.4098248–112.485937

112.485938–420.420406

Source: NCIMS, NSW Health

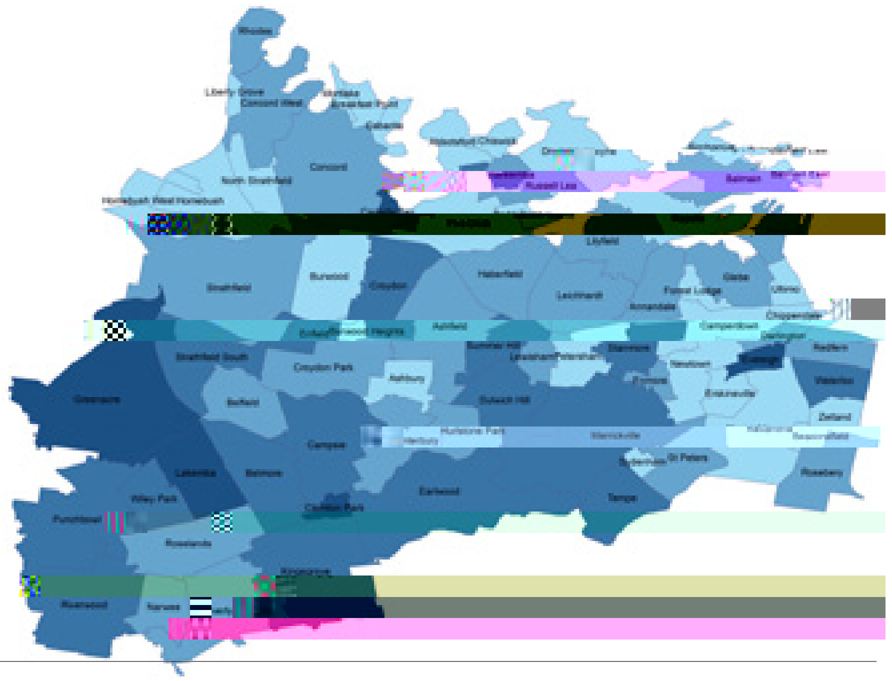


Figure 20 Relationship between socioeconomic disadvantage and reported COVID-19 case rate to 21 February 2022

● Suburb

Note: Lower IRSD score means more disadvantaged. Only suburbs with IRSD score < 990are labeled.

Sources: Australian Bureau of Statistics (2016b) and NCIMS, NSW Health

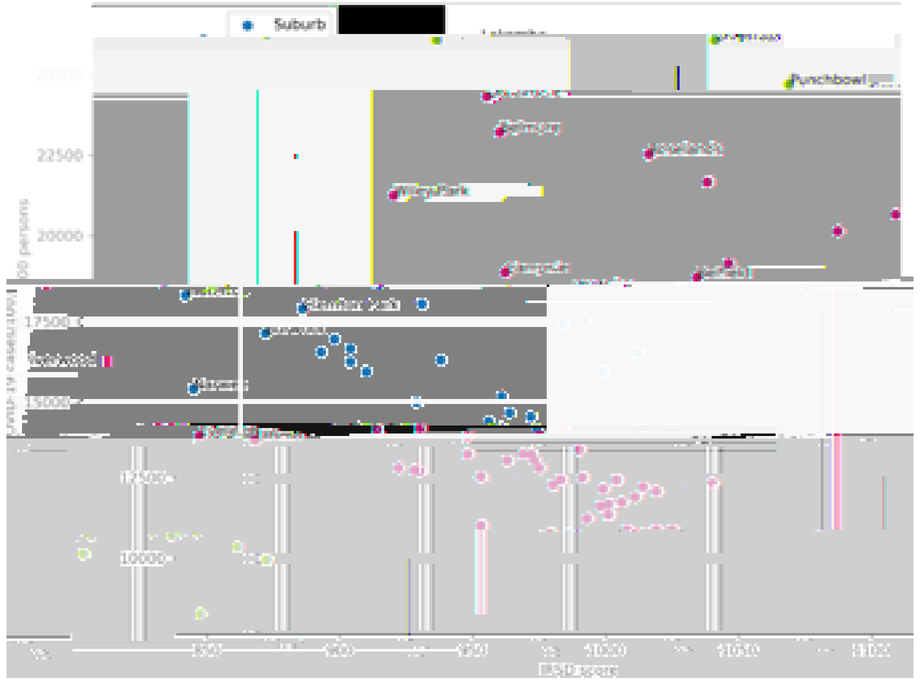


Figure 21 Relationship between socioeconomic disadvantage and COVID-19 hospitalisation rate to 21 February 2022

● Suburb

Note: Lower IRSD score means more disadvantaged. Only suburbs with IRSD score < 990are labeled.

Sources: Australian Bureau of Statistics (2016b) and NCIMS, NSW Health

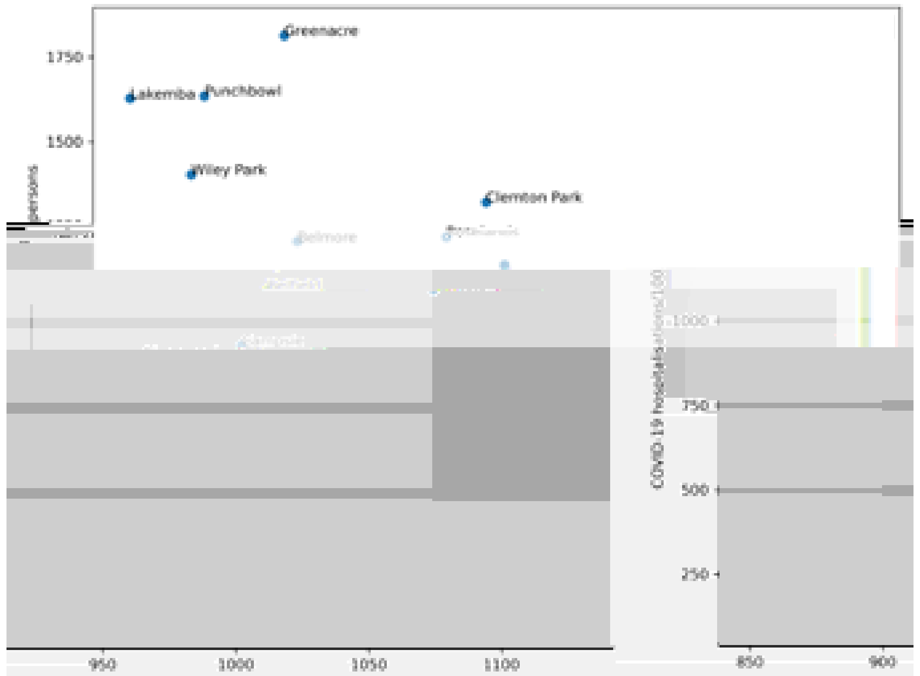
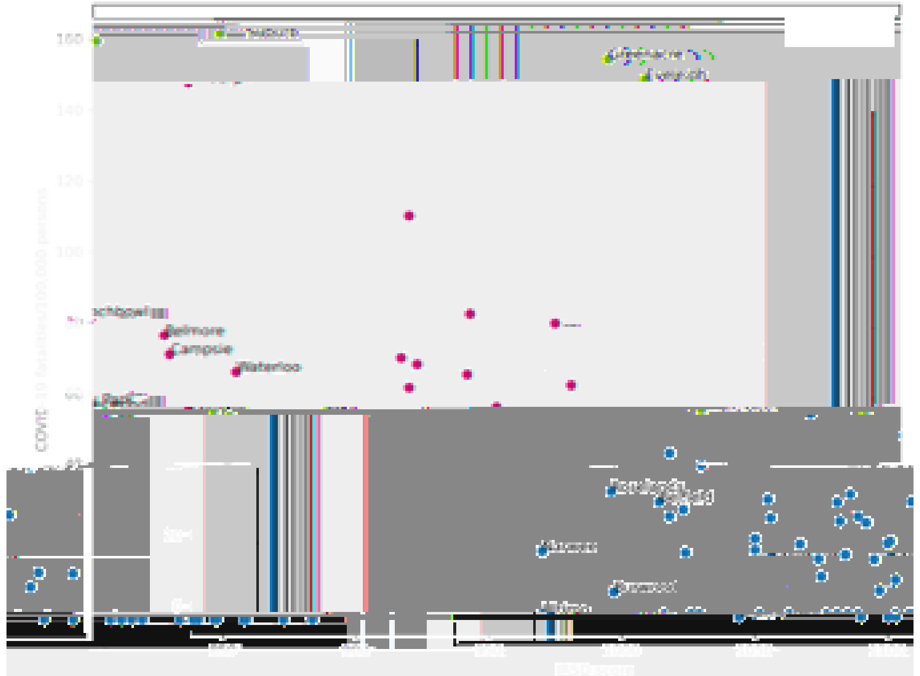


Figure 22 Relationship between socioeconomic disadvantage and COVID-19 fatality rate to 21 February 2022



● Suburb

Notes:
1 Lower IRSD score means more disadvantaged. Only suburbs with IRSD score < 990are labeled.
2 Excludes Clemton Park which has a small population (1,665) and a large residential aged care facility.

Sources: Australian Bureau of Statistics (2016b) and NCIMS, NSW Health

For the logistic regression analyses of hospitalisation and fatality likelihood, 62,029 cases with incomplete/ unknown information or belonging to a category with a very low frequency were dropped, leaving 40,566 cases. The logistic regression model of case hospitalisation likelihood (Table 5) was statistically R % Œ ß2Ã6%=Z,1017.72, p < .001). The model explained 13.3% (Nagelkerke R2) of the variance % ,RH ZÃ RÃZ ,% K R Ã%å ß,KKêßZ } ß ÃRR Œêå 93.5% of cases. Aboriginal and/or Torres Strait Islander cases were more than 60% more likely to be hospitalised than non-Aboriginal or Torres Strait Islander cases (adjusted odds ratio (AOR) 1.64, š–F ß,%Œåê%ßê %ZêKvÃ ó Fô 'â"˜û'âš—ôâ X ê ,,å of hospitalisation increased with age, with a case aged 50–69 more than two times as likely to be hospitalised as a case aged 20–49 (AOR 2.63, 95% CI 2.37–2.92), and a case aged 70+ about 12 times as likely to be hospitalised (AOR 11.60, 95% CI 10.43–12.92). Increasing IRSD score (i.e., decreasing socioeconomic disadvantage) was associated with

explained 32.7% (Nagelkerke R2) of the variance % ÿÃZÃ Z} K R Ã%å ß,KKêßZ } ß Ã
Likelihood of death from COVID-19 increased with age: a case aged 50–69 was more than 60 times as likely to die as a case aged 20–49 (AOR 63.56, 95% CI 19.73–204.81) and a case aged 70+ was more than 550 times as likely to die (AOR 562.74, 95% CI 179.13–1,767.82). Male cases were more likely to die than female ones (AOR 1.53, 95% CI 1.13–2.06). ” êKê wÃR %,Z Ã RZÃZ RZ ßÃ } R % between Indigenous status and likelihood of death, nor between IRSD score and likelihood of death. Note that many fatalities occurred in aged care facilities in a small number of SA2 areas, making Z $,Kê å ÿŒß` Z Z, êRZÃÞ R Ã% Ã IRSD score and fatality likelihood. Note also the large ß,%Œåê%ßê %ZêKvÃ ó‘â“•û“â•˜ô ÿ, status AOR.

In summary, people living in the more socioeconomically disadvantaged areas of SLHD were more likely to be infected, to be hospitalised and to die from COVID-19. However, once a person did Þêß,$ê %ÿêßZêåã wê ßÃ% Œ%å %, êv åê%ßê Z ÃZ Z ê} 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 (Figure 23(b)). 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).

Table 6 Logistic regression model of COVID-19 case fatality likelihood in SLHD

Independent variables	AOR[a]	95% CI (lower)	95% CI (upper)	p value[b]
Gender				
Female[c]	1.000			
Male	1.527	1.131	2.061	.006
Indigenous status				
Not Aboriginal or Torres Strait Islander[c]	1.000			
Aboriginal and/or Torres Strait Islander	0.774	0.242	2.469	.665
Socioeconomic disadvantage				
IRSD score of SA2 where case lives	0.999	0.996	1.001	
Age group				
0–19	0.000	0.000		.981
20–49c	1.000			< .001
50–69	63.559	19.725	204.806	< .001
70+	562.740	179.133	1767.824	< .001
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Chi square	p < .001			
Nagelkerke's R2	0.327			
0Prediction success				

controlling for other variables in the model.T9 0 F13 (ol)14.5 (o)3 (ox)1.5 (432C BT6.5 0 8)-1 5lotthet-delwiceETEMC a/P <</L2P <</or 'IJETETEMC.Lang (en-US)/MCID 2970 BDC BT6.5 0 0 Tf9 0 0 9 48.1097 150 D 23208 Tm(a)Tj/S73.7252DEext<FEFF00203BDC <020E5jC 1.308 0 .5 85/Span<</10 <015A2 <0.72/Span<E5008Cn i15A0103<015221033<01525TJET<</Ln i15A01JETEMC 715

4.1.3 Factors contributing to disparities in infection risk and consequences

There are a variety of potential intertwined reasons for the observed disparities in the case, hospitalisation and fatality rates and risks. Several
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infection rates related to intersecting vulnerabilities, including low income, poor housing quality,

The impact of changes to work, including working
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at the scoping stage of the EFHIA. COVID-19 had
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practices for all people living in Australia, but
the changes induced by the pandemic were not
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equally, and evidence suggests strong spatial and occupational differences. During the pandemic, the primary fault line was between people who could work from home (WFH) (because they were in computer and desk-based roles) and those who could not. The latter were employed in caregiving and person-contact roles that required physical proximity, like in aged and disability care, or in roles requiring physical presence at work, e.g., physical production, warehousing and transport (Productivity Commission, 2021). Early in the

The changes in work processes that accompanied remote work were seen as most positive when they included ways to stay connected with colleagues through different "touchpoints" (e.g., SMS, online check-ins and huddles): "We're very careful to protect that time", one manager shared (i8). Conversely, a sense of isolation, missed opportunities to interact or collaborate with colleagues, and "Zoom fatigue"

So she was asking whether we could provide a letter to explain to her work that she can't be available for two-hour meetings (FG carer).

” êRê Œ%å % R ÃKê êß ,êå % Z ê ZêKÃZ`Kêã showing women spent more time than men doing unpaid care work (childcare, eldercare, remote learning supervising) during lockdowns, with more severe outcomes in terms of wellbeing. Women also bore a disproportionate economic burden with more women forced to reduce work hours or leave the ÃÞ,`K ÿ,Kßê Ã Z, êZ êK ó Þ`ÿÃKÃ êZ Ã âã “‘“’å Xue & McMunn, 2021a). Indeed, ABS statistics show many single parents (mostly women) were unable to work and care for children and left the workforce (Jarvis, 2021 at 19). These additional burdens impacted w,$ê% Œ%Ã%ß Ã } Ã%å $ê%ZÃ }ã w Z %ê ÃZ vê •,wù on effects for children because of disrupted routines (Wen et al., 2021).

4.2.2 Economic changes: unemployment and precarious work

COVID-19 and its associated restrictions have anxiety for asylum seekers and migrants (Quandt

This is particularly the case when other informal

hardship, and/or dedicated community services close

Deal et al., 2021).

Equally concerning was the exclusion of casual employees, university workers and gig/zero-hour contract workers from JobKeeper and disaster payments, despite accounting for over half of the job losses in 2020, and an even larger share in 2021

who were both casual and part-timers made up three quarters of all job losses in 2021 (Stanford, 2021). Because women experience higher rates of casual and precarious employment than men, they were also disproportionally affected (Stanford, 2021).

The new support payments were also, in part, a response to the emergence of a newly vulnerable group in the pandemic, known as both the 'working poor' and 'precarious workers', that is, people

("living from pay check to pay check", as one participant put it, i5). This group is particularly vulnerable to economic shocks and not able to weather them well. There is evidence showing that precarious employment is an emerging social determinant of health through different pathways connected to chronic stress (uncertainty about the future), income instability, worse psychosocial working conditions, adverse physical conditions (low OHS prevention), greater workload, unequal workplace power relations and material and social deprivation (Benach et al., 2014).

There are no data available on the number, characteristics and spatial distribution of precarious workers living in SLHD. However, the Bankwest Curtin Economics Centre (BCEC), which has developed an index of precarious employment using data from the HILDA Survey (see Table 7), reported in 2018 (Cassells et al., 2018) that, at the national level:

- Women had consistently higher levels of precarious employment than men
- Precarious employment had increased for both men and women since 2009, but more rapidly for men
- The industries with the highest levels of precarious employment were, in declining order:
  - Accommodation and Food
  - Agriculture, Forestry and Fishing
  - Arts and Recreation Services
  - Retail Trade
  - Construction.

We expect that the precarious work situation in SLHD would be similar, noting that there are very few residents employed in the Agriculture, Forestry and Fishing industry.

The pandemic has aggravated some of the risks and adverse health-related impacts of precarious work. For example, precarious workers in some sectors were

(ABS, 2022a) connected to the large proportion of essential workers going to work, becoming infected and in turn infecting their families (Holloway et al., 2021). A similar pattern of COVID-19 infections overlapping with areas of socioeconomic and locational disadvantage, was observed in other high-

and the provision and communication around PPE had consistently improved, and this was perceived positively. Transparent communication around risk, exposure and available mitigation measures (e.g., masks and PPE at the start of the pandemic,
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emphasised as an important lesson from the early days of the pandemic.

Cognisant of these challenges and the need to protect staff, SLHD has worked on the development
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2020, staff, who can do so, to WFH. Many participants
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arrangements (primarily WFH) was not uniform, “people experienced it very differently across the district” (i3). As the review conducted by the Strategic Initiatives Division of SLHD early in the pandemic indicates, this initial shift to WFH was ‘highly variable’, with some teams and departments moving partially or entirely to WFH, some being shifted to an online only environment because of COVID outbreak, and others not being able to WFH at all (Knoblanche, 2021). Hence while some participants experienced the
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earlier), others expressed that requests to WFH had been denied. Some reported that this caused stress, frustration and feelings of disempowerment and lack of control, negatively affecting their mental wellbeing and work satisfaction. There is evidence that health workers unable to work from home experienced stress and anxiety while working in patient-facing roles and
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et al., 2021). On the other hand, other studies show stress and burnout rates higher among physicians who were not directly involved in the treatment of the virus, compared to those immediately on the
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in terms of respite and leave-taking, participants said that opportunities to do so have been limited and not distributed equally across different teams and departments on the frontline (e.g., ICU nurses, midwifery staff and SHA staff were reportedly more impacted) creating inequities and built-up fatigue.

The pandemic response required the development of new work processes and communications which were experienced positively by participants when they felt listened to, included and given more autonomy in the process. As one health manager (i15) put it, it was paramount that staff “felt like they were on the journey with us” and that their health and safety was valued:

of their lives, as well as providing face-to-face service, has been tricky" (i13). Extended isolation

(e.g., population-based services like disease prevention) have been routinely used to prepare for COVID-19, deal with surges and protect the safety of staff and service users (WHO 2021).

In NSW at the start of the pandemic, resources were quickly diverted to preparing for and managing COVID-19 outbreaks. This extensive preparation proved to be valuable in dealing with successive waves of COVID-19 infection when hospitals began

SLHD pursued a careful approach to changes in health services that was “risk assessed” and “evidence based” as per NSW Health guidelines to reduce potential COVID-19 transmission (SLHD, 2021).Some services and health promotion activities were moved to online/virtual care as quickly as feasible (SLHD, 2021), or where possible patients were offered alternative services (e.g., non-urgent oral health patient appointments were offered Oral Health Fee for Service scheme vouchers, email communication, key informant validation April 2022). However, the decreased availability and accessibility of services and clinicians, combined with the postponement of investigation and treatments, raised concern among staff regarding the effects on delaying care, detection and intervention,and the potential long-term negative impacts for patients (physical and mental health) and services (additional workload). Delayed care is likely to generate additional waiting list pressures and stretch resources. For instance, in child and family health, one staff explained the impacts of service disruption:

> The disruption is to access to our services, so we’re not able to provide a foterm tieidisequs9G t ablse( )]T6 (ol)6.5 (w)3 n(e)a7t(t)]T07.9 18

Women have been really stuck in their violent situations. I mean, some of the women I'm working with at the moment, COVID has been sort of the worst. Because they haven't had the ability to kind of see their friend who they have for support or get out of the house for any reason […] some of that safety planning you do with families around domestic violence, even around mental health. Often you're talking to people, go for a walk or do this or do that and that's not accessible to them. So yeah, I think absolutely that's going to have long-term impacts (i10)

A recent Australian study documented similar issues that have increased in complexity compared to pre-pandemic times, with disrupted services, more emotional distress, substance abuse, women dealing
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housing (Heward-Belle et al., 2021). One social worker further noted that the suspension of in-person drug
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children and families when treatment is a condition under child protection services (i16). Studies with agencies working with IPV from CALD background in the US, similarly described escalating needs from clients but a shrinking of resources and capacities because of the pandemic, compromising access,
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Williams et al., 2021). On a community level, this led
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individually pre-existing inequities for survivors were
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and those with poor English, cultural barriers or limited access to technology (Williams et al., 2021).

Our consultation also highlighted the disruption which specialised care in community health had on substantial equity impacts, including in place-based health services for Aboriginal and/or Torres Strait Islander people, reproductive and sexual health
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SLHD), sexual health clinics (including services used by LGBTIQ+ people) and multicultural and refugee health services. For instance, one staff member notes that suspending "normal ways of connecting to community" in-place was likely to create disproportionate negative impacts for Aboriginal

Redeployment of staff reduced inpatient and community psychosocial support services. In our consultation, practitioners in the mental health sector spoke of some cases of worsened symptoms and increased presentation to emergency, as patients saw it as their only option “in order to receive that face-to-face care, it’s been to present to ED rather than to present to the GP” (FG Mental Health). The latest data from the AIHW (2022a) shows suicidal behaviour was one of the most frequent reasons to attend ED among young people (aged 15-24), and that there was increased demand for mental health services and crisis and support organisations in 2020 and 2021. For in-community mental health treatment, participants
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> Patients are reporting that it’s really hard to access
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> a lot of psychologists I know, they’ve closed their books, so they just can’t take on anymore. And, it’s creating a real gap […] which is allowing or creating a kind of space of people not getting the care and treatment that’s probably required (i1)

Several studies also document mental health patients being prematurely discharged, having treatment suspended/remaining on waiting lists and having
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negative impacts on wellbeing and worsened health
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in getting care for CALD minorities within this landscape (Gillard et al., 2021), and for sexual and gender minorities (Diaz et al., 2021).

Unmet mental health care needs are not distributed evenly. There is only partially available data on this in Australia, but higher levels of need and demand
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unaffordable housing costs, families with children at risk who may need child protection services, older people needing support including for those who live in RACFs, and informal carers who provide care for older people and those with disability (AIHW,
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women experiencing perinatal depression, CALD Communities, people who have attempted or are

Combined with a climate of fear and anxiety around the virus, and some stigmatising media coverage, ß,%• ßZ % $êRRÃ % ÿK,$ `%Kê ÃÞ ê R,`KßêR and misinformation about COVID-19 among CALD ß,$$`% Z êR ó }Kê êZ Ã âã "'"'å °ê% êZ Ã âã "'"'ô R likely to have contributed to reduced health-seeking behaviour, according to some participants (FG refugee êÃ Z å '•ôâ (v åê%ßê ÿK,$ ,vêKRêÃR R` êRZR R $ ÃK issues of fear of exposure and lack of information on restrictions and available services among migrant and refugee communities in Canada (Benjamen et al., 2021). SLHD held meetings with community organisations and leaders to provide information and resources across a range of media. Frequently changing information and limitations on content and ÿ,K$,ÿ %ÿ,K$ÃZ ,% wêKê Ã R, åê%Z Œêå ÃR $HÃßZ % 'trust' and therefore patients' use of services:

> From a service perspective, the inconsistencies in ZêK$R ,ÿ Z ,Rê K` êR Œ ZêK % å,w%ã w ÃZ wê ßÃ% Ã%å can't provide, how we can and can't provide it and the short notice in terms of how we have to remodel and change that, it does sort of undermine that trust with reaching out to people and their reliance on a service

to put a lot of those [health education programs] online and that's been a fantastic resource to have" (FG refugee health). Virtual care made it easier to access a range of services in aged care as well:

> I think the teleconferencing with patients that the geriatricians have been using, that also our OTs, our physios, the Zoom sessions, etcetera. I think that, again wouldn't have happened without COVID […] The whole teleconference thing has been a positive, and again I think we'll continue to use that method for patient care in the future (FG aged care)

Telehealth appointments can lower some existing barriers to access (cost, travel time, lack of transport, General literacy and health literacy is a factor that often intersects with low SES and/or CALD status in studies on barriers to access and virtual care óV ,,% êZ Ã âã “‘“’å ŒH,,%êK êZ Ã âã “‘’˜å °Ã êK êZ al., 2020). Developing accessible material in different formats, and across different channels, in plain English and translated into community languages other than English has long been recognised as an important step to mitigate such barriers (Houghton, 2020) and SLHD Diversity Hub actively provided such a response (see equity-focused response in SLHD, p.109). There is also a need to provide easy access

with the intellectual disability clients, it's really hard to explain to them about the change that's happening and why they need to be in lockdown (FG carer)

Certainly the lack of ability to visit. Particularly again people with disability living in Group Homes has been a major challenge and quite detrimental to people's emotional wellbeing (i9)

There is strong evidence from the literature that service disruptions have far-ranging impacts for people with a disability on: physical health and
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loneliness and wellbeing (loss of support services, community networks or visit
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Over time, SLHD continued to develop IPAC preparedness and outbreak management plans across these sectors. Each of the SLHD's 58 RACFs were provided with an IPAC review, training and recommendations, and many of the 80 disability group homes in the District received a comprehensive review (SLHD, 2021 p.78). District specialists also contributed a to social housing high rise management plan (EquityFest, 2021). Sustained and enhanced collaboration was embedded through the creation of Community of Practice groups for RACFs, local disability providers and NGOs/community sectors, that met very regularly for information sharing and to feedback to the SLHD concerns from their clients/participants. This laid the foundation for a responsive and adaptive response, and received enthusiastic support from stakeholders involved (SLHD Disability Inclusion & Strategy Manager, EquityFest, 2021). One participant from the NGO sector, described Community of Practice group meetings as fostering an "open, transparent, collegiate" relationship, and ÃR Ã $`Z`Ã } Þê%êŒß Ã ê|êKß Rê Z ÃZ %êêåêå building upon (i5).

Developing guidance and information that was accessible to a wide range of people, was also åê%Z Œêå ÃR Ã HK ,K Z} % KêRH,%å % Z, êJ` Z} concerns around health information and literacy, and to barriers in following advice. SLHD provided a range of targeted resources in response:

- The disability team produced "easy English documentation" for people with disabilities, and signage for group homes (SLHD, 2021)
- The Aboriginal cultural response team produced communication strategies and documents for Aboriginal communities (SLHD, 2021)
- The Diversity Hub produced over 1,000 "multilingual assets" across 30 languages and multiple platforms (EquityFest, 2021),<0152cBT10 0 0 nl(a)33..5 (a)33.5np (,)7.5 o,se It (n)8Rhcm10 0 0 n/2257.3hl communities (Sand signage t (n)8S9d.7.6772 Ti.7g-l2shitieμ8pZáZZZZZZ•E

SLHD and beyond) participated in the management of the outbreak and in responding to actual needs in socially and culturally appropriate ways. Because frontline and community health workers already knew the community they serviced, they could quickly respond and engage key community networks ("reaching in"), communicating "often door-to-door" with people to make sure they understood guidance/ways to "reach out", and had the means to safely and effectively isolate (SLHD Director of Integration Strategy and Partnerships, EquityFest, 2021).

Managers involved in OMT described this process as "hyper-local", unfolding at the level of neighbourhoods or even individual social housing buildings and
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communities affected had opportunities to share their lived experiences and concerns and get tailored support, whether that was individual requests for
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EquityFest, 2021), or active support to mitigate disruptions to routine and activities in group homes (maintaining quality of life in some ways) (SLHD Disability Inclusion & Strategy Manager, EquityFest, 2021). As such, OMT's work puts into practice SLHD core principles of patient-and family-centred care, as described by another practitioner: "we've actually individualised care and tried to meet the diverse needs of families to the best we can in a really challenging time and I'm pretty proud of the way it worked out" (i13).

5.1.4

Unaccompanied minors (12–16 years old) were
another large cohort of particularly vul7 (ar)o1im4.5 (arl)17.5 (y)2.5 ((t)0.9 (s)2.i7r (t o)21 (f 87 Tc)7 (0Tm[)ETEMomp (accsep)21 (f2(t)14.521 (f)-15.5 (p)7/Lang (en-US)/MCID) (ar)ng (5 (a)16 (vi)t10 0 0 1222)98..811 79.Tm90 0 S388s).811 7o7ang (en-USt R)1

rpavirtual overview of care in the Canterbury-Bankstown Local Government Area during the period of the Delta Variant outbreak

There was no interruption to RPA Virtual Hospital (rpavirtual) patient care during the periods of high COVID-19 community transmission and suburb lockdown in the Canterbury-Bankstown Local Government Area. This included the provision of in-home nursing care and palliative care, and COVID-19 care and monitoring. A total of 5,528 patients residing in the Canterbury-Bankstown LGA received clinical care from rpavirtual during the period of the Delta Variant outbreak, 15 June to 25 November 2021. There were 51,673 Occasions of Service.

Virtual Care Centre

Overall total of 4,914 patients received virtual care with 37,068 occasions of service–main cohorts:

3,572	COVID-19 positive patients isolating at home
878	COVID-19 positive patients in quarantine
85	COVID-19 negative patients in quarantine receiving clinical care, included 20 pregnant women receiving antenatal care
13	Patients received Virtual Fracture Clinic care

Sydney District Nursing

Overall total of 614 patients received in-home nursing care with 14,605 occasions of service–main cohorts:

268	General Community Nursing (wound care, catheter care, etc) patients
191	Palliative Care patients
109	Hospital in The Home patients

81 patients who received any rpavirtual care in this period completed a Patient Reported Experience survey.

20% (n=16) of respondents spoke a LOTE at home.

99% (n=80) of respondents rated the care they received as ‘excellent or good’ and one patient rated the care they received as ‘fair or poor’.

Gaining public support for response measures is a two-way process that involves clear messages, delivered via appropriate platforms, tailored for diverse audiences, and shared by trusted people (Hyland-Wood et al., 2021, p.). Hence translation is not enough, and appropriate dissemination came up as an issue, as described by this expert from the community sector:

> Having a police presence in a community of people who historically probably don't have good relationships at all with the police, is not necessarily going to foster that kind of sense that we're all in this together and we all need to do our bit to kind of keep transmission down […] If you're partnering with local services and local community leaders who are the ones who are actually kind of helping you with that messaging and everything, you're going to have a much different outcome (i5)

"You need community leader endorsement" a manager in multicultural health commented. For example, a focus group described existing programs like volunteer "community educators" to disseminate COVID-19 advice and gather information about community concerns (FG Refugee health). A similar effort was deployed in the Aboriginal response team with information videos on testing/isolation featuring local Aboriginal community members (SLHD, Director Aboriginal Health EquityFest, 2021) .

Another key challenge from an equity perspective arose when people who were effectively disadvantaged and/or marginalised were not able to access the targeted network of support and

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Consultation with key informants revealed other elements of SLHD's equity-focused response to broader service disruption. We provide a brief snapshot of this response below.

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Overall, the ways in which the COVID-19 pandemic has affected the SLHD community, both directly and %å KêßZ }ã Kê•êßZ Z ê ÞK,ÃåêK $êß Ã% R$R Þ} w ß health inequities are created and sustained. We have seen that vulnerability to the indirect impacts of the pandemic is not the result of inherent characteristics

6.1 Risks and consequences of COVID-19 infection

COVID-19 infection exacerbates existing inequalities within and between groups and geographic areas, ßÃ`R % åêŒ% Zêã $Ã ,Kã R ,KZ Z, $êã $ûZêK$ negative and probable major, long-term negative, impacts on health equity.

Determinants and outcomes

In addition to physical health impacts, including $,KZÃ Z}ã f¯F#ù'š %ÿêßZ ,% ßÃ`RêR åêŒ% Zêã moderate to major consequence

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to continue to affect health equity into the future:

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work, including health care

3 Changes to employment and economic status.

We found strong evidence of overlapping and
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Impact	Determinant	Direction			

public transport if usage drops. Changes to transport
possibly impact on climate change.

Employers (and systems) who adapt and adopt WFH
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Impact	Determinant	Direction	Likelihood	Œ % Œ ß Ã % ß ê	Latency/ timeframe
Actions to mitigate the impacts of unemployment, income loss and support community services can have both positive and negative impacts on trust and community cohesion. Income support $ ê Ã R ` K ê R ê Ã R ê Œ % Ã % ß Ã R Z K ê R R Ã % å $ Ã } positively affect health inequities in the short term. However: • Positive impacts from enhanced safety net for eligible Australians, and increased funding support to community services • If only available during the short-term, then there is unlikely to be a positive impact on health inequities beyond the short-term • Negative impacts from exclusion of international students, migrants, refugees and other visa holders from safety nets. People are told to 'go home' instead • Mixed impacts/probable negative impacts from reduced safety net measures in 2021 ('disaster payments') and uneven restrictions in LGAs of concern.	• Income, employment and work • Social cultural and interpersonal-community cohesion	+	# ê Œ %	Moderate to major positive impact for those who can access supports.	Short-term
		–	# ê Œ %	Major negative impact on those who cannot access.	Short-term
			Possible	Negative impacts on social cohesion and trust if support inconsistently available and/or short-term	Medium-to long-term
Increasing precarious work force is likely to negatively affect health and wellbeing: • chronic stress (uncertainty about the future) • income instabilit, • worse psychosocial working conditions (low control, low support) • adverse physical conditions (low OHS prevention, COVID-19 risk) • greater workload • unequal workplace power relations • material and social deprivation.	• Income, employment and work • Mental wellbeing	–	# ê Œ %	Moderate to major	Short-, med5p)

Equity – Individual and household level

Stress, fatigue, chronic uncertainty and anxiety associated with working within Health Services during a pandemic are likely to have a differential impact on staff in relation to their role, working context and individual characteristics. Changes to w,K % K, êRã R`ß ÃR KêåêH ,}$ê%Zã %Zê%R ŒßÃZ % of work and changes to work content, can have varying impacts depending on people's personal circumstances.

Equity – Community and system level

Pandemic related impacts on health service staff will also have systems level impacts, with potential increased absences, turnover of staff and potential å ÿŒß` Z êR % KêßK` Z$ê%Zâ " R organisational culture and further exacerbate potential negative staff impacts. Service delivery may also be affected. There are potentially positive system level impacts through increased culture ,ÿ HK,v å % ,HH,KZ`% Z êR Z, work environment, developing skills and experience, and participation in decision making. The impacts of long COVID are currently unclear, it is possible that long COVID will also affect health service staff Ã%å RZÃÿŒ% â

°ê åê%Z Œêå Z ê ÿ, ,w % H,H` ÃZ as being differentially affected:

Staff with less control and autonomy:

- Experience higher levels of stress (when exposed to similar experiences) at work during the pandemic, compared to staff who have more control and autonomy (e.g., such as nurses and support staff versus doctors and paramedics)
- Are less likely to be engaged in decision making and planning processes and more likely to feel Ã Ãß ,ÿ ß,%ZK, Ã%å HÃKZ ß HÃZ workplace
- Experience relatively higher levels of fatigue and burn out
- More likely to experience negative impacts of redeployment if redeployment continues to provide low levels of control, autonomy or opportunities to learn develop new skills and experiences. However, if redeployment provides opportunities for growth, autonomy, new experiences etc., then this may have a positive impact on staff
- More likely to experience the double burden of uncertainty, unpredictability and reduced agency/control in work as well as personal spheres.

Women are more likely to experience the double burden of stress and burden in relation to managing family and caring responsibilities as well as work pressures.

Lower paid workers such as cleaning staff, junior admin roles, aged care workers, lower-level roles:

- Lower levels of autonomy and less likely to be engaged in decision making and planning processes
- More likely to come from at higher risk groups for COVID-19 infection
- ì XêRR ê } Z, Ãvê ÃßßêRR Z, •ê| Þ ê ,K °<B ,HZ ,%Râ If able to WFH, are also less likely to have digital access and literacy, a quiet space to work, etc.
- More likely to have limited capacity to isolate at home, lower income workers being more likely to live in overcrowded or share housing and less likely to be able to afford alternative accommodation.

Staff from already marginalised population groups are more likely to experience intersecting vulnerabilities and more limited capacity to take protective action including:

- Support with childcare and caring obligations
- Living in overcrowded housing
- Living in locationally disadvantaged neighbourhoods (LGAs of concern, long commuting distances, impacted on by travel restrictions, etc.)
- Stigma and discrimination outside of work.

Community based workers and peer health workers:

- Likely to have higher levels of exposure to COVID-19
- More likely to experience dual burden in relation to personal and working life (high risk environments, affected by movement restrictions)
- Directly working with vulnerable communities with high need, and are often also part of these communities themselves
- Sometimes experience mixed unclear guidance due to non-hospital role.

Staff in high contact roles such as nurses and aged care staff

- Higher exposure risk.

Workers with limited capacity to isolate at home:

- Those with families/caring responsibilities
- Workers in share houses
- Lower income workers more likely to live in o ten&Rgh ÃZ mmu itt rtesponr30.5775 (me)4em COesplte a5 (c)7 (aphn-U)3 (s)]TJET

Determinants and outcomes

Impact	Determinant	Direction	Likelihood	Œ % Œ ß Ã % ß ê	Latency/ timeframe
Prioritisation of COVID-19 response probably reduces infection (screening clinics/community outreach), severity of morbidity and reduces mortality resulting from COVID-19.	• Physical and biological	+	# ê Œ %	Major	Short-and medium-term impact
Delaying care, detection and intervention has potential long-term negative impacts for patients (physical and mental health, unmet needs) and services (additional workload, waiting lists): • This will disproportionately impact on services that had waiting list challenges before COVID-19 (e.g., oral health, occupational therapy, speech pathology, counselling and mental health). These services are responding to the needs of already vulnerable and marginalised population groups • Higher impact on people who had high use of health care services before the pandemic (older people, people with chronic health issues) • People who had higher unmet needs/access issues before COVID (socially and economically vulnerable people, people living in low SES communities with more limited access to services, people who experience stigma and discrimination, migrants, Aboriginal and Torres Strait Islander people, people without private health insurance) • People with increasing economic vulnerability (low SES, Aboriginal and Torres Strait Islander people and CALD groups) (disproportionately impacting women, lone parents' young people and people with disabilities).	• Access and quality of services • Physical and biological • Mental wellbeing	–	# ê Œ %	Major	Short
			Probable		Medium-and long-term unintended impact in health equity (availability, accessibility, quality)

Impact	Determinant	Direction	Likelihood	Œ % Œ ß Ã % ß ê	Latency/ timeframe
Temporarily stopping services because of redeployment to COVID-19 response or to reduce risk of transmission (prioritisation of COVID-19 response). In particular where services are: • Responding to needs of already vulnerable and marginalised groups (e.g., child and family health services, mental health services and psychosocial support, substance use disorders, LGBT services, HIV testing, management of chronic conditions and dental care), ì F % • ` ê % ß % å ê Z ê K $ % Ã % Z R , ÿ ê Ã Z ê J ` Z } (e.g., child and family health services provide diagnosis and support for developmental issues that impact on children's ability to learn) • Addressing outcomes of health inequities (e.g., dental, alcohol and other drug problems) • Target population groups already experiencing a variety of barriers to access ranging from cost to distance and availability of health providers • Shifting focus from early intervention to crisis response (e.g., eating disorders, child health and development, or for complex socio-medical needs like high-risk pregnancies in contexts of violence, poverty and/or substance abuse) • Some potential positive impact resulting from lower levels of unnecessary care.	• Access and quality of services • Physical and biological • Mental wellbeing	–	# ê Œ %	Major	Short
		+	Probable	Major	Medium
			Possible	Major	Long-term unintended negative impact on health equity (availability)
Changes in patient behaviours may lead to: • Disengagement from health services • Worsening health outcomes due to late diagnosis and presentation • Impact on the health system from delayed presentation and worsening severity at presentation • There are possible positive impacts resulting from increases in adaption, empowerment and resilience in some patient groups as they responded to changes in services	• Access and quality of services • Physical and biological • Mental wellbeing	–	Possible-probable	Moderate	Short, medium and long-term negative unintended impacts

Impact	Determinant	Direction	Likelihood	Œ % Œ ß Ã % ß ê	Latency/ timeframe
Virtual care has positive and negative impacts on health equity: • Moving face to face services online allows service to continue that may have otherwise been stopped • Virtual care options reduced risk of COVID-19 transmission (for patients and staff) • Can provide opportunities for increased engagement in health services, including health promotion activities, especially for patients with limited mobility and access to services • Virtual care can remove some barriers to access (cost, travel, distance, availability of specialist services, time) • For some, online or virtual environment provides a preferred mode of communication/ engagement (e.g., some mental health patients) •					

Impact	Determinant	Direction	Likelihood	Œ % Œ ß Ã % ß ê	Latency/ timeframe
Infection control restrictions (e.g., testing prior to appointments, re-structuring of hospital wards for risk minimisation, triaging in ED and K ê R Z K ß Z , % R , % v R Z Ã Z , % R ô å ê Œ % Z ê } H , R Z v ê } impacts on risk of COVID-19 transmission: • Vulnerable and marginalised patients are more likely to forego or miss out on care due to restrictions • Potential perceived increased stigma if use of obvious PPE (e.g., on home visits or in public areas of health services) acts as a visual R % Œ ê K , ÿ K R $ Ã } Ã ß Z Ã R Ã å ê Z ê K K ê % Z Z , seeking services • Restrictions on support persons/carers disproportionately impacts on some areas of care and patients (e.g., perisio5ri4.5 n (s)2.5 ( )]TJE/( )]TJE/( )]TJE/( )]TJE/( )]TJE/( )]TJE/( )]TJID 11261 BDC BT9 0 0 9 51.0236 545.386 Tm((s)2.5 ( )]TJE/(9 51.0236 486.3860)n-US)/MCID 111.0236 48f9su3T0 0 9 51.0236 593.386 Tm[(l)0.5 (i)-47asmisaCO					

Carers:

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Recommendation

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

5

Recommendation

Continue to build and invest in sustainable equity infrastructure

Implication

Sustainable embedded equity infrastructure that addresses the determinants of health equity and can be drawn on/ramped-up as needed.

Translating existing infrastructure to reach a wider SLHD population, building capacity, capability and resilience.

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a Introduce KPIs/reporting around equity, and identify opportunities for how principles of equity are built into all service plans.

b Strengthen and embed pre-existing platforms (see Rec 2-our platforms have been tested and some RR`êR Ãvê Þêê% åê%Z Œêåôâ

c Proactively identify new platforms (where the equity gaps are, such as newly vulnerable, those not accessing services, etc.).

d Consult with users as to where, what and how.

e. Maintain sustainable dedicated equity capacity and expertise. Engage staff whose opinions/ experiences/ideas could be leveraged off to extend equity programs that are already proven.

f Continue to support and build consistent approaches to place based work.

g Create sustainable long-term funding for equity infrastructure. Invest time, trust and tenacity in systems, tools, resourcing and capacity building.

What we need to do more of

7

Recommendation

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.

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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

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

15 Recommendation

Continue to address data gaps

Implication	B,wóê|Ã$H êRô
Increased knowledge of populations groups likely to experience inequitable impacts.	a. Include: • number, characteristics and spatial distribution of people in precarious employment. • people living in congregate housing e.g. boarding houses, temples, backpacker hostels, pub accommodation b. More inclusive recording of the gender in NCIMS: Currently only four options: Male, Female, Transgender, Not stated/inadequately described. c. Review eligibility, demand and access, especially in pockets of socioeconomic disadvantage and 'new' areas of intersectional disadvantage that came to the fore during the pandemic. d. Develop a set of equity indicators for SLHD

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

Changes to work (in addition to previous)

16 Recommendation

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

Implication	B,wóê|Ã$H êRô
Taking action on health inequalities resulting from differences in material living conditions that are shaped by economic and political structures. Acting on the determinants of health equity outside of health care provision. Platforms for equity-focused action that can be directly mobilised.	a Actions that challenge gender norms and address the unequal caring and unpaid work burden experienced by women. b Intimate Partner Violence policies and procedures that incorporate WFH guidance and responses. c Actions to address the digital divide (ability, affordability and access). d Advocate for reducing transport costs for people who cannot WFH. e Within SLHD, support staff transitioning into online work, identify individual and role/area of work RHêß Œß å ZÃ ÞÃKK êKR Z, ,% %ê w f Encourage and support partner organisations Z, Ãå,HZ R`HH,KZ vê •ê| Þ ê w,K HKÃß g Draw attention to the health implications of inequities.

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

17

Health Services (in addition to previous)

19

Recommendation

Continue to build equity sensitive health services

Implication

Health services that are available, acceptable, ication199f anl/or .5 aatw(vic)87 (ic)5 (a)29 (tion)]TETEMC /P ‹5 12240 BDC-0.015 Tw 1 Tf10 0 3 ((6 626 (abl)70.8047 (th se-22.5 (vice)2.2 (s)2.- (a)1a4 1(onH)5 (del (sitiv) (t ar)12d).)7 (ic)5 (a)29 (tion)]TETE

8 Conclusion

This EFHIA was carried out to identify potential health equity impacts of the COVID-19 pandemic and the associated response, and to provide recommendations to inform future planning processes of SLHD.

Three areas of focus were determined by the EFHIA Steering Committee: risk and consequences of COVID-19 infection, changes to work and changes to health services. Based on multiple literature reviews, stakeholder and key informant interviews and

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health equity impacts in all three areas. Some of these impacts have already occurred and many are likely to continue to affect health equity into the future.

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we have developed a set of evidenceÃ%ßZSwYGNÃservices. Based-25.9 (v he).5 (al)35jETE5 <300DF2 8 (sed-25.9 (v)14.6 (o)21 (f)]TJETEMChD <EID 124kng (en-US)/MCID 12412 BDC BT/i8- f(n-US)/0 42.5197 545.9803 Tmact010_89(en-US)/M9803 Tma

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