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# *"I would be very proud to be part of an initiative that didn't exclude people because it was hard"*: mapping and contextualising health equity responsibilities and decision-making tensions in the implementation of a multi-level system reform initiative

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## Abstract

**Background** Health systems face competing demands when implementing health sector reforms. While health equity principles are generally promoted during reform discussions, they are often deprioritised during implementation. This qualitative study aimed to (1) identify how implementers and designers expected health equity to be included in the implementation of a place-based health system reform initiative, and (2) identify factors that influenced prioritisation of health equity during early implementation.

**Method** We conducted eighteen semi-structured interviews in 2022 and 2023 with a purposive sample of senior policy executives, programme managers and clinicians involved in the design and early implementation of a place-based health system reform initiative in New South Wales, Australia. Informed by a grounded approach, data were analysed inductively drawing on a constant comparative approach. Emerging health equity definitions and expectations informed the development of a Theory of Change (ToC) articulating participants' expectations about how health equity was intended to be embedded in the programme. We also identified opportunities and challenges to prioritise action to address health equity throughout implementation, which informed critical appraisal of the ToC.

**Results** We identified diffuse actions and responsibilities to address health equity in this state-wide, place-based health reform, articulating these actions and responsibilities in a ToC. This showed diffuse responsibilities for health equity across system levels. We also identified six critical decision-making tensions that influenced health equity prioritisation during early implementation, reflecting participants' perceptions that health equity prioritisation was in conflict with attention to other priorities. These were equity-efficiency; localisation-capacity for health equity; diffuse

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responsibilities-enforceability; invisible-vocal sub-populations; and health equity-sustainable business models for private providers.

**Conclusion** The distribution of heath equity responsibilities, as we demonstrated through a ToC of a decentralised, place-based reform, present risk to health equity prioritisation. Risks were particularly present when local resourcing and capacity were stretched, and limited policy guardrails were in place to counteract decision-making tensions, such as clear health equity accountabilities, responsibilities, and actions.

**Keywords** Health equity, Policy implementation, System reform, Multi-level health system, Theory of change

## Background

Health equity is often stated as a goal or principle underlying health system reforms and government initiatives, however, despite the often-stated goals or principles, disparities in health continue to persist globally [1–5]. In Australia, inequities continue to persist with life expectancy and other measures of health disparities showing marked differences by Aboriginality, socio-economic status, mental well-being, intellectual ability, and rurality [6–9].

While many determinants of health equity, including social determinants, lie outside the health system [9, 10], health system reforms provide a unique opportunity to address health equity. Prioritising health equity within reform goals is a critical starting point [11]. However, change within health systems is complex, non-linear, emergent and unpredictable [12]. Whether an effective system response that is consistent with prioritising health equity emerges during implementation will depend on decisions taken by those within the system responsible for implementation, and the range of factors influencing these decisions and their execution [13, 14]. Such factors include for example, values and ethical dilemmas of implementers [14–16], and a biomedical care system oriented to addressing individual, rather than population health needs [13, 14].

In this paper, we adopt the definition of health equity proposed by Braveman, Arkin [17], "*Health equity is the ethical and human rights principle that motivates people to eliminate disparities in health and in the determinants of health that adversely affect excluded or marginalised groups. Progress toward health equity is measured by reductions in health disparities*". This is consistent with the WHO conceptualisation of health equity that is operationalised through *"systematically identifying and eliminating inequities resulting from differences in health…"* [18].

In this study we are concerned with how health equity promoting policies and actions can be systematically approached and reinforced within a system during reform efforts, and where and why challenges to health equity prioritisation occur [11, 19–26]. Health equity prioritisation here means the degree to which implementers and designers actively give attention to health equity as part of a broader reform and promote actions to address inequities, such as technical or financial allocation.

In 2020–2021, to address local health priorities in New South Wales (NSW) - Australia's most populous state; the NSW Ministry of Health initiated a statewide, region-based initiative, termed Collaborative Commissioning [27]. Within each region, Regional Alliances were formed to oversee design, implementation, and ongoing operations of the initiative. The Regional Alliances comprised Local Health Districts (LHDs), Primary Health Networks (PHNs) and other local organisations, which are well placed to address local health inequities [22, 28]. LHDs are state funded and governed organisations responsible and accountable for health service planning and population health within their regions [29], while PHNs are federally funded organisations responsible for commissioning and coordinating programmes that support primary health services across a region [30].

The Collaborative Commissioning initiative established locally designed, patient-centred, quality models of care designed to promote value-based healthcare across the hospital and community, with a focus on improved access, quality, and experience [27]. Like many initiatives worldwide [31, 32], the models established under Collaborative Commissioning sought to deliver care closer to home and reduce inappropriate hospital demand. Health equity was a principle embedded in the design of Collaborative Commissioning overall and in each of the agreed locally designed models [27].

In this study we aimed to: (1) identify how implementers and designers expected health equity to be included in the implementation of a place-based health system reform initiative; and (2) identify factors that influenced prioritisation of health equity during early implementation.

## Methods

### Study design

Drawing on a grounded theory informed approach, we conducted a qualitative study using an inductive, constant comparative approach [33]. The purpose of using an inductive approach was the systematic generation of theory from collected data [34]. We started with an area of interest—implementer expectations and early experiences of health equity in implementation of a health reform initiative – and collected and analysed data, allowing relevant ideas to develop without preconceived theories that need to be tested for confirmation.

This meant that we were able to (1) construct a theory of change as an interpretation of how health equity promoting approaches were expected to be included in the implementation of the initiative from the perspective of implementers and designers; and (2) identify factors that influenced prioritisation of health equity during early implementation - also from implementer and designer perspectives. We then used the theory of change as a framework to contextualise and understand the risk to implementation posed by the factors identified in (2).

A theory of change approach was appropriate to our study as this approach seeks to surface 'hidden assumptions' about how change is expected to occur. It is used alongside programme implementation, to promote shared understanding of how a programme is intended to achieve its aims, and to guide monitoring and evaluation [35, 36].

Ethics approval for the study was granted from University of New South Wales Human Research Ethics Committee (HREA Panel D: Biomedical - HC200419).

## Setting

The study included three regions across New South Wales, Australia's most populous state. Collaborative Commissioning in each region was contracted under the same policy with the NSW Ministry of Health (statewide), but each region had a distinct programme focus and population characteristics (Table 1). The Regional Alliance in the single rural region comprised an alliance between four organisations, in one metropolitan region it comprised an alliance between two organisations, and in the remaining metropolitan region the initiative was delivered solely through the PHN.

## Interview design

We developed a semi-structured interview guide (Appendix A, Additional file 1) informed by existing health equity implementation frameworks [39] and team discussions [40]. The interview guide was designed to elicit local stakeholder expectations, actions, needs, and perceived barriers to addressing health inequities in the initiative [24]. We structured questions through a backward facing mapping approach, starting with eliciting participant perceptions of the intended outcomes of the initiative [41]. This method also elicited understanding of process, assumptions, beneficiaries, and strategic choices [42]. The order was critical, so that topics relating to perceived barriers or challenges did not influence the responses relevant to developing a theory of change (ToC). We intentionally did not provide a definition of health equity to participants, but sought to elicit their understanding of health equity as it related to the programme being implemented. We did not provide examples of specific population groups because we were interested in the categories and definitions provided by participants in relation to the health equity intent of the reform.

### *Recruitment and participants*

Data collection occurred in 2022 and 2023, corresponding to the first year of implementation of Collaborative Commissioning in each region. Participants were eligible to take part in the study if they were policy makers, managers or senior clinicians engaged in design or implementation of Collaborative Commissioning in any of the three participating regions, or at a state level.

Within these broad groups, we sought to include participants holding different roles in the initiative, from the different participating organisations, and at all levels of the health system (state, regional level and health provider level), to obtain variance in perspectives. We leveraged the support of programme leads to snowball sample additional participants to reach stakeholders that were not included in the initial sampling frame [40, 43]. We continued recruitment until stakeholders from all participating organisations were interviewed. As part of the recruitment process, background information on the research team and aims of the study were provided to all participants. Participants were aware that the

**Table 1** Study regions and organisations included

| Location | Organisation | Programme focus | Population |
|---|---|---|---|
| Rural region | Western NSW LHD<br>Far West NSW LHD<br>Western NSW PHN<br>Rural Doctors Network | Diabetes management and identification | High proportion of Aboriginal people and populations spread across a geographically vast area. |
| Metropolitan region | Northern Sydney LHD<br>Northern Sydney PHN | Frailty | A proportionately large elderly population in a highly affluent metropolitan region. |
| Metropolitan region | Western Sydney PHN | Urgent care centres | A highly culturally and linguistically diverse population, and rapidly growing population. |
| Statewide | NSW Ministry of Health | Overall initiative (Collaborative Commissioning) | All populations mentioned above. |

Population details are informed by the NSW Government Population projections [37] and Australian Census data 2021 [38] information they provided would be used to report on the programme they were involved in.

#### *Data collection*

The lead author (TB) conducted all interviews in-person or virtually through Microsoft Teams (Microsoft, Seattle, WA). Interviews ran for 30 min to one-hour and were conducted one-to-one except for one interview, which was done with two participants together at their request. All participants provided recorded verbal informed consent for interview. All interviews were recorded through Microsoft Teams (Microsoft, Seattle, WA), which also established initial transcriptions of interviews. Transcriptions and notes were cleaned by the lead author prior to being uploaded into NVivo 14 (QSR International, Melb, Vic).

### Data analysis and reporting

Within a grounded theory approach, we used an inductive constant comparative method, which involved a process of comparing incident to incident, incident to concept, and concept to concept [34, 44]. Two members of the team inductively coded the data (TB, SP). The team double coded the initial five transcripts, followed by single coding and reviewing each other's work for the remainder. Emerging codes and proposed key concepts were iteratively discussed among the broader research team (TB, DP, DN, SP and GS) and refined. Final concepts were then categorised under the key interview topic areas including health equity conceptualisation, initiative expectations, actions, decisions, and challenges associated with ensuring health equity.

Drawing on the key concepts related to health equity conceptualisation, initiative expectations, actions, and decisions, we developed a draft ToC detailing where health equity promoting actions were expected to occur at each health system level, and what was required for these actions to occur. Regular discussions were held within the team (TB, DP, DN, and GS) to refine the ToC, and participants were consulted on its' final design.

To identify factors influencing health equity prioritisation during implementation, we drew on the concepts that were coded under 'challenges with health equity prioritisation'. We checked these for coherence, and considered relationships between the concepts, refining the labels through team discussions, and in consultation with participants. We have reported the study in accordance with the Consolidated criteria for reporting qualitative research (COREQ) framework (Appendix B in Additional file 1) [45].

**Table 2** Participant characteristics

| Demographics | Counts |
|---|---|
| Role | |
| *Senior executive/general manager/executive manager* | 4 |
| *Director/senior programme manager* | 4 |
| *Programme manager* | 8 |
| *Clinical lead* | 2 |
| Regional responsibility of participant's role | |
| *Regional and rural (Western and Far West NSW)* | 10 |
| *Metropolitan (Northern Sydney or Western Sydney)* | 6 |
| *Statewide* | 2 |

### Research team

The research team are independent to the organisations involved in programme design and implementation. The team has a balanced gender, age and experience split with 3 females and 3 males. The lead author TB is a researcher with extensive experience working with health system designers, decision-makers, and implementers, having previously worked in various health policy and programme operation roles. DP is a senior clinician researcher, GS an evaluation specialist, DN is an experienced equity researcher, SP is a medical student, and SAP is an experienced health systems researcher. All team members have worked in NSW other than DN who is based in India. The interviewer (TB) was known to 8 of 18 participants through his role as Research Associate with the broader independent evaluation of Collaborative Commissioning that is being conducted by our team.

## Results

In total, 18 interviews were conducted (Table 2). Four people invited to participate were not interviewed due to changing job roles during the recruitment period (three), and not responding to an invitation (one person). Interviewees were professionally trained in managerial positions overseeing the programme development and implementation.

### How health equity was expected to be promoted in Collaborative Commissioning – through a theory of change

Across the interviews, participants described health equity in relation to Collaborative Commissioning in various ways (Appendix C, Additional file 1). Overall, three conceptions of health equity were apparent. Health equity was framed as (1) a location-based concept, with different priorities based on the local population; (2) reaching hard-to-reach populations and supporting people based on their needs; and (3) relating to health and access disparities between specific population groups.

These conceptualisations of health equity shaped the framing of the ToC, which expressed how designers and implementers expected health equity to be promoted within Collaborative Commissioning as implementation progressed (Fig. 1).

Through the process we took to develop the ToC, it became clear that the NSW Ministry of Health sought

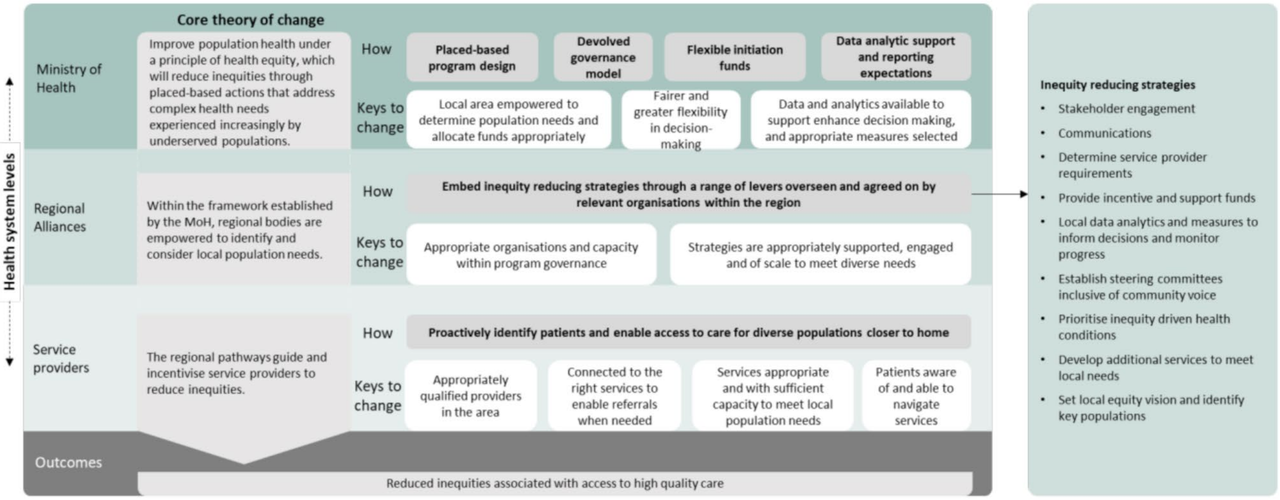

**Fig. 1** Theory of change: addressing health equity within a system reform initiative

to embed an overarching principle of health equity into Collaborative Commissioning. Actions to promote health equity were expected to occur through a place-based design, which involved a transfer of powers to Regional Alliances under a decentralised governance model, recognising that "*equity would be a different challenge and a different process in every single not just location, but pathway… It happens very early in the process of working with the partnerships…And that was what this was all about, local partnership empowerment*" (Participant 2).

The NSW Ministry of Health also provided modelling support to guide the selection of performance indicators, funding, and set the broad health outcome expectations. These allowed for regional discretion on programme focus and funding allocation. Achieving the NSW Ministry of Health aspirations for decentralised governance – that, it was theorised would promote health equity - depended on empowerment of Regional Alliances, appropriate dispersal of funds, fair and flexible decision-making, and data support ('keys to change' in Fig. 1).

Regional Alliances could self-determine their approaches to address health equity and used a range of strategies to do so. For example, one region enhanced consumer voice with consumer engagement training, to support consumers to better engage with government discussions. "*We've supported them through attending consumers Health Forum Australia conferences and really giving them the tools to be able to contribute in a meaningful and valuable way*" (Participant 5). Another region tailored communication for diverse populations. "*Ads were put onto the radio in their native tongue, and we did that with multiple languages*" (Participant 6). Other strategies mentioned included using data to guide consideration of underserved populations, establish support funds and incentives, and an explicit local health equity vision. Some Regional Alliances contracted specialist organisations to deliver technical or consumer engagement activities supporting design or delivery of their strategies.

Responsibility for ensuring health equity was often left to service providers to manage. Some responsibilities were explicit, such as meeting minimum care delivery standards including cultural competency and disability accessibility. Some implementers and designers expressed views that service providers would address relevant patient needs related to the local initiative, and by extension health equity – however, the expectation around health equity responsibility did not appear to be made explicit in their agreements or discussions with service providers. Some Regional Alliances provided supports for clinicians and patients to navigate care pathways through connections to other support services (e.g. translation services for non-English speakers). "*If a patient calls… they are not disadvantaged because they speak another language, they're able to get in touch with the translator*" (Participant 6). Other service providers were provided discrete funds that programme managers could use to resource health equity. "*We want to provide GPs with additional support, but what it is that they need to manage that patient isn't clearly outlined, so if they were to need a translator. There's nothing stopping them from using the funding that we provide them for that*" (Participant 3).

In general, there were few supports provided to service providers to explicitly address health equity, despite expectations of service providers to do so in the model. Expectations were framed around proactive identification and access to care for diverse patients.

### *Health equity responsibilities and accountabilities*

Through the process of developing a ToC, we identified diffuse responsibilities for ensuring health equity across

**Table 3** Decision-making tension dichotomies influencing health equity prioritisation during implementation of Collaborative Commissioning

| The six decision-making tension dichotomies | Tension description |
|---|---|
| Health equity-efficiency | Situations in which health equity prioritisation is considered to conflict with achieving efficiency in programme delivery |
| Localisation-capacity for health equity prioritisation | Shared local responsibility for design, planning and implementation of Collaborative Commissioning (while anticipated in programme design to be a vehicle through which health equity would be addressed) absorbs local capacity, leaving little capacity left for health equity prioritisation |
| Diffuse responsibilities in devolved governance - Health equity enforceability | Promoting devolved governance encourages diffuse responsibilities and decision-making on health equity and this conflicts with enforceability for health equity |
| Invisible populations - Vocal populations | Developing strategies to meet the needs of 'invisible' groups is seen to be in conflict with meeting the needs of populations and communities who are already connected to the health system and vocal about having their needs met |
| Health equity-health workforce scarcity | Shortage of health providers is considered to be a constraint that needs to be addressed before health equity prioritisation can be considered |
| Health equity-sustainable business models in general practice | In our study setting, general practices, while subsidised by the Federal Government, operate as private businesses, who set their own fees for service users; prioritising health equity, including delivering fee-free services, is perceived to conflict with sustainable business models for general practice |

health system levels, captured by the *How* at each system level within the ToC (Fig. 1). For the most part, responsibilities for health equity were not made explicit beyond the health equity principle of the initiative, and the decentralised approach. All other responsibilities were expected to be self-determined as the model progressed. "*Specific discussions around [health] equity haven't really happened. It's just kind of assumed that it [sic.] will*" (Participant 1). Each system level also managed how they addressed health equity promoting responsibilities, captured in Fig. 1 as *keys to change.* Actors at each level of the system tended to take on actions that played to their strengths and could self-determine the scale of their actions to promote health equity.

Overall, aligning with the devolved governance framing, few health equity accountabilities were explicitly built into the model. As an example of this, we were unable to determine any health equity targets established for service providers, Regional Alliances, or the NSW Ministry of Health to report against. The main accountability we identified, was one health equity related service agreement requirement. "*As part of the [service agreement] sign-off, within there is a kind of checklist of what… to achieve… There is the one equity thing that's spelled out in there is [sic.] around Aboriginal impact statement" (Participant 1).* As it stands, the initiative relies on self-appointed health equity responsibilities, and requires sufficient motivation for implementers to overcome potential health equity prioritisation challenges.

Thus, to achieve an effective response for health equity within this this system reform, Regional Alliances, programme designers and implementers at all levels each needed to explicitly prioritise health equity. Challenges that they experienced in doing so are identified below.

### Factors that influenced prioritisation of health equity during early implementation

From our analysis of interview data, we identified six common situations that resulted in challenges to health equity prioritisation. We describe these as *decision-making tension dichotomies* (Table 3). We use the term *decision-making tension dichotomy* as it reflects the divisions evident between two opposing or different phenomena. In our study, addressing health equity during the implementation of Collaborative Commissioning was described by participants to be at odds with, or in opposition to another key aspect or requirement of implementation – this tension creates a constraint to health equity prioritisation. Challenges to addressing health equity described by participants often presented as ethical decisions framed in conflict, whereby attention to health equity was perceived to be at the expense of attention to another priority. For example, "*to get out of that development phase as fast [as possible]… a lot of the easy things to step aside are like equity*" (Participant 1).

### Health equity-efficiency

A perceived conflict between health equity prioritisation and demonstrating programme efficiency was described by participants in relation to a need by both Regional Alliances and NSW Ministry of Health to demonstrate that service targets agreed to between the NSW Ministry of Health and the Regional Alliances were being met. Participants at both state and regional levels considered that a solution to this tension was to sequence programme focus (achieving scale, then promote health equity). They also recognised that there were flaws in this approach, including distorting which service providers the Regional Alliance would select to work with.

*"It kind of comes down, unfortunately, to how quickly can we get this contract signed and how quickly can we get*

*patients through the door. And not really concerned about who they are and getting the balance right. We can sort that out later...which is not ideal, but it's just how it plays out a lot of the time"* (Participant 1).

*"It's going to be very tempting to pick really well functioning practices with lots of people already on their book... You can go for those big numbers, so it looks like we're achieving these milestones"* (Participant 9).

Some participants expressed the view that addressing health equity would come at a cost that could not be justified until the economic viability of the model overall was established, and a supporting structure was in place. *"From an economic sense, that's [addressing health equity] not necessarily feasible in the first instance. So, what we're trying to do is say, OK, let's get this out... Let's get some runs on the board to... prove that there's value in this service. And then as part of the structure, once we've done that, now we want to focus on these communities"* (Participant 5).

Implicit in these sentiments was a notion that once the care delivery model achieved critical mass, health equity could be more actively explored in subsequent stages. "*There is a balance, maybe sometimes between operationalising just an initiative in and of itself, and then considering equity*" (Participant 17). However, we found that protections to health equity prioritisation could be maintained from strong local leadership. *"If we're going to do this properly, equity has to be a fundamental part of it... it would be easier for us to crank out the numbers and ignore the really hard places. But we know we're committed to all of that" (Participant 17).*

### Localisation-capacity for health equity prioritisation

Devolving responsibility for design, planning and implementation of care pathways to the Regional Alliances was valued by the Alliances as a vehicle through which health equity could be addressed. However, for some participants, the work required at regional level to make this happen, absorbed available capacity, leaving little capacity for health equity prioritisation. For example, the work needed to establish a shared vision between organisations was described as precluding health equity prioritisation during early implementation.

*"We all say that, yes, absolutely, these things [addressing health equity] need to be done right from the very beginning. But sometimes the challenge is trying to create that vision and understanding between...parties"* (Participant 4).

Another participant suggested that by allocating already constrained local resources to prioritise health equity, other aspects of the programme would suffer. "*Sometimes you don't have the resources, so in order to give time to something you have to give something else up. So, if we're talking about the access and equity issue... What are you dropping to put this up to the top?*" (Participant 15).

However, while some local capacity constraints were in conflict with health equity prioritisation, other aspects of local capacity – specifically community partnerships, and regional leaders committed to health equity - were seen to be protective of prioritisation. Local partnerships with communities, and recruitment of a community engagement officer to the programme, was described by participants in one of the regions as enabling the community engagement that was needed for health equity prioritisation.

*"I'm working with some of our cultural leader groups... So, utilising those contacts and leveraging that... Now's our chance to really make a difference in those vulnerable populations" (Participant 5).*

The same Regional Alliance allocated project funds to support Aboriginal community engagement.

"*We've got our own Aboriginal health and well-being team... we're going to have members of that team using funding we've got, to go out and be a part of this engagement*" (Participant 11).

Furthermore, local leadership in the region promoted a shared vision and strong commitment for health equity.

*"I would be very proud to be part of an initiative that didn't exclude people because it was hard" (Participant 9).*

The shared commitment to health equity in the region seemed to stem from the shared experience of living in rural areas where access barriers were very apparent.

"*I think that [health equity is] ingrained in us out here... we feel like it's not equitable... So, I feel like it's very much on our radar, when you're not in a major city, when you have health concerns yourself or family members with health concerns, it's pretty obvious that things are not equitable*" (Participant 18).

For this decision-making tension dichotomy, combined 'protective factors' of community links, and strong local leadership committed to health equity helped to mitigate effects of other local capacity constraints on health equity prioritisation.

### Diffuse responsibility in devolved governance - health equity enforceability

A tension was experienced between the promotion of devolved governance and health equity enforceability. The architecture of Collaborative Commissioning in which programme responsibility, and responsibility for ensuring health equity was spread across different actors at different system levels, was a challenge to health equity prioritisation during implementation. Through the decentralisation of decision making and responsibilities, priorities shifted across regions resulting in less priority given to health equity *"...other pressures that come along like... what does this mean for my budget? What's* *the long-term commitment I'm signing up for?... How does that look to me politically?... Are we doing what we say we're doing?"* (Participant 12).

Furthermore, state ability to enforce accountability for health equity was diminished because of the devolved governance approach. While health equity was a principle in the design of Collaborative Commissioning, without clear lines of accountability, it became a 'checklist item' that could easily be put aside due to perceived competing priorities. "*Part of the issue has been... It's all urgent now, we need to get this done. So, I think those kind of checklist issues [related to health equity] get dropped off the list and not seen as important"* (Participant 1).

The tension between devolved governance and health equity enforceability appeared to be moderated by the system structures through which funding and decision-making is made. The Ministry of Health and Regional Alliances were constrained in their ability to undertake actions to address health equity (e.g. community engagement), when these processes did not easily fit into annual funding cycles. These structures exerted pressures on implementers' capacity to prioritise health equity. *"The financial year cycle is the bane of our existence... unfortunately, meeting health needs doesn't work to the financial year... some engagement takes longer...but the money has to be spent. So, it's a dreadful driver of perverse behaviour... particularly hazardous for things that are softer at the perimeter, like for example community engagement"* (Participant 2).

### Invisible populations - vocal populations

There was a perceived conflict between addressing the needs of different sub-population groups, with participants expressing concerns that by addressing the needs of the most vocal, they would be neglecting the needs of the more 'invisible'.

Prioritising one sub-population over another, was described by participants as being influenced by service sectors outside of the health system that advocate for some sub-populations, usually the most vocal, and not others. *"A lot of those multi-organisation conversations are around people that are causing someone a problem. That's how they get onto the list. They're not the person that's quietly living under the bridge... usually police, or housing put their hand up and say we need to talk about this person's circumstances"* (Participant 10).

While more vocal groups have clear and urgent needs, these arrangements led to prioritisation of select populations to the detriment of actions to identify and meet the needs of populations who were less vocal. *"We know that there's a number of people out there who have very limited engagement with the health system... so we're going to be missing probably the most disadvantage and the most vulnerable patient cohort that might be out there because we're just not going to have that contact"* (Participant 9).

At the same time, sub-populations that were either small or less vocal was seen to make it harder to prioritise activity to reach that population.

*"[this area] for instance, might not be particularly focused on Aboriginality because the population is pretty small [in the area]... And potentially not as visible and vocal... So, they can kind of lose a bit of focus on prioritising activity around making sure that things are equitable for them or not. It... falls off their radar."* (Participant 1).

### Health equity-workforce scarcity

For some participants, addressing health equity in implementation of Collaborative Commissioning was contingent on finding solutions to workforce shortages in particular geographic regions. For these participants, workforce challenges needed to be addressed first, before consideration of health equity, relegating health equity to a second order consideration contingent on successful recruitment and retention of the workforce. *"There's been a lot of conversations about equity of access for our rural and remote regions where the services don't exist. So that is a huge barrier, which is a workforce challenge as well. We just do not have some of the services in some of the regions"* (Participant 16).

We also found that discussion on health equity would often shift to discussions on workforce challenges, particularly in rural areas. Health equity concerns became concerns of geography, without consideration of the sub-populations or communities in the areas. "*We have problems with workforce for GP, everybody does. Ours are worse because they don't want to be here, they want to be in Sydney where their families are"* (Participant 11). The issue was summarised succinctly by Participant 1 - "*When you're worried about engaging your clinicians and signing up your GP's... having those discussions and getting your model of care kind of worked out. Those kinds of issues around... who are the patients and how are you going to engage with them... kind of get lost a little bit".*

### Health equity-sustainable business models in general practice

Each of the Regional Alliances sought to incorporate general practice into their local models of care. In so doing, the Regional Alliances and the general practices were confronted with a tension between private business operation requirements and preferences and health equity prioritisation.

These tensions arise due to the nature of Australia's primary care funding structure, where GPs as private businesses, have discretion to charge a gap-fee above the government funded rate, which is then passed on as an out-of-pocket charge to the patient [46, 47]. Ultimately, the nature of the funding structure passes on ethical decision-making to service providers, who must decide between meeting business needs and promoting equitable access and outcomes.

*"There are practices that go no, you can't come here unless you're going pay a copayment, and if you can't, you just need to get your health somewhere else…You gotta understand that they are running a small business. They've got people, livelihoods as well as people's health dependent on them"* (Participant 11).

This decision-making tension is particularly pronounced for rural areas, where a lack of competition driven by low supply of GPs, means that the GP may be the only one in a small town or area.

*"Here you have higher complexity on average, so you'll need a longer consult, and then that affects the business model. You might have gaps… because… smaller patients mean… higher variability and presentations… If your throughput is your only revenue source, which it is… then the business risks are high, plus the cost of the workforce is higher"* (Participant 12).

As a result, the current funding model risks exacerbating health inequities through embedding perverse incentives that are more readily accessible to providers who manage the 'ideal user'. *"The payment…that's linked to those outcome measures… works really well for compliant, treatment adhering patients who don't necessarily have the social barriers and challenges to attend"* (Participant 17).

Implementers experienced decision-making tensions between supporting local practice and health equity prioritisation due to the inability of primary care businesses to easily adapt to meet local needs. Despite financial incentives offered in some regions, the incentives were not always sufficient to incentivise GPs to engage in addressing the needs of vulnerable populations, either because the funding was insufficient or because other constraints precluded their participation or support.

*"We will usually offer to that practice… to provide the clinic that we will fund, and if they decline, we will… bring in a visiting service, and that sometimes upsets people, even though we offer them to provide the service. I have responded to more than one ministerial because some of these people have the local MP [member of parliament] on speed dial… we really don't want to disrupt or make local health services unviable. We really want to support them, but when you're trading that off against vulnerable needs population…"* (Participant 12).

As a result, certain care models have had to compromise on health equity prioritisation and revise the programme to meet the needs of private business models. For example, one participant described having to adjust the model in favor of private business interests, and potentially delaying patient care.

*"We have to apparently give the patient time – The first half of the day to be able to call their GP and if they happen to call [the programme service]… before that time, they're not allowed to be referred [to the programme service]… because they have to be referred back to their GP"* (Participant 8).

In some cases, the programme helped to support fee-free primary care by supporting practices to optimise their Medicare billing, and by providing practice support payments to general practices that helped to cover out of pocket costs that would otherwise be incurred by patients under the programme. *"The general practices are either MBS reimbursed, or it's topped up for additional activities that may not be paid by Medicare. We've taken cost out of the equation, which is a huge disadvantage for a lot of people" (Participant 2).*

Some participants from a Regional Alliance described that it was necessary for some general practices to change established ways of working if the programme was to be accessible to underserved groups. They described advocating with general practices to allow walk-in patients, rather than the status quo of requiring all patients to have pre-booked appointments.

"*We've had to advocate very, very loudly… to be able to have walk-in patients*" (Participant 8). Programme managers perceived their advocacy as a critical element to the model to enable access for population groups who would otherwise not access the services.

## Discussion

Through the theory of change, we captured actions and responsibilities to address health equity in a state-wide, place-based health reform in New South Wales, Australia, and identified six critical decision-making tensions that influenced health equity prioritisation during early implementation. Our study contributes to the body of literature examining health equity benefits to decentralisation of governance and place-based initiatives [48]. We extend this body of work through identifying that supportive system structures, capacity and funding across system levels is needed for postulated benefits to be realised. We also show that without attention to these issues, there are risks that decentralised reforms may exacerbate health inequities, despite often being well suited to address them.

Our use of the theory of change approach to reflect implementers and designers' understanding of how health equity would be addressed through Collaborative Commissioning, found that responsibilities to address health equity were diffuse and distributed across system levels, with limited accountability for health equity at each level. Similar to Doherty, Quinn [49], who explored health equity in a place-based intervention, we found that early principles for embedding health equity in

Collaborative Commissioning became less visible over time.

Our framing of the factors influencing prioritisation of health equity during early implementation as 'decision-making tension dichotomies' was the best fit for our data. Decision-making tensions were framed ultimately as X contingent on Y, rather than exclusively binary X or Y. This concurs with the notion that while dichotomous framing "simplifies complex relationships", it instils a hierarchy of values [50]. In our study, implementers perceived that during the initial period before the latter option is considered, the options were mutually exclusive – and actions to address health equity tended to be deferred in favour of the 'other' option. Thus, our findings suggest that dichotomous framing risks increasing inequities.

Similar to the findings of Marcellus, Pauly [13], we found that much of the responsibility for health equity in Collaborative Commissioning devolved to the service provider level. That policy implementation ultimately comes down to the people (the 'street level bureaucrats') at the service level is well recognised [51]. Our findings suggest that if service providers are to successfully navigate their responsibilities towards prioritising health equity in implementation, the tensions they experience in doing so need to be addressed.

A review of the UK Clinical Commissioning Groups published nearly a decade ago found that local autonomy and decision-making enabled by the decentralised approach, did not provide sufficient incentives for implementers to address health equity [1]. Our finding - that supportive system structures, capacity and funding are needed if health equity is to be effectively incorporated in a decentralised policy reform - concurs with those of others. For example, studies highlight the need for a shared understanding of what health equity means in the local context, indicators to measure health equity, supportive guidelines and strategies, accountability, co-ordination, leadership, and ring-fenced health equity funds as enablers for health equity prioritisation [23, 52–55].

Our study findings suggested several factors appeared to mitigate the decision-making tensions experienced during implementation. For example, our data showed that regional leadership was particularly important in navigating the decision-making tension '*localisation-capacity for health equity*', with committed leadership helping to keep a focus on health equity despite local capacity constraints. Importantly, shared recognition and understanding of the diversity of needs helped overcome the tendency towards addressing the '*ideal user*' or '*general population*', which is often the outcome of initiatives through the implementation process [56].

Incentives available to general practices through some of the Collaborative Commissioning regional models, appeared to mitigate the *health equity-sustainable business model* tension but were seen by some participants to work less well for practices where patients experienced social challenges to attend for care, thus risking amplifying inequities. The need for incentives to be structured in a way to avoid perpetuating inequities has been highlighted by others [57], although little is known about how to best incentivise quality and equity for resource-limited providers [58].

In our study setting where responsibilities for community, primary and acute care are spilt across Federal and State levels, system structures, capacity and funding for embedding health equity in policy needs to be acceptable and appropriate to a range of local health system actors who have different accountabilities, different models of operation, and in the case of general practices, a high degree of autonomy.

There are several implications of our study for policy, practice and research communities. Firstly, at all levels of the health system, real or perceived ethical decisions had consequences on prioritisation of health equity. Without a unifying concept of health equity, and diffuse health equity responsibilities, a range of health equity related decision-making tension points occurred throughout implementation.

Second, our framing of challenges to health equity prioritisation as decision-making tension dichotomies invites reflection by health system policy makers, programme designers and implementers regarding whether two poles of each 'tension' really are mutually exclusive, and needing to be sequenced, or if both could be addressed in tandem to more effectively achieve programme goals. For example, in relation to the equity-efficiency tension dichotomy, where a programme goal is to reduce avoidable emergency department utilisation through enhanced community care, priorities often shifted to volume rather than need. Concerningly, no participants commented on the potential risk that prioritising volume over need may exacerbate or entrench inequities over the short-to-medium term. There is an argument that a 'deliberative process' can exist that recognises both as necessary to achieve the required outcomes [59]. In many cases, tensions present dual initiative requirements rather than a conflict.

Third, our finding that in this devolved governance reform, much of the responsibility for decisions about health equity prioritisation devolved to service providers who faced unique decision-making tensions in relation to incorporating health equity, suggests that policy makers need to pay particular attention to facilitating prioritisation of health equity at the service provider level. While we identified several decision-making tensions experienced by service providers in our study setting (*Localisation-capacity for health equity prioritisation*, *Invisible* *populations - Vocal populations*, *Health equity-health workforce scarcity*, *and Health equity-sustainable business models in general practice*), further research may be needed to identify commonalities and differences in how service providers experience these and other tensions in promoting health equity across different health system contexts.

Fourth, our findings, and those of others, that quality incentives for general practice will not on their own be sufficient to incentivise health equity, coupled with the particular challenges of engaging autonomous providers in a policy reform, invites health system policy makers and program designers to retain a focus on general practice engagement for health equity, not just engagement as the goal. This implies ensuring that incentives work for resource-limited practices, not only those that are high performing, and including patient-level equity indicators in monitoring and performance targets.

Finally, our finding that there was a decision-making tension dichotomy between '*invisible-vocal populations*' raises questions about the role of health system managers in determining which population groups to include in health equity prioritisation.

### Strengths and limitations

Our study had strengths and limitations. Our study which sought to elicit the views of senior policy executives, programme managers and clinicians responsible for designing and implementing the policy, was necessarily limited to the people occupying these roles, and these did not include people from historically marginalised populations.

Participants' views may have been influenced by cognitive bias, with the result that we may not have identified all possible factors influencing health equity prioritisation – particularly if participants were not aware of them. Similarly, our research team, while having cultural and gender diversity, and decades of experience working closely with historically marginalised populations across a diversity of contexts, does not include members who are necessarily part of marginalised populations, which also may have limited our interpretation of the data. These limitations were mitigated through an open-ended qualitative data collection guide, by a reflexive and iterative approach to data analysis, and by the oversight of this study by a health equity consumer reference group including diverse members capturing a range of ages, experience, ethnicity, and interests.

While the lead interviewer (TB) and research team had some pre-existing working relations with several of the interviewees, this likely promoted more honest responses, as participants were clear on the interviewer's position and how the information captured would be used. It is also important to note that this study forms part of a broader research project focused on evaluation of Collaborative Commissioning, and perspectives of consumer and sub-population groups will be reported elsewhere.

A key strength of our study is the presentation of the ToC alongside an in-depth analysis of decision-making tensions. The novel approach captured responsibilities and expectations across a multi-level system, while also providing contextual details on how and why the risks identified were occurring.

During the period of the study, there were two contextual changes that may have influenced health equity prioritisation in Collaborative Commissioning. First, the health system was still undergoing a period of adjustment following the COVID-19 pandemic response, so health system managers may have been at capacity managing change, and second, there were changes in government at both federal and state levels, which may have resulted in changed priorities and programme emphasis. While a study undertaken at a different time may have resulted in greater (or lesser) attention to health equity prioritisation during implementation, the theory of change and the decision-making tension dichotomies that we identified were not explicitly linked to these contextual changes. Further, contextual changes are a reality in implementation of policy reform, which underscores the need for supportive structures, funding and resources that can help an initial focus on health equity to endure.

## Conclusion

While place-based initiatives with devolved governance present opportunities to address local needs, there are associated health equity risks shaped by the distribution of health equity responsibilities. In our study, risks were particularly evident when local resourcing and capacity were stretched, and limited policy guardrails are in place to counteract decision-making tensions, such as clear health equity accountabilities and strategies. Mitigation factors at all levels can safeguard health equity prioritisation and goal preservation against challenging decision-making tension adjudication within a place-based reform initiative. However, careful consideration of health equity clarity and framing, accountabilities, responsibilities, and resourcing appear necessary to ensure health equity prioritisation and mitigate delays to health equity action.

## Supplementary Information

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Additional file 1: Description of data Appendices

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### Author contributions

TB, DP, DN, GS designed the overarching study and interview design. TB conducted the interviews, TB and SP coded and analysed the data. TB, DP, DN, GS, SP reviewed the coding and analysis of the data and interpretations. TB prepared Fig. 1, and led drafting of main manuscript text with contributions from DP, DN, GS, SP, and SAP. All authors held discussions to guide interpretations of the findings, figure design, review the paper, and maintain quality control, in addition to editing contributions. All authors have read the final manuscript, and have approved the final version for submission.

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### Data availability

The interview transcripts and recordings from this study are not available due to the sensitive nature of the content and difficulty anonymising the data. Significant attempts have been made to include detailed quotes in the paper in lieu of full data release. Specific requests may be directed to the lead author, to consider feasibility.

## Declarations

### Ethics approval and consent to participate

Ethical approval was granted by the University of New South Wales Human Research Ethics Committee (HREA Panel D: Biomedical) on 11 May 2022 (HC200419, Protocol titled "Developing a Theory of Change for Collaborative Commissioning in New South Wales, Australia"). The study was conducted in compliance with the Helsinki Declaration. Participants provided verbal informed consent prior to their participation in the interview.

### Consent for publication

All authors approved the final manuscript and the submission to this journal.

### Competing interests

The authors declare no competing interests.

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## Publisher's note