Equity Focussed Health Impact Assessment of NMML After-hours Care Planning to Extend

After-hours Services

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# Executive Summary

This report describes the process of, and details recommendations from, an Equity Focussed Health Impact Assessment (EFHIA) of after-hours care planning for the Northern Melbourne Medicare Local (NMML). EFHIA works by assessing the potential impacts of a policy, proposal or plan. In this instance the EFHIA assessed the expression of interest that was successful in the tendering process for extending after-hours services to cover unsociable hours in the Medicare Local region. The EFHIA was undertaken by staff from the Centre for Health Equity Training, Research and Evaluation, in collaboration with NMML, as part of a research project piloting the use of EFHIA on local planning for after-hours care by Medicare Locals and Local Health Districts. The report lays out the steps of the EFHIA and outlines recommendations to assist NMML to further improve the equity and access of the services provided. Sources of information included the existing needs assessment and population profile, a review of the literature on equity and after hours service provision, and local and national expert opinion. Using this information the EFHIA assessed the equity implications of the expression of interest against established dimensions of equitable access to quality services; availability, appropriateness, affordability, continuity, coordination, quality, comprehensiveness and monitoring and reporting. The assessment showed that the expression of interest includes equity-related information which is likely to result in positive health impacts and mitigate potential inequities. There are also areas where NMML can facilitate to improve equity, including strengthening access to General Practice in normal and unsociable hours, the collection of new data and information, training about different population groups accessing services, and routine monitoring of service reach to different population groups. Specific recommendations are presented across the dimensions of equity used to assess the expression of interest.

Glossary

|  |  |
| --- | --- |
| EFHIA | Equity Focussed Health Impact Assessment |
|  |  |
| NMML | Northern Melbourne Medicare Local |
|  |  |
| CALD | Culturally and Linguistically Diverse |
|  |  |
| SES | Socio-economic status |

Background

This EFHIA was carried out as part of a research project piloting the use of EFHIA on local planning for after-hours care by Medicare Locals and Local Health Districts.

## 

## The project

Equity Focussed Health Impact Assessment (EFHIA) is a formal step wise process which involves a range of stakeholders in assessing the consequences of a proposed policy, program or project, before it is implemented. The needs of vulnerable populations are considered at each step and all the impacts - positive, negative or unintended are considered. As a result it makes recommendations to improve the proposal so that any positive impacts are enhanced and negative or unintended impacts are minimised. The specific needs of vulnerable populations are considered at each stage to minimise unfair, unjust differential impacts between population groups.

This project (‘The impact of a Rapid Equity Focussed Health Impact Assessment (EFHIA) on local planning for after-hours care to better meet the needs of vulnerable populations’) aims to develop and evaluate EFHIA as a practical tool for Medicare Locals and Local Health Districts to use in modifying their service plans to engage vulnerable groups and address their needs. It examines how feasible and effective this approach is. The project is funded by Australian Primary Health Care Research Institute and resulted from a call for proposals investigating how primary health care for vulnerable consumers can be consumer centred, best delivered and coordinated.

The project has two primary research questions:

1. Is the use of Equity Focussed Health Impact Assessment (EFHIA) a feasible and effective way to improve local planning for Medicare Locals/LHDs to improve the access of vulnerable groups to afterhours care?

2. In the emerging governance structures of Medicare Locals and Local Health Districts does EFHIA offer an effective mechanism to engage health service consumers and other members of vulnerable groups in local health planning?

The study design involves undertaking rapid EFHIA on after-hours implementation plans being developed by participating Medicare Locals. The EFHIAs will then be evaluated and a report developed summarising the EFHIAs and evaluating their impact on the planning and decision making processes of the Medicare Locals in relation to after-hours services.

Northern Melbourne Medicare Local (NMML) is participating as a pilot site in the project. The EFHIA focuses on the Stage One Afterhours Care Plan.

# NMML After-hours care plan

Medicare Locals have been given responsibility for developing After-hours Care Plans. The plans aim to:

* Ensure that local afterhours 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 disadvantaged 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
* Better support health professionals in the arrangement and/or provision of afterhours care for patients.

A comprehensive Needs Assessment was carried out by NMML to identify gaps in access to after-hours primary care in the NMML region. This needs assessment was used to identify priorities for Stage 1. Stage 2 Plans are to be submitted in February 2013.

Based on the Needs Assessment, the five gaps in after-hours primary care identified in NMML region were identified as:

*1. Some residents have limited or no access to GP clinic–based and/or locum services– particularly during the ‘unsociable’ hours period in parts of the catchment.*

The NMML region has two of Melbourne’s five growth corridors, which has resulted in exponential population growth–Whittlesea and Hume, both Local Government Areas that include many areas on Melbourne’s urban fringe, the city’s fastest growing areas.

There are currently few after–hours services operating in the ‘unsociable’ hour periods; and there is increasing demand on Emergency Departments at public hospitals within the region. There is a mismatch between the location of current after–hours services and areas of highest population growth.

*2. Residents living in aged care home throughout the NMML have varying and inequitable levels of access to after–hours service providers such as nurses and GPs for advice, triage and after–hours visits.*

*3. After–hours access impacted by lack of community and provider awareness of local after-hours options*

There are significant information gaps in both provider and consumer knowledge about local after-hours services. Providing information and increasing community awareness about local service will assist all residents but particularly vulnerable groups– to make decisions about the most appropriate service to contact after-hours.

*4. Some residents living in the NMML region experience difficulties in accessing effective after-hours primary care due to locum doctors and other after-hours providers not having appropriate skills and knowledge relevant to their circumstances.*

Locum doctors face particular challenges when working after-hours. Vulnerable populations particularly the elderly (but also people from diverse cultures and Aboriginal people) commonly present after-hours in the NMML Region with chronic diseases such as diabetes and heart failure. More could be done to assist locum doctors so that they have the skills and training required in after-hours situations.

*5. A lack of available after–hours services access for people with mental illness*

Mental disorders are a major cause of ill health in the NMML region and there is a growing demand for mental health services. There is a high level of presentations by people with mental illness to emergency departments, particularly after–hours. A lack of available services combined with the acute social isolation results in a need for effective and timely support in the ‘after-hours’ period.

# The EFHIA Process

EFHIA is a structured process, that follows the steps commonly used in Health Impact Assessment, but in addition assesses the impact of the proposal on equity of outcomes in each step (in this case: “Is there likely to be systematic differences in access to high quality after-hours care for particular population groups?”). The steps, their purpose and what took place are shown in Table 1.

**Table 1: Steps in the modified EFHIA undertaken with NMML**

|  |  |  |
| --- | --- | --- |
| Stage of EFHIA | Purpose | What we did |
| Screening | Developing an overview of the proposal, the potential equity implications and opportunities to influence. | Screening and scoping was undertaken over two teleconferences and in one face to face meeting held in Melbourne on 30 July 2012.  A screening report (included in Appendix 1) was used in discussions between the research team and the NMML staff about whether to proceed with the EFHIA. |
| Scoping | Planning the EFHIA including identifying activities to be assessed | Scoping in this instance involved   * meeting with key individuals within NMML, * identifying where an EFHIA may add value to after-hours planning that was already underway, and * developing a plan for how that would be done.   Specifically this process involved agreeing on the focus of the EFHIA on the key priority area of after hours services in unsociable hours, particularly in high growth areas. |
| Identification of impacts | Collecting evidence about the potential impacts of the activities. | Identification of relevant data and information within the modified EFHIA involved   * Further Review of the Needs Assessment and Stage 1 plans of the NMML against an equity framework * Including relevant data from a literature review undertaken by the research team * Confirmation of issues in a teleconference with NMML |
| Assessment of impacts | Assess the activities of the proposal against the evidence of impacts | Draft assessment was carried out by the research team  This step involved linking data from the identification step to the priority area of unsociable hours and how this was addressed within the successful tenderer’s plans. This involved asking key questions   1. What groups are likely to benefit? 2. What groups are likely to miss out? |
| Reporting and recommendations |  | Recommendations based on the assessment were developed in collaboration with NMML  The EFHIA report was drafted and circulated to the EFHIA working group and then to the NMML board for sign off. |
| Evaluation |  | An evaluation will be undertaken as part of the larger research project |

## 

## Screening

*Screening identifies whether an EFHIA is appropriate or required. Screening provides a brief*

*overview of the proposal being assessed, an introduction to the potential impacts of that proposal, describes the decision making context and makes recommendations about proceeding with an HIA.*

The research team approached NMML in early 2012 to see whether an EFHIA would add value to after-hours care planning for the region. Two teleconferences were held in mid-2012 where it was agreed that although a needs assessment had already been undertaken, and a plan to address the priority gaps identified in this needs assessment had been developed, an EFHIA could potentially add value to help ensure equity was considered in the planning process. Following this teleconference the research team rapidly reviewed both the needs assessment and the plan to identify the points at which an EFHIA could add value. This is shown in Appendix 1.

## 

## Scoping

## *Scoping involves planning and designing the EFHIA, setting out its parameters.*

## *Scoping results in a clear and transparent project plan and a concrete commitment to this plan*.

In mid-2012 two members of the research team visited NMML to meet with key staff responsible for after-hours care planning to introduce them to EFHIA and to scope the project.

The NMML After-Hours Program Stage One Plan (NMML, 2012a) identified 5 priority gaps. These focused on:

* the unsociable hours period,
* frail elderly residents in aged care facilities,
* the need for raised community awareness of afterhours services,
* skills and capacity of medical staff in after-hours services and,
* the needs of people with mental illness.

Of the five strategies to address identified priority gaps, Extending After-Hours Services for Unsociable hours (from 11 p.m. to 7 a.m.) was suggested as the most appropriate for an EFHIA to be conducted on. This was seen as a high priority issue, with a large number of suburbs, particularly new growth areas with high projected population growth, having essentially no access to after-hours care after 8pm at night or after noon on Saturday. It also had overlaps with priority populations including: the needs of people with mental illness; the needs of frail elderly residents in aged care facilities; and skills and capacity of medical staff to provide high quality after-hours care.

Specifically it was agreed the EFHIA could influence the tendering process and selection criteria for this identified priority gap.

An ‘overview of requirements for extending after-hours services’ was developed and disseminated by NMML for interested parties to develop an expression of interest. This document incorporates equity considerations and which were agreed to subsequently be used to shape the tendering process to incorporate the findings from the EFHIA. The overview states that after-hours service provides must provide services that include:

* Appropriate to the patient’s condition
* Timely access to face to face after-hours services
* Availability for all residents of the region
* Affordability
* Equitable access to appropriate and affordable care regardless of mobility, geographical isolation, age, gender, or socio economic status.
  + Individuals should not experience physical barriers in accessing care
  + Services should be accessible by public transport where possible
  + Individuals should have access to culturally appropriate care specific to the region

Additional concerns were raised in the scoping meeting about responding to population growth in the growth corridors of Whittlesea and Hume.

### 

### Modifying the EFHIA process

Following the scoping meeting due to ethical concerns the EFHIA was unable to be undertaken as part of the selection process for the tenders. NMML agreed that the EFHIA could instead be undertaken on the successful EOI, potentially influencing subsequent activities and planning. Given the timing of the EOI process, a desktop EFHIA was undertaken which used existing information (see next section) to assess the EOI. The successful tendering organization agreed that their EOI could be released to the research team for the purposes of the EFHIA.

## 

## Identification of impacts

Identification develops a profile of the community or population likely to be affected by the

proposal and collects information to identify the potential health impacts of a proposal.

Identification results in a transparent summary report of different techniques and approaches

used to collect information, why they were used and their strengths and limitations.

A summary of the impacts identified should be included.

**Summary of data sources used**

This EFHIA is based on four information sources:

* Local needs assessment undertaken by the NMML (NMML, 2012b)
  + The needs assessment commissioned by NMML provided local data on the range of issues in the area and assisted in identifying potential vulnerable and disadvantaged groups.
* Population profile developed by the NMML (NMML, 2012b)
  + The population profile in the local needs assessment provided information on potentially vulnerable and disadvantaged groups, for example, the number of older people. However for some groups it is hard to identify population based information, for example children in remand.
* The successful EOI
  + The successful EOI was provided for the EFHIA and itself includes detail on both equity relevant activities (even if these have not been explicitly badged as equity related) and areas where further work to incorporate equity considerations could occur.
* Literature review undertaken by the EFHIA research team (provided to NMML with this report)
  + The aim was to identify evidence of effective practice in addressing equity of access to after-hours primary care services. The review facilitated use of wider knowledge base on what kinds of interventions in After-hours Services have been shown to be effective. However the level of relevant Australian evidence is limited and relies heavily on expert opinion. In addition the evidence mostly focusses on the problem of access and equity to after-hours care and is limited in presenting strategies to resolve this. Most of the strategies included concerned access and equity for Aboriginal and Torres Strait Islander communities.
* Local expert and national knowledge.
  + Local knowledge through NMML and access to the experience of experts in the field of primary health care and equity on the research team have helped to provide depth to areas where there is limited evidence and provide the context in which the initiative will be implemented.

### 

### Community Profile

The Northern Melbourne Medicare Local region (NMML) is located in the northern metropolitan region of Melbourne. It covers most of the northern suburbs of Melbourne, excluding a number of inner–suburban areas in the north–east and north–west. At 30 June 2010, the total population of the NMML region was estimated at 620,364.

NMML includes the local government areas (LGAs) of Banyule, Darebin, Hume (part), Nillumbik and Whittlesea, and covers 12 statistical local areas (SLAs). Banyule covers the hilly north–eastern suburbs of Melbourne and is primarily residential. Darebin, bounded by the Merri Creek to the west and Darebin Creek to the east, incorporates a mix of residential, industrial and retail areas.

Parts of Hume LGA are included in the NMML region; specifically, the two SLAs of Broadmeadows, 44.3 square kilometres and Craigieburn, 221.7 square kilometres. Hume has a very strong industrial base, with both motor vehicle manufacturing and heavy engineering as the major industries. The southern parts of the city include well–established urban areas and the Hume Growth Area, while the north remains rural in character.

NMML has two of Melbourne’s five growth corridors, which has resulted in exponential growth in population. Whittlesea and Hume include many areas on Melbourne’s urban fringe, the city’s fastest–growing areas.

**Figure 1. Map of the NMML region**



***Source: Australian Government Department of Health and Ageing***

The NMML region has two distinct population profiles. The first, the municipalities of Banyule and Darebin, are established areas with a larger proportion of older residents. In particular, there is a higher proportion of residents aged over 65 years in Banyule (15.3 per cent) and Darebin (14.8 per cent), compared to Victoria (14 per cent).

The growth areas and interface municipalities (Hume, Whittlesea and Nillumbik) have a younger population profile. At 30 June 2010, there were 43,301 (7.0 per cent) children under 4 years of age in the region, which is higher than the state average of 6.5 per cent. Of all the areas in the region, North Whittlesea (9.9 per cent) had a significantly larger proportion of children less than 4 years, compared to the Melbourne Statistical Division (MSD, 6.5 per cent) followed by Craigieburn (8.3 per cent) and Broadmeadows (7.8 per cent).

In 2006, the NMML’s catchment had approximately 3796 people who identified as having an Aboriginal and/or Torres Strait Islander background – a relatively small part of the region’s total population. However, this was a significant proportion of Indigenous residents living in Melbourne as a whole. The LGAs with the highest proportion of Indigenous people were Darebin (0.9 per cent), Whittlesea (0.7 per cent) and Hume (0.6 per cent).

Based on the Needs Assessment Table 2 below presents the identified vulnerable/disadvantaged populations in the NMML catchment area.

**Table 2: Groups, detail and justification, and priority from needs assessment**

| **Population Group** | **Details from population profile and consultation** | **Justification for inclusion as vulnerable group** |
| --- | --- | --- |
| **Older** | ***Population aging***  Regionally 65+ lower (11.6%) than state average (13.8), higher in Banyule (15.3) and Darebin (14.8).  Currently more than 50,000 over 70. Over 70 and over 85 doubling by 2025  ***Mental health and isolation problem***  Mental health (veterans), social isolation (esp. women aged 75 and older in Banyule and Nillumbik and men in Hume and Darebin) are projected issues. | ***Population aging:***  Tenth of population currently and growing, specific activities in Banyule and Darebin  Mental health services and support services need to be developed  Aged persons more likely to have multiple complex conditions, have admission/readmission to hospital |
| **Residential care** | Heavy reliance on deputising services providing after-hours urgent care in residential care, replacing GPs  GPs interviewed expressed concern about capacity to provide RACF services for clients with significant and urgent requirements  Combination of geographic growth and ageing identified as an issue | ***After hour provision to residential care***:  Increased trend in urgent and emergency presentations from residential care between 2007 to 11, decrease in semi- and non-urgent presentations |
| **Indigenous** | 3796 people identifying as Aboriginal and Torres Strait Islander in region, similar to Victorian average of 0.7%. Darebin (.9), Whittlesea (.7), Hume (.6) As a proportion of the total population, NMML’s Indigenous community is strongest in the City of Darebin, which has both the largest number, and the highest proportion, of Indigenous residents of l of the municipalities in metropolitan Melbourne*.* Identification of vulnerable populations.  Higher numbers < 15yrs than state average (aged less but 65+ only age given – need 40+)  Lower SES, more families, less internet  Banyule and Darebin more likely to have disability and all LGAs save Hume high numbers of carers.  Mental health, poor access to dental care | Some of most disadvantaged and vulnerable in the region  Difficulties accessing to after-hours care and cultural appropriateness training and service development limited to in-hours |
| **Newly arrived** | Hume highest numbers  Refugees more likely to present to ED, difficulties accessing GP / after-hours care | Most disadvantaged in the region |
| **CALD** | Higher number of non-English speakers (23.5%) compared to state (17.3). Italy (3.9), Greece (2.3) and India (1.2) highest but this also suggests more countries (not reported)  Whittlesea, Hume and Darebin high numbers of non-English speakers | Community identify language barriers and need for translated information Need to increase cultural competency of services |
| **Low SES** | Hume most disadvantaged in state, Nillumbik second least disadvantaged in state, Banyule and Whittlesea (6th most disadvantaged on SEIFA) have high pockets of disadvantage  North Darebin more prominent disadvantage than south |  |
| **Geographic location (growth and disadvant-aged areas)** | Whittlesea and Hume are two growth corridors  Outer fringe and semi-rural have poor transport infrastructure | Two of Melbourne’s five growth corridors - increasing prevalence of chronic and complex conditions driving increased demand for services, and mismatch of services to these areas of highest population growth  Mismatch in Victoria between population distribution and health services |
| **Children and carers** | High numbers of under 4 (7 %) and 5 - 14 (12.4%).  Under 4: North Whittlesea (9.9 per cent) Craigieburn (8.3 per cent) and Broadmeadows (7.8 per cent) | Similar to Melbourne (7%) |

## 

## Assessment

*Assessment synthesises and critically assesses the information collected during identification,*

*in order to prioritise impacts. Assessment results in prioritising potential impacts and initial recommendations to enhance positive impacts and mitigate negative ones.*

In this EFHIA (see Table 3) to make the assessment we reviewed the strategies suggested in the successful EOI (column 2) against the equity issues (column 1) which arose in the identification step. We then assessed, using the literature and local and expert opinion, the likely positive impacts (column 3) and areas of potential inequity (column 4). This activity was first completed by the research team, then discussed with NMML and modified to incorporate this input.

**Table 3: Assessment summary - Tender strategies mapped to equity of access framework**

| **Dimensions of equitable access** | **What the successful EOI is trying to do to address the issue (Taken from EOI)** | **Potential positive health impacts** | **Potential for inequity of access** |
| --- | --- | --- | --- |
| **Availability** | MMDS operates 24 hours a day, 365 days a year and provides homes visits for the entire after-hours period. In 2011 MMDS delivered an average of almost 10,000 home visits each month (9905.66) and to date in 2012 has delivered an average of almost 11,000 per month (10,933).  Patients have universal and easy access to an after-hours home visit. The patient will usually ring their GP whose phone will have been diverted to MMDS after-hours or will have a message that advises the patient to contact MMDS after-hours and gives the MMDS number. Alternatively, the patient may contact MMDS direct via phone or through a smart phone app that they have downloaded from the web | Increases access across the NMML area 24/7  Affordable care  Problems of access to transport minimised  Potential for Reduced demand on emergency services, support for aged care services  Serious Health problems may be diagnosed earlier and referred to emergency services | Not all patients have GP  Many disadvantaged patients may not be aware of MMDS or its phone number or have access to smart phones or internet  Insufficient information about likely waiting time  Needs to be supported by access to imaging, pathology etc and specialised services for mental health and D&A services |
| **Appropriateness:**  Timely care and referral to appropriate services:   * Monitoring of triage system * Use of & training in use of interpreter services * CME on cultural competence in CME/Orientation program. | All incoming calls are triaged (not by medical staff) to recognise and refer emergency medical problems to the ambulance service where necessary. MMDS Operators and Dispatchers are trained to St John First Aid Level 2.  VMOs treat patients from all socio-economic and cultural backgrounds and in all age groups and manage and take responsible action on any medical problem with which a patient presents. They record a history of presenting complaint, relevant history, current medications, allergies, examination findings, a diagnosis and a management plan which may require referring the patient to see their regular doctor for follow up and ongoing care.  As a prerequisite to commencement, clinical personnel must complete a comprehensive induction program (accredited by the RACGP as a Category 1 Active Learning Module). | People receive care appropriate to medical need in a timely way  Needs of vulnerable population need to be understood and feedback from VMOS on problems sought | Telephone triage is not as effective as GP triage and needs to be monitored  (McKinstry et al; 2010)  Unknown  groups who potentially have special needs include:  CALD and recent migrants, Indigenous, people with mental illness may have special needs  No mention of use of interpreter services  CME programs to support cultural competence, drug and alcohol, mental health. |
| **Affordability** | All patients attended after-hours are bulk-billed. | Improved access to primary health care afterhours by  removal of a significant barrier to access by Aboriginal, migrant and low income communities | Needs to be supported by affordable access to imaging, pathology and other incidental costs |
| **Continuity** | MMDS and its VMOs are the after-hours component of general practice and as such play a crucial role in the continuity of care and preservation of the therapeutic relationship between the patient and their principal GP. They provide principal GPs with a comprehensive clinical note for each of their patients attended after-hours. The clinical note is typed into a secure website and within an hour of completion is transferred electronically to the clinical software of the patient’s principal GP – which in turn it is uploaded into the relevant patient file. In addition, MMDS monitors the ‘receipt and read’ status of all clinical notes – when a clinical note has not be opened by the principal GP within a defined time, automatic follow up is activated. The MMDS database holds over 1.5 million patient records and all the personal contact details for the almost 3000 GPs who use MMDS to provide after-hours care for their patients This ensures direct contact with a patients principal GP after-hours if necessary, e.g., urgent pathology results or special instructions regarding a particular patient. | Good informational continuity provided patient has a GP  Unlikely to see the same doctor from afterhours service if happens again unless doctors have similar localities of coverage  Can actively support the uptake of patient controlled electronic records | Patients without a regular GP may not receive this continuity.  Depends on good access to GP in hours  Low SES groups tend to use afterhours care more  People with complex health problems : not clear where can access GP records |
| **Coordination** | While the GP always remains the gatekeeper and coordinator of the patient’s care, it is often the VMO who provides care over time for individual patients as required by the principal GP. For example, in the case of special management patients with complex, chronic illnesses there is close liaison between the practice and MMDS which ensures that a VMO is able to provide consistency of care at return visits on behalf of the GP. | Good coordination if patient has a regular GP. May be reduced by lack of continuity of after-hours doctors  Orientation processes can positively inform VMOs of local services and referral pathways | Complex coordination may be required for patients with special needs including those who do not speak English or have cognitive impairment.  Unclear what access afterhours service will have of GPs records  Potentially unfair impact on such patients who are not well linked into a GP (especially low SES, low income Indigenous etc.) i.e. who already have unmet need, or newly arrived |
| **Quality** | MMDS has a pool of 100+ Visiting Medical Officers (VMOs) who work across the after-hours period. The majority work part-time, and twelve are full-time. Approximately two-thirds are vocationally registered practitioners who hold FRACGP, the remaining doctors are on their way to Fellowship of the RACGP and working with MMDS under the auspices of the Approved Medical Deputising Service (AMDS) Program, a Commonwealth initiative to increase after-hours workforce and reduce reliance on overseas temporary resident doctors. MMDS is an approved provider under the AMDS Program. As a prerequisite to commencement, clinical personnel must complete a comprehensive induction program (accredited by the RACGP as a Category 1 Active Learning Module). Each of the three medical directors is a Fellow of the RACGP. They are available on-call, contactable by mobile phone as necessary during the after-hours period for Control Room staff and VMOs. The principal medical director manages all clinical governance. The Control Room is staffed by 14 personnel (primarily part-time on rotating rosters) who are trained in customer relations, first aid and triage procedures to a level that ensures patient safety. The Operator’s role is to arrange a home visit or provide appropriate referral information; it is not their role to provide medical advice. | Structures for clinical governance and support for consultation in place  Large numbers of VMOs have or are working towards vocational registration  Structured Induction into afterhours care is likely to improve the quality of care | The large number of part time staff may reduce continuity care for patients with complex needs  The induction of staff (both clinical and telephone staff) may not be sufficient to deal with particular population groups including those from CALD backgrounds(see earlier comment about knowledge of local services) |
| **Comprehensive Care** |  | There will be timely and successful referral of all groups to meet their needs through support services and linkages. Health needs of all groups will be adequately addressed either through the scope of direct service provision or timely referral through MMDS | Patients with severe mental illness, dementia or drug and alcohol problems may not receive the care they need in a timely way  Children from vulnerable and disadvantaged populations may experience delays in urgent treatment although they are at greater risk |
| **Monitoring and reporting** | Ongoing monitoring and reporting | Ability to identify if there are systematic differences between identified vulnerable groups and take action to improve access | Currently there is little empirical data on access and equity in deputizing services and so inequities are not recognised or addressed |

### 

### Summary of the Equity Focussed Health Impact Assessment

The EOI includes equity-related information which is likely to result in positive health impacts and mitigate potential inequities. The explicit inclusion of a comprehensive care framework means that the health needs of all groups are likely to be adequately addressed either through the scope of direct service provision or timely referral. Bulk-billing should also have a positive impact and ensure financial barriers to accessing care are reduced. A strength of the EOI is the potential for the existing IT system to provide valuable information on the services being offered and in particular its capacity to identify areas of inequity in uptake of services (e.g. waiting times). The focus on reporting data and monitoring service use over time provides the ability to identify if there are systematic differences between identified vulnerable groups and take action to improve equity of access if needed. The expansion of services to the growth corridors of Whittlesea and Hume is important, given the high need and high disadvantage in these areas.

There are also areas which can be strengthened to improve equity. We identified four key areas in which we have made recommendations as outlined below. These are:

1. The importance of access to GPs in normal and unsociable hours,
2. recommendations that imply the collection of new data and information,
3. recommendations that focus on training about different population groups accessing services, and
4. recommendations about routine monitoring of service reach to different population groups in the ML area.

Overall, improving equitable access to services in the NMML region is complex and requires service systems to collaborate and coordinate their business. NMML is well place to play a facilitating role to negotiate between service providers to foster that collaboration. Therefore many of these recommendations are oriented to facilitating NMML’s coordinating role. Recommendations and implications for identified population groups

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### Availability

**Equity issue 1: GP access**. Populations at greater risk of not having GP access are Aboriginal and Torres Strait Islander, 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 GP 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.

***Recommendations:*** *Identify the number and characteristics of people accessing the after-hours service who do not have a regular GP and how their follow up needs are met. Consider alternative strategies for linking these people with existing GPs.*

**Equity issue 2: Reliance on technology.** Populations at risk of not owning technology are elderly, residential care, newly arrived, low SES, Aboriginal and Torres Strait Islander. Increasingly smart phone technology is being used to access services. This is briefly referred to in the EOI where it is suggested that patients may request after hours visits via smart phone apps. 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.

***Recommendation:*** *Use of smart phones, e-mails and web based systems to access services is likely to make services less accessible for vulnerable populations and existing phone based services should be maintained and the reach of newer forms of access to services should be monitored.*

**Equity issue 3: Waiting times for service.** All populations affected. Waiting times are a key indicator of access to services. New growth areas that have not previously been served by the after-hours services are more distant from the service and may potentially have longer waiting times for services, despite similar needs. Monitoring waiting times in different parts of the region is important to ensuring equity of access to timely care is achieved.

***Recommendation:*** *Monitor and report on waiting times for service to understand which different groups have longer waiting times.*

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### Appropriate services

**Equity issue 4: Appropriate service.** All populations affected. Monitoring appropriateness and quality of care is important in delivering equitable services. There is evidence from in-hours primary care that disadvantaged groups commonly receive different quality of care e.g. duration of consultations, prescribing rates, referral rates. Monitoring key quality indicators across different regions and population groups will be important to ensure equity of access to quality care.

***Recommendation:*** *Encourage feedback from VMOs on areas where more appropriate service delivery is required.*

**Equity issue 5: Routine use of interpreter services.** Populations requiring interpreter services are CALD and newly arrived. Access to interpreters is important in ensuring quality and appropriate care. Monitoring use of interpreters and ensuring that all patients from CALD backgrounds have access to interpreters (available to medical practitioners by phone) is an important part of ensuring equity of access to appropriate quality care.

***Recommendation:*** *Develop policy of routine use of interpreter services, including VMOs trained in use of interpreters.*

**Equity issue 6: Cultural awareness.** Populations requiring culturally competent staff and service include CALD, newly arrived, Aboriginal and Torres Strait Islander. Similarly, provision of appropriate and quality of care equitably across cultural differences means ensuring that providers are appropriately trained in cultural awareness and safety and cross-cultural communication.

***Recommendation:*** *Service provider include cultural awareness (including needs of newly arrived refugees) training.*

**Equity issue 7: Low literacy.** Populations at risk of low literacy include Aboriginal and Torres Strait Islander, CALD, newly arrived, low SES, elderly and young people. Ensuring providers are appropriately trained in working with patients with low health literacy will help deliver equity of access to appropriate quality care

***Recommendation:*** *Service provider include working with people with low health literacy training in orientation program.*

### 

### Affordable

**Equity issue 8: Bulk-billing.** All populations affected but improved access for Aboriginal and Torres Strait Islander, CALD, Low SES. While the service is bulk-billing which ensures immediate financial barriers to access are removed, flow on costs via pharmacy, pathology imaging etc. may still present financial barriers and potentially create inequities. Developing policies in relation to use of bulk-billing services for imaging and pathology could help ensure financial barriers are minimised.

***Recommendation:*** *Monitor, through feedback from VMOs to the service provider, whether and how access to imaging, pathology, pharmacy services are organized, including whether there are charges associated with these services and if these services are available in newly established areas afterhours.*

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### Continuity

**Equity issue 9: Continuity of care.** All populations but complex health problems more likely in Aboriginal and Torres Strait Islander, low SES, newly arrived, elderly. One strategy contained in the EOI to help ensure continuity of care is through promoting use of the PCEHR. It is not yet clear how access to and use of the PCEHR will be taken up by different population groups. Potential inequities may arise if this is relied on as the remains to ensure continuity of care, which is particularly important 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 will help reduce potential inequities.

***Recommendation:*** *Encourage use of patient controlled electronic health records to access information on managing patients with complex health care problems. These patients are more likely to be higher in vulnerable and disadvantaged populations. Alternative strategies which are not reliant on patients or carers use of technology will be required for populations with known poor access to broadband including the elderly and areas of low SES.*

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### Coordination

Equity issue 10: Complex coordination. May be required for patients with special needs including children, newly arrived, Aboriginal and Torres Strait Islander, those with limited English language (CALD, newly arrived), cognitive impairment (elderly).

***Recommendations:*** *Develop protocols for referral to other services such as mental health, dementia, and child protection. Monitor adherence to referral protocols and the characteristics of patients managed under these protocols.*

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### Quality

**Equity issue 11: Staff numbers.** New staff may not be as skilled in maintaining continuity of care for populations with complex needs (see equity issue 9 above) and may require training about appropriate service (see equity issues 4-7 above).

***Recommendations:*** Maintain regular CME program with some inclusion on managing the needs of vulnerable and disadvantaged populations. Orientation should include information of local services used frequently by patients.

Comprehensive Care

**Equity issue 12: Timely care**. All populations but greater risk for elderly, newly arrived (greater risk of mental illness), those with drug and alcohol problems, and children from vulnerable populations (CALD, low SES, Aboriginal and Torres Strait Islander) at risk of presenting with urgent needs.

***Recommendation (already in successful EOI)****: timely and successful referral of all groups to meet their needs through support services and linkages in health needs of all groups will be adequately addressed either through the scope of direct service provision or timely referral through MMDS).*

Monitoring and evaluation

**Equity issue 11: IT system.** All population groups. One very important strategy for monitoring equity of service provision is collection and reporting routinely of characteristics of service users. This is important for the monitoring distribution of care characteristics such as waiting times, clinical care processed, use of interpreters, providing evidence of any differences in access to services by vulnerable and disadvantaged groups.

***Recommendation:*** *Ensure IT system developed includes information on age, gender, country of birth, place of residence, time until service provided, address/location, education level, occupational group, employment status, length of time in area, and refugee status.*

# References

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Appendix 1: **Screening of North Melbourne Medicare Local Needs Analysis and Implementation Strategy for After-hours Care Planning**

**Background**

A rapid desk-top review of North Melbourne Medicare Local (NMML) Local Needs Analysis (2012a) and Implementation Strategy (2012b) for After-hours Care Planning was undertaken to inform the screening step of a potential Equity Focussed Health Impact Assessment (EFHIA) on the plan. These documents provided a comprehensive overview of the needs of the catchment population in the NMML, the problems and gaps associated with providing health services to this catchment, and detailed plans to address these problems and gaps.

The review also demonstrates that an EFHIA could add value to the implementation plan by developing specific equity oriented actions to address potential inequities in access to quality after-hours care. The planning of an EFHIA could be scoped tightly to focus on specific hard to reach populations for specific identified ‘priority gaps’.

**Points identified where EFHIA could add value**

As an example of this value, one priority gap in the plan, ‘After-hours access impacted by lack of community and provider awareness’, was rapidly reviewed against the key questions used in an EFHIA to assess the impact of initiatives (i.e. an EFHIA Framework). The recommendations from this review against this identified priority gap were:

* Implementation details concerning equity could be extended – While problems are identified and solutions and strategies are proposed, ways to implement the strategy to address equity could be further developed.
* Explicit links to the broader literature may provide detail on the benefits and risks of the currently proposed strategy.
* Links to the data in the needs analysis could be strengthened. For example particular after-hours needs of the newly developing corridor populations could be stated more explicitly.
* Explicit link to other vulnerable groups in relation to activities could be developed and ‘hard to reach’ groups identified. The EFHIA process can help to explicitly identify who these populations are including their size and distribution and what can be done to link to these groups. Examples are:
* Access to the internet in aged groups who are high users of afterhours care
* CALD or refugee or Aboriginal and Torres Strait Islander populations who may be well connected to community leaders or community organisations.
* Causal links between groups (and their reasons for current afterhours service use), proposed actions, and potential service implications and health outcomes could be made clearer.

**Suggested ways forward**

Similar rapid reviews as part of an initial screening and scoping to undertake the EFHIA could reveal areas to strengthen priority strategies already identified within the plan. If this finds no gaps or opportunities for equity oriented change then the EFHIA should not proceed beyond a desk based review with associated recommendations. Initial work should identify how much implementation detail to address equity is required within the overall planning process (for example linking to tendering processes).