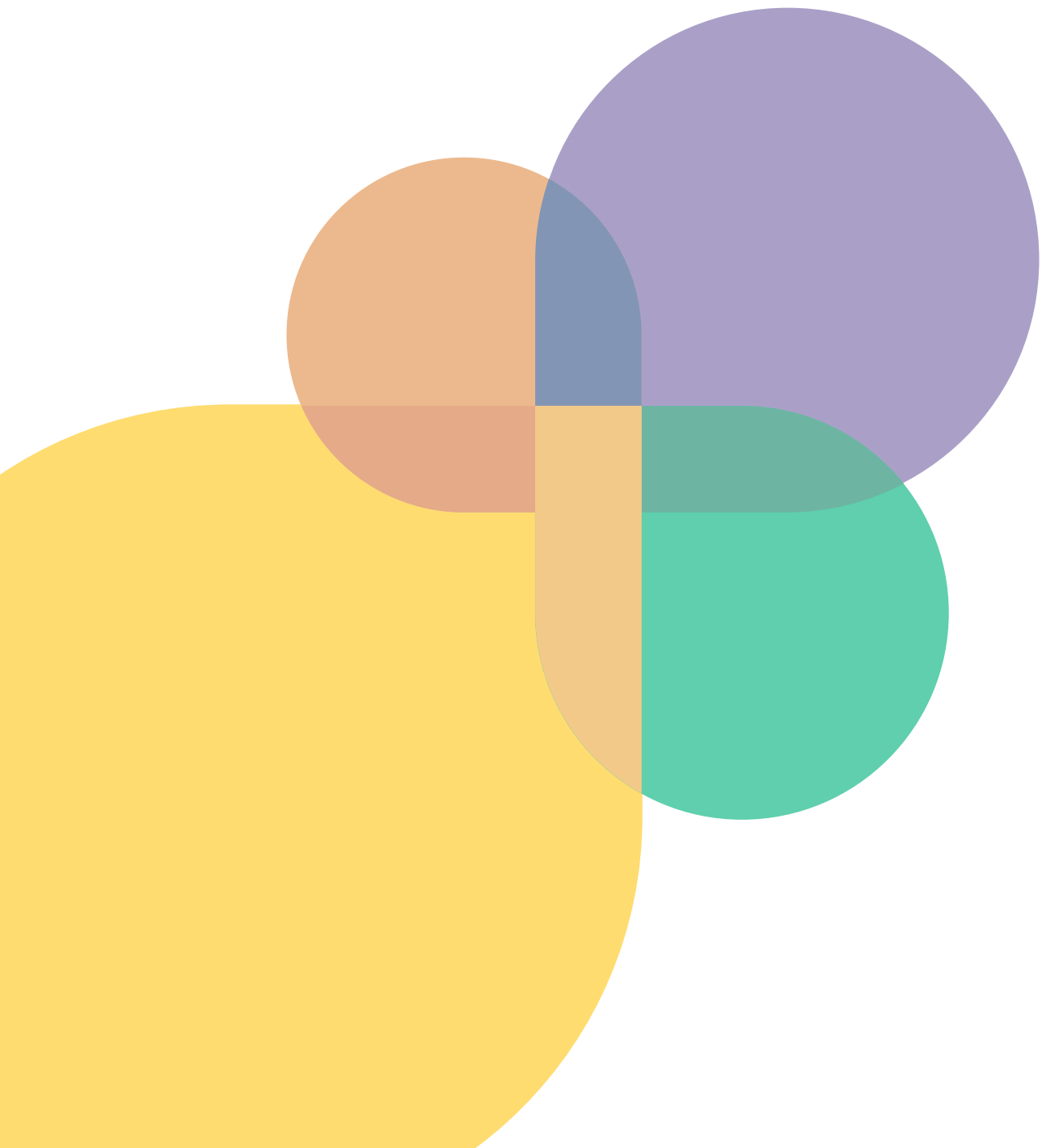
Access and Equity Framework

A framework for improving health equity in the North Western Melbourne PHN region

July 2021 to June 2024

phn
NORTH WESTERN MELBOURNE

An Australian Government Initiative



From our Chair and CEO

At North Western Melbourne Primary Health Network (NWMPHN) we believe everyone has the right to the best health care possible. While we have a strong public health system made up of dedicated health professionals and organisations, not everyone in our community is able to access that system in an equitable way.

Our region is highly diverse: socially, culturally and economically. Our diversity makes us stronger and more resilient, however it also brings challenges. We have a rapidly growing population, areas of both low and high income, social housing areas with concentrated disadvantage, a high concentration of statewide hospitals and health services in inner regions, and significant numbers of newly arrived refugees and asylum seekers. Systemic differences in health status exist across population groups in our region, with an individual's ability to access healthcare shaped by their social and community context.

Health equity requires more than simply providing health services – people need to be able to access safe, local and culturally appropriate care in order to thrive. Health equity is possible when all community members have access to opportunities and supports to thrive both physically and mentally, without barriers because of their race, ethnicity, religion, age, gender, sexual orientation, social class and/or socioeconomic status.

We acknowledge that the health system which NWMPHN is part of has a key role to play to address health inequities in our region. To improve health equity for all community members, especially those who need it most and are at the greatest risk of poor health outcomes, we have defined five key priority areas for action:

1. **Show leadership and commitment to equity as a strategic priority.**
2. **Embed equity into everything we do.**
3. **Use data and evidence to support action.**
4. **Engage with communities including people with lived experience and partner with collaborators.**
5. **Build capacity and develop skills.**

We have developed the NWMPHN Access and Equity Framework 2021 to 2024 (the Framework) to provide a foundation for identifying inequitable health outcomes in the NWMPHN region and describing the key priority areas for action. Addressing health inequities is a complex process, and requires commitment over the long-term. We also recognise that by working together we can create meaningful and ongoing change.

The NWMPHN Access and Equity Framework outlines:

- **Why we have developed the Framework.**
- **How access and equity is considered at NWMPHN including our guiding principles and action plan.**
- **Practical activities including tools, systems and processes that will be developed to ensure that NWMPHN is supporting health equity.**

The Framework has been informed by consultation with the NWMPHN Clinical Council and Community Council as well as staff across all levels of our organisation to ensure that the Framework's design reflects the perspective of our staff who will bring it to life.

Dr Ines Rio
Chair
North Western Melbourne Primary Health Network

Mr Chris Carter
CEO
North Western Melbourne Primary Health Network

Acknowledgements

North Western Melbourne Primary Health Network (NWMPHN) acknowledges the peoples of the Kulin nation as the Traditional Custodians of the land on which our work in the community takes place.
We pay our respects to their Elders past and present.

We also recognise, respect and affirm the central role played in our work by people with lived experience, their families and/or carers.

We would like to thank everyone who has supported the development of the Framework, especially Sarah Simpson, Director EquiACT for sharing her time and subject matter expertise.

We would also like to thank NWMPHN Community and Clinical Council members for their input and review of the Framework. The Framework has been reviewed by a number of People Bank members, a NWMPHN program that includes representatives from people in our community.

North Western Melbourne Primary Health Network

ABN 93 153 323 436

Telephone: (03) 9347 1188

Fax: (03) 9347 7433

Street address: Level 1, 369 Royal Parade, Parkville, Victoria 3052

Postal address: PO Box 139, Parkville, Victoria 3052

Email enquiries: nwmphn@nwmphn.org.au

Disclaimer

While the Australian Government Department of Health has contributed to the funding of this material, the information contained in it does not necessarily reflect the views of the Australian Government and is not advice that is provided, or information that is endorsed, by the Australian Government. The Australian Government is not responsible in negligence or otherwise for any injury, loss or damage however arising from the use of or reliance on the information provided herein.

Cover image by Janusz Mollinski Photography

Page 23 and 25 by Leigh Henningham Photography

Page 21 by John Donegan

Contents

1.0 Framework at a glance

The North Western Melbourne Primary Health Network (NWMPHN) Access and Equity Framework provides a foundation for identifying health inequality in the NWMPHN region and describes the key priority areas for action.

Vision

A healthy community, a healthy system

Mission

Better care, every day in every way

Values

Equity
Respect
Collaboration
Innovation

Access and equity enablers

The access and equity framework aims to...

Embed approaches that address health inequities to improve access to health services for all community members, especially those who need it most and are at greatest risk of poor health outcomes.

Guiding approaches & principles

Guiding approaches and principles informing the framework include...

- Human rights based approach to health
- Social determinants of health
- Community participation and co-design
- Cultural safety and inclusion
- Intersectionality
- Accountability

Access and equity priority areas

Access and equity priority areas are...

Priority Area 1
Show leadership and commitment to equity as a strategic priority

Priority Area 2
Embed equity into everything we do

Priority Area 3
Use data and evidence to support action

Priority Area 4
Engage with communities including people with lived experience and partner with collaborators

Priority Area 5
Build capacity and skills

2.0 Context

2.1 What is health equity?

Health equity means all people (individuals, groups and communities) have a fair chance to reach their full health potential and are not disadvantaged by social, economic and environmental conditions. This includes equitable (fair) access to healthcare professionals, healthy food and a safe living environment. It means the ability to be well across all aspects of life, from work to home life and to medical care.

It is important to recognise that health equity is not the same as health equality. Health equality means each individual or group of people is given the same resources or opportunities, whereas health equity recognises that each individual has different needs and may require different resources and opportunities to reach their best health.

Figure 1. Demonstrating the difference between health equality and health equity

Equality. The resources and opportunities are the same for all.

Equity. Individuals receive the exact resources and opportunities they need.

2.2 What are the drivers of health inequity?

Health inequities are differences in health status and outcomes between different population groups that are unfair, unjust, and avoidable. They are largely influenced by a range of social and economic factors called the 'social determinants' of health – these are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to support health and deal with illness[1]. These circumstances are in turn shaped by a wider set of influences: economics, social policies, and politics.

Some health inequities in Australia

- **Some groups have shorter lives and poorer health than others:** for example, Aboriginal and Torres Strait Islander people have ten years' less life expectancy, are six times more likely to be hospitalised for diabetes and are almost three times more likely to experience high or very high levels of psychological distress than the general population.[2]
- **Some groups have limited access to health care:** for example, people with low health literacy.
- **Some services are not used by all those that need them:** for example, infants from non-English speaking backgrounds are significantly less likely to access maternal and child health services or general practitioners compared to infants from English speaking backgrounds.[3]
- **Some localities/communities have a very high burden of disadvantage:** for example, Brimbank, Hume and Melton experience the most socio-economic disadvantage as well as the highest rates of high/very high psychological distress in the NWMPHN region. Approximately 31% of the region's population was born in a country that does not predominately speak English.[4]

1 Social determinants of health: key concepts. World Health Organisation, 2013
2 'Australia's health 2018: in brief.' Australian Institute of Health and Welfare, 2018
3 Ou, L., Chen, J. & Hillman, K. Health services utilisation disparities between English speaking and non-English speaking background Australian infants. BMC Public Health 10, 182 (2010). https://doi.org/10.1186/1471-2458-10-182
4 Primary Health Network Health Needs Assessment Reporting, North Western Melbourne PHN, 2020

Evidence shows that in general, the lower an individual's socioeconomic position the worse their health. There is a social gradient in health that runs from top to the bottom of the socioeconomic spectrum, and it means that health inequities affect a greater proportion of people at the lower end[5].

Socioeconomic disadvantage may intersect with or compound other forms of disadvantage such as discrimination, that can effect a person's ability to secure meaningful employment. Other examples include people who:

- live in a disadvantaged suburb which is under-served with access to services, fresh food, and open spaces
- face stigma and discrimination due to sexual orientation or gender identity
- live with a disability, or a mental health issue
- live in a peri-urban area without adequate public transport
- do not speak English
- have limited educational attainment
- have a history of trauma.[6]

Health providers also have a role to play in managing health inequities. They can do that by considering and responding to the intersecting forms of disadvantage and discrimination to cater to all diverse needs.[7] Practically this means understanding the needs of the population they serve, how that population is able to access their services and what they can do to ensure that their services are provided in a way that is culturally responsive to an individual's needs.

37% of people living in the NWMPHN region were born overseas.

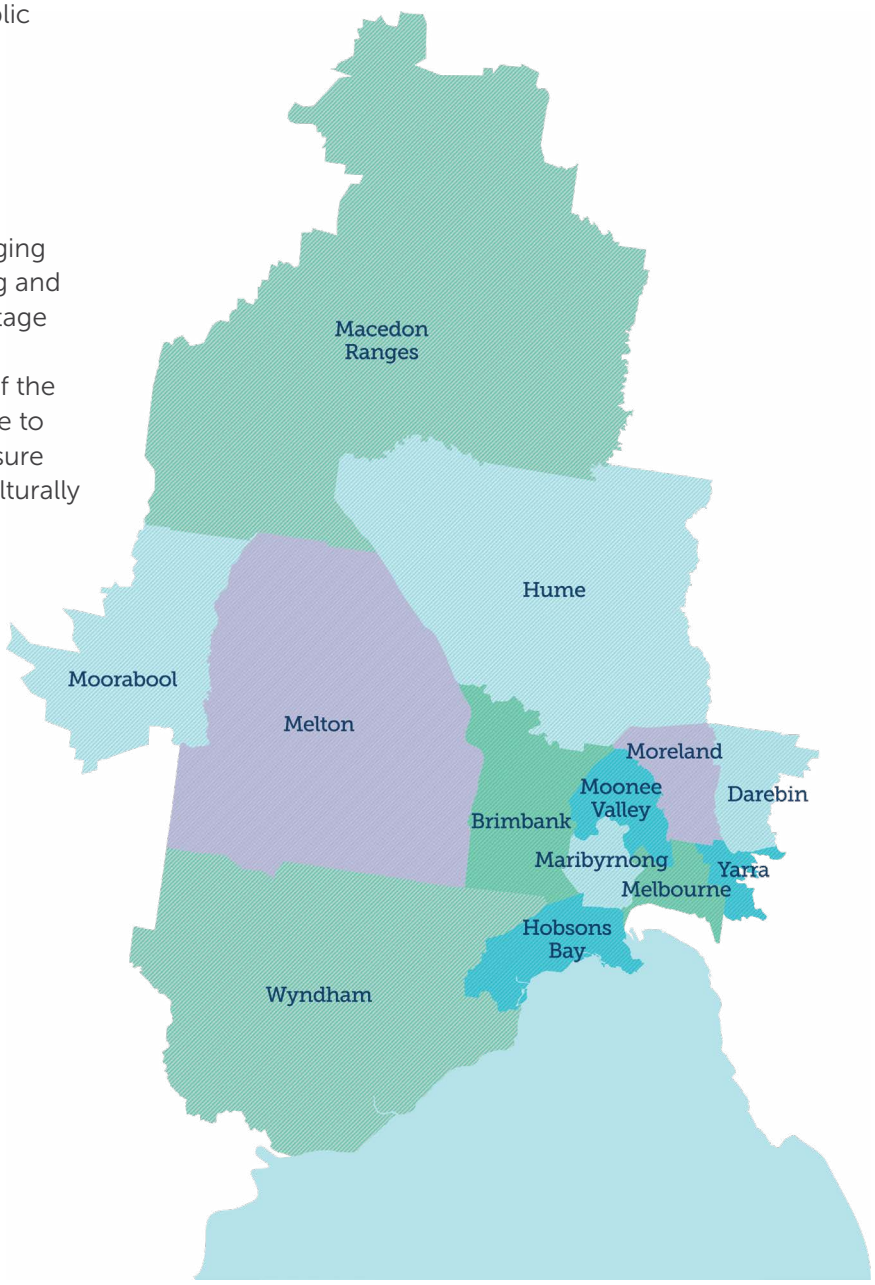
40% speak a language other than English at home.

2.3 Health inequities in the NWMPHN region

The NWMPHN region is one of the most diverse and complex regions in Victoria. It stretches from coastal Cocoroc in the south, to the regional areas around Lancefield in the north, and as far west as Bacchus Marsh. It encompasses urban, peri-urban and regional communities with a range of health and community needs.

The region is demographically diverse, characterised by high levels of cultural diversity, a growing population, areas of low income, social housing areas with concentrated disadvantage, and significant numbers of humanitarian entrants settling in the catchment.

Figure 2. NWMPHN Region



5 Social determinants of health: key concepts. World Health Organisation, 2013
6 'A framework for improving health equity in Sydney Local Health District.' Sydney Local Health District, 2017
7 State of Victoria (Family Safety Victoria), Everybody matters equity and inclusion statement, 2018

Table 1. Community profile differences between the NWMPHN region and Victoria

Differences in health outcomes exist in the NWMPHN region, with marginalised populations experiencing poorer health. Some of these differences include:

Population characteristic	NWMPHN	VIC	Range within NWMPHN
Born overseas (2016)[1]	37%	28.4%	Moorabool 12.3% ~ Melbourne 55.7%
Speak a language other than English at home (2016)[2]	40%	32%	Macedon Ranges 11% ~ Brimbank 64.3%
Identifies as LGBTIQ (2017)[3]	3%	5.7%	Moorabool 4% ~ Darebin 10.6%
Aboriginal and Torres Strait Islander people (2016)[4]	0.7%	0.9%	Moonee Valley 0.42% ~ Moorabool 1.4%
Humanitarian entrants settled (2016)[5]	30,537 (47.6% of VIC intake)	64,092	Moorabool 7 ~ Hume 9642
People living with a profound or severe disability (2016)[6]	5.3%	5.4%	Melbourne 1.9% ~ Brimbank 6.7%
Unemployment rate (2016)[7]	5.8%	4.8%	Macedon Ranges 2% ~ Brimbank 8.6%
Index of Relative Socio-economic Disadvantage (IRSD) (2016)[8]	993.8	1010.5	Brimbank 921 ~ Macedon Ranges 1060

1,2,4,7,8 Australian Bureau of Statistics (ABS) Census 2016
3 2017 Victorian Population Health Survey
5 PHIDU, compiled from Australian Bureau of Statistics (ABS) Census 2016 and Migrants Integrated Dataset, August 2016
6 PHIDU, compiled from Australian Bureau of Statistics (ABS) Census 2016

Table 2. Health outcome differences between NWMPHN region and Victoria

In addition to different health outcomes for individuals, adverse health outcomes can occur because of where someone lives, referred to as place-based disadvantage. There are also people within population or priority groups within communities that also can have poor health outcomes.

Outcome	NWMPHN	VIC	Range within NWMPHN
Life expectancy at birth (2018) [1]	83.9	83.5	Not available
Rates of potentially preventable hospitalisations for vaccine preventable conditions per 100,000 population (2017 to 2018)[2]	311	260	Macedon Ranges 138 ~ Brimbank 422
Prevalence of diabetes (2017-2018)[3]	6%	6.2%	Macedon Ranges 3.3% ~ Brimbank 8.2%
Prevalence of asthma (2017-2018)[4]	10.7%	11.5%	Melbourne 6.9% ~ Moorabool 16.1%

1 Australian Institute of Health and Wellbeing, analysis of the Australian Bureau of Statistics (ABS) Life Tables.
2 PHIDU and Australian Institute of Health and Wellbeing, as compiled from the Victorian Admitted Episodes Dataset.
3 Australian Bureau of Statistics (ABS) National Health Survey 2017-2018
4 Australian Bureau of Statistics (ABS) National Health Survey 2017-2018

2.3.1 Place-based disadvantage

People who live in disadvantaged places in general have higher rates of illness, disability and death, and live shorter lives than those from less disadvantaged places. The prevalence of some chronic diseases can also be higher among adults in lower socioeconomic groups.[8]

Pockets of disadvantage exist in places across the NWMPHN region within local government areas. Examples include Brimbank, Hume, Melton and Maribyrnong that have some of the lowest scores for the SEIFA Index of Relative Socio-Economic Disadvantage (IRSD) in Victoria. For example, in some areas of Brimbank there are communities that experience higher levels of unemployment, low household incomes and a high proportion of people who do not speak English well compared to other parts of the catchment.

2.3.2 Population groups at risk of poor health outcomes

In the NWMPHN region there are several population groups at greater risk of poorer health outcomes. While not every person in every group has the same experience, there are some groups that are more likely to experience inequities in health and wellbeing due to social determinants such as place-based disadvantage, stigma, discrimination and the unequal distribution of resources, among other things.

Examples of groups more likely to experience inequities include:

- **Aboriginal and Torres Strait Islander communities:** in addition to experiencing the ongoing impact of colonisation resulting in trauma, overall the community has higher levels of disadvantage and ill health throughout the region. Aboriginal people are almost three times more likely to experience high or very high levels of psychological distress.[9]
- **People who are lesbian, gay, bisexual, transgender, intersex or queer (LGBTIQ):** have higher rates of suicide and self-harm and can experience stigma and discrimination which contribute to poorer mental health outcomes and are a barrier to accessing safe services.[10]
- **People from refugee backgrounds and people seeking asylum:** have high rates of trauma and mental illness and are underrepresented in the service usage data.
- **People experiencing homelessness:** are more likely to report having a mental health condition or a long-term health condition, with depression, back pain or back problems, anxiety, and asthma the most reported long-term conditions.[11]
- **People who have been incarcerated and are now living in the community:** have significant and complex health needs including higher rates of mental health conditions, chronic disease, communicable disease, acquired brain injury, tobacco smoking, high-risk alcohol consumption, recent illicit drug use, and recent injecting drug use, than the general population.[12]

2.4 Understanding health equity issues with the use of tools

A wide range of tools exist to measure access and equity issues related to health service provision. The Tanahashi model[13] for effective coverage can be used to identify barriers that different groups in the community may be experiencing in accessing services and enable a focus on equity. Barriers are considered in terms of availability, accessibility, acceptability and effective coverage with quality as a cross-cutting issue. The Tanahashi model is consistent with and underpinned by the "right to health" approach (AAAQ Framework) which defines standards around availability, accessibility, acceptability and quality of healthcare services.

The application of the Tanahashi lens and implications for more equitable health service provision are outlined in the case study about Anna.

Case study: Anna from the North Western Melbourne PHN region

Anna is a 36-year-old woman who recently arrived in Australia as a refugee from Iraq with her husband and three young children. Anna and her family live in a northern suburb of Melbourne. During an appointment at the local health service, the general practitioner (GP) noticed that Anna displayed symptoms of mental health distress. The GP referred Anna to the local mental health service for initial assessment and referral.

8 'Australia's health 2016. Australia's health series no. 15.' Australian Institute of Health and Welfare, 2016
9 'Australia's health 2018: in brief.' Australian Institute of Health and Welfare, 2018
10 'Blueprint for better health. A community report on mental health, alcohol and other drugs and suicide prevention in the north western Melbourne region.' North Western Melbourne PHN, 2020
11 'Australia's health snapshots 2020.' Australian Institute of Health and Welfare, 2021
12 'The health of Australia's prisoners 2018.' Australian Institute of Health and Welfare, 2019
13 Tanahashi T. 'Health service coverage and its evaluation.' Bulletin World Health Organization, 1978

Table 3. A case study using the effective health service coverage domains to understand barriers to accessing a mental health service

Effective health service coverage domain	Barriers to health service provision	Potential solutions to provide equitable health service provision
Availability Sufficient resources (human, financial and other) are provided for delivery of effective interventions.	• Anna was not offered an interpreter for the initial telephone screening despite her limited English. • Anna is put on a long waitlist for the initial assessment.	• Embed language services into the service and make it easy to access for consumers and clinicians. • Provide alternative health pathways (if available) and advise GP of waitlist.
Accessibility This can include geographic, financial (direct and indirect) and organisational barriers such as the provision of information and limited opening hours.	• The referral process to the service and waiting times were not clear to Anna's GP. • The service is open from 9am to 5pm which is not suitable to Anna who has caring responsibilities during these hours. • Due to a lack of public transport options to the health service, Anna will find it difficult to attend the appointment.	• Simplify the referral process and communicate this to GPs via HealthPathways Melbourne [14] and on the health service website. • Offer outreach and after-hours services. • Address the issue of availability of suitably trained clinicians of all genders to ensure availability of same-gender providers as required.
Acceptability How the service is perceived by the patient and their willingness to use it. Issues might include discriminatory attitudes by health providers and lack of connection to cultural beliefs.	• Anna is not convinced that her need for the service is a priority relative to physical and or other health needs – it is just life. • Anna's previous experience with health care providers in Australia is limited and she is concerned about opening up to a health professional from a different cultural background, who may not understand her and who may be discriminatory. • Anna has heard from others in her local community that not all health care providers are supportive. • Anna is concerned that she may not be able to receive services from a female health professional.	• Employ clinicians from diverse backgrounds. • Provide training and support for clinicians in working with people from refugee backgrounds. • Use shared decision-making processes to minimise barriers, increase patient understanding, and empower the consumer.
Effectiveness This includes care, intervention, or action that achieves the desired outcome from both the clinical and patient perspective.	• After three sessions, Anna remains unclear about her treatment plan and is having difficulty in attending sessions due to challenges juggling child commitments. Anna decides to not return for future appointments and believes that the support from her local community will be enough.	• Use Patient Reported Outcome Measures (PROMs) tools to routinely collect patient feedback to assess treatment progress and tailor as needs change.

14 HealthPathways Melbourne is a free, web-based portal for health professionals with relevant information on the assessment and management of common clinical conditions including referral guidance.

3.0 Addressing health inequity in the North Western Melbourne PHN region

3.1 Why is health access and equity important to North Western Melbourne Primary Health Network?

At NWMPHN, we believe everyone has the right to the best health care possible. We seek to improve our community's health and well-being with a special focus on addressing the needs of the most disadvantaged and those who are at the greatest risk of poor health outcomes.

We are guided by our values of equity, respect, collaboration, and innovation as we strive for better care, every day in every way.

Health access and equity is important to NWMPHN because:

- addressing health inequities improves health outcomes,
- access to health is a human right,
- failing to address health inequities contributes to discrimination and further disadvantage,
- health inequities create cost and capacity pressure on the health system, and
- addressing health and social inequities can level the playing field for people.

3.2 Policy context

The NWMPHN Access and Equity Framework is informed by a number of national, state and local policies and frameworks. These are dedicated to addressing health outcomes for different populations and disadvantaged groups among their broader commitments to improve the health system.

More detail on the National and State policies can be found in Appendix C.

NWMPHN strategic frameworks and plans also inform and enable the NWMPHN Access and Equity Framework:

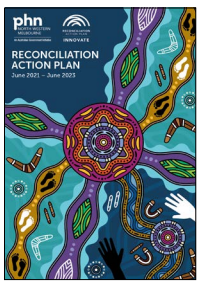
- **NWMPHN Strategic Framework 2021-2024**
- **NWMPHN Commissioning Framework** includes access and equity principles and considerations throughout the entire commissioning cycle.
- **NWMPHN Health Needs Assessment** identifies barriers to access for priority populations that are at greatest risk of poor health outcomes.
- **Blueprint for better health - mental health, alcohol and other drug and suicide prevention regional plan** focuses on building community and workforce capacity, and on people whose health is influenced by intersecting forms of structural inequity.
- **NWMPHN Stakeholder Engagement Framework** outlines our commitment and approach to engagement in accordance with IAP2 principles.
- **NWMPHN Reconciliation Action Plan** outlines the actions we are undertaking to contribute to reconciliation.

Internal documents include:

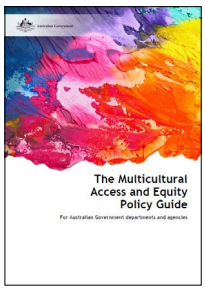
- **NWMPHN Strategic Planning and Performance Management Framework** includes outcomes and indicators that measure access and equity.
- **NWMPHN Community Participation Plan** ensures that priority populations are included in NWMPHN activities.
- **PHN Program Performance and Quality Framework** refers to access and equity, cultural responsiveness, and health literacy.

Local

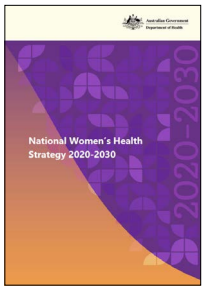
NWMPHN Reconciliation Action Plan



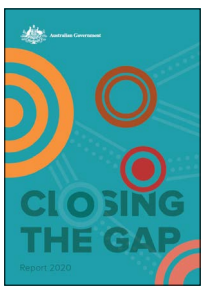
National



Multicultural Access and Equity Policy Guide

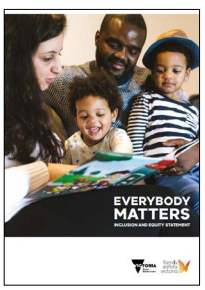


National Women's Health Strategy 2020-2030



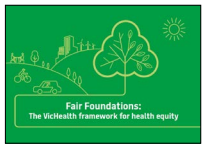
Closing the gap 2020

State



Everybody matters: Inclusion and Equity Statement

Partnering in healthcare: A framework for better care and outcomes



Fair Foundations: The VicHealth framework for health equity

3.3 Guiding principles

NWMPHN has identified six principles that guide our priority areas for action on health equity.

Table 4. Guiding principles for the NWMPHN Access and Equity Framework

Human rights-based approach to health	"The right to health requires an effective, responsive, integrated health system of good quality that is accessible to all. Key principles include that health services must be available, accessible, acceptable, of appropriate quality, and provided without discrimination. People have the right to participate in decision making, and reporting needs to be transparent and accountable."[15] **The principles and standards of human rights will be integrated when planning and delivering activities.**
Social determinants of health	Social determinants of health (SDOH) are non-medical factors that influence health outcomes and include factors such as gender, education, employment, financial situation, cultural and ethnic background.[16] **The social determinants of health will be used to understand and address inequities in our catchment.**
Community participation and co-design	Community participation is integral to the work we do at NWMPHN. The aim of community participation is to enable members of the community to contribute to decisions regarding healthcare and service access, leading to better health outcomes. **Engagement with communities experiencing health inequities will allow for meaningful participation and co-design.**
Cultural safety and inclusion	"Cultural safety is the practice of recognising, respecting and nurturing people's unique cultural identity which includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socio-economic status; ethnic origin or migrant experience; religious or spiritual beliefs; and disability."[17] **We will endeavor to ensure that our commissioning activities are culturally safe and inclusive. We also commit to practicing cultural humility and reflecting on our own biases and beliefs.**
Intersectionality	"Intersectionality recognises that individual characteristics that inform our social identity intersect to create complex forms of oppression as a result of systems and structures that devalue certain population groups or people with specific characteristics."[18] **An intersectionality lens will consider and respond to the intersecting forms of disadvantage and discrimination in order to cater to all diverse needs.**
Accountability	"Accountability entails the procedures and processes by which one party justifies and takes responsibility for its activities."[19] **All activities will be monitored, evaluated, and reported on through a health equity lens.**

15 'Fair Health Matters Equity Framework to 2025.' South Western Sydney Local Health District, 2020
16 Health Topics - Social Determinants of Health, World Health Organisation at https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1
17 LGBTIQ+ Intersect Project. Victorian Transcultural Mental Health, 2017 at http://www.lgbtiqintersect.org.au/glossary/
18 'Everybody matters equity and inclusion statement,' State of Victoria (Family Safety Victoria), 2018
19 Emanuel EJ, Emanuel LL. 'What is accountability in health care?' Ann Intern Med. 1996 Jan 15;124(2):229-39. doi: 10.7326/0003-4819-124-2-199601150-00007. PMID: 8533999

3.4 Key priority areas for action

There is already strong support for addressing health inequity within NWMPHN. This Framework describes how we will strengthen those efforts over the next three years. Our 2021-2024 Reconciliation Action Plan and internal plans such as our Community Participation Plan will also make important contributions towards achieving the objectives of this Framework. Further details, including specific actions and delivery timeframes can be found in Appendix A. NWMPHN Access and Equity Action Plan 2021 - 2024.

Show leadership and commitment to equity as a strategic priority

Objectives

- To demonstrate leadership and commitment to improving health equity in the NWMPHN region.
- To take a systemic and whole of organisation approach to embed an "equity lens" including providing appropriate resourcing to progress equity.

What are we currently doing?

- Development of key strategic documents to support equity.
- Purposeful investment in under-served areas and priority populations.

Key activities over the next three years:

1.1 Develop and implement an equity focused approach to resource distribution.

1.2 Develop and apply an equity lens into strategic documents, planning, commissioning, reporting and quality improvement processes.

1.3 Improve understanding and identification of priority populations through the process of Health Needs Assessment.

Embed equity into everything we do

Objectives

- To ensure that funded services are equitable, accessible, and culturally responsive.
- To identify and support quality improvement activities that can be undertaken by the funded providers and general practice to address health inequities.

What are we currently doing?

- Development of equity and diversity focused tools to support commissioning processes e.g. diversity and community participation guidance for tenders.
- Increased diversity of community members and subject matter experts in activities.

Key activities over the next three years:

2.1 Develop and implement additional equity and diversity focused tools and resources and embed into commissioning processes.

2.2 Support NWMPHN commissioned providers and other services to ensure that services are equitable, accessible, and culturally responsive.

.

Use data and evidence to support action

Objective

To use data and evidence to describe heath inequities, translate evidence into practice, and evaluate the impact of interventions on health equity.

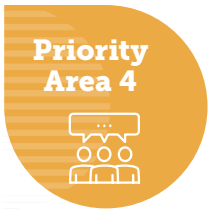
What are we currently doing?

- Community engagement is at the core of our Health Needs Assessment including community surveys (telephone and online) and priority population focus group sessions.
- Examination of health indicators in at-risk (priority) populations.

Key activities over the next three years:

3.1 Improve data collection systems and reporting requirements to better capture data related to equity and diversity.

3.2 Systemically apply an equity lens to evaluation.



Engage with communities including people with lived experience and partner with collaborators

Objective

To partner with communities including people with lived experience and organisations representing different sectors to address health inequities.

What are we currently doing?

- Cross-sector partnerships e.g. The Collaborative.
- Collaborating with organisations representing diverse communities.
- Community participation processes and platforms in place including Community Council and People Bank.

Key activities over the next three years:

4.1 Build diverse representation within the organisation across governance, leadership, working groups and expert advisory groups.

4.2 Build partnerships with communities experiencing health inequities and engage with them based on the principles of codesign.

4.3 Develop more inclusive community engagement strategies and ensure reporting back to the community.

Build capacity and skills

Objective

To build the capacity of NWMPHN staff, funded providers and general practice to provide equity focused, inclusive and culturally responsive services.

What are we currently doing?

Cultural responsiveness and awareness training for funded providers and NWMPHN staff.

Key activities over the next three years:

5.1 Embed equity and understanding of diversity as key competencies for NWMPHN staff.

5.2 Develop and implement equity focused human resources practices.

5.3 Embed equity and diversity as key competencies for funded providers and general practice.

3.4.1 Applying an equity lens to North Western Melbourne PHN activities

In addition to the specific activities outlined in the NWMPHN Access and Equity Action Plan 2021 - 2024, we commit to applying a **health equity lens** across the activities we undertake and/or commission in order to identify ways in which the programs and services may be contributing to health inequities.

A health equity 'lens' is a set of reflective questions that bring to focus the impact that practises and policies have on shaping the economic, social, and built environments which can lead to health inequities. It can be applied at various stages of commissioning and delivery including assessing community need, determining desired outcomes, designing and implementing solutions, and monitoring and evaluating the effectiveness of those solutions.

To consider equity we will ask the following questions as a minimum before before planning any of our activities:

- **What health inequities and/or related barriers exist in relation to this activity/issue?**
- **How are we involving people with lived experience in this process?**
- **Could the planned activity have a negative impact on some populations or communities? If so, how can the negative/inequitable impacts be mitigated?**
- **How might (intersecting) disadvantage impact how people experience this issue or proposed activity, compared to other people?**
- **How do we better consider the needs of disadvantaged individuals and communities, and priority populations?**
- **How will the activity contribute to addressing barriers to more equitable health outcomes?**

3.5 What can service providers in the North Western Melbourne region do?

NWMPHN acknowledges that many service providers in the North Western Melbourne region have policies and processes in place to actively engage with and adapt service delivery to accommodate individuals who are more likely to experience inequities.

The considerations for service providers include:

1. How they deliver welcoming and appropriate services.
2. How their organisations' internal structures, procedures and policies recognise and embed health equity as a strategic priority.
3. Ensure processes are in place to monitor if unmet need exists.

Table 5. Considerations for service providers

How can providers deliver services that are welcoming and appropriate for each person?	
Cultural safety and responsiveness	• Cultural safety and responsiveness training is provided as part of orientation and performance review requirements. • Information about local diverse community profiles including Aboriginal and Torres Strait Islander communities, common languages and cultures within their service delivery area is readily available. • Staff have a good understanding of the needs and barriers to accessing services for people from diverse backgrounds including Aboriginal and Torres Strait Islander people, people from migrant and refugee backgrounds and people who identify as LGBTIQ. • Employment of staff members reflects the diversity of the local communities including people with lived experience, Aboriginal and Torres Strait Islander people, people from migrant and refugee backgrounds and people who identify as LGBTIQ.
Communication	• Credentialed interpreters are provided via face-to-face, telephone or video conference where appropriate. • Website and advertising materials are clear, meet accessibility guidelines and cater to the multiple language options of consumer groups. • Inclusive and respectful use of language and visuals that reflect the full diversity of the community and avoid stereotypes and assumptions. • Employment of staff skilled in AUSLAN (Australian Sign Language), or provision of training where necessary. • Braille variants of materials are provided, where appropriate.
Person centered service provision	• Different modes of service delivery are provided e.g. outreach, telehealth, group programs. • Services allow sufficient times for appointments to cater for individual needs e.g. need for interpreter, complex needs and mobility restrictions. • Intake, assessment and management processes are culturally appropriate e.g. – Accommodation of specific culture-based needs such as childcare needs, family roles and obligations, dietary needs, religious needs and observations – Sufficient time is taken to build trust and rapport – Cultural, religious, community and family supports are explored as potential protective factors. • Identify consumer needs beyond the presenting issue (e.g. mental health, housing, employment). • Sensitivity to privacy, especially for those services where stigma may exist (e.g. alcohol and other drugs, and blood-borne viruses).
Linkages with other services	• Establish clear referral pathways to other services including general practice (GP) to meet all the needs of consumers (e.g. mental health, housing, employment). • Ensure that the consumer is linked with a local GP.
Welcoming environment	• The environment is culturally safe and welcoming to people from diverse backgrounds. This includes: – Aboriginal and Torres Strait Island flags are displayed – LGBTIQ flag is displayed – Information in other languages is displayed – Information on access to free interpreters is displayed – Posters and other information in the waiting area feature people from diverse communities – All gender and all abilities toilets. • The environment is accessible for people with disabilities including: – Ramp access – Designated and adequate disability parking – Facilities built to accommodate low or nil vision.

Continued over page

How providers can recognise and embed health equity as a strategic priority.

- Include commitment to equity and diversity as an integral part of strategic documents and policies.
- Build knowledge of the demographic profile of the local community.
- Regularly review service usage data and identify who is accessing the services and who is missing out.
- Delivery of cultural awareness and safety training for all staff members.
- Employ staff from diverse backgrounds (including those from disadvantaged backgrounds) at all levels of the organisation including people with lived experience, Aboriginal and Torres Strait Islander people and bi-cultural workers.
- Build working relationships with local diverse communities and community organisations.
- Involve community organisations and people from diverse backgrounds, including people with lived experience in the planning, implementation, monitoring and evaluation of the program.

4.0 Governance, implementation and monitoring

4.1 Governance

The NWMPHN Executive Director, Insight, Performance and Digital Services is the executive sponsor for this Framework and will lead the implementation of the activities and associated actions on behalf of the NWMPHN senior leadership team.

The NWMPHN Access, Equity and Engagement Lead will be responsible for providing day-to-day support for the delivery and management of the specific actions outlined in Appendix A. The lead will work closely with key members of the Reconciliation Action Plan working group and community engagement team to ensure that activities already underway are leveraged and recognised under this Framework, where appropriate.

4.2 Roles and responsibilities to address health inequities

The responsibility to ensure these actions have impact across our region is shared across NWMPHN. The NWMPHN Access, Equity and Engagement Lead has a key role in implementation and monitoring of progress against the priority areas for action, however everyone in the organisation has a role to play as outlined below.

- The Board and senior leadership team can make equity a priority; work with partner organisations to address social determinants of unequal health; involve consumers and groups from disadvantaged communities in planning, service development and in relevant committees; advocate at a local, state-wide and national level to influence policy and strategy.
- Managers can ensure that funded services reach those most in need by reviewing available data and evidence on addressing health inequities. Managers can also ensure that staff have the skills and support to address health inequities and work in a culturally responsive way.
- Program staff can support funded providers and general practitioners to ensure that health services are equitable, culturally responsive and inclusive. Program staff can also ensure that the activities they are involved in are informed by evidence, data and consultations with community members.

4.3 Monitoring and reporting

Addressing health inequities is a complex process and requires long-term commitment. Implementation of the Framework will be monitored as part of the NWMPHN Strategic Planning and Performance Management Framework quarterly reporting process. Implementation progress including key achievements will be included in our Annual Report.

4.4 Supporting tools and resources

A set of key tools and resources (Appendix B) have been identified that can be used in commissioning and other activities to ensure that a health equity lens is being applied.

Appendix A.

NWMPHN Access and Equity Action Plan 2021 – 2024

Show leadership and commitment to equity as a strategic priority

Timeframes:

Short term:
1 year July 2021 – June 2022

Medium term:
to June 2023

Long term:
to June 2024

Ongoing

Objectives

- To demonstrate leadership and commitment to improving health equity in the NWMPHN region.
- To take a systemic and whole of organisation approach to embed an "equity lens" including providing appropriate resourcing to progress equity.

Activities	Actions	Timeframe
1.1 Develop and implement an equity focused approach to resource distribution.	Develop a transparent approach to prioritise the distribution of funds across the organisation. For example, an equity-based resource distribution formula and/or proportionate universalism approach to funds allocation.	**Long term**
	Develop funding models to enable responses that might require additional effort to support access for diverse communities.	**Long term**
1.2 Develop and apply an equity lens into strategic documents, planning, commissioning, reporting and quality improvement processes.	Develop and apply an "equity lens" into strategic documents, planning, commissioning, reporting and quality improvement processes.	**Short term**
1.3 Improve understanding and identification of priority populations through the process of Health Needs Assessment.	Build our understanding across the organisation on how social determinants of health impact people's healthcare access, outcomes and experiences.	**Ongoing**
	Ensure processes are in place that identify priority populations to a deeper level of sophistication for the problems we are trying to solve.	**Short term**

Priority Area 2

Embed equity into everything we do

Timeframes:

Short term:
1 year July 2021 – June 2022

Medium term:
to June 2023

Long term:
to June 2024

Ongoing

Objectives

- To ensure that funded services are equitable, accessible, and culturally responsive.
- To identify and support quality improvement activities that can be undertaken by the funded providers and general practice to address health inequities.

Activities	Actions	Timeframe
2.1 Develop and implement additional equity and diversity focused tools and resources and embed into commissioning processes.	Utilise equity and diversity focussed decision support tools on funding programs that are able to respond to diverse needs.	**Short term**
	Develop a repository of equity and diversity KPIs to be used in all commissioning contracts.	**Short term**
2.2 Support NWMPHN commissioned providers and other services to ensure that services are equitable, accessible, and culturally responsive.	Establish a baseline capability for commissioned providers in relation to equity and diversity – build tools into procurement, selection and contracts.	**Medium term**
	Use a tool to assess funded providers' equitable and culturally responsive practices and to identify areas of improvement.	**Short term**
	Investigate and establish appropriate mechanisms to enable peer-to-peer learning and support regarding good practice for working with diverse communities.	**Long term**

Vinay Cooper - ITC program participant
Photo by John Donegan

Use data and evidence to support action

Timeframes:

Short term:
1 year July 2021 – June 2022

Medium term:
to June 2023

Long term:
to June 2024

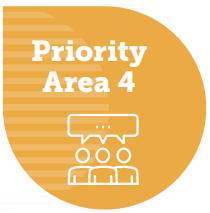
Ongoing

Objective

To use data and evidence to describe heath inequities, translate evidence into practice, and evaluate the impact of interventions on health equity.

Activities	Actions	Timeframe
3.1 Improve data collection systems and reporting requirements to better capture data related to equity and diversity.	Incorporate key lines of enquiry regarding equity into the Health Needs Assessment.	**Short term**
	Develop a "minimum equity data set" to be used by all funded providers.	**Medium term**
	Analyse existing disaggregated data, identify gaps, and supplement gaps with qualitative data e.g. from targeted focus groups.	**Short term**
3.2 Systematically apply an equity lens to evaluation.	Develop equity and diversity baseline and key indicators of success in projects.	**Medium term**
	Establish the evaluation criteria for external consultants to include a weighting for relevant community representation.	**Medium term**
	Incorporate equity and diversity considerations into consumer experience surveys and tools.	**Ongoing**

Collingwood Homeless Services. Photo by Leigh Henningham.



Engage with communities including people with lived experience and partner with collaborators

Timeframes:

Short term:
1 year July 2021 – June 2022

Medium term:
to June 2023

Long term:
to June 2024

Ongoing

Objective

To partner with communities including people with lived experience and organisations representing different sectors to address health inequities.

Activities	Actions	Timeframe
4.1 Build diverse representation within the organisation across governance, leadership, working groups and expert advisory groups.	Ensure diverse consumers including people with lived experience are part of the Community and Clinical Councils and People Bank. Ensure that Community Council members are well connected to diverse communities across the region.	**Short term**
	Ensure diverse experts are part of working groups and expert advisory groups.	**Short term**
4.2 Build partnerships with communities experiencing health inequities and engage with them based on the principles of codesign.	Identify key representative groups for communities of interest in NWMPHN region through strategic mapping.	**Short term**
	Maintain partnerships with key stakeholder groups including different sectors, peaks and representative bodies.	**Short term**
	Ensure NWMPHN participation in representative groups of relevance within the community - including those outside of the health sector.	**Short term**
	Ensure diverse community participants in relevant consultation sessions, forums and events.	**Short term**
	Ensure community participant engagement in all stages of our commissioning process.	**Short term**
4.3 Develop more inclusive community engagement strategies and ensure reporting back to the community.	Ensure transparent reporting back to the community on our work.	**Short term**

Edith James and walking group. Photo by Keith Evans.

Build capacity and skills

Timeframes:

Short term:
1 year July 2021 – June 2022

Medium term:
to June 2023

Long term:
to June 2024

Ongoing

Objective

To build the capacity of NWMPHN staff, funded providers, and general practice to provide equity focused, inclusive and culturally responsive services.

Activities	Actions	Timeframes
5.1 Embed equity and understanding of diversity as key competencies for NWMPHN staff.	Develop clear orientation process for new staff regarding the Framework and its practical application.	**Short term**
	Provide staff with opportunities to improve their understanding of diversity, equity and the impacts of social determinants of health.	**Short term**
	Support staff to build knowledge and understanding of the diverse needs of people in our region through review of demographic data and fostering connections with diverse communities and community organisations.	**Short term**
5.2 Develop and implement equity focused human resources practices.	Capture data on NWMPHN workforce diversity.	**Short term**
	Improve recruitment processes to attract a more diverse workforce, and one that reflects the diversity of the community in our catchment.	**Medium term**
	Ensure diversity of NWMPHN staff reflects the diversity of the community in our catchment.	**Long term**
5.3 Embed equity and diversity as key competencies for funded providers and general practice.	Identify diversity and equity focussed competencies for general practices and funded providers.	**Medium term**
	Identify support needs of GPs and funded providers to undertake quality improvement work in the areas of diversity and equity.	**Medium term**
	Support regular training and other capacity building activities for funded providers and general practice.	**Medium term**

Appendix B. Equity tools and resources

Tool	Description
Health equity lens[1]	A health equity "lens" brings to focus the impact policies and practices have on shaping the economic, social and built environments which can lead to health inequities. It shifts the way we think about our work and make decisions. In essence, it is a set of questions that lead to different actions. The questions include: • Who is affected/impacted? • Have those affected helped to shape this? • Who is included/excluded? • Who benefits and who is harmed? • What are the assumptions taking place? • What does the data tell us? • What data is missing? • Who is/is not at the decision-making table? • What values underlie the decision-making process? • What revisions are needed/what could be done differently?
Equity lens tools[2]	• Equity lens tools are designed to integrate explicit consideration of equity — most often, racial equity – into decisions before they are made and implemented (e.g. policies, programs, plans, and budgets). • The goal is to systematically assess how different groups might be affected by a decision, identify adverse consequences, and propose recommendations to address impacts.
Availability, Accessibility, Acceptability, Quality (AAAQ) Framework[3]	A Framework designed to ensure that healthcare services provide quality services for all people, particularly those who are vulnerable or marginalised.
Barriers assessment (based on Tanahashi Framework)[4]	• The Tanahashi Framework is used to analyse barriers to health services and provides a stepped approach to assessing health service coverage. • The Framework identifies five dimensions of effective coverage: availability, accessibility, acceptability, contact/use, and effective coverage.
Progress and Progress-Plus[5]	PROGRESS – Plus is an acronym used to identify characteristics that stratify health opportunities and outcomes.
Health Impact Assessment[6] and Equity-oriented Health Impact Assessment[7]	Health Impact Assessment (HIA) is a practical approach used to judge the potential health effects of a policy, program, or project on a population, particularly on vulnerable or disadvantaged groups.

1 Minnesota Department of Health: Center for Health Equity
2 *Bringing Light & Heat: An Equity Guide for Healthcare Transformation and Accountability,* Human Impact Partners, July 2021
3 United Nations Office of the High Commissioner for Human Rights, *OHCHR and the right to health*
4 Tanahashi T. (1978). Health service coverage and its evaluation. *Bulletin of the World Health Organization*, 56(2), 295–303
5 The Campbell and Cochrane Equity Group: Cochrane Methods Equity: Rosemary Morgan (Johns Hopkins Bloomberg School of Public Health), Canada
6 World Health Organisation:Health impact assessment
7 Health Impact Assessment Connect, Manuals and Guides

Tool	Description
The Health Equity Assessment Tool (HEAT)[8]	Developed in New Zealand, the HEAT is a planning tool that improves the ability of mainstream health policies, programs, and services to promote health equity.
NWMPHN diversity, community participation and health literacy guidance for tenders (an internal PHN document)	The guidance has been developed and incorporated into the broader set of tender evaluation criteria to ensure that services we fund are accessible and equitable to all, especially to populations who are at increased risk of poorer health outcomes.
Culturally Responsive Assessment Tool (CRAT)	NWMPHN commissioned the Ethnic Communities Council of Victoria (ECCV) to develop a culturally responsive assessment tool for health practitioners. The tool is being piloted with a selection of providers and it is anticipated that a modified version will be available in 2022.
Practical Strategies for Culturally Competent Evaluation[9]	This guide provides important strategies for approaching an evaluation with a critical cultural lens to ensure that evaluation efforts have cultural relevance.

8 The Health Equity Assessment Tool: A user's guide.2008. Wellington: Ministry of Health New Zealand: Signal, L., Martin, J., Cram, F., and Robson, B.
9 Centers for Disease Control and Prevention. Practical Strategies for Culturally Competent Evaluation. Atlanta, GA: US Dept of Health and Human Services; 2014

Appendix C.
National and State policy context

Policy	More information
National	
Multicultural Access and Equity Policy	• The Multicultural Access and Equity Policy is about ensuring that Australian Government programs and services meet the needs of all Australians, regardless of their cultural and linguistic backgrounds. • The policy contains six commitments essential to the effective delivery of government programs and services in a multicultural society. It includes leadership, engagement, performance, capability, responsiveness, and openness. Those commitments align with the domains identified in the NWMPHN Access and Equity Framework.
Embrace Multicultural Mental Health Framework	• The Framework has been developed to support Australian mental health services, practitioners, Primary Health Networks and others to work effectively in a multicultural context. • It is mapped against national standards to help organisations meet their existing requirements. • The domains in the Embrace Framework align with the domains identified in the NWMPHN Access and Equity Framework.
National Women's Health Strategy 2020 – 2030	• The Strategy outlines Australia's national approach to improving health outcomes for all women and girls, particularly those at greatest risk of poor health. • It aims to drive continuing improvement in the health and wellbeing of all women in Australia. It identifies specific actions to address the health issues that affect women and girls throughout their lives and aims to reduce inequities in health outcomes between men and women, and between sub-population groups of women and girls.
Royal Commission into Aged Care Quality and Safety Final Report	• The Commission's final report has a strong focus on equity and diversity, stating that diversity should be core business in aged care. • The final report recommends measures to ensure the aged care system is designed for diversity, difference, complexity, and individuality. Some of the measures include: – the requirement for training in cultural safety and trauma-informed service delivery to be provided for all front line workers in the aged care system. The provision of this training should be a condition of approval of providers. – collection, monitoring and analysis of data about the diverse backgrounds and life experiences of older people seeking or receiving aged care.
Closing the Gap 2020	Closing the Gap is a national framework to achieve equality for Aboriginal and Torres Strait Islander people in health and life expectancy within a generation.

Policy	More information
State	
Everybody Matters: Inclusion and Equity Statement	• The Statement outlines the Victorian Government's 10-year vision for a more inclusive, safe, responsive and accountable family violence system. • Guiding principles of this statement align with the principles identified in the NWMPHN Access and Equity Framework.
Partnering in Healthcare Framework	• The Framework replaced the Cultural Responsiveness Framework and it gives health services practical strategies to improve healthcare and outcomes for Victorians by better involving consumers and their families. • Consumer, carer and community participation is a central part of the NWMPHN Access and Equity Framework.
Fair Foundations: The VicHealth framework for health equity	The Framework is a planning tool for health promotion policy and practice. It outlines the social determinants of health inequities, suggesting entry points for action.
Department of Health Designing for Diversity	Designing for Diversity is an initiative to embed responsiveness to diversity at the outset of any policy reform or service design process. The department recognises that diversity responsive design is critical to ensuring positive and equitable health and wellbeing outcomes for all Victorians.
Royal Commission into Victoria's Mental Health System Final Report	• The Commission's final report has a strong emphasis on diversity and intersectionality. • Some of the themes and recommendations align with and support the NWMPHN Access and Equity Framework such as: – Culturally appropriate care for Aboriginal people including the establishment of an Aboriginal Social and Emotional Wellbeing Centre. – Engagement and co-design approaches with communities in the region to inform Regional Boards and the development of programs/initiatives. – Working in partnership with and improving accessibility for diverse communities. – Co-design and embedding the voice of lived experience of mental health.


phn
NORTH WESTERN
MELBOURNE
An Australian Government Initiative