VCCC Alliance

Overcoming cancer together

CANCER EQUITY FRAMEWORK

Acknowledgements

The Cancer Equity Frameworks reflects a significant investment of time, energy, and critical thinking of many people. This includes the clinical staff, researchers, educators, members of key health and cancer organisations and consumers we interviewed and consulted with throughout the project.

Over the past 2.5 years many people have contributed to the project, and we thank all who have been involved but are not named here.

Special acknowledgements to Vijaya Joshi, Beverly Woon, and Tilini Gunatillake for their work in initiating the project, developing the methodology, and conducting the stakeholder interviews that form the foundation of the framework. Major recognition to Jennifer Philip and Kalinda Griffith for their significant intellectual contributions and guidance to the project team throughout. Appreciation to Lesley McKarney for providing outstanding support in the final stages. We also thank the Equity Advisory Group for their contributions. Heartfelt gratitude to the consumers on VCCC Alliance's health equity governance groups – Tess Marotta, Clarel Philbert, Jo Cockwill and Melissa Sheldon – for their invaluable insights and for ensuring that the consumer perspective is central to the framework. Finally, a special thanks to Alice Tinning, who took over leading Phase One of the project and the development of this report.

This project has been supported and funded by the Victorian State Government.

Note: *Generative AI was used to copy-edit this report. A full draft was developed before AI was employed, and no new ideas or concepts were introduced during the editing stage.*

Table of Contents

Chapter 1: Introduction

1. VCCC Alliance Vision

The vision of the VCCC Alliance 2024-2029 Strategy (the Strategy) is to save lives through the integration of cancer research, education and patient care driven by improvements in prevention, detection, treatment and survivorship for all. Building on progress and achievements resulting from the programs established in the Strategic Program Plan 2021-2024 (SPP), the VCCC Alliance will continue working to decrease the cancer burden and further improve outcomes for all cancer patients in Victoria. All Victorians should have access to world-class cancer care closer to home, fast-track to new therapies, better care through upskilling of health workers, and benefit from utilisation of new technologies to link data particularly between primary care and hospitals to improve early detection. Patient-centred care will be championed to be at the forefront in each Victorian health service, helping hospitals care for complex cancer patients facing intersecting disadvantages. Clinical research will be embedded into routine care, and new models trialled for early palliative care for regional Victorians with cancer.

The VCCC Alliance will achieve this vision by working on five strategic areas:

1. Collaborative research – to bring the best minds and organisations together to turn research into better cancer outcomes.
2. Data and technology – to drive better sharing of data and knowledge, and use of technology, so patients benefit from latest evidence and advance.
3. Equitable care and outcomes – to ensure ALL patients have access to optimal care.
4. Patient-powered – to integrate diverse consumer perspectives to improve research and care.
5. Leadership and learning – to upskill, support and inspire the cancer workforce to deliver world-leading outcomes.

2. Overview of Cancer Equity Framework

Australia has made significant strides in cancer outcomes through advances in early detection, comprehensive public health initiatives, and improved access to high-quality, evidence-based care. However, despite having some of the best cancer patient outcomes globally, persistent inequities remain within the Victorian cancer sector. The lack of quality data on priority populations limits a full understanding of unwarranted variations in diagnosis, treatment, and support, preventing resources from being targeted to those most in need.

Inequitable access to high-quality, evidence-based cancer care disproportionately affects specific populations, with disparities evident across race, ethnicity, geography, and other demographic and socioeconomic factors. Recognising that these disparities stem from the interaction between social determinants of health (SDOH) and systemic inequities is essential for progressing beyond identifying disparities to achieving health equity in advocacy and research.

The persistent and pervasive health disparities witnessed in cancer care, driven by inequitable access and systemic barriers, highlights the urgent need for action. The Cancer Equity Framework was developed to provide a road map to address these disparities by embedding equity into cancer care, research, and education and training.

While there are examples of excellent work addressing inequities, the health system—and particularly the cancer sector—needs resources and capacity to meet the needs of patients facing multiple and intersecting disadvantages. As individuals move through different areas within the cancer care sector, a comprehensive, whole-of system approach is crucial to effectively address and mitigate inequities.

At the policy level, this commitment is reflected in the Australian Cancer Plan (2023-33), the Victorian Cancer Plan (2024-28), the National Aboriginal Community Controlled Health Organisation's Cancer Plan, the Victorian Aboriginal Community Controlled Health Organisation's Cancer Journey Strategy, and the Victorian Aboriginal Research Accord. At the service level, individual organisations have introduced initiatives to close healthcare gaps for underserved populations, including language-specific educational materials for clinical trials, ethno-specific support groups for patients and carers, and tailored resources for the LGBTIQA+ community in cancer care.

Empowering cancer researchers and services to integrate an equity lens provides a valuable opportunity to drive systemic change and reduce disparities in cancer outcomes. Preliminary scoping indicates that, while many health equity resources exist, there are no comprehensive tools for embedding health equity within cancer research, workforce training, or service delivery.

This Framework serves as a guide for the VCCC Alliance to collaborate with health services, educators, researchers, consumers, and communities to co-design and create the activities and resources necessary to help leaders, educators, researchers, and practitioners systematically apply an equity lens to cancer care and research.

3. Aims of Cancer Equity Framework

1. Develop a Cancer Equity Framework to help health services, the cancer workforce, and researchers identify the factors driving disparities in service delivery and outcomes across the entire cancer care continuum (current stage).
2. Create practical tools and guides to aid in the development and implementation of health equity strategies, and pilot these across various health services (next stage).
3. Facilitate collaborative efforts within the VCCC Alliance and beyond to address inequities and identify examples of good practice across the alliance for potential adaptation and scaling (next stage).

4. Purpose of Cancer Equity Framework

The Cancer Equity Framework provides a strategic approach to transforming perceptions, knowledge, and practices to improve cancer treatment and outcomes for individuals facing disadvantage and discrimination. This approach aligns with the Optimal Care Pathways, addressing all stages of the cancer journey, including screening and prevention, early detection, investigation and referral, diagnosis, treatment and care, managing recurrent disease, and end-of-life care.

By utilising the Cancer Equity Framework, our vision is for health services, researchers, and education providers to systematically apply an equity lens to cancer care, laying the groundwork for the long-term goal of improved inclusion and health outcomes for those disadvantaged within current cancer care systems.

5. Outputs of the Cancer Equity Framework

1. **Current Stage (2024-2026):** Establishing a framework that enables health services, the cancer workforce, and researchers to integrate an equity lens into their core activities to address disparities in service delivery and cancer outcomes.

2. **Second Stage (2026-2028):** Developing practical tools and guides to support the formulation and implementation of health equity strategies that align with the framework.

3. **Ongoing:** Fostering collaboration and knowledge-sharing within the VCCC Alliance and beyond, leveraging collective efforts across the sector.

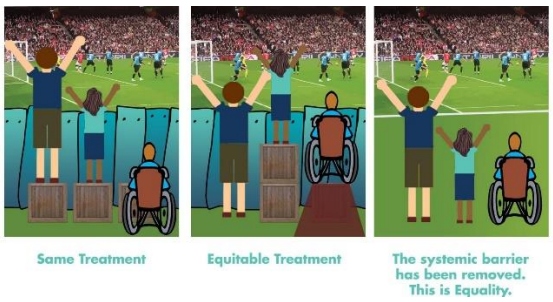
Chapter 2: Building a shared understanding through foundational concepts to advance health equity

A key principle guiding the Cancer Equity Framework (the Framework) is the importance of fostering a common understanding. A shared understanding of a problem enables more effective collaboration in creating solutions. Our understanding of health inequity is central to conceptualising, measuring, and addressing this issue. The Framework incorporates foundational concepts related to health inequity that require widespread comprehension within the cancer sector to develop effective strategies for addressing disparities. These concepts can be complex and are not consistently covered in health services, educational institutions, or medical research settings. Equity work requires ongoing self-reflection and self-awareness, representing a continuous journey of learning and unlearning. The purpose of this section is to support the cancer workforce in building a common understanding of the underlying drivers of disadvantage and discrimination contributing to health inequity.

1. Equity vs. equality

It is essential to distinguish between equity and equality. Whilst equality means each individual or group of people is given the same resources or opportunities. Equity recognises that each person has different circumstances and allocates the exact resources and opportunities needed to reach an equal outcome. A widely recognised illustration depicts three individuals with unequal access to viewing a soccer game.

Figure 1: Demonstrating Equity v's Equality (Center for Story-Based Strategy and the Interaction Institute for Social Change)



When each person is given an equal-sized box, the ability to see the game remains unequal. An equitable approach, however, provides everyone with the resources required to achieve an equal outcome. The third illustration, representing justice, addresses the root causes of inequality by removing systemic barriers. This approach ensures sustainable, equitable access for all in the future.

2. Health Equity

The World Health Organization (WHO) defines health equity as "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically, or geographically" (WHO, 2024). Similarly, the Australian Cancer Plan describes health equity as "the absence of disparities for people with different levels of social advantage" (Australian Cancer Plan, 2023).

In developing this framework, we have adopted a comprehensive definition of health equity, which not only identifies the issue but also informs remedial action. It addresses the social, economic, environmental, and structural inequities contributing to health disparities among different groups.

> *"Health equity means that everyone has a fair and just opportunity to be as healthy as possible. Achieving this requires removing obstacles to health, such as poverty and discrimination, and addressing their consequences, which include*

powerlessness and lack of access to good jobs with fair pay, quality education, housing, health care, and safe environments" (Braverman et al, 2018).

3. Health Disparities

In this report, the terms "health disparities" and "health inequity" are used with the implicit understanding that differences in health may be avoidable and unfair. The definition of 'health disparity' is crucial to how we conceptualise and measure this issue (Braverman 2006, Keppell et al., 2006). However, there is no universal agreement on the meaning of 'health disparity' or related terms like 'health inequality,' 'health inequity,' or 'social inequalities,' which are subtly synonymous yet conceptually distinct. The term 'equity' conveys clear associations with fairness and justice, while 'equality' emphasises equivalence (Merriam-Webster).

Disparities may or may not be discussed with the assumption that health differences are avoidable and unfair. Since health differences are not inherently 'inequitable' or 'unequal,' using the term 'health disparities' is appropriate when addressing the broad range of factors contributing to health differences. Additionally, health disparities affect sub-populations that face ongoing, systemic barriers to health and healthcare, with health equity defined as the absence of these disparities (Braverman and Gruskin 2003).

While estimating the extent of disparities caused by unfairness and injustice is complex, there is a pragmatic understanding that disparities exist when sub-populations experience preventable variations in disease burden. This operational definition identifies three key components for assessing disparities: the sub-population(s) of interest, the health measure to be evaluated (health indicator), and the chosen disparity metric to compare the health indicator between the sub-population(s) and the reference groups.

4. Health as a human right

A human rights approach to health equity calls for a fair distribution of the resources essential for health, including determinants such as living and working conditions, as well as medical care. Ratifying human rights agreements "obliges governments to direct special effort toward equalizing the rights of vulnerable groups facing more obstacles to realizing their rights" (Braverman et al., 2011).

Under international human rights agreements, signatory governments are obligated to respect, protect, fulfil, and promote the rights of all individuals. Australia, as a signatory, has ratified key international agreements recognising the right to health. This includes *The International Covenant on Economic, Social, and Cultural Rights,* which acknowledges "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Article 12) and the *Universal Declaration of Human Rights*.

"Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing, and medical care and necessary social services" (Universal Declaration of Human Rights, Article 25.1).

5. Root causes of inequity

The root causes of health inequity are diverse, complex, and interconnected. Understanding these underlying factors is essential for developing interventions that not only address immediate health disparities but also target the systemic issues perpetuating inequity.

5.1 Social determinants of health (SDOH)

Globally, the social determinants of health significantly influence health inequities including in Australia. Across countries with varying levels of national wealth, a consistent pattern emerges; lower socioeconomic status is associated with poorer health outcomes. According to the World Health Organization (WHO), social determinants account for 30–55% of health outcomes (WHO, 2023). The example in Figure 2 represents a broadly accepted model, describing SDOH grouped across 7 key domains.

"The social determinants of health (SDoH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems" (The World Health Organization, 2023).

Figure 2:

The Social Determinants of Health

(adapted from National Academies of Sciences, Engineering, and Medicine, 2016)

Economic Stability	Neighbourhood and Physical Environment	Education	Food	Community and Social Context	Early Life	Health Care System
Employment Income Expenses Debt	Housing Transportation Safety Parks Walkability	Literacy Language Early Childhood Education Vocational Training Higher Education	Access to healthy options Hunger	Social integration Support systems Community engagement Discrimination	In-utero environment Physical development Social and emotional support	Health insurance Provider access Quality of care

We know poverty is associated with poor health:

- Poor education and literacy are linked to poor health status, and affect the capacity of people to use health information;
- Poorer income reduces the accessibility of health care services and medicines;
- Overcrowded and run-down housing is associated with poverty and contributes to the spread of communicable disease;
- Poor infant diet is associated with poverty and chronic diseases later in life; and
- Smoking and high-risk behaviour is associated with lower socio-economic status.

(Australian Human Rights Commission, 2007)

These social determinants are a legacy of the historical treatment of marginalised and excluded groups. The ongoing poverty and inequality that such groups experience reflect this historical context. The persistent health disparities they face can be attributed to systemic discrimination.

5.2 Structural inequities

Structural inequities arise when disparities in wealth distribution, resource availability, and access to power are reinforced by entrenched social, economic, and political systems that have developed over time. These systems create power imbalances by allowing certain groups to establish rules, either intentionally or unintentionally, that exclude others from wealth, resources, and power.

Systems such as housing, education, employment, healthcare, and criminal justice have historically favoured certain groups while disadvantaging others, leading to inequalities among racial, gender, socioeconomic, LGBTQI+, and other marginalised groups. These systems perpetuate inequity and discrimination, including racism, sexism, classism, ableism, xenophobia, homophobia, and transphobia, reinforcing patterns of exclusion and marginalisation (NASEM, 2017).

For instance, Aboriginal and Torres Strait Islander peoples have historically been denied access to well-paying jobs, educational institutions, and affluent neighbourhoods (Australian Human Rights Commission). In contrast, non-Indigenous Australians have accumulated wealth, education, and high-status jobs that were systematically denied to Indigenous communities. Research indicates that these socio-economic disparities significantly contribute to the gap in health outcomes between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians.

Recognising structural influences shifts the focus from blaming individuals for poorer outcomes to understanding the systems that shape these outcomes, regardless of personal choices or efforts (Amemiya et al., 2022).

5.3 Reconfiguring the social determinants of health framework to include the root cause (structural discrimination)

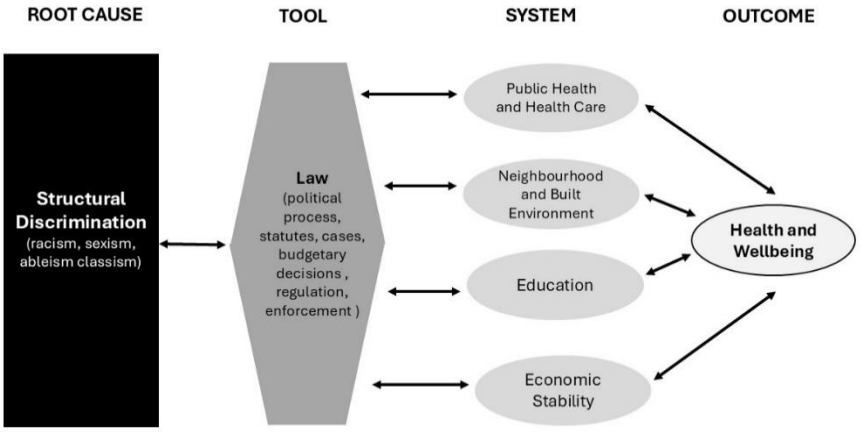
Yearby et al. (2020) have put forward a reimagined social determinants of health (SDoH) framework, identifying the root causes and mechanisms that structure systems in discriminatory ways, leading to health inequities (see Figure 3). Versions of the SDoH framework, such as the one depicted in Figure 2, present a widely accepted model, emphasising key factors like education, income, and housing that shape health status. However, these frameworks often fail to explicitly address systemic barriers and power dynamics that perpetuate inequalities and impact overall health outcomes.

While this version was proposed to address structural racism, the reimagined SDoH framework also addresses all forms of structural discrimination that contribute to disparities in health outcomes among marginalised groups, including those based on race, gender, socioeconomic status, and the LGBTQI+ community. Structural discrimination refers to how systems—such as healthcare, education, employment, housing, and public health—are organised to favour the majority while disadvantaging racial, ethnic, and other minority groups (Yearby et al., 2020).

This revised SDoH framework enables a deeper understanding of the connections between structural discrimination, laws, systems, and health disparities. For instance, the traditional SDoH framework acknowledges that inequities in employment systems are linked to health disparities, but it may not fully explore the root causes of these inequities. In this example, the updated framework encourages an examination of the underlying factors contributing to inequities within employment systems, such as lower income and economic instability, which perpetuate health disparities. This approach aims to guide more effective strategies for addressing these issues (Yearby et al., 2020).

Figure 3:

Structural Racism and health disparities; reconfiguring the social determinants of health framework to include the roots cause (reproduced from Yearby et al., 2020)



Expanding on this employment example, in Australia, individuals from Culturally and Linguistically Diverse (CALD) backgrounds are more likely to occupy the lower end of the household income scale. Data indicate that 26% of those born in non-English speaking countries fall within the lowest 20% income group, compared to 18% of individuals from major English-speaking countries (ACCOS, 2024).

Barriers to employment significantly limit the economic participation, income, and job security of CALD individuals. Many find themselves in low-paid and low-skilled positions that fail to reflect their qualifications and prior experience. The historical impact of discriminatory policies and related practices has left a lasting legacy of discrimination, also affecting the employment opportunities for second- and third-generation CALD Australians. Despite local qualifications and cultural assimilation, non-Anglo individuals continue to face systemic barriers to employment and career advancement (Breunig et al., 2023).

This ongoing structural discrimination, or racism, is the root cause of inequities in employment systems and contributes to health disparities among people from CALD backgrounds, as well as other historically marginalised groups. Economic instability resulting from lower incomes is linked to poorer health outcomes (Australian Human Rights Commission, 2007), and the same discriminatory dynamics observed in employment systems are also present in health systems. Racism within employment systems leads to a lack of diversity in the healthcare workforce, especially in senior roles. Research suggests that a diverse health workforce can improve access to care and patient outcomes (LaVeist and Pierre, 2014). Addressing racism, as the root cause of these inequities, must therefore be prioritised to advance health equity.

6. Cultural determinants of health

The World Health Organization recognises “culture, customs, and traditions” as key factors influencing individual health and well-being. For Aboriginal and Torres Strait Islander peoples, health is deeply connected to culture, community, and self-determination. Stronger connections to culture and Country are linked to better health and social outcomes, while self-determination is associated with greater overall well-being (Verbunt et al., 2021). Similarly, many Culturally and Linguistically Diverse (CALD) communities in Australia have health practices closely tied to cultural beliefs. However, these practices often receive limited recognition within the broader Australian context. Individuals from diverse backgrounds may encounter stigma related to their cultural practices and beliefs, which can create barriers to accessing appropriate healthcare.

Cultural determinants of health emphasise a holistic approach to health and well-being, as is particularly evident within Aboriginal and Torres Strait Islander culture. Connection is a key component, acknowledging the significance of kinship and the connection to Country—physically, spiritually, and

through traditional knowledge sharing and storytelling. Cultural determinants such as family kinship and community, self-determination, Indigenous beliefs and knowledge, connection to Country, Indigenous language, and cultural expression and continuity are all strongly associated with positive health and well-being outcomes for Aboriginal and Torres Strait Islander peoples (Verbunt et al., 2021).

These cultural determinants are interconnected and fundamental to Aboriginal and Torres Strait Islander ways of knowing, doing, and being. They recognise the inherent strength of Aboriginal and Torres Strait Islander peoples and the principle of self-determination to foster improved outcomes at all levels, including influencing positive change at individual, structural, political, and cultural levels (NAACHO 2023).

7. Commercial Determinants of Health

"The Commercial Determinants of Health are the private sector activities impacting public health, either positively or negatively, and the enabling political, economic systems and norms."(World Health Organization)

Commercial determinants of health (CDoH) are a significant social determinant, referring to the actions, or inaction, of commercial actors that impact health. The practices of commercial actors can positively impact health and equity by ensuring fair access to essential goods and services and by providing safe, secure working conditions and employment. However, as former WHO Director-General Margaret Chan noted, "efforts to prevent non-communicable diseases go against the business interests of powerful economic operators" (WHO, 2013).

Current systems enable commercial entities to engage in practices that create environmental risks, promote unhealthy products and choices, and contribute to increasing levels of preventable ill health and health inequity (Kickbusch et al., 2016). See Table 1 for some examples of positive and negative actions by commercial actors. This dynamic allows certain commercial actors to generate substantial profits and accumulate wealth and power while reducing the capacity of governments and non-government organisations to hold them accountable. These entities use their growing influence to shape norms, systems, and policies that support health-damaging practices, prioritising profits over the well-being of individuals, society, and the environment.

Addressing the influence of commercial practices on health is crucial for advancing health equity. Achieving transformative change requires creating a system in which the commercial and public sectors collaborate to improve the health of both people and the planet.

Table 1:

Examples of positive and negative actions by commercial actors

(adapted from the World Health Organization's comprehensive discussion of Commercial Determinants of Health)

Examples Positive Influence	Example of Negative Influence
• Expanding the availability of essential medicines and health technologies, while enhancing access to safe, effective, high-quality, and affordable medical products • Reformulating goods and products to minimize harm and injury, such as implementing seat belts in vehicles, reducing salt content in food production, and eliminating trans fats from the global food supply	• Corporate decisions in the production, pricing, and targeted marketing of products like breast-milk substitutes, ultra-processed foods, tobacco, sugar-sweetened beverages, and alcohol contribute to diseases such as cardiovascular disease, type 2 diabetes, certain cancers, hypertension, and obesity • Intensive animal agriculture is a major driver of climate change, deforestation, antimicrobial resistance, and environmental pollution of air, soil, and water. Consumption of animal-derived food products is associated with increased rates of noncommunicable diseases, including certain cancers and diabetes

8. Impacts of colonisation

> *"Indigenous health research and the brutal history of colonialism in Australia are forever entangled: they are not identical, merged, parallel, nor independent, but intricately and variously enmeshed" (D. Thomas 2004, cited in Johnstone, 2007).*

Aboriginal and Torres Strait Islander peoples continue to experience the most significant health disparities of any population group in Australia. These disparities are deeply entrenched in the country's colonial history. Historical and contemporary policies and practices originating from British colonisation have profoundly impacted Indigenous health outcomes. Colonisation's effects are intergenerational, with its legacy permeating across generations of Aboriginal and Torres Strait Islander people (Griffiths et al., 2016).

Since colonisation, the systematic violation of Indigenous human rights has had a lasting impact on the social and emotional well-being of Indigenous individuals, families, and communities, contributing to an unacceptable gap in health equity. The disruption of traditional lifestyles, loss of land, cultural dislocation, and breakdown of social structures, combined with the introduction of Western medical practices, have eroded traditional knowledge and practices essential for maintaining physical, mental, and spiritual health. This legacy includes adverse social determinants of health, such as poverty, limited healthcare access, and poor nutrition (Australian Institute Health and Welfare). Addressing this issue requires non-Indigenous healthcare workers and researchers, as well as the institutions that support them, to acknowledge the connection between the current state of Indigenous healthcare and Australia's colonial history (Johnstone, 2007).

Aboriginal and Torres Strait Islander communities often face barriers to accessing timely and culturally appropriate cancer screening and treatment services, resulting in late-stage diagnoses and poorer prognoses compared to non-Indigenous Australians. Challenges are particularly pronounced in rural and remote areas, where there are fewer services—such as specialist care—and workforce shortages compared to urban centres (Sanjida et al., 2022). Historical trauma and ongoing systemic racism further contribute to distrust in healthcare systems that have historically marginalised these communities (Durey & Thompson, 2012).

Systems and structures built on the colonial legacy have also led to a lack of representation in cancer research, limiting the development of targeted prevention and treatment strategies that address the

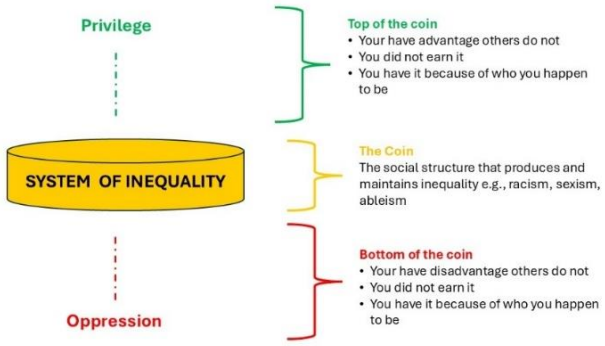
unique needs of Aboriginal and Torres Strait Islander peoples. Addressing these inequities requires integrating Indigenous perspectives into cancer care and policy and ensuring culturally safe and accessible healthcare services.

9. Understanding and practicing critical allyship

While it is crucial to understand inequities as the unfair consequences of systems that create disadvantage, fostering transformative change also requires recognising how these same systems grant unearned advantages, or privileges, to certain groups, thus contributing to health inequities. Nixon's (2020) Coin Model of Privilege and Critical Allyship (see Figures 4 & 5) offers a framework to understand how systems of inequality—such as sexism, racism, and ableism—interact to produce both privilege and oppression.

> *This is "a call to action for all working in health to (1) recognise their positions of privilege, and (2) use this understanding to reorient their approach from saving unfortunate people to working in solidarity and collective action on systems of inequality"* (Nixon, 2019).

Figure 4:
The Coin Model of Privilege and Critical Allyship (reproduced from Nixon, 2019).

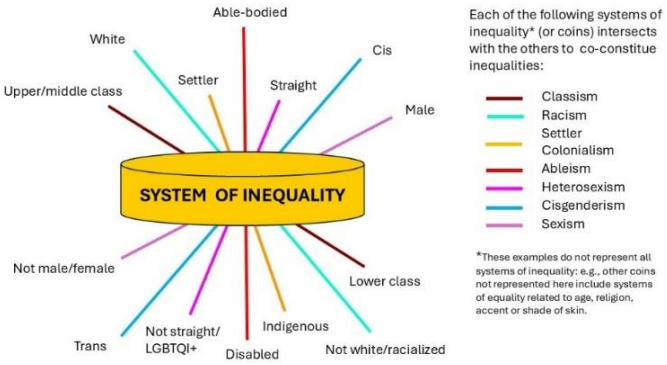


Each coin represents a different system of inequality that sustains and reproduces inequity. Individuals are "on top of the coin" if they align with the norms of that particular system. For example, able-bodied individuals are at the top of the coin of ableism, and white individuals are at the top of the coin of racism. This top position grants unearned advantages not linked to merit but rather to alignment with historical structures of privilege.

Conversely, individuals are at the "bottom of the coin" if they do not align with these norms. For instance, disabled individuals are at the bottom of the coin of ableism, and non-white individuals are at the bottom of the coin of racism. This bottom position results in unearned disadvantages, not due to a lack of merit but due to alignment with historical structures of oppression.

Figure 5:

The intersecting nature of the coins which produce complex patterns of advantage and disadvantage (reproduced from Nixon, 2019).



The aim is not to shift people from one side of the coin to the other but to dismantle the coin (the system of inequality) that creates these unfair advantages and disadvantages. Systems of inequality maintain the status quo largely when those in privileged positions are unaware of their role in perpetuating these systems. Recognising one's position on the top of the coin is crucial to becoming a critical ally working in solidarity to dismantle these structures.

People within the health system who hold privileged positions generally do not intend to cause harm. However, it is not the intent but the impact that matters. A lack of awareness among those at the top of the coin can have profoundly harmful consequences. Building the capacity to identify and understand privilege requires both learning and unlearning, which can be an uncomfortable process. Embracing the responsibility to challenge dominant norms that uphold systems of inequality is essential to critical allyship (See Table 2 on Practicing Critical Allyship).

Addressing privilege can evoke feelings of guilt when individuals confront the unearned advantages, they hold by being at the top of the coin. These feelings may lead to discomfort, denial, or distancing from the issue, sometimes referred to as "white fragility" in the context of racism. The Coin Model encourages examining how focusing on guilt can either reinforce or dismantle systems of inequality. When attention centres on guilt, it can shift the focus to the needs and feelings of those at the top, inadvertently reinforcing inequality by overshadowing the needs and experiences of those at the bottom.

Table 1:

Practicing Critical Allyship (sourced directly from Nixon and Gidey, date unknown)

PRACTICING CRITICAL ALLYSHIP
Practicing critical allyship means rejecting an orientation of saving, fixing or helping people on the bottom of the coin. Rather, it means embracing the following commitments: 1. I see and understand my own role in upholding systems of oppression that create inequities. 2. I learn from the expertise of, give credit to, and work in solidarity with, people on the bottom of the coin to help me address inequities. 3. This includes working to help build insight and mobilise action among people in positions of privilege. 4. I mobilize in collective action under the leadership of and with accountability to people on the bottom of the coin to dismantle systems of inequality.

10. Data equity principles

The Principles for Using Public Health Data to Drive Equity, developed by the CDC Foundation, is an excellent resource providing insights into the "why, how, and what" of health data collection. The" why" behind health data collection is foundational: data gathered with an equity focus helps identify health needs across populations, especially among underserved communities, empowering policymakers and health systems to recognise and respond to these unique needs. Making equity a core motivation for the

"why" also enables data practitioners to design collection methods that address disparities and promote inclusivity.

How data is collected influences its usefulness and relevance. Equitable practices throughout the data life cycle—such as incorporating community perspectives, broadening data categories to capture social determinants, and ensuring data democratisation—are key (See Table 2). Data democratisation, or making data accessible and understandable, is crucial for fostering community engagement and building trust in public health systems.

What is collected determines the narratives the data can tell; selecting meaningful indicators beyond traditional health metrics provides a fuller view of health equity. When the why, how, and what of data collection align with equity goals, public health initiatives can more effectively address health disparities and drive meaningful, systemic change (CDC Foundation).

Table 2:
Five Equity Principles to apply throughout data life cycle (sourced directly from CDC Foundation)

To eliminate health inequities, organizations and individuals should incorporate the following five equity principles throughout the entire data life cycle, from project and research conception to data use, dissemination and action.

1. Recognise and define systemic, social and economic factors that affect individual health outcomes and communities' ability to thrive.
2. Use equity-mindedness as the guide for language and action in a continual process of learning, disaggregating data and questioning assumptions about relevance and effectiveness.
3. Proactively include participants from the communities of interest in research and program design to allow for cultural modifications to standard data collection tools, analysis and sharing.
4. Collaborate with agencies and the community to generate a shared data development agenda ensuring a plan for data completeness, access and prioritized use to answer high-interest questions.
5. Facilitate data sovereignty by paving the way for communities to govern the collection, ownership, dissemination and application of their own data.

11. Understanding Intersectionality

Inequities are compounded when people experience overlapping forms of discrimination or disadvantage based on attributes such as Aboriginality; age; disability; ethnicity; gender identity; race; religion; regionality; income and social status; and sexual orientation.

12. Being Patient Centred

Patient-centred care emphasises partnerships in health between patients and healthcare professionals. This approach views patients holistically and acknowledges individual preferences and seeks to move beyond the traditional paternalistic approach to health care. Patient and carer centred care is more than just how healthcare professional treats individuals. It is also about how healthcare services and governments create and support policies to put healthcare users, not healthcare organisations, at the centre of care.

13. Being Trauma Informed

Being trauma-informed is essential for advancing health equity in Australia, as it acknowledges the pervasive impact of trauma, particularly for Aboriginal and Torres Strait Islander peoples and other marginalised groups. Historical and systemic factors—such as colonisation, racism, and socioeconomic inequality—have created significant health disparities that are intergenerational and deeply embedded in

social structures (Atkinson 2013). Trauma-informed care recognises that such experiences can affect physical, emotional, and mental health, influencing how individuals interact with healthcare systems.

Trauma-informed care must integrate both organisational and clinical practices to fully address the complex impact trauma has on patients and providers alike (See Table 3). While well-intentioned healthcare providers often invest in training clinical staff in trauma-specific treatment approaches, many neglect to implement wider organisational changes necessary to truly support trauma-informed care. A holistic trauma-informed model involves creating environments where all staff are equipped to understand and address trauma's effects, ensuring that policies, procedures, and daily interactions are aligned to promote safety, trust, and empowerment for both patients and staff (Menschner and Maul, 2016).

*" Trying to implement trauma-specific clinical practices without first implementing trauma-informed organizational culture change is like throwing seeds on dry land" (*Sandra Bloom, MD, Creator of the Sanctuary Model cited in Menschner and Maul, 2016*)*

Table 3:
Key Ingredients for Creating a Trauma-Informed Approach to Care
(sourced directly from Menschner and Maul, 2016)

Organisational	Clinical
• Leading and communicating about the transformation process • Engaging patients in organizational planning • Training clinical as well as non-clinical staff members • Creating a safe environment • Preventing secondary traumatic stress in staff • Hiring a trauma-informed workforce	• Involving patients in the treatment process • Screening for trauma • Training staff in trauma-specific treatment approaches • Engaging referral sources and partnering organizations

14. Strengths based approach

A strengths-based approach shifts the focus from solely examining the challenges faced by communities to recognising their capacities and resilience. This perspective moves away from deficit discourse, which often results in persistent negative portrayals of groups or communities, reinforcing harmful stereotypes and fostering discriminatory attitudes and behaviours. Deficit discourse can have adverse effects, leading to the internalisation of negative beliefs by members of the targeted group, contributing to low self-esteem, psychological distress, and reduced motivation to engage in health-promoting behaviours. Emphasising gaps and problems can, paradoxically, exacerbate existing inequities rather than addressing them (Thurber, 2021).

In contrast, a strengths-based approach considers who is thriving, who is facing challenges, and what is effective or ineffective. This approach shifts attention from risk factors to protective factors, focusing on elements that promote health and wellbeing. The aim is not to disregard problems or ignore existing inequalities but to refocus research and policy on identifying strengths and enabling factors within individuals and communities and finding ways to build on and extend these to achieve positive outcomes (Thurber, 2021).

In cancer research, strengths-based approaches can enhance collaboration with patients and communities, enabling researchers to gain valuable insights into cultural and environmental factors influencing health behaviours and outcomes. This collaborative approach enhances the relevance of research findings and empowers communities to contribute actively to generate knowledge and in the application of research findings. Engaging Aboriginal and Torres Strait Islanders and other marginalised populations in research

can help identify culturally specific strategies for prevention and treatment, leading to more effective interventions to address health disparities.

By focusing on what communities and the cancer workforce can achieve together, a strengths-based approach empowers individuals and communities to take control of their health, fostering more sustainable health improvements.

15. Health Equity is not a zero-sum game

Health equity is not a zero-sum game, rather it is a collective effort that improves outcomes for all individuals and communities. The zero-sum perspective suggests that one group's gain in health equity necessarily results in another group's loss. This misconception can prevent progress toward a more equitable health system. Achieving health equity requires collective action and commitment from multiple sectors, recognising that everyone has a shared interest in achieving better health outcomes. By rejecting the notion of a zero-sum game, we can work together to build a healthier, more equitable future for all.

Chapter 3: Priority Populations and current state of inequities

Priority Populations

Throughout the report, we will adopt the definitions and terminology for priority populations as outlined in *The Australian Cancer Plan* (2023-33). It is important to acknowledge that individuals may identify with or belong to multiple priority groups, and this intersectionality can lead to compounded impacts of structural, social, cultural, and environmental determinants of health on cancer experiences and outcomes.

It is essential to recognise that identifying as part of a priority population facing disadvantage and discrimination does not define an individual. Individuals from these populations are leading productive, purposeful, and meaningful lives. It is equally important to acknowledge their unique experiences, as well as those of their carers, families, and supporters. The purpose of identification is to ensure the system can adequately respond to specific areas of need.

Current State of Inequities

The following section draws on data from *The Australian Cancer Plan* and the Australian Institute of Health and Welfare (AIHW), highlighting the lack of comprehensive health and cancer data for priority populations in Australia. Limited and inconsistent data collection impedes accurate assessments of the cancer burden and outcomes among groups such as Indigenous communities, culturally and linguistically diverse populations, LGBTIQA+ individuals, and those living in rural and remote areas. This data gap restricts the development of targeted interventions and policies to enhance cancer care and outcomes. Addressing this issue requires improved data collection and reporting frameworks to better capture the diverse experiences and needs of priority populations across Australia.

The lack of research on and with these groups compounds the inequitable experiences and outcomes faced by these groups. A snapshot analysis undertaken by the VCCC Alliance in 2021 identified the paucity of funded cancer research on and with priority populations. Across the Medical Research Future Fund, Australian Research Council, and National Health and Medical Research Council grants schemes, the VCCC Alliance found that between 2016 and 2020, less than 1% of grants were awarded to research focusing on Aboriginal and Torres Strait Islander populations and culturally and linguistically diverse groups.

The following section provides an analysis of the negative impact of the social determinants of health on specific populations, where data is available. There are several other groups experiencing inequity in cancer care and outcomes that are not discussed in detail here. These include individuals who are homeless, who face unique challenges such as limited access to healthcare services, delayed diagnoses, and higher rates of comorbidities. Those who use illicit drugs often encounter stigma, reduced engagement with the healthcare system, and inadequate support for managing their health. Similarly, people who are incarcerated face barriers to timely cancer screening, diagnosis, and treatment due to systemic gaps in correctional healthcare services.

1. People from lower socio-economic groups

Income, educational attainment, and occupation level are three social determinants of health commonly used to measure socioeconomic position. As stated by the Australian Institute of Health and Welfare (AIHW 2024) “in general, every step up the socioeconomic ladder is accompanied by a benefit for health.” According to the latest available data, approximately 10% of the population lived in low-income households in 2017–18.

Educational attainment affects occupation level, which subsequently influences income status and health outcomes. Higher educational attainment is associated with increased total incomes and more diverse sources of income. Compared with their socioeconomically advantaged peers, individuals from low socioeconomic status (SES) backgrounds are less likely to enrol in higher education. Research also indicates

that higher educational attainment, which enhances health literacy, is linked with healthier behaviours, such as never smoking, meeting exercise guidelines, and responsible alcohol consumption (AIHW 2023; Australian Government Department of Education).

"People in the lowest socioeconomic group are also more likely to delay cancer symptom presentation and have lower overall engagement with healthcare services due to factors such as costs, limited access to services, lower health literacy, and poorer cancer symptom knowledge."(The Australian Cancer Plan 2023)

People in the lowest socioeconomic groups are more likely to be diagnosed with cancer and face a higher likelihood of dying from it. Compared with those living in the least socioeconomically disadvantaged areas, cancer incidence rates in the most disadvantaged areas were 5% higher, while survival rates were nearly 20% lower, and cancer mortality rates were over 40% higher (AIWH, 2021). Adults in the lowest socioeconomic group are also at increased risk for certain cancer risk factors. They are 3.6 times more likely to smoke daily, 1.6 times more likely to be obese, and 1.3 times more likely to be insufficiently active compared to adults in the highest socioeconomic group.

2. Aboriginal and Torres Strait Islander people

The Indigenous people of the land now known as Australia belong to two distinct cultural groups: Aboriginal and Torres Strait Islander peoples. Aboriginal people alone speak over 250 languages and 800 dialects, reflecting a broad diversity rather than a single, homogeneous cultural group. Aboriginal and Torres Strait Islander peoples live across all parts of Australia, including urban, regional, remote, and very remote areas. While many live in urban and regional locations, the proportion of Aboriginal and Torres Strait Islander people is higher in regional, remote, and very remote areas.

Cancer is the leading cause of death for Aboriginal and Torres Strait Islander peoples, and the gap in cancer mortality rates between them and non-Indigenous Australians is growing. Indigenous people in Australia are 14% more likely to be diagnosed with cancer and 20% less likely to survive at least five years after diagnosis compared to non-Indigenous Australians. Survival rates are particularly lower in regional and remote areas (AIHW, 2021). Data from the Victorian Cancer Registry (VCR) for 2017-2021 highlights a significant gap in cancer incidence and mortality between Aboriginal and non-Aboriginal Victorians. Aboriginal people in Victorian are twice as likely to be diagnosed with cancer compared to non-Aboriginal Victorians, with Aboriginal males 3.3 times more likely and Aboriginal females 3.1 times more likely to die from cancer than their non-Aboriginal counterparts. Aboriginal males in Victoria are over twice as likely to be diagnosed with cancers of the liver, lung, and head and neck, while Aboriginal females in the state show more than double the likelihood of diagnosis for liver, lung, and head and neck cancers, as well as lymphoma and leukaemia. The most common cancers among Aboriginal people in Victoria are lung, prostate, breast, and bowel cancers, making up 47.3% of cancer diagnoses in this population (VCR, 2022).

These statistics highlight the urgent need to address health inequities and the factors impacting cancer risk and survival for Aboriginal and Torres Strait Islander communities.

3. People from Culturally and Linguistically Diverse Backgrounds (CALD*)

The collective term 'CALD' in this report encompasses a wide range of ethnic and cultural groups within Australia, reflecting variations in language, family, and community structures. Despite making up a substantial proportion of the Australian population, national health data on these groups remain insufficient to accurately assess disparities in cancer outcomes or their underlying causes. However, available data indicate that people from diverse backgrounds face greater challenges in accessing culturally responsive care and information due to communication barriers, lower health literacy, and cultural differences (*Australian Cancer Plan*, 2023). Demographic factors, including ethnicity, are associated with

significant differences in risk factors, screening, diagnosis, prognosis, and treatment across various conditions.

Internationally, migration is recognised as a determinant of health and wellbeing, with refugees and migrants often being among the most vulnerable and neglected groups (World Health Organization, 2022). In Australia, the health outcomes of migrant populations are highly varied and shaped by their migration experiences and pathways. Their health and wellbeing are further influenced by determinants such as education, income, housing, access to services, and the presence of linguistic, cultural, legal, and other barriers, along with the interplay of these factors over their life course (AIHW, 2022).

Australia's culturally and linguistically diverse (CALD) population remains significantly underrepresented in health and medical research, including clinical trials. Given their substantial representation in the broader population, enhancing CALD participation in clinical trials is essential and must be prioritised.

***** *A note on the definition of CALD*

It is important to acknowledge the heterogeneity within and between Australia's many people from CALD backgrounds. This group encompasses individuals born overseas, those with a parent born overseas, and those who speak a range of languages. However, the definition of CALD is not universally agreed upon, and various approaches are used to identify and report on these populations. The Australian Bureau of Statistics (ABS) primarily defines the CALD population based on factors such as country of birth, language spoken at home, English proficiency, and additional attributes, including year of arrival, parents' country of birth, and religious affiliation. Notably, Aboriginal and Torres Strait Islander populations, as Australia's First Nations peoples, are excluded from CALD population descriptions.

4. People Living in Rural and Remote areas

"People living in rural and remote areas face barriers to accessing health care due to challenges of geographic spread, low population density, limited infrastructure, and the higher costs of delivering rural and remote health care." (Australian Cancer Plan, 2023)

Geographical areas in Australia are classified into five categories: major cities, inner regional, outer regional, remote, and very remote. These classifications are based on road distance to essential services. Approximately 28% of Australians, or around 7 million people, reside in rural or remote areas. People in remote areas are 1.3 times more likely to die from cancer and have lower five-year relative survival rates compared to those in major cities.

They are also more likely to engage in risky behaviours, such as smoking and excessive alcohol consumption, and are less likely to participate in cancer screening services (*Australian Cancer Plan*, 2023). The Victorian Cancer Registry (VCR) highlights a disparity in cancer diagnosis rates between regional Victorians and those in major cities, with regional residents being 10% more likely to be diagnosed with cancer and 16% more likely to die from cancer. Specifically, melanoma is 47% more prevalent in regional areas, lung cancer rates are 11% higher, and head and neck cancers are diagnosed 33% more frequently among regional males compared to their urban counterparts (VCR, 2022).

5. Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, and Asexual (LGBTIQA+)

Currently, there are no nationally available cancer datasets for LGBTIQA+ individuals in Australia. However, it is broadly estimated that 3.5%–11% of the population identifies with a diverse sexual or gender identity. According to the Australian Cancer Plan (2023), "LGBTIQA+ people continue to experience discrimination, harassment, and hostility in many parts of everyday life, including when accessing health services."

Research indicates that LGBTIQA+ individuals are more likely to avoid or delay engagement with health services, including essential cancer screening programs, due to fears of discrimination and the inadequacy of health professionals' knowledge and skills regarding inclusivity and the specific needs and preferences of LGBTIQA+ people (*Australian Cancer Plan*, 2023).

6. People Living with a Mental Illness

Mental health is influenced by various socioeconomic factors, including access to services, living conditions, and employment status. These impacts extend beyond the individual to their families and carers. Key findings highlight that 42.9% of people aged 16–85 years have experienced a mental disorder at some point in their life, while 21.5% have experienced a mental disorder within the past 12 months, with anxiety disorders being the most common, affecting 17.2% of this age group.

Although linked data in Australia are limited, the 2017–18 Australian National Health Survey identified a higher rate of cancer among those with mental illness (2.6%) compared to those without (1.6%) (*Australian Cancer Plan*, 2023). Internationally, a recent study in England found that individuals with mental illness have an average life expectancy 20 years shorter than the general population. Severe mental illness (SMI) significantly impairs individuals' ability to function in daily and occupational activities. This study also found that people with SMI are 2.1 times at higher risk of dying from cancer before age 75 compared to those without SMI, with cancer as the leading cause of premature death. Contributing factors include delayed cancer diagnosis, treatment choices, non-adherence to treatment, and lower cancer screening participation (Tuschick et al., 2024). Similarly, an Australian study found low breast cancer screening rates among New South Wales mental health service users, suggesting a heightened risk of late-stage detection, potentially leading to more invasive treatment and increased premature mortality (Lambeth et al., 2023).

The relationship between mental illness and tobacco use is also significant. People with mental illness are more likely to smoke, with 23.9% reporting current smoking compared to 16.3% of all persons aged 15–74 years (National Health Survey, 2014–15). This has major health implications; in 2011, lung cancer was the second leading cause of death among individuals who accessed mental health-related treatments, with a standardised death rate 2.6 times higher than the total Australian population. For persons aged 15–74 years who accessed these treatments, the lung cancer mortality rate was 74.8 deaths per 100,000 population, compared to 29.1 deaths per 100,000 for the total population in the same age group.

7. People Living with a Disability

Nationally available cancer data for people living with disability are currently lacking, though the AIHW reports generally poorer health outcomes and higher rates of certain cancer risk factors and behaviours among this population. Individuals with disability often face greater barriers and reduced access to preventive care and cancer screening services, which may lead to an underestimation of cancer risk behaviours and hinder disease detection. Additionally, cancer survivors are more likely to experience disability and poorer wellbeing outcomes than those without cancer. For those who acquire a disability as a result of their cancer experience, navigating support systems can be challenging and confusing (*The Australian Cancer Plan*, 2023)

> *"in general, people with disability report poorer general health and higher levels of psychological distress than people without disability. People with disability also have higher rates of some modifiable health risk factors and behaviours, such as poor diet and tobacco smoking, than people without disability."(*Australian Institute for Health and Welfare*, 2024)*

Chapter 4: Policy context

1. Summary

The Cancer Equity Framework closely aligns with federal and state policies aimed at addressing disparities in cancer outcomes through systemic reforms, cultural safety, and workforce development. The Australian and Victorian Cancer Plans incorporate an equity focus to mitigate barriers such as racism, lack of cultural safety, and underrepresentation in cancer care. They advocate for culturally safe practices, workforce diversity, and patient-centred care.

The Aboriginal and Torres Strait Islander Cancer Plan and Victorian Aboriginal Cancer Journey Strategy emphasise self-determination, data sovereignty, and culturally safe healthcare, prioritising Aboriginal leadership and the protection of cultural knowledge. The Victorian *marra ngarrgoo, marra goorri* Accord sets standards for ethical research, focusing on trust, knowledge recognition, and equitable practices. Additionally, the Multicultural Health Action Plan and VicHealth's Health Equity Strategy prioritise culturally competent care and address social determinants of health by engaging diverse communities and promoting equitable access.

Collectively, these strategies aim to create a healthcare system that acknowledges and addresses structural inequities through inclusive policies, culturally responsive practices, and shared decision-making with priority populations.

2. Historical policies impacting health equity

Christopher Mayes' 2020 article explores how historical and institutionalised racism, rooted in Eurocentric and colonial frameworks, has created and sustained structural inequities within the Australian healthcare system, which significantly impact Aboriginal and Torres Strait Islander communities. Mayes argues that addressing disparities in health outcomes, including cancer, requires understanding how current healthcare policies and practices are shaped by a history of racialised institutions influenced by discriminatory policies like the White Australia Policy. This policy, in effect from 1901 to 1973, institutionalised racial discrimination by legally excluding non-European immigrants and promoting a racially homogeneous society that privileged "whiteness" as the norm. These exclusionary policies created a healthcare system where Indigenous knowledge, practices, and contributions of other cultural groups were marginalised, embedding barriers to equitable healthcare and leading to persistent health disparities.

The legacy of these Eurocentric norms continues to impact Australian healthcare by prioritising white, Western frameworks, often at the expense of Indigenous communities and other racial groups. For Aboriginal and Torres Strait Islander people institutional racism in health systems manifests through unequal treatment, restricted access to care, and a lack of culturally appropriate services. To achieve health equity, Mayes advocates for policies that recognise this historical context and support Indigenous-led initiatives and culturally responsive care. Confronting these systemic disparities through culturally sensitive approaches is essential to dismantling the lasting effects of institutional racism and ensuring equitable health outcomes for all Australians (Mayes, 2020).

3. Australia Cancer Plan 2023 -2033

The Australian Cancer Plan embeds an equity lens to improve outcomes for all Australians, focusing on groups with the poorest results. Achieving equity requires a collaborative, system-wide approach. The plan identifies racism and discrimination as significant barriers and stresses the importance of understanding the social, cultural, and environmental factors affecting priority populations. Engaging these groups in co-designing health services is crucial. It also highlights the need to address gaps in cultural responsiveness, emphasising workforce training and diversity measures to ensure inclusive, patient-centred care that reflects Australia's population.

The plan highlights knowledge and skills gaps in cultural responsiveness and safety, emphasising the need to raise workforce awareness and support the provision of culturally safe care for all Australians, particularly Aboriginal and Torres Strait Islander people and other priority groups. Building workforce diversity is also a priority, aiming to develop a cancer care workforce pipeline that meets demand while ensuring diversity measures are embedded in training, recruitment, and talent management to reflect the patient population.

4. Victorian Cancer Plan 2024-28

The Victorian Cancer Plan 2024–2028 aims to achieve equitable cancer outcomes by addressing disparities in prevention, screening, treatment, and supportive care. It focuses on groups facing systemic barriers, such as Aboriginal Victorians, culturally diverse communities, and rural residents. The plan promotes culturally responsive services and evidence-based, consistent care through Optimal Care Pathways. Building a skilled, diverse workforce and leveraging data are key strategies. Community-led, patient-centred approaches are prioritised, along with improving early detection and access to clinical trials. The plan's four key priorities include engaging consumers, ensuring access to integrated care, supporting the workforce, and enhancing data capabilities to create a more inclusive and fair cancer care system.

5. Aboriginal and Torres Strait Islander Cancer Plan by National Aboriginal Community Controlled Health Organisation (NACCHO)

The *Aboriginal and Torres Strait Islander Cancer Plan* by NACCHO, calls for active anti-racism efforts to eliminate racism in cancer care for Aboriginal and Torres Strait Islander peoples. This involves addressing institutional racism, collecting and using data to highlight disparities in survival and treatment outcomes, and prioritising Indigenous Data Sovereignty for shared decision-making. The plan emphasises culturally safe mainstream services and the development of a skilled Aboriginal workforce, with a focus on leadership. It also stresses the need for culturally safe training and research priorities led by Aboriginal communities.

6. Victorian Aboriginal Cancer Journey Strategy 2023-2028 by Victorian Aboriginal Community Controlled Health Organisation (VACCHO)

The *Victorian Aboriginal Cancer Journey Strategy 2023–2028* by VACCHO aims to close the cancer outcome gap for Aboriginal communities in Victoria by addressing health inequities. The strategy centres around self-determination, cultural connection, workforce support, and cultural safety within the healthcare system. Key principles include recognising the social, cultural, and historical determinants of health and rebuilding trust in mainstream services, which are often viewed with suspicion due to past injustices and ongoing racism.

A key focus of the strategy is empowering Aboriginal leadership and ensuring that cultural strengths are valued in healthcare services. The strategy calls for the provision of culturally safe cancer treatment and care, which involves training Aboriginal Health Liaison Officers (AHLOs) to support patients, expanding Aboriginal Cancer Coordinator roles, and integrating wrap-around services.

The strategy also emphasises that mainstream healthcare must embrace a holistic and culturally inclusive approach, viewing culture as a protective factor rather than a deficit. This includes co-designing healthcare initiatives with communities, incorporating traditional practices, and improving culturally safe spaces in health settings.

7. marra ngarrgoo marra goorri (The Victorian Aboriginal Health, Medical and Wellbeing Research Accord)

The *marra ngarrgoo, marra goorri* Accord, led by the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), aims to improve the ethical standards of health, medical, and wellbeing research involving Aboriginal and Torres Strait Islander peoples in Victoria. The Accord prioritises Aboriginal-led research, emphasising self-determination, cultural safety, and equity. It seeks to address historical trauma and marginalisation by ensuring that research is co-designed, ethically governed, and aligned with the priorities and knowledge systems of Aboriginal communities. The Accord calls for greater Aboriginal leadership in identifying research priorities, participation in the design and execution of research, and the protection of cultural and intellectual property.

The Accord's guiding principles include trust, equity, cultural safety, and knowledge recognition. It emphasises that ethical research should be co-led or governed by Aboriginal and Torres Strait Islander communities, ensuring fair and transparent processes. The Accord also underscores the importance of respecting Aboriginal lore, customs, and practices, and protecting the sovereignty of data and knowledge shared within research projects.

A key objective is to establish equitable research partnerships between Aboriginal and non-Aboriginal stakeholders, focusing on mutual benefits and improved health outcomes. By implementing actions like developing accreditation and ethical review systems, training initiatives, and culturally safe frameworks, the Accord aims to transform the research landscape. This includes monitoring mechanisms, increased funding opportunities, and a dedicated research network to support emerging Aboriginal researchers.

8. Victorian Multicultural Health Plan

The *Multicultural Health Action Plan 2023–27* aims to improve health equity by providing culturally competent care and ensuring better health outcomes for multicultural communities in Victoria. The plan focuses on several key areas to achieve this, including investing in targeted programs and services, delivering accessible and culturally responsive healthcare, and building community engagement and capacity. It highlights the importance of tailored support for diverse groups, addressing barriers like language and discrimination, and promoting inclusive policies and training.

In the context of cancer care, the plan outlines initiatives to improve cancer screening participation among multicultural communities. This includes culturally adapted education sessions, tailored communications in multiple languages, and employing community leaders to promote awareness. The goal is to address barriers like low health literacy, lack of familiarity with the healthcare system, and cultural stigmas around cancer screening. The plan also emphasises using data to track disparities and engaging bicultural workers to bridge gaps in service delivery.

9. VicHealth Health Equity Strategy

VicHealth's *Health Equity Strategy 2017-2019* aims to address health inequities in Victoria using its *Fair Foundations* framework. The strategy focuses on embedding health equity across all organisational practices, supporting the health promotion sector, and forming partnerships to address social, economic, and environmental determinants of health. It recognises that barriers to good health are often shaped by broader social and political contexts, impacting groups based on income, education, gender, race, and location.

The strategy identifies three levels of health inequity: socio-political context, daily living conditions, and individual factors. VicHealth plans to address these by prioritising vulnerable populations, integrating health equity into governance, and actively measuring and adjusting efforts. The principle of "nothing about us without us" underpins the strategy, ensuring that communities play a key role in decision-making and designing targeted interventions.

10. The National Women's Health Advisory Council and the Victorian Women's Health Advisory Council

Addressing systemic gender biases in healthcare, often referred to as "medical misogyny," has become a policy priority in Australia. The Australian Government established the National Women's Health Advisory Council to provide advice and recommendations to improve health outcomes for women and girls in Australia. Similarly, the Victorian Government has established the Victorian Women's Health Advisory Council to lead significant government investment in women's health.

Medical misogyny in healthcare is a persistent issue. Historically, women in healthcare have often been perceived as “overly emotional” or “hysterical,” leading to their symptoms being dismissed or underestimated by healthcare providers (Vearrier, 2016). This bias has caused significant gaps in care, with women facing underdiagnosis, misdiagnosis, and substandard treatment, especially for conditions primarily affecting them. In cancer care, medical misogyny surfaces in the delayed diagnoses of cancers like ovarian and endometrial, which receive less attention and resources than cancers more commonly associated with men(Ovarian Cancer Research Foundation; Women Can). Research shows that women globally experience disparities in cancer prevention and treatment due to imbalanced power structures in society, which hinder the development of diagnostic tools and treatments tailored to women’s specific needs, resulting in poorer outcomes (Keenan et al., 2023).

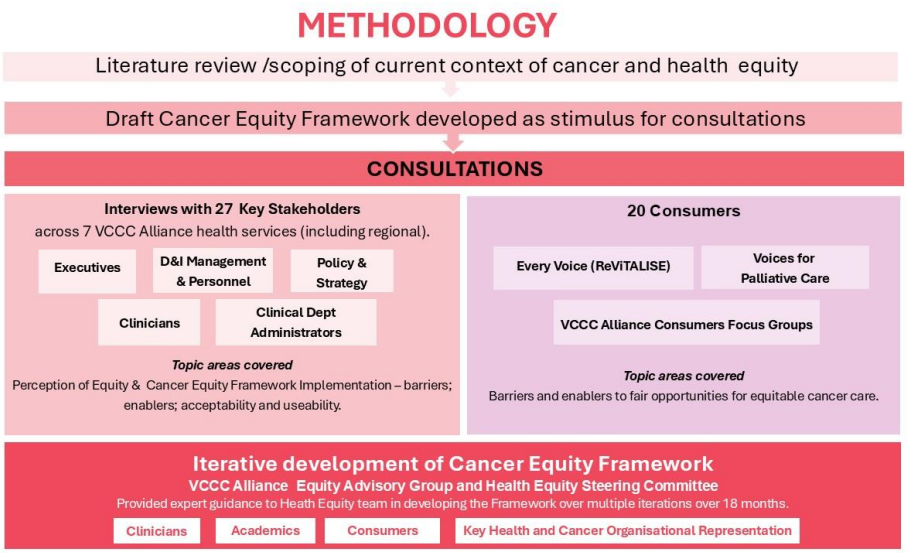
Gender bias also affects female cancer clinicians, creating barriers in career growth, fair pay, and leadership roles, which limits their ability to champion women’s health in oncology. With fewer women in research leadership, there is often less focus on female-specific cancers, hindering progress in treatment options. Tackling these biases calls for policy changes and stronger institutional support to build an equitable field in oncology, ensuring women get the care they need and female clinicians and clinical researchers have the chance to drive advancements in women’s health (Keenan et al., 2023).

Chapter 5: Methodology for developing the Cancer Equity Framework

1. Summary

The Cancer Equity Framework was developed following a review of the literature, and stakeholder interviews with representative from health services including executives, policy and strategy managers, diversity and inclusion managers, and clinicians. Oversight through consultations with the VCCC Alliance's Equity Advisory Group and members of the VCCC Alliance Consumers Network were integral in developing the Framework over multiple iterations.

Figure 8:
Methodology for developing the Cancer Equity Framework



2. Literature review/scoping of current context of cancer and equity

Overview

At the beginning of the project, a comprehensive scoping review of health equity frameworks and toolkits was conducted, focusing on resources addressing priority populations in Australia. This review sought to identify and evaluate existing frameworks that could inform the development of a tailored Cancer Equity Framework for the VCCC Alliance. A structured search strategy was employed, utilising a range of academic and public databases, including JSTOR, Google Scholar, Medline, and the Australian Institute of Health and Welfare Library.

The review identified numerous health equity frameworks, both international and Australian, aimed at improving health outcomes for diverse populations, including Indigenous communities, racial minorities, culturally and linguistically diverse (CALD) groups, rural populations, and individuals experiencing socio-economic disadvantage. While often designed for specific population needs, these frameworks share the common goal of advancing equity and enhancing health outcomes within the broader system.

This collection of frameworks and related health equity literature provided valuable insights that informed the development of the VCCC Alliance Cancer Equity Framework. Key elements from the literature and

existing frameworks have been synthesised and adapted within our framework and the accompanying supportive documentation, with appropriate citations included throughout the report.

Key themes in the literature incorporated in the Framework.

Health Equity Frameworks: The scoping of existing health equity frameworks revealed a gap and the need for a framework which could provide an overarching collation of principles, tools, and resources for embedding health equity within cancer research training, consumer engagement, and health service delivery.

Foundations of Health Equity: The reviewed literature encompassed foundational concepts of health equity, including the distinctions between equity and equality, the impacts of social determinants of health (SDOH), and the role of structural inequities. Exemplar definitions and frameworks from key organisations and prominent health equity researchers were incorporated into the framework, providing a theoretical basis for addressing disparities in cancer care.

Priority Populations and Intersectionality: The reviewed literature examined the challenges faced by priority populations and the compounded impacts of overlapping forms of disadvantage (e.g., race, socioeconomic status, and geographic location).

Cultural Determinants of Health: The reviewed literature included research on the cultural determinants of health, particularly for Aboriginal and Torres Strait Islander peoples. It emphasised the importance of cultural connection and self-determination in achieving improved outcomes.

Data Equity: The reviewed literature underscored the importance of inclusive data practices, community involvement, and the need for metrics that capture the lived experiences of underserved populations.

Workforce Diversification and Leadership: The literature emphasised the significance of cultivating a diverse workforce, particularly in leadership positions, to advance health equity. A workforce that mirrors the diversity of the communities it serves is better positioned to understand and address the specific needs and challenges of priority populations. Ensuring greater representation of marginalised groups in leadership roles enhances decision-making processes by incorporating lived experiences and cultural perspectives.

Consumer and Community Involvement: The reviewed literature highlighted the critical role of involving consumers and communities in the development and implementation of equity initiatives. This includes an emphasis on co-design methodologies, where consumers and community representatives actively contribute to shaping strategies, policies, and interventions.

3. Consultations – overview

Health Service Stakeholders

The primary objective of the interviews was to gather insights to guide the development of a cancer equity framework (CEF). Specifically, these interviews sought to capture perspectives from health service stakeholders on the drivers and experiences of inequity among their patient cohorts, both broadly and specifically concerning cancer services, and to identify barriers and enablers to implementing a fit for purpose CEF. Key stakeholders from metropolitan and regional areas across Victoria were invited to participate in semi-structured interviews that explored (1) perceptions of health (in)equity and (2) the enablers and barriers to implementing a CEF within hospital settings. A total of 27 participants were interviewed, representing various roles, including executive, policy and strategy, middle management, diversity and inclusion managers, and clinicians.

Consumers

The focus group and consultations aimed to inform the development of a CEF by gathering input from the community, especially from individuals underserved by the current cancer care system. In these consultations, participants were asked to reflect on what measures could ensure equitable access to quality cancer treatment. Discussions focused on identifying needed supports, potential changes, and strategic actions that could be implemented to promote fairer opportunities for all.

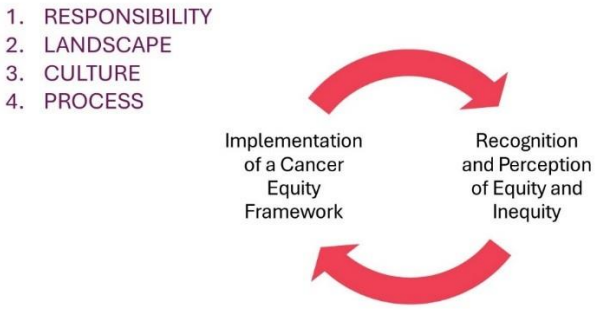
Equity Advisory Group

Formed in 2021 with members recruited from diverse community and professional backgrounds, the Equity Advisory Group (EAG) provides strategic guidance to the VCCC Alliance Health Equity Program, focusing on developing and implementing strategies to reduce inequities in cancer outcomes across Victoria. The EAG played a critical oversight role in this project and contributed significantly to the framework's development over multiple iterations.

4. Consultations – key themes

Through interviews and consultations, a wide range of insights were gathered around how health inequities were perceived and experienced by both the cancer care workforce and consumers. The interviews uncovered the barriers that many people face in accessing and dispensing fair and effective cancer care, including issues related to culture, language, income, and location. They also showed how these inequities impact patient outcomes, job satisfaction among healthcare workers, and overall care quality.

Figure 9:
Key themes identified through interviews and consultations



By listening to the perspectives of healthcare providers, policymakers, community leaders, and consumers, key areas needing change were identified. These perspectives, categorised under four key themes, helped identify specific areas for improvement and informed the structure, objectives, and strategies embedded within the Cancer Equity Framework.

Responsibility

- **Health service accountability:** Most participants recognised that addressing health inequity falls under the responsibility of health services, though some pointed out that societal factors, not health services alone, generate inequity.
- **Executive-level commitment**: Stakeholders emphasised the need for executive-level "buy-in" to drive meaningful changes, as well as the involvement of champions at all levels to foster support.
- **Diversity in governance:** A priority focus area identified by stakeholders was greater diversity at governance and decision-making levels. A real change in health equity requires ensuring that decision-making bodies reflect the populations they serve.
- **Policy support for equity initiatives**: Stakeholders noted that government support through policy reform was essential to establish and sustain an equity-focused framework within health services.

This support extends to creating policies that prioritise diversity in the health workforce, particularly in governance roles, to better reflect and serve Australia's diverse population.

- **Ensuring adequate resourcing:** Lack of resources, both financial and human resources, was identified as a barrier to implementation of an equity framework. The need to invest for in longer-term efforts (change takes time) to ensure continuity of projects in priority groups was considered important.

Landscape

- **Structural barriers and framework integration**: Stakeholders and consumers identified systemic issues such as stigma, unconscious bias, and institutionalised racism as core contributors to health inequity. This requires systems change, embedding equity into every level of health services, with a need for practical frameworks that integrated health equity into daily practice rather than as separate, additional efforts.

- **Resource limitations**: Financial and human resource shortages were significant barriers to implementing a comprehensive cancer equity framework, with long-term investment necessary for sustained impact.

Culture

- **'Equity is a culture'**: Participants stressed the importance of embedding equity as a core value within health services. This culture shift would involve prioritising health equity at all levels, combating stigma, bias, and institutionalised racism.

- **Diverse and inclusive workforce:** Both stakeholders and consumers recognised the value of a workforce that reflects Australia's diverse population. This diversity was seen as critical to providing culturally safe and responsive care.

- **'It's a journey':** The journey toward health equity was viewed as a gradual, evolving process requiring sustained effort, commitment, and adaptability. It was acknowledged the recognition of the impact of colonisation and historic discrimination on health inequities varies across the health service, indicating the need for continued education and awareness.

Process

- **Embedding equity into daily practice:** Equity interventions need to be integrated into everyday practices rather than treated as add-ons. Stakeholders emphasised that these interventions should fit seamlessly into workflows to avoid overwhelming the already stretched health workforce.

- **Advocacy and incremental improvements**: Consumers proposed a pragmatic approach to system change, advocating for both broad reforms and smaller, impactful tweaks to existing processes. This approach, which focuses on enhancing current practices to increase accessibility and safety, would allow for steady progress without overwhelming the system.

- **Building the capacity of the workforce***:* Throughout the interviews, the need to build the capacity of all health service workers (from strategy/policy through to clinicians), to embed equity in their daily practice was identified. Time pressures were again mentioned in this context, and it was suggested that the workforce could be supported by readily accessible and relevant resources.

- **Resource development and accessibility**: Suggested resources included training, policies, and case studies. The framework should provide clear, accessible, and interactive resources that guide health service workers at all levels in implementing equity.

- Consumer involvement in framework development: Both practical resources and the cancer equity framework itself should be co-designed with consumers and community members, and account for timelines needed for effective collaboration.

- Continuous improvement: Stakeholders recommended that the framework should be a "living document," regularly reviewed and adapted to reflect changing societal needs, disparities, and maintain relevance.

- Consumer-centred approach: Participants noted that achieving health equity required health services to prioritise the needs and voices of patients, particularly those historically underserved.

Chapter 6: The Cancer Equity Framework

1. Overview

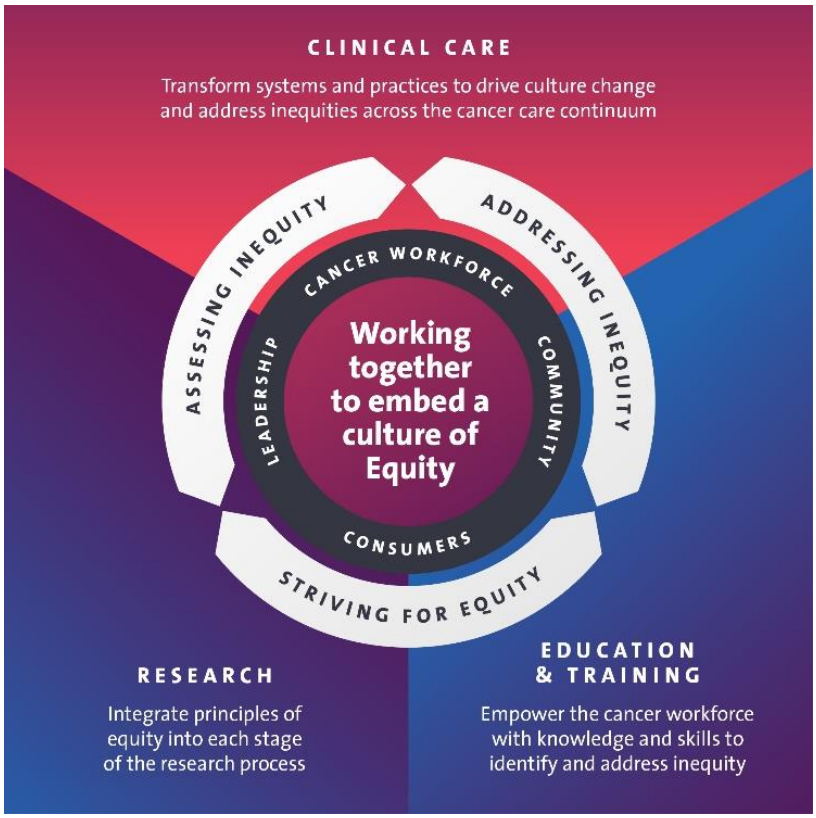
Health equity is achieved when all individuals have optimal opportunities to attain the best health possible. This requires recognising that each person has different circumstances. Rather than allocating the same resources and opportunities to all individuals or groups (equality), we allocate the exact resources and opportunities specifically needed to achieve equal outcomes (equity). Achieving health equity in research and clinical practice requires approaches centred on fairness and social justice, reforming systems to produce long-term, sustainable, and equitable outcomes.

Health equity must be elevated as a strategic priority by sector leaders, and efforts need to move beyond individual interventions towards sector-wide culture change. This requires the cancer sector to understand the ongoing impact of historical and oppressive systems of power and unequal access to the social determinants of health. While achieving health equity in healthcare may feel beyond the power of the individual, every interaction with patients and carers within the cancer care system—whether in clinical care or research—is an opportunity to advance health equity. A cancer workforce that is informed, committed, and supported to deliver equitable care in all aspects must be a goal of all health services.

System-wide change towards equity begins with each individual working in health. The Cancer Equity Framework (the Framework) is conceptualised as a "call to action" to bring sector leaders, educators, researchers, and health practitioners together with consumers and communities, making health equity a shared vision. The VCCC Alliance integrates education, research, and clinical care through its membership and is well-positioned to drive collective efforts to promote the cultural changes needed to realise the systemic reforms outlined in federal and state-based cancer control plans and strategies.

The Framework serves as a guide for the VCCC Alliance to collaborate with its members and the broader sector to co-design activities and resources that support embedding a culture of equity.

Figure 6: The Cancer Equity Framework



2. Foundational understanding of health inequity

The way we understand health inequity is central to how we conceptualise, measure, and find solutions for the issue. The Social Determinants of Health (SDoH) framework recognises that social factors beyond an individual's control drive disparities in health outcomes. The Cancer Equity Framework (the Framework) is based on an understanding that health inequity is driven by the SDoH. Acknowledging and addressing the SDoH also requires recognition of their root causes and attention to the connections between structural discrimination and ongoing disparities (Yearby, 2020). The Cancer Equity Framework seeks to do both.

The factors contributing to the root causes of health inequity are diverse, complex, and interconnected. In virtually every society, socioeconomic status (SES) strongly predicts variations in health. Factors such as income, education, employment conditions, and social support either strengthen or undermine the health of individuals and communities. However, SES alone does not fully explain health disparities related to race, ethnicity, sexual orientation, and gender identity (Williams & Purdie-Vaughns, 2015). Beneath these social determinants of health is the unequal distribution of power and resources within society and the culture that sustains it. Much of the observed adverse health outcomes and disparities result from structural inequities, as multiple layers of inequality are experienced across various systems. The differences observed as a result of social determinants of health stem from structural factors that exist prior to and shape the social risks impacting health outcomes (Egede et al., 2023).

As noted, structural inequities refer to the systemic disadvantages faced by one social group in comparison to others within the same society. Structural inequities occur when differences in access, wealth distribution, and resource availability are reinforced through systemic mechanisms (National Academies Press, 2019). When these differences are based on race or ethnicity, structural inequities are more accurately described as structural racism. Systems providing fundamental needs, such as education, employment, criminal justice, and healthcare, have historically benefitted some while disadvantaging others and continue to perpetuate discrimination in its many forms, including racism, sexism, classism, ableism, xenophobia, homophobia, and transphobia.

Understanding health inequity from this perspective acknowledges how we got here, the consequences of our current state, and provides an approach embedded in truth to start working together to improve health outcomes. Achieving health equity starts with a culture that confronts institutional racism, homophobia, transphobia, ableism, misogyny, classism, and ageism. Culture change is needed.

3. Working together to embed a culture of equity

It is well established that there are profound inequities in healthcare in Australia. Despite some success with priority population-focused interventions, persistent inequities remain. A paradigm shift in addressing inequity is necessary.

Many traditional public health interventions assume a level of "personal agency". Personal agency can be defined as "the ability to initiate and direct actions toward the achievement of defined goals" (Zimmerman & Cleary, 2006). In the context of health, this implies that individuals have the capacity to choose, control, or change their circumstances to enhance their health and reduce the risks of chronic illness and premature death. This approach frames health problems as individual issues, leading to interventions designed to change individual behaviours. For example, these interventions focus on increasing knowledge, skills, and self-efficacy to reduce risk-taking behaviours and encourage health-promoting behaviours. Enhancing individuals' abilities to access services and improve health outcomes through health literacy and self-management approaches is an important part of the solution. However, these measures alone fail to acknowledge the structural inequities that restrict "personal agency" and prevent individuals and communities from achieving optimal health outcomes (Petersen et al., 2020). Taking a systems approach to equity helps explain why addressing inequities through individual interventions alone is often unsuccessful or unsustainable.

Despite growing awareness of and significant commitment to addressing health inequities, the education, research, and health service institutions that make up the cancer control and care system exist within a historical legacy of discrimination. Advancing health equity requires confronting the complex legacies of colonialism and historic discrimination embedded in all institutions, including cancer care institutions (Todic et al., 2022). Recognising that the healthcare ecosystem is structurally unequal enables a new approach to achieving health equity.

There is an urgent need to address the needs of those in our community who are poorly served by the current systems of cancer care and control, and to change those systems. Transforming organisational culture is increasingly seen as an essential component of health system reform (Scott et al., 2003). To realise the visions for equity outlined in Australia's national and state cancer control plans and strategies (see Chapter 4 for more details on Policy Context), a culture of equity within the organisations that constitute the cancer care and control system is essential.

"Advancing health equity requires building a culture of equity in which all employees—individually and collectively—identify and reflect on the structural inequalities that reproduce health inequities and engage in activities to transform them" (Todic et al., 2022).

There is an urgent need to address the needs of those in our community who are poorly served by the current systems of cancer care and control, and to change those systems. Transforming organisational culture is increasingly seen as an essential component of health system reform (Scott et al., 2003). To realise the visions for equity outlined in Australia's national and state cancer control plans and strategies (see Chapter 4 for more details on Policy Context), a culture of equity within the organisations that constitute the cancer care and control system is essential. Leadership engagement and support are critical to driving this cultural change. Creating and sustaining a culture of equity requires time and sustained attention. It calls for compassion and humility, reflecting on one's own cultural values and those of others while building knowledge and skills at all levels of organisations. A strong culture of equity requires more than just acknowledging health inequities in the communities served; it demands that staff see these disparities as unacceptable and actively seek solutions to address them.

Addressing inequities demands meaningful engagement and equitable partnerships between the cancer workforce and those currently poorly served by the cancer care and control system. Central to this is engaging consumers and communities to better understand their needs and co-designing health services and systems to accommodate these needs.

4. Domains of Action

Culture change is not a linear process; it involves multiple interdependent and interacting elements that complicate planning and implementation. This Framework envisions culture change as a continuous cycle of action, where leaders, the cancer workforce, consumers, and the community collaborate to understand and address the underlying drivers of health inequities.

4.1 Assessing Inequities

Across the cancer care continuum, assess unwarranted and avoidable disparities in prevention, diagnosis, treatment and outcomes, diagnose the root causes and identify those systems and practices that create or perpetuate these inequities.

To increase health equity, it is essential to both identify health inequalities and distinguish between inequalities that arise from random variation or immutable biological differences and those that can be reduced through tailored medical, public health, or social policy interventions (Nolan et al.,2005). Effective

data collection and analytics are crucial to implementing and sustaining organisational change and promoting health equity (Doherty et al, 2021).

Better data on priority populations in health services is needed, along with an understanding of the broader impact of social, cultural, and environmental determinants on cancer outcomes for these populations. Central to this effort is determining what data are missing to gain a clearer understanding of the needs and experiences of different communities and building the data infrastructure necessary to collect and act on this information (Linfield et al., 2023). This requires working closely with priority populations to inform what information to collect and how the data can be appropriately used (See Data Equity Principles in Chapter 2 for further discussion).

Advancing health equity requires carefully assessing the design of policies and processes, including the assumptions embedded within them, which may be perpetuating inequities. "Critically assessing policies and processes can help reveal hidden assumptions, which then can lead to the development of a different set of explicit, shared assumptions and open opportunities for new ways of thinking and acting" (Minnesota Department of Health). In this way, understanding how systems, policies, and processes perpetuate inequities can guide action to change how they operate.

4.2 Addressing Inequities

Co-design interventions with affected populations and support the development of a culture of equity. Adopt an approach of continuous improvement and learning; test and adapt interventions, evaluate efforts, reassess, and plan next steps.

To advance health and healthcare equity, interventions must address the root causes of inequities and be targeted at different levels of change: the individual level (patient, clinician, educator, researcher), the organisational level (leadership, strategy, and policy), and the broader community and societal levels (law, government policy, and investment).

Interventions can range from simpler initiatives, such as cultural safety training, to more complex measures, such as systemic data collection to identify combinations of factors leading to poorer outcomes. These efforts should be co-designed and implemented by interdisciplinary teams of practitioners, researchers, affected populations, and policymakers. Co-designing interventions with affected populations, including healthcare consumers and representatives of priority groups, throughout the entire process is crucial. Collaboratively identifying problems and developing solutions encourages these populations to take ownership of the process, ensuring that interventions are both acceptable and sustainable. To ensure continuous improvement, interventions must be followed by ongoing monitoring and evaluation, creating a sustained cycle of change.

4.3 Striving for Equity

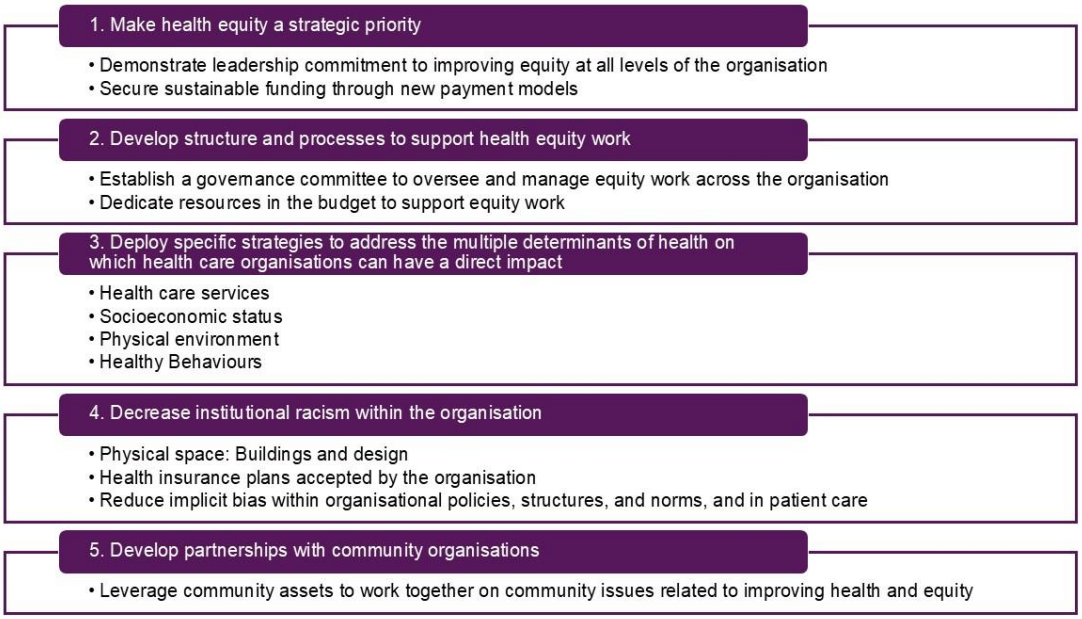
Commit to addressing identified inequity. Build a shared vision for a culture of equity, set goals to achieve this vision, engage the cancer workforce, consumers and community in the process and prioritise and resource efforts.

Striving for a culture of equity should be elevated to a strategic priority in organisations within the cancer care and control system. Developing systematic approaches to drive cultural change in promoting health equity and appropriately resourcing these efforts is crucial. This includes creating a long-term vision and setting strategic goals to achieve sustainable organisational cultural change. Developing structures and processes to support health equity work and integrating this work across functional departments, such as patient safety, quality, population health, communications, and clinical leadership (e.g., nursing and emergency departments), is essential. According to Doherty et al. (2021), "Broad, cross-cutting work promotes collaboration within the organisation while also reducing the fragmentation associated with having separate, uncoordinated equity initiatives underway within the organisation."

Cultivating a culture of equity is a collaborative process that involves supporting the workforce in understanding the vision for change and building their capacity to contribute. Frequent, clear, and consistent communication from leadership is essential. Every employee must understand not only the organisation's vision but also their role, responsibilities, and the specific actions necessary to achieve it. Creating opportunities for crucial conversations about health equity and enabling the workforce to transition from discussion to action ("walking the talk") is a central element of internal organisational change in addressing institutional inequities.

The Institute of Healthcare Improvement's white paper *Achieving Health Equity: A Guide for Health Care Organizations* offers guidance on reducing health disparities within healthcare organisations, related to racial or ethnic background, religion, socioeconomic status, gender, age, mental health, cognitive, sensory, or physical disability, sexual orientation or gender identity, geographic location, or other characteristics historically associated with discrimination or exclusion. For healthcare organisations prepared to initiate or advance this work, the Institute of Healthcare Improvement proposes five core principles to support the integration of health equity across the organisation (see Figure 7).

Figure 7:
A Framework for Health care Organisations to Achieve Health Equity
(reproduced from *Achieving Health Equity: A Guide for Health Care Organizations*, Institute of Healthcare Improvement, 2016)



FURTHER RESOURCES

See Appendix 1 for links to some useful resources that have been developed to support health and research organisations advance heath equity.

5. Focus Areas - Clinical Care

Transform systems and practices to address inequities across the cancer care continuum and drive culture change

Overview - What will drive equity in Clinical Care?

- The seven steps of Optimal Care Pathways are useful for exposing patterns of unfair and avoidable disparities across the cancer continuum.
- Systems and practices across the entire cancer care continuum are reviewed to identify whether they cause or exacerbate inequity.
- Practical tools and resources are developed to support the workforce to embed equity into systems and everyday practice.
- Cultural safety and humility in the healthcare system is improved along the entire cancer care pathway.
- Consumers and communities are integrally engaged to better understand their needs, and co-design health services and systems to accommodate those needs.
- Greater diversity among the cancer workforce, at all levels including leadership, reduces the barriers patients face when seeking care.

"The issue is not work harder, the difference is work smarter, find little things that are going to make big changes…What I think we need to do is to work with what we've got, but in a manner that we get a better result than what we're having now… So practises need to be looked at to see where they can be tweaked without actually costing a lot of money…just making the process we have in place work better and work smarter"

Consumer during consultations for the Framework.

Exposing patterns of inequity across the cancer care continuum.

The seven stages of Optimal Care Pathways (OCP) provide an important context for considering inequity throughout the cancer illness course. These stages are designed to guide health professionals and policymakers in delivering consistent, high-quality care. They also offer key points in the illness course for assessing if disparities exist, including unjust and avoidable disparities, particularly among vulnerable populations. Embedded in the Australian Cancer Plan, the OCPs enable the cancer care sector to systematically review care pathways and gain a deeper understanding of the inequities affecting access to and quality of cancer care. In addition, mapping existing interventions against the OCP can help identify gaps in efforts to promote equity.

Table 4:
The Seven Stages of the Optimal Care Pathways

1. Prevention and Early Detection
2. Presentation, initial investigations, and referral of patients
3. Diagnosis, staging and treatment planning.
4. Treatment
5. Care after initial treatment and recovery
6. Managing recurrent, residual or metastatic disease
7. End-of-life care

Reviewing clinical care systems

To advance health equity, it is essential to critically examine systems and practices across the entire continuum of care, from prevention and diagnosis to treatment and survivorship. Health inequities often result from structural disparities within these systems, leading to unequal access, delayed diagnosis, and poorer outcomes for marginalised populations. A thorough review of these systems allows health services to identify practices that contribute to or exacerbate disparities in care, which may relate to geography, socioeconomic status, race, ethnicity, or other social determinants of health.

Reviewing policies and practices helps ensure that outdated or harmful systems are reformed or replaced with those prioritising equity and delivering high-quality care to all patients, regardless of their background. Health Equity Impact Assessments (HEIA) are used to evaluate how new programs, policies, or innovations affect health equity across different population groups. This process can also assess existing systems and practices. When conducting an HEIA, it is important to determine whether the needs of individuals experiencing multiple forms of discrimination are considered and if appropriate adaptations have been made. The assessment should also evaluate whether downstream, midstream, and upstream determinants of health—i.e., individual, community, and structural factors—are being considered (see Table 5). To effectively promote health equity, multiple approaches, and specifically upstream (structural) actions, are necessary to maximise impact (see the resources section for a good practice example of an HEIA).

Table 5:
Upstream, midstream, and downstream determinants
(adapted from Wellbeing SA and Stretton Health Equity, University of Adelaide, 2023)

Downstream Determinants	Downstream determinants of health are micro-level factors that influence biological functioning and focus on individual-level impacts. For example, genetics and personal healthcare are considered downstream determinants. In the context of food security, emergency food relief services represent a downstream approach
Midstream Determinants	Midstream determinants are environmental or community-level factors that influence the choices people make. For example, midstream measures to reduce smoking rates include price controls and restricting access to tobacco products.
Upstream Determinants	Upstream determinants are structural factors, such as social and economic policies, that influence housing, income, and education. These factors extend beyond individual control and can negatively impact people's access to, use of, and benefit from policies or programs. An example of an upstream initiative is increasing income support payments to lift people out of poverty.

Greater diversity among the cancer workforce, at all levels including leadership is a key step toward eliminating health care disparities.

Many patients continue to be managed by care teams whose profile does not reflect the broader community they serve. The *Australian Cancer Plan* identifies the need to build workforce diversity and ensure "a cancer care workforce pipeline that meets demand for optimal cancer care, with diversity measures in training, recruitment, and talent management to ensure the cancer workforce represents the diversity of the patient population" (*Australian Cancer Plan*, Action 5.5.1).

Advancing health equity requires understanding the perspectives, needs, and concerns of underserved communities. A diverse workforce, “a workforce with real-world experiences that reflect the diverse society it is serving, is key to tackling the challenges ahead” (Beebeejaun & Littleford, 2023). Workforce diversity provides broader perspectives, experiences, and cultural insights essential for addressing patient needs. In cancer care, where outcomes can disproportionately affect certain racial and ethnic groups, having healthcare providers who reflect these populations is vital for improving health equity. Cancer care, research, and education organisations should aim for diversity at all levels to reflect the communities they

serve. This commitment includes valuing the skills and expertise of employees from diverse backgrounds while avoiding overburdening them as cultural representatives of a particular group.

Research indicates that increasing workplace diversity positively impacts performance, productivity, and innovation. While limited studies focus specifically on diversity and medical outcomes, research suggests workforce diversity can enhance the quality of care. A 2014 meta-analysis of 25 studies found that diverse medical teams gave more accurate diagnoses, had higher patient satisfaction, and achieved greater compliance (LaVeist & Pierre, 2014). A 2019 review of healthcare diversity identified key enabling factors: policies supporting diversity, open environments minimising friction during culture change, genuine inclusion beyond "tokenism," and diversity in top management and board positions (Gomez & Bernet, 2019). Diversity in decision-making positions is crucial for driving health equity.

Increasing diversity in the cancer workforce, particularly in leadership, is essential for reducing healthcare disparities. Promoting diversity in leadership fosters inclusion and ensures decision-making processes reflect varied perspectives, driving systemic changes in cancer care and reducing disparities.

Cultural humility is essential for a safe and equitable cancer care system.

"Cultural humility refers to an orientation towards caring for one's patients that is based on: self-reflexivity and assessment, appreciation of patients' expertise on the social and cultural context of their lives, openness to establishing power-balanced relationships with patients, and a lifelong dedication to learning. Cultural humility means admitting that one does not know and is willing to learn from patients about their experiences, while being aware of one's own embeddedness in culture(s)" (Lekas et al., 2020).

Providing culturally safe care requires the cancer workforce to have knowledge of different cultures, cultural norms, and values. More importantly, it involves reflecting on their own beliefs, values, and biases and understanding how these impact interactions with patients from diverse backgrounds.

Cultural awareness and cultural competence are widely recognised concepts, and training in these areas is common in many organisations, including healthcare. However, there are limitations to this approach. It suggests that an outsider can acquire sufficient knowledge to "know" or become "competent" in another culture. When framed this way, culture risks being simplified into a static, "tick-box" exercise—an item to check off a medical training list (MacKenzie & Hatala, 2019).

Culture is not static, and people have multiple, intersecting identities with too many cultural cues to effectively "teach". Incorporating cultural humility training can strengthen efforts to build the skills and knowledge of the cancer workforce in providing culturally safe care. Rather than focusing on "competence" and expertise in the cultural "other," cultural humility involves lifelong learning and critical self-reflection. It is a process of developing self-awareness about one's own beliefs and biases (both explicit and implicit) and understanding their impact on interactions with others. Cultural humility training should also build an understanding of systemic racism and the influence of dominant Western power structures on non-Western individuals. It helps individuals, particularly those who identify with the dominant culture, to grasp what is and isn't culturally appropriate.

Actionable Steps

- Utilise the Optimal Care Pathways: Use the seven stages of the Optimal Care Pathways to systematically assess and address disparities across the cancer care continuum.
- Conduct Health Equity Impact Assessments (HEIA): Regularly evaluate programs, policies, and practices to ensure they promote health equity, especially for groups facing multiple forms of discrimination.
- Review Clinical Systems for Bias: Continuously examine and reform systems and practices that may contribute to inequities, ensuring that care quality does not vary by geography, socioeconomic status, or ethnicity.
- Increase leadership and workforce and Diversity: Build diversity at all levels, including leadership, in the cancer care workforce to better reflect the communities served and foster inclusive perspectives.
- Foster cultural humility: Move beyond cultural awareness training to embed cultural humility through lifelong learning and self-reflection, focusing on understanding and valuing patients' unique social and cultural contexts.
- Engage consumers and communities: Actively involve community members in the co-design of health services, ensuring their needs are understood and met in a culturally safe environment.

FURTHER RESOURCES

See Appendix 1 for links to some useful resources relevant to discussions above.

6. Focus Area - Research

Integrate principles of equity into each stage of the research process

"I think consumers add an important viewpoint to research at every stage—like choosing the research questions, thinking about ethics, sharing patient information, deciding on funding, and sharing results. Their personal experience with a condition helps researchers understand what patients need, making the research more relevant, open, and supported by the community".

VCCC Alliance Consumer Representative

Overview - What will drive equity in Research?

- The health issues and knowledge of communities that have been historically invisible in much of the research and data, are represented in health research.
- Researchers are provided with training and resources to develop the knowledge and skills to successfully navigate relationships with communities impacted by research.
- Researchers meaningfully engage and create equitable partnerships to co-create knowledge with communities impacted by research.
- Consumers and community members are engaged in prioritisation, design, conduct and dissemination of research findings.
- Cancer research teams reflect the diversity of the Australian community and research should include representation of all communities where possible.
- Institutional support is provided to promote equity in research

"Global health research reflects and can either perpetuate or challenge the complex power hierarchies and inequities that characterise our health systems and the societies in which they are situated" (Kakoti et al., 2023).

People historically invisible in research and data must be adequately represented in health research.

The vast majority of quantitative human research is focused on WEIRD populations—Western, Educated, Industrialised, Rich, and Democratic (Clancy & Davis, 2019). As a result, many populations are rendered invisible in research and data. The literature often labels these groups as "traditionally hard-to-reach," typically referring to Aboriginal and Torres Strait Islander people, Culturally and Linguistically Diverse (CALD) individuals, members of the LGBTQIA+ community, homeless people, people with disabilities, and elderly populations. It is crucial that the health issues and knowledge of these communities are made visible in health research topics and questions (Pratt, 2021).

To achieve health equity, researchers must meaningfully engage with the communities affected by their research.

The approach of "nothing about us without us" has been employed by marginalised communities to seek inclusion in policy and decision-making. Researchers should adopt this mindset and strive to engage meaningfully with communities affected by research at all stages of the research process. To challenge entrenched power hierarchies in health research, cancer researchers must engage meaningfully and establish equitable partnerships with communities impacted by research. This involves setting research priorities identified and led by priority populations and involving these communities in the design, conduct, and dissemination of findings.

Meaningful engagement occurs when researchers recognise the value and benefits of equitable partnerships with communities. "They must not only value the perspectives and experiential knowledge of communities and view them as equally important as the academic knowledge that researchers possess but also be willing to co-create knowledge through these partnerships" (Minkler, 2004). Researchers require training and resources to develop the skills needed to navigate relationships with communities that have historically held no power in research processes and have at times experienced neglect, deception, and exploitation, which have led to mistrust (Venkateswaran et al., 2023).

While meaningful community engagement can be slow and challenging, it should be integrated into research plans from inception. The pressures of academia and scientific research can hinder effective engagement within timelines and budgets, but allocating adequate time and resources must be a leadership priority.

Cancer research needs reflect the diversity of the Australian community both as participants in clinical research and composition of research teams.

A more inclusive approach to cancer research is critical for ensuring that scientific findings are applicable to all Australians, regardless of their cultural, ethnic, or socioeconomic background. This inclusivity is key to addressing health disparities and improving outcomes for underrepresented groups, who may experience different cancer risk factors, levels of access to care, and treatment responses.

In clinical research

Cancer clinical trials are vital for improving patient care and outcomes, introducing new standards through precision medicine and advanced therapies. Despite their importance, participation remains low, with only 2% to 8% of adults with cancer participating, though most report positive experiences. Participants tend to be younger, healthier, and less diverse in race, ethnicity, and geography compared to typical clinic patients. This limited diversity raises concerns about the generalisability of results and contributes to racial disparities in cancer outcomes. Despite ongoing efforts, progress in increasing diversity in clinical trials

remains limited. Removing enrolment barriers for underrepresented groups is key to advancing health equity (Oyer et al., 2022).

Underrepresented groups in medical research are not necessarily unwilling to participate; instead, multiple factors must be considered. Health literacy among potential participants has been identified as a barrier to research engagement, while limited economic resources can make voluntary participation difficult. Rural populations, in particular, face structural barriers, such as limited healthcare access and transportation issues. Any discussion about the low participation rates of underrepresented groups in medical research must also address distrust and mistrust of systems, including healthcare systems, that have historically benefitted some while disadvantaging others. Acknowledging historical and current discrimination and abuses is crucial, as these factors drive disengagement from both healthcare and research (National Academies of Sciences, Engineering, and Medicine, 2022). Addressing these issues is key to fostering inclusivity and trust in medical research for currently underrepresented groups (Johnstone, 2007).

Efforts must focus on understanding and overcoming barriers to participation for different groups. These barriers are complex and interrelated, necessitating action at multiple levels. For example, individual researchers and research organisations can address language barriers by providing recruitment materials in multiple languages. Conversely, improving healthcare access for rural populations requires government action to build the rural health workforce and expand services.

Observing ethical guidelines is essential for ensuring respectful and equitable interactions between researchers and minority group participants. In Australia, the *National Statement on Ethical Conduct in Human Research* by the National Health and Medical Research Council, Australian Research Council, and Universities Australia establishes principles such as informed consent, cultural sensitivity, and managing power imbalances. It emphasises autonomy, transparency, and fairness. *marra ngarrgoo, marra goorri* (The Victorian Aboriginal Health, Medical, and Wellbeing Research Accord) aims to elevate the ethical standards of Aboriginal and Torres Strait Islander health, medical, and wellbeing research in Victoria by aligning with principles of self-determination, promoting Aboriginal-led research, fostering trust, enhancing community benefits, ensuring cultural appropriateness, and protecting Aboriginal knowledge and data.

Increasing diversity and representativeness in clinical trials and ensuring that research adheres to guidelines for respectful and equitable engagement are critical for promoting fairness and building trust in marginalised communities.

In research leadership and teams

White, cisgender, heterosexual men dominate the ranks of senior academic positions within Australia's education and research institutions. In contrast, individuals with other marginalised identities, particularly non-White academics, are often confined to roles as tutors, lecturers, and part-time faculty. This lack of diversity among faculty, and consequently among lead researchers, limits the depth and quality of research produced by these institutions (Hattery et al., 2022).

Research groups composed of individuals from diverse backgrounds offer a wider range of perspectives, ideas, and approaches, enhancing productivity, creativity, and problem-solving capabilities. Studies demonstrate that diverse teams are more effective at addressing complex challenges and producing meaningful solutions, which boosts the scientific impact of their research outputs (Fischer et al., 2024). This increased impact extends to greater public health benefits, as more inclusive research leads to comprehensive solutions that better serve diverse communities. A diverse research workforce is also better positioned to build trust with marginalised communities, encouraging their participation in clinical research.

Ethical and research guidelines are essential for fostering respectful and equitable interactions between researchers and participants from underrepresented groups who may hold less power. Similar attention is needed to address power differentials within research teams and to promote genuine inclusion of underrepresented members who may face barriers to participation and influence within a team. Appointing someone from an underrepresented group to a role or committee without genuinely valuing their input is performative and tokenistic; it involves actions taken merely for compliance or to enhance an organisation's image, rather than fostering real change (New Frontiers in Research Fund). This lack of

genuine inclusion also risks producing research that does not fully capture the needs and perspectives of these communities. Effective strategies include involving all team members in planning, decision-making, and evaluation and creating a safe, respectful space for open dialogue, conflict resolution, and feedback. Practicing cultural humility—a continuous process of self-reflection and learning—is crucial to acknowledging and addressing biases within teams. By adopting these practices, research teams can better ensure that all members, regardless of background, contribute meaningfully to the research process (Fritter & Shihabuddin, 2024).

Actionable Steps

Building Partnerships and Recruitment

- Allocate time to understand your institution's reputation within the local community.
- Build long-standing relationships with patients, patient advocacy groups, and community leaders and groups.
- Identify and assess the needs of the community at the outset and align the research protocol accordingly.
- Involve the community as a partner from trial design through to retention, protocol compliance, and result dissemination.
- Incorporate community engagement into budgets, timelines, and project scopes.
- Maintain partnerships with the community beyond the trial's conclusion.
- Offer and promote participation opportunities to a diverse population, including translating recruitment materials.

Accessibility

- Focus on participant access and experience during trial design.
- Implement decentralised approaches to reduce geographic barriers.

Workforce

- Develop strategies and action plans to promote diversity within the clinical research workforce.
- Ensure those designing or conducting trials complete regular education and evaluation to demonstrate and maintain cross-cultural competencies, mitigate bias, and communicate effectively to build trust. (Programs should be developed with involvement of patients, community leaders, and groups and informed by their experience).

Adapted from : Kelsey et al.,2022 and Oyer et al., 2022

FURTHER RESOURCES

See Appendix 1 for links to some useful resources relevant to discussions above.

7. Focus Area - Education

Empower the cancer workforce with knowledge and skills to identify and address inequity

Overview – What will drive equity in research and training

- Embedding health equity into training enables the workforce to reflect critically about the influence of the cultural and social determinants of health and to provide culturally appropriate, safe, and inclusive care.
- Rather than being siloed as a standalone subject, discussions of equity and healthcare disparities should be integrated across existing curriculum for the cancer workforce.
- Incorporating cultural perspectives into training supports the cancer workforce to approach care for all patients respectfully and knowledgeably with an appreciation of their values and needs.
- Training and education should include opportunities to explore awareness of one's own socio-cultural background, identity, and biases, and how these factors impact patient-provider communication in the management of cancer.

"…what they need to learn to do as a clinician, in whatever part of the health service, is to look at the person in front of them. Don't think about the person they saw before; don't think about the person they saw afterwards. Deal with the person they have in front of them. And if they do that, they will tick the equity box because they are seeing that that patient as a person who deserves their full and 110% perception [sic] at that time… not thinking about anything or anybody else, seeing the patient that's in front of them, addressing the patient that's in front of them".

Consumer during consultations for the Framework

Education and training should equip the research and healthcare workforce with the knowledge, awareness, and skills needed to understand broader issues impacting health to achieve improved outcomes for communities.

"Integration of the social determinants of health into education and training will prepare the workforce to adjust clinical practice, define appropriate public health programmes, and leverage cross-sector policies and mechanisms" (World Health Organization).

The healthcare workforce must be equipped with knowledge of social and cultural determinants of health and an understanding of how structural inequalities drive disparities in the causes and burden of disease across different patient groups. Educating about structural discrimination in medical schools is essential for addressing health inequities and improving patient care.

Structural discrimination refers to the policies, practices, and societal norms that systematically disadvantage certain groups based on characteristics such as race, ethnicity, gender, or socioeconomic status. When students learn about health disparities without understanding the impact of structural racism, historical segregation, biased views on gender and sexuality, and medicine's role in promoting racial biases, they may wrongly attribute blame instead of recognising the harmful systems driving disparities.

Education and training should focus on developing the skills necessary for respectful communication between healthcare professionals and patients from varying backgrounds, such as socioeconomic status, age, sexuality, ethnicity, religion, or gender (Ziegler et al., 2022). This culturally inclusive approach supports healthcare professionals in delivering care with an appreciation of each patient's values and needs. Importantly, it enhances workforce preparedness for working in Indigenous health, fostering openness, increased awareness, effective advocacy, and a deeper understanding of Indigenous health issues (Australian Institute of Health and Welfare, 2015).

Rather than being siloed as standalone topics, discussions on equity and healthcare disparities should be integrated into existing education and training for the healthcare workforce. A lack of integration further distances clinicians from the social contexts affecting patients' health. The overarching goal should be to eliminate the separation of health equity and medicine (Landry, 2021).

Intentional discussions about privilege should be integrated into the education and training of cancer care practitioners and researchers, facilitated by culturally knowledgeable and competent educators. Faculty and organisational leaders can model cultural humility by demonstrating an "ego-less" attitude and sharing examples of their past mistakes and the lessons learned from them. These reflections help broaden students' understanding of barriers to healthcare. Educators can encourage students to compare the experience of listening with a "judging eye" or "clinical eye" versus a curious, respectful, attentive, and open-minded approach, fostering a deeper appreciation for patient perspectives (Fitzgerald et al., 2019).

Training should also provide opportunities for healthcare professionals to reflect on their own socio-cultural backgrounds, identities, and the biases they may unconsciously hold. This self-awareness is crucial for recognising implicit prejudices and tendencies to stereotype, which can shape attitudes and behaviours in clinical settings. By fostering an environment of self-reflection, education programs can help healthcare workers better understand how these factors influence patient interactions and care decisions, ultimately promoting more empathetic, respectful, and culturally responsive healthcare delivery.

Diversity is essential within healthcare education and training, encompassing both those being trained and those providing the training.

To increase diversity in the healthcare workforce, the culture of healthcare education and training must change. The underrepresentation of people from diverse backgrounds in healthcare is closely linked to disparities in access to post-secondary education and training. This underrepresentation of minorities in medical training (URiM) includes both those being trained and those conducting the training, especially at senior faculty levels, largely due to systemic challenges and biased academic barriers. Greater support is required for URiM trainees and faculty to help them overcome these barriers (Carethers, 2020). A current lack of role models and representation in faculty positions negatively impacts the aspirations of underrepresented minority students.

This underrepresentation is problematic as it, in turn, results in a healthcare workforce that does not reflect Australia's diverse population, and those in training miss vital opportunities to gain cultural perspectives from their peers. Training a healthcare workforce that can meet the needs of Australia's diverse population is difficult within a culturally restricted environment. This absence of cultural diversity undermines the quality of education and adversely affects the health status of minority populations (Sullivan Commission, 2016).

Proactive measures are needed to facilitate greater access to education and training for underrepresented minorities, requiring leadership, commitment, and accountability at the highest institutional and governmental levels.

Actionable Steps

- Education and Training organisations should assess their current diversity status using demographic data and faculty and trainee surveys on diversity culture.
- Leadership should collaborate with committees and task forces with diverse representation to establish a vision and mission statement on actively addressing diversity, followed by a strategic plan informed by these assessments.
- A strategic action plan must be implemented with clear communication, integrating the plan across the entire organisation. This should include measures such as targeted scholarships, inclusive curricula, mentorship programs, and reducing reliance on standardised tests for admissions to schools of medicine, nursing, and dentistry
- Recognising that meaningful progress takes time, begin efforts by collaborating with experts and those with lived experience to incorporate diverse perspectives and drive workforce transformation to embed equity into cancer education and training, clinical care and research.

Adapted from Sullivan Commission and 2016; Carethers, 2020

FURTHER RESOURCES
See Appendix 1 for links to some useful resources relevant to discussions above.

8. Everybody has a role to play in achieving health equity

"When it comes to equity in general, there needs to be embedded foundational learning across the workforce, and leaders need to role model cultural humility, redistribution of power, and visibly support a diverse workforce. Much like the mental health system reform in Victoria, it needs to centre "Lived Experience". ***What this means is that the system needs to centre the voice of consumers. This is part of creating equity. It needs to not only occur at this level of policy and strategy design, but also in service delivery, research, evaluation, and monitoring.*** *Co-creation, so to speak. The starting point for this is intentional and purposeful connection, listening, being trauma informed, respectful of diversity, using inclusive language, taking a curious mindset, and finding common ground. "*

Consumer during consultations for the Framework

Creating equitable health systems takes a true partnership between leadership, the cancer workforce, consumers and community. To elevate health equity as a priority, it is critical to have dedicated leaders capable of leading the change, and the commitment of financial and human resources to ongoing change efforts. Representation of a diversity of voices of people who experience barriers to healthcare access is also essential. Everyone has a role and responsibilities to fulfil in order to move towards an equitable health system.

Leadership

Committed and engaged leadership is vital to fostering a culture of equity. Achieving cultural change requires strong, strategic executive leadership across the cancer care and control system. Diverse representation at the leadership level is key, as it signals to the organisation and beyond the value placed on diversity and the necessity of varied perspectives to drive change. Health equity must be prioritised strategically, extending beyond individual interventions to systematic, organisation-wide changes. According to Doherty et al. (2021), "Dedicated leaders are crucial to sustaining change efforts, committing financial and human resources, and championing transformation."

The central role of leadership in driving change to address complex systemic and societal issues related to inequality is well recognised. For example, the Champions of Change Coalition is a globally recognised strategy to promote gender equality, advance women in leadership, and build inclusive workplaces, supporting leaders to drive and be accountable for change within their organisations. Similarly, Our Watch's Leadership Commitment Checklist highlights the role of leadership commitment in driving change. Genuine cultural change relies on strategic leadership, backed by systems, policies, and processes that uphold cultural safety and respect. Leaders must set the standard by demonstrating a commitment to continuous learning, reflective practices, and openness to change, creating an environment where cultural safety and respect are embedded norms.

Cancer Workforce

Cancer healthcare, research, and education organisations support their workforces in embedding equity in everyday practices and strive for a diverse workforce at all levels that reflects the heterogeneity of the communities they serve. Commitment to a diverse workforce includes valuing employees from diverse backgrounds without overburdening them.

Front-line health workers

When acknowledging the historical forces that have created systemic barriers perpetuating health inequities, the pursuit of health equity might feel like an insurmountable task. However, for individual front-line clinicians, every interaction with patients and carers within cancer care services presents an opportunity to advance equity. Front-line staff are the health system's most valuable asset in achieving health equity, as they are closest to patients and best positioned to identify barriers to high-quality care. All health services must aim to support and empower front-line staff to deliver equitable care in every aspect.

Researchers

Researchers play a critical role in achieving health equity by identifying and addressing disparities in healthcare access, outcomes, and opportunities. By collaborating with consumers and communities and implementing culturally informed methodologies, researchers help generate evidence-based interventions that are more effective and equitable. Their work drives policy change, informs healthcare practices, and promotes a more just and inclusive healthcare system that serves all populations fairly. Research teams should be intentionally established to be diverse and inclusive, ideally reflecting the population represented in or affected by the research. This diversity includes researchers with varied backgrounds and experiences, such as geographic location, sexual orientation, gender identity, religion, caste, Indigenous or ethnic background, caregiving responsibilities, career stage, lived experience, and disciplinary expertise. This inclusive approach strengthens research by incorporating multiple perspectives, helping to identify and address different needs and issues more effectively.

Educators

Educators are responsible for shaping the future cancer care workforce and play a crucial role in fostering cultures of equity within cancer care organisations. Their influence extends beyond teaching technical skills to promoting inclusive values and role-modelling practices that address disparities in patient care. To achieve this, it is essential to enhance diversity within institutions that provide education and training, ensuring representation at all levels—from leadership positions to classroom settings. This approach helps

create a healthcare environment where diverse perspectives are valued, enriching both the learning experience and the delivery of equitable patient care.

Consumers

Consumers play a vital role in advancing health equity and should be included as key collaborators in research processes. Meaningful consumer engagement ensures that the issues prioritised reflect the real needs of the community, enhancing the relevance and communication of research findings. This collaborative approach helps turn research findings into practical solutions that make healthcare delivery and policy more inclusive and fairer. Involving consumers also helps direct resources towards projects that can create the most positive change, ensuring efforts align with the needs and well-being of different communities.

See the VCCC Alliance Consumer Engagement Toolkit to learn more about partnering with consumers to improve health equity outcomes.

Community

Identifying problems of inequity and developing solutions together with affected populations, allows ownership over the process and ensures that interventions are sustainable and acceptable to the community at large. Communities play a crucial role in advancing healthcare equity by bringing diverse voices and experiences to the forefront. When community members are actively involved in healthcare planning, research, and policymaking, they help identify real-world challenges and align solutions with the needs of those affected. Community engagement fosters trust, strengthens relationships between healthcare providers and patients, and ensures culturally relevant care.

Chapter 7: VCCC Alliance Collaborative Projects to Support Cancer Equity Framework

We have aligned these projects to the action areas of the Cancer Equity Framework and identified the priority populations they seek to serve, but these projects are multidimensional and have potential to address multiple facets of inequity across the cancer care and research.

Project Name	Action Areas	Focus Area	Collaborators	Targeted Population(s)
Cancer Equity Framework (CEF) Collation and development of resources to support CEF e.g. resources for leadership and cancer workforce to support inclusive and culturally safe practices.	All	All	VCCC Alliance member organisations, key cancer and health organisations, consumers, and community orgnisations.	All
Aboriginal and Torres Strait Islander Programs Building relationships and working with Aboriginal Community Controlled organisations to support efforts to reduce disparities for Aboriginal and Torres Strait Islander people. E.g. Advocating for implementation of the Victorian Aboriginal Health, Medical and Wellbeing Research Accord.	All	All	Victorian Aboriginal Community Controlled Health Organisation (VACCHO), Aboriginal Community Controlled Organisations (ACCOs), National Aboriginal Community Controlled Health Organisation (NACCHO)	Aboriginal and Torres Strait Islander
Data improvement (1) Education module to improve identification of CALD population in health service data;(2) support development of Indigenous data Sovereignty and Governance modules	Assessing	Clinical care	Health services, Victorian Cancer Registry, Australian Institute of Health and Welfare, Australian Bureau of Statistics, Victorian Agency for Health Information, Cancer Australia, Aboriginal Community Controlled Organisations	Aboriginal and Torres Strait Islander, CALD
The nursing equity assessment tool (NEAT) Co-design training resources with regional cancer nurses to support implementation of the NEAT as a component of usual nursing care. Develop new resource page on WeCan website. Develop education module for NEAT uptake.	Assessing	Clinical care	University of Melbourne, Regional health services	All, Regional

Lung Cancer Screening Pilot with Aboriginal and Torres Strait Islander communities Develop and pilot an education resources and tools for a navigator model of care for Aboriginal and Torres Strait Islander people being referred into the National Lung Cancer Screening Program	Addressing	Clinical care	VACCHO, ACCOs, Peter MacCallum Cancer Centre, Australian National University	Aboriginal and Torres Strait Islander, Regional, All
Lung Cancer Screening implementation in primary care for CALD patients Develop tools and resources for primary care physicians and CALD communities through co-design with community partners, to ensure referral into the National Lung cancer Screening Program for CALD participants	Addressing	Clinical Care	University of Melbourne	CALD, All
Cassowary-CALD Identify adaptations needed of the Cassowary clinical trial protocol to facilitate patients from CALD communities to participate in primary care-based cancer clinical trials.	Addressing	Clinical care	University of Melbourne, Primary care providers	CALD
ADVANCE-ACCESS Providing equitable access to cancer symptom care for medical oncology patients from a culturally and linguistically diverse (CALD) background.	Addressing	Clinical care	Peter MacCallum Cancer Centre, Austin Health, Ethnic Communities Council of Victoria	CALD
Health Research for All Building capability and development of an online platform of educational tools for health & medical researchers to embed equity practices when working with priority populations.	Addressing	Research	Murdoch Children's Research Institute, Association of Australian Medical Research Institutes	All
Care Plus Extend Extension of the Care Plus program to measure the clinical effectiveness, benefits and barriers of a telehealth model of palliative care delivered to people with Sarcoma, Lung and Colon Cancer in regional and metropolitan settings.	Addressing	Clinical care	Peter MacCallum Cancer Centre, Royal Melbourne Hospital University of Melbourne, St Vincent's Hospital, Regional Cancer Services	Regional

APPENDIX 1: RESOURCES

Useful resources to support health organisations advance heath equity that were accessed in the development of the framework are listed here.

For organisations striving for health equity

Organizational Checklist

This checklist, developed by the Association of State and Territorial Health Officials (US), is designed to support organisational improvement in advancing health equity. It includes comprehensive questions on current practices across seven aspirational "Foundational Practices for Health Equity.".

Building Organizational Capacity for Health Equity Action: A Framework and Assessment Tool for Public Health

This framework, developed by Lambton Public Health, outlines key elements essential for driving equity action at the local level. It seeks to encompass the various dimensions of public health practice by identifying two broad drivers of capacity for equity action: internal organisational factors and external organisational factors.

Improving Health Equity: Assessment Tool for Health Care Organizations

The Institute for Healthcare Improvement (IHI) developed this assessment tool to assist healthcare organisations in evaluating their current health equity efforts and identifying areas for improvement. Teams utilise the assessment to guide the development of an equity strategy and facilitate discussions within the organisation to advance health equity.

A Blueprint for Health Equity Circles

This resource provides detailed guidance on establishing a practice of Health Equity Circles within in your organisation. These circles provide a safe space for crucial conversations related to health equity and to exchange ideas to personally and/or professionally move from discussion to action

Principles for Using Public Health Data to Drive Equity

This resource offers framework to understand how methods across the entire data life cycle can enhance the impact and equity of public health data systems. The data equity principles offer guidance on incorporating equity-mindedness throughout the data life cycle to build more just and inclusive data systems.

What is Cultural Humility

In this video by Wollongong City Libraries, we hear from health professionals and community members exploring the concept of cultural humility and its practical applications. These conversations aimed to deepen understanding of cultural humility as a continuous, self-reflective process that goes beyond mere awareness of cultural differences.

Cultural Humility Toolkit

This tool is designed to help organisations initiate actions toward developing a cultural humility plan. It provides links to resources for creating a plan and for fostering individual self-reflection. Group or institutional members start by assessing their readiness to engage in antiracism and cultural humility efforts. The tool then offers two pathways: one for those prepared to work deeply and immediately, and another focused on facilitating courageous conversations that may be essential for laying the groundwork for cultural humility initiatives.

Clinical Care

Building Equity into Public Policies Designed to Promote Health A study of health equity impact assessment tools

An excellent resource is available in the Appendix (Page 44) of this comprehensive study on health equity impact assessment tools by Wellbeing SA and Stretton Health Equity, University of Adelaide. It includes a six-step rapid checklist for quick reference when resources are limited (Part A) and a detailed flow chart for gathering additional information, such as data, community engagement, power dynamics, and policy considerations (Part B).

Equity and Performance Improvement: A Novel Toolkit That Makes Using an Equity Lens the Default

Quality improvement (QI) methods are widely utilised in healthcare; however, most lack prompts or frameworks that encourage analysis of the role and impact of bias, inequity, and social determinants of health (SDOH) on improving outcomes. This article discusses the development and pilot testing of a toolkit designed to support QI teams in evaluating diversity, equity, and inclusion (DEI) and SDoH considerations at each stage of the QI process. The toolkit includes templates for assessment and planning, which can be utilised or adapted by organisations aiming to incorporate DEI and consideration of SDoH into their QI processes.

How cultural humility and cultural competence impact belonging

This easy to read and accessible article provides a great introduction to cultural humility and explores five ways a team can practice cultural humility in terms of team bonding, coaching, conversing, using what you learn, and understanding limitations.

Research

marra ngarrgoo, marra goorri (The Victorian Aboriginal Health, Medical and Wellbeing Research Accord)

The Victorian Aboriginal Research Accord is a key initiative under the Aboriginal Health and Wellbeing Partnership Agreement between VACCHO and the Victorian Government, endorsed in May 2023. Research organisations involved in health, medical, and wellbeing research impacting Aboriginal and Torres Strait Islander people in Victoria are encouraged to contact the Accord Team for participation in its implementation.

How to do (or not to do)…how to embed equity in the conduct of health research: lessons from piloting the 8Quity tool

This article introduces the '8Quity' tool which comprises eight domains of equity which roughly correspond to the typical stages in the research process—from team formation to capacity strengthening, research ethics and governance to relationships with research partners, participants and stakeholders beyond the project period.

Education

Social Determinants of Health: A Framework for Educating Health Professionals

This framework has been developed as a guiding tool for health professional educators to cultivate a health workforce of lifelong learners who recognise the importance of relationships and collaborations in understanding and addressing community-identified needs, while also enhancing community assets.