

**Background Paper to VicHealth
Position Statement on
Health Inequalities**

October 2005



VicHealth



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1 Preamble

The Victorian Health Promotion Foundation (VicHealth) is a statutory organisation established under the *Tobacco Act 1987*. VicHealth works with a range of partner organisations to deliver innovative responses to the complex social, economic and environmental forces that influence the health of Victorians.

It does this by working for all Victorians, through partnerships at all levels of government and in different sectors and by creating innovative programs based on research and evaluation.

In improving the health of all Victorians, VicHealth is committed to reducing inequalities in health. VicHealth's *Strategic Directions 2003–2006* identifies addressing health inequalities a key activity, stating that in this work it will seek to:

- increase the knowledge base about social and economic factors that cause poor health and identify effective ways for reducing inequalities; and
- establish partnerships with others working with and representing disadvantaged groups to reduce social and health inequalities.

VicHealth's vision is of a community where:

- health is a fundamental right;
- everyone shares in the responsibility for promoting health; and
- everyone benefits from improved health outcomes.

The Foundation's mission is to build the capabilities of organisations, communities and individuals in ways that change social, economic, cultural and physical environments to improve health for all Victorians; and to strengthen the understanding and skills of individuals in ways that support their efforts to achieve and maintain health.

This background paper is the basis for VicHealth's Position Statement on Health Inequalities available at www.vichealth.vic.gov.au/inequalities

2 VicHealth notes the following:

2.1 *Marked health inequalities exist in Australia*

- 2.1.1 Inequalities exist in the health of Australians across a range of health status indicators, including mortality (all-cause and specific-cause), morbidity, life and health expectancy* and self-perceived health. Inequalities also exist in factors associated with health, including health risk factors; health knowledge, attitudes and behaviours; and use of health and preventative services. These inequalities exist across a range of social, economic and cultural measures, the most significant and persistent being education level, occupation, income, employment status, refugee background, disability, Aboriginality and area-based measures of socioeconomic disadvantage.¹⁻¹⁹
- 2.1.2 Health inequalities are most marked between Indigenous and non-Indigenous Australians. Aboriginal men and women have a life expectancy that is 17 years lower than the national average.²⁰ Cardiovascular disease, injuries and poisonings (including accidents, self harm and assaults), cancer, respiratory diseases (including pneumonia, asthma and emphysema) and endocrine diseases (especially diabetes) are key contributors to ill-health and excess mortality in Aboriginal people.^{3,4,21}
- 2.1.3 Numerous Australian and international studies indicate that refugee populations in countries of settlement experience relatively poor health as a result of their exposure to extreme deprivation, war, conflict and human rights abuses in countries of origin and asylum, together with the stresses of settling in a new country. People from refugee backgrounds have relatively poor access to the resources required for health and wellbeing in Australia, including employment, income and housing.¹³ Many recent refugee arrivals are from countries ranked by the United Nations as having the lowest levels of human development and life expectancy in the world.^{22,23} Evidence suggests a high rate of parasitic and communicable disease; poor oral health; nutritional deficiencies; depressive, anxiety and post-traumatic stress disorders; chronic illness and child developmental problems.^{15,24,25} As refugees are not distinguished from migrants and the Australian-born in most data collection, it is difficult to quantify their relative health disadvantage on most commonly used health status indicators. Comparative data is available on self-reported health, with refugees being more likely to rate their health as fair (19%) or poor (13%) than people in the general population (14% and 5% respectively).^{3,13} They are also markedly more likely to report experiencing a significant level of psychological stress.^{3,13} Refugee populations face a number of barriers to accessing health services and have lower rates of participation in illness prevention programs.¹⁵

* Health expectancy is a population-based measure of the proportion of expected lifespan estimated to be healthful and fulfilling, or free of illness, disease and disability according to social norms and perceptions and professional standards.

2.1.4 People with disabilities tend to have poorer health as measured on a number of indicators. Some forms of disability have been found to be associated with lower life expectancy and higher morbidity rates.²⁶⁻²⁹ People with a disability are more likely to report poor self-rated health than the general population (11% compared with 5% in the general population) and are less likely to report that their health is excellent (9% compared with 19% of the general population).³ Rating of self-reported health tends to decline the greater the degree of disability.³ People with disabilities have also been found to have demonstrably poorer access to the social and economic resources required for health, experiencing higher rates of social isolation,³⁰ unemployment (9% compared with 5% for the general population)³¹ and violence³²; lower rates of workforce participation (53% compared with 81% in the general population) and lower average incomes.³¹ There is strong evidence that people with disabilities face barriers to accessing health care services and have lower rates of participation in illness prevention programs.^{24,26,29,33} The relationship between health and disability is complex, being influenced by complications of the disability itself, the impact of functional limitations associated with the disability, and by broader social and economic conditions experienced by people with disabilities. There is also variability in the extent and nature of disability. Nevertheless, it is widely accepted that this group is 'deserving of attention in its own right from the perspective of health as well as disability'.³

2.2 *There is a social gradient in health that favours those higher up the social scale*

2.2.1 Socioeconomic status is a major predictor of health outcomes across all societies: the association between health and socioeconomic status is one of the most consistent findings in health research. Socioeconomic differences in health exist for males and females at all stages of the lifespan. Low socioeconomic status is associated with higher morbidity, higher all-cause mortality rates and higher mortality rates for many major causes of death. It is also associated with increased health risk behaviour (e.g. smoking, lack of exercise, poor nutrition).^{1,3,6,8,35}

2.2.2 Health inequalities relate to both absolute and relative socioeconomic disadvantage. People in lower socioeconomic groups indisputably have the worst health status; however, the gradient increase in health associated with increasing socioeconomic status across populations indicates that a person's place on the socioeconomic grid also impacts on their health.³⁶

2.3 *Health inequalities are embedded in social and economic inequalities and are influenced by macro social and economic policy*

2.3.1 Inequalities in health status between population groups are embedded in social and economic inequalities. They are the outcomes of causal chains that 'run back into and from the basic structures of society'.³⁷ These chains of causation run from macro socioeconomic, cultural and environmental conditions, through living and working conditions and social and community networks,

to individual lifestyle factors. Inequalities in health status result from interactions between all these 'layers of influence'.^{37,38}

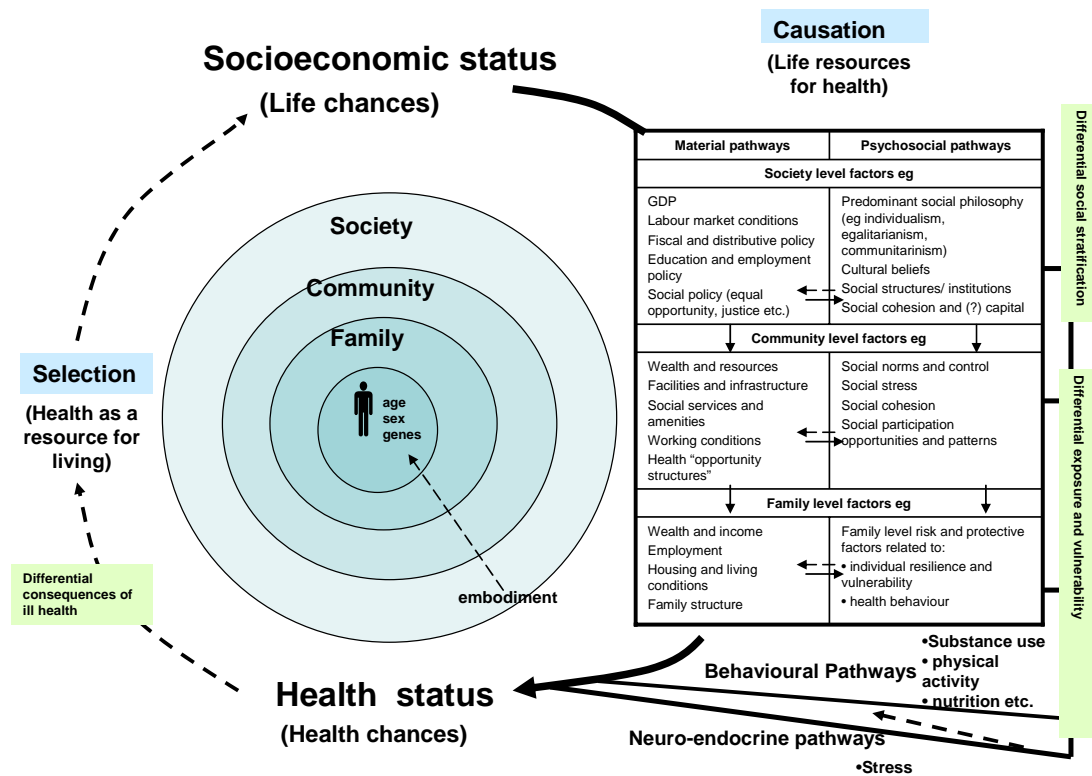
- 2.3.2 'Upstream' macro socioeconomic policy interventions may be powerful ways to address health inequalities. Interventions that address 'midstream' and 'downstream' determinants of health (e.g. health behaviour) may be easier to deliver; however, there is no guarantee that they will be effective in reducing health inequalities if root causes remain the same. This has led some to argue that interventions addressing downstream determinants of health will have little progress in reducing health inequalities without a redistribution of resources to the disadvantaged, and that income equality and the reduction of poverty must be fundamental policy goals.³⁹⁻⁴² The UK Department of Health has argued this approach by asserting that 'tackling inequalities generally is the best way of tackling health inequalities in particular'.⁴²
- 2.3.3 Experience in other countries suggests that macro-level approaches that address structural determinants of disadvantage may be effective in preventing health inequalities. The universalist social and healthcare policies in Nordic countries, including progressive taxation and social security benefits pegged to average incomes, have resulted in smaller absolute health inequalities and a better overall average population health status than countries such as Australia, the United States and the United Kingdom.^{43,44}

2.4 Health inequalities result from both causal and selection mechanisms and are related to both material and psychosocial factors

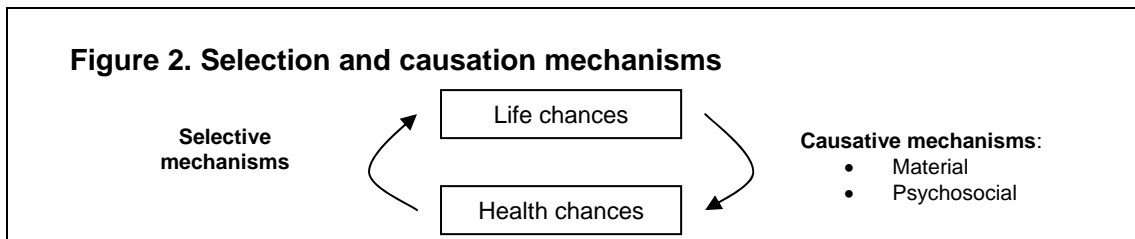
- 2.4.1 Even though the association between health and socioeconomic factors is well established, the mechanisms behind this association are less clear. There are three categories of explanation for this observed association: causal mechanisms, selection mechanisms (social mobility or reverse causation) and artifactual mechanisms (measurement error). The emergence of better quality evidence increasingly demonstrates that artifactual mechanisms do not explain much inequality in health.⁴⁵
- 2.4.2 There is general consensus that observed inequalities in health are driven largely by a complex set of causal mechanisms. Causal mechanisms that have been proposed include material and psychosocial factors.⁴⁵
- 2.4.3 Health inequalities are largely explained by unequal access to material factors necessary for health such as good housing, adequate income, healthy food, opportunities for recreation and access to health services (the 'material pathways' explanation).⁴³
- 2.4.4 These material inequities may also result in psychosocial factors which may in themselves be health damaging. Perceptions of inequality, social distrust and isolation may disrupt social processes among sectors of the community and also contribute to poor health in disadvantaged groups (the 'psychosocial pathways' explanation).^{43,46,47}

- 2.4.5 Both material and psychosocial factors influence the adoption of healthy or unhealthy behaviours, for example through the provision of physical environments which support good health (e.g. safe public places) and the establishment of community norms and patterns of social control.^{38,48}
- 2.4.6 At an individual-level, increased exposure to stressors associated with material or psychosocial factors may activate neuroendocrine responses that over time have direct deleterious effects on health, as well as indirect effects through influencing health-related behaviour (see figure 1).^{45,49,50}

Figure 1. An explanatory model of health inequalities



2.4.7 Social mobility and intergenerational poverty add to the complexity of understanding health inequalities. Longitudinal studies suggest that it is social position which predominantly determines health, rather than the reverse.⁴⁵ However, selection mechanisms also result in less healthy people being more likely to be downwardly socially mobile. Thus, the relationship between poor health and socioeconomic disadvantage, and between selection and causation mechanisms, may become cyclical across the lifespan. This can also be described as the relationship between life chances and health chances (see figure 2).^{45,49,50}



2.5 *Health inequalities result from the influence of these factors over a lifetime*

2.5.1 Health inequalities are the outcomes of differential exposure to adverse material conditions and psychosocial risks across the lifespan. Early life exposures may be expressed later in adult life in both health behaviour and disease (known as Barker's hypothesis or the 'latency pathway'). Adult health may also be seen as the result of the cumulation of exposure and risk across the life-course (the 'cumulative pathway'). There may be periods in life when people are especially vulnerable. Childhood is a particularly crucial time because of the influence of early life on developing behaviours and subsequent mental and physical health and development.^{37,38,43,50-52}

2.6 *The relationship between social and economic inequalities and health inequalities is complex*

2.6.1 Health inequalities cannot be simply addressed, as the relationship between social and economic inequalities and health inequalities is very complex. Health damaging exposures are not randomly distributed across the population but tend to cluster together in particular social groups. Groups may have more than one form of disadvantage and the impacts of multiple forms of disadvantage on health may be cumulative, synergistic and/or cyclical. For example, education is important in determining people's social and economic status and through this their health: people with lower education levels may be more likely to have poor working conditions, to be in receipt of a low income and to be unemployed or lack job security.^{35,51,53,54}

2.6.2 Interactions between 'layers of influence' on health (e.g. macro socioeconomic factors, working and living conditions, and social and community networks) contribute to the complexity of the relationship between socioeconomic disadvantage and health. For example, structural and institutional racial discrimination may lead

to social exclusion and socioeconomic disadvantage and consequently to poorer health. The interpersonal experience of racism may also have independent effects on health through the direct impact of the associated psychological stress.^{19,55,56}

2.7 Health inequalities also result from the effects of places and areas on health

2.7.1 As well as social inequalities in health between different subgroups of the population, there are spatial health inequalities that exist across different geographical areas. Mortality (years of life lost) in the most disadvantaged areas in Victoria is 30% higher for men and 19% higher for women when compared to the least disadvantaged areas.

2.7.2 Spatial inequalities are important because they indicate the potential influence of environment and support the existence of area-level influences on health. Spatial inequalities in health are mostly 'compositional': that is, the result of people with similar types of health behaviours, health risks and health status living in similar places. However, they may also be 'contextual' and due to the effect of the areas in which people live. Put another way, 'people create places and places create people' (p. 26).⁵⁷ While composition appears to be the primary cause of spatial differences in health, people may experience poorer health in part because they live in environments which do not support good health (e.g. without accessible, cheap and healthy food; safe streets; recreation facilities; and opportunities for meaningful social participation).⁵⁷⁻⁶⁰

2.7.3 Contextual or area-level influences on health relate to the physical, economic and social environment and may exist from the neighbourhood up to the societal-level. They may be related to material or psychosocial differences between areas. Contextual or area-level effects on health are important for two reasons. Firstly, because they suggest that socioeconomic inequality may affect everyone's health, not only those who are disadvantaged; and secondly, because they highlight the importance of addressing environmental determinants of health inequalities.^{57,59-61}

2.7.4 In understanding health inequalities, it is useful to combine the concept of contextual influences on health with a cumulative lifespan perspective. In this respect, individual health measured at one point in time is partly the result of contextual influences earlier in life.

2.8 There are ideological and strategic issues that influence responses to health inequalities

2.8.1 Not only is there an incomplete understanding of the underlying causal pathways that generate health inequalities but there are also ideological differences about the nature of society that influence policy responses to health inequalities. Acceptance of health as an intrinsic human right requires consideration of the mechanisms for achieving equity in health, that is, the reduction of unfair inequalities.

- 2.8.2 Equality and equity are different principles, but are sometimes used interchangeably. Equality refers to people having equal shares of a resource (such as government resources for health programs). Equity is concerned with the fairness of the distribution, which may or may not result in people having equal shares depending on the resources they already have (for example, the extent of their own health resources or level of health). Some health inequalities are not inequitable as they result from biological factors and are unable to be avoided (for example, some health differences between age groups). However, most health inequalities are differences that are avoidable and unnecessary and are therefore unfair and unjust.⁶²
- 2.8.3 In addressing health inequalities, the distribution of scarce health resources is a major concern for health promotion. A critical challenge in this is whether we are concerned with improving the health of the poorest alone, or reducing the differences across the gradient of socioeconomic disadvantage from poor to rich.
- 2.8.4 The balance of universalist (population-wide) or selectivist (targeted) approaches is a key strategic challenge in addressing health inequalities. Public health has traditionally relied on population-wide strategies. Population-wide approaches are an appropriate response to the socioeconomic gradient of health, as they result in the greatest net benefit whenever risk is diffused through the whole population.⁶³
- 2.8.5 Population health approaches may not reduce relative health inequalities (e.g. the ratio between the death rates in the lower and upper socioeconomic classes may remain the same) but they may reduce absolute health inequalities (e.g. reducing death rates evenly across the population will prevent more deaths per 100 000 in the lower socioeconomic groups because of their relatively higher rates of death).³⁹
- 2.8.6 Behaviourist (lifestyle) population health approaches have historically been more effective among higher socioeconomic groups, however, and population health gain may reflect the comparative health improvement of this group relative to others. Thus, population-wide behavioural strategies may increase, rather than reduce, health inequalities. To effectively address health inequalities we need to:
- use more effective universal strategies, such as social policy and environmental approaches that reduce risk across the population;
 - more effectively tailor universal behavioural strategies to reach high risk groups; and
 - selectively target high risk groups.^{39,64,65}
- 2.8.7 There is a large theoretical base to explain the existence and causes of health inequalities but little empirical evidence on the effectiveness of interventions to reduce health inequalities.^{44,64,66}
- 2.8.8 There is a lack of research on the sociopolitical causes of health inequalities. Activity has focused on trying to prevent identified

downstream outcomes as opposed to addressing the upstream underlying causes of inequality.⁶⁵⁻⁶⁷ There is evidence to suggest that macro policy approaches can achieve a reduction in health inequalities: if policy can result in widening health differentials, then alternative policy can potentially decrease these differentials.⁶⁸⁻⁷⁰

2.8.9 Further studies measuring social mobility, socioeconomic status and health over multiple points of time are needed to expand understanding of the complex relationship between socioeconomic disadvantage and poor health.^{46,71}

2.8.10 Research challenges in health inequalities include designing evaluation studies of interventions which can improve life and health chances; creating a 'joined up science of health inequalities' which combines epidemiological research on health inequalities and research on socioeconomic inequality; and, more generally, moving the research agenda from description to intervention and explanation.³⁸

2.9 Health inequalities are emerging as key issues on policy agendas

2.9.1 Growing evidence on the extent of discrepancies in health between different social groups has placed health inequalities on the public health policy agenda internationally. The United Kingdom, Sweden, Canada, the Netherlands and New Zealand have been particularly active.^{39,72}

2.9.2 Although countries have developed different policy responses to health inequalities they share common policy 'entry points' in aiming to:

- reduce inequalities in power, prestige, income and wealth (e.g. through redistributive mechanisms);
- reduce the effect of health on socioeconomic position (e.g. reduce the economic consequences of poor health through illness benefit);
- reduce the effect of socioeconomic position on the risk of negative health exposures (e.g. by providing good public housing for low income earners); and
- reduce the health effects of being in a low socioeconomic position (e.g. through providing appropriate primary care as illustrated by the approach taken by the Netherlands shown in table 1).⁵⁰

2.9.3 The issue of health inequalities has progressively emerged on Commonwealth and State Government policy agendas. In 1999, the Commonwealth Department of Health and Aged Care produced a discussion paper examining the relationship between health and socioeconomic disadvantage. This document identified the significant impact of structural issues on health (including housing, employment, education and transport) in addition to the broader influences of social and economic policy. It also acknowledged the

role of governments in addressing the social and economic determinants of health and in alleviating poverty.⁵⁴

- 2.9.4 In 2004, the NSW Department of Health released the NSW Health and Equity Statement: In All Fairness, Increasing Equity in Health Across NSW. The statement provides a framework for planning, outlines six key focus areas for action including investment in early life and strengthening primary care, and acts as a 'foundation for integrating equity into the core business of NSW Health'.⁷³

Table 1. Strategic entry points for intervention in an integrated policy model: Examples from public health policy in the Netherlands

A. Interventions and policies targeting socioeconomic disadvantage

- Policies that promote educational achievement of children from lower socioeconomic families
- Tax and social security policies that reduce/prevent increases in income inequalities
- Antipoverty policies, particularly those that relieve long-term poverty through special benefit schemes and help with finding paid employment
- Development and implementation of special benefit schemes for families whose financial situation threatens the health of their children

B. Interventions and policies to reduce effects of health on socioeconomic disadvantage

- Benefits for long-term inability to work, particularly for those who are totally or partially disabled due to occupational health problems
- Adaptation of working conditions for chronically ill and disabled people to increase work participation
- Health interventions among long-term recipients of social benefits to remove barriers to finding paid employment
- Development and implementation of counselling schemes for school pupils with regular or long-term health related absenteeism

C. Interventions and policies targeting factors mediating the effect of socioeconomic disadvantage on health

- Adapting health promotion programs to the needs of lower socioeconomic groups, particularly by focusing on environmental measures, including introducing free fruit at primary schools
- Implementing school health promotion programs that target health related behaviour (particularly smoking) among children from lower socioeconomic families
- Introducing health promotion into urban regeneration programs
- Implementation of technical and organisational measures to reduce physical workload in manual occupations

D. Interventions and policies to improve accessibility and quality of health care services

- Maintaining good financial accessibility of health care for people from lower socioeconomic groups
- Relieving the shortage of general practitioners in disadvantaged areas
- Reinforcing primary health care in disadvantaged areas by employing more practice assistants, nurse practitioners and peer educators to, for example, implement cardiovascular disease prevention programs and better care for people who are chronically ill
- Implementation of local care networks aiming for the prevention of homelessness and other social problems among chronic psychiatric patients

2.9.5 Over the last 15 years, the Victorian Government has incorporated addressing health inequalities into health policy related to specific population groups and priority health areas as well as general public health and health promotion policy. Health inequalities have also been flagged in community building initiatives designed to address the wellbeing and life chances of people in particular geographic communities.⁷⁴ In 2001, the State Government developed a 10 year vision for Victoria – *Growing Victoria Together* – which identified ‘tackling health issues linked to inequality including mental and dental health’ as a priority action.⁶⁸ The vision explicitly outlined the reduction of inequalities in health, education and wellbeing between communities as a measure of progress. This was followed by trials of programs to address social inequalities, including Best Start and Neighbourhood Renewal programs. Following on from the Growing Victoria Together initiative, the State released a position paper – *Challenges in Addressing Disadvantage* – in March 2005 and subsequently an action plan – *A Fairer Victoria: Creating Opportunity and Addressing Disadvantage*.^{69,70} These documents argue that reducing socioeconomic disadvantage is in the interests of all Victorians and include a commitment to tackle disadvantage over the medium term in five key ways:

- reducing barriers to opportunity;
- ensuring that universal services provide equal opportunity for all;
- strengthening assistance to disadvantaged groups;
- providing targeted support to the highest risk areas; and
- involving communities in decisions affecting their lives and making it easier to work with government.

The action plan contains 85 actions to be undertaken by the Government under 14 key strategies.

2.9.6 Health inequalities have been an important focus of State Government health monitoring and surveillance initiatives, including the reports on the health status of Victorians, burden of disease studies and population health surveys. The Public Health Group of the Department of Human Services has identified health inequalities as a strategic priority and is beginning to identify the population-level interventions that are most appropriate in addressing health inequalities.⁷⁵

3 VicHealth principles

VicHealth adopts a goal for health equity to create equal opportunities for health and bring health differentials down to the lowest level possible.⁶² In particular, VicHealth acknowledges that:

- 3.1 Societies that strive to enable all individuals to participate fully in social, economic and cultural life are more likely to have healthy citizens than societies that allow individuals to be excluded, marginalised and deprived.

- 3.2 Equitable access to social, economic and environmental conditions that sustain and promote health is a fundamental human right. In Victoria, significant differentials in these conditions for health and health status exist between population subgroups.
- 3.3 Health promotion efforts should alleviate and not exacerbate health inequalities. The aim of health promotion should not be to eliminate all health inequalities, but rather to reduce or eliminate those that result from factors that are potentially avoidable and unfair and which result in significant disease burden among disadvantaged groups.
- 3.4 Interventions to address health inequalities should recognise that the relationship between social and economic inequalities and health inequalities is complex and results from the influence of material, psychosocial and behavioural factors over a lifetime and across generations.
- 3.5 Policy responses need to address multiple leverage points to be effective in reducing health inequalities (see, for example, table 1).
- 3.6 Policy responses need to look at points of intervention that address both the influence of adverse socioeconomic factors on health and the influence of ill-health on socioeconomic status.
- 3.7 Addressing the root causes of socioeconomic inequality is difficult but may be the most effective way to reduce population health inequalities.
- 3.8 Success in promoting better health is more likely to be achieved through ensuring that improvements in the psychosocial environment are accompanied by improvements in the material and economic environment.
- 3.9 To reduce health inequalities health promotion approaches must work with both people and the places in which they live their lives.
- 3.10 Action on the social and economic determinants of health requires greater engagement with a range of sectors, including social services, environment and infrastructure, housing, education and employment.
- 3.11 Health promotion interventions are most likely to be effective in reducing future inequalities in health when they relate to present and future parents, especially mothers, and children.
- 3.12 Health promotion interventions to address inequalities need to respond appropriately to culturally diverse and Indigenous populations and take account of the role of gender in contributing to health, social and economic inequality.
- 3.13 Disadvantaged communities need to be part of the decision-making process at the state and local level if we are to effectively address health inequalities.

4 VicHealth will undertake to:

4.1 Build knowledge to improve capacity across sectors to address health inequalities

- 4.1.1 Identify interventions that will reduce inequalities in the social and economic determinants of health, health behaviours and health status between subgroups of the Victorian population.
- 4.1.2 Advocate and support the development of systems for monitoring the extent and distribution of health inequalities in Victoria.
- 4.1.3 Prioritise capacity building for public health research addressing health inequalities, in particular inequalities affecting low socioeconomic, Indigenous and refugee communities and people with disabilities.

4.2 Engage in advocacy to reduce health inequalities

- 4.2.1 Engage in advocacy to increase understanding of the relationship between social and economic inequalities and health inequalities, and seek to influence broader social and economic policy that will have an effect on health inequalities.
- 4.2.2 Work in partnership with key agencies and individuals working with and representing disadvantaged groups to reduce health, social and economic inequalities.
- 4.2.3 Disseminate information to public health professionals and communities to improve skills, knowledge and practice in reducing health inequalities.

4.3 Develop projects and programs to address health inequalities

- 4.3.1 Continue to invest in area-based programs in relatively disadvantaged socioeconomic areas and work with local governments in addressing health inequalities.
- 4.3.2 Continue to invest in programs and projects that engage the participation of population groups particularly affected by health inequalities, including those of low socioeconomic status, Indigenous and refugee communities and people with disabilities.
- 4.3.3 Develop projects and programs which seek to maintain and extend the implementation of health promoting policies across sectors that respond to the needs of the most disadvantaged.
- 4.3.4 Explore opportunities to adopt a life-course perspective on health inequalities and identify the best options for investing in interventions targeted on people of different ages within VicHealth-funded programs.

4.4 Explore operational options for reducing health inequalities

- 4.4.1 Continue to strengthen links between VicHealth-funded research and its programs to ensure they are based on sound evidence and to build an evidence base for both policy advocacy and workforce development focusing on addressing health inequalities.
- 4.4.2 Ensure that, where possible, VicHealth-funded programs, grant-making processes and activities address health inequalities through a range of strategies and reduce, rather than increase, health inequalities.
- 4.4.3 Strengthen and refine systems for assessing and monitoring the reach of VicHealth-funded programs and their impact on groups particularly affected by health inequalities.
- 4.4.4 Strengthen processes for ensuring that groups particularly affected by health inequalities are actively involved in decision-making in VicHealth-funded activity.
- 4.4.5 Strengthen the capacity of the VicHealth workforce to understand and address health inequality.
- 4.4.6 Develop documentation to guide and monitor the implementation of this policy.

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