Final Report

Advancing Equitable, Patient-Centred Care at Peter Mac

Developing a structured multi-criteria framework for cancer equity action

Kate Ioannou

June 2026

VICS Western & Central Melbourne Integrated Cancer Service

Our Partners: Mercy Health, Peter Mac, the women's, Western Health, The Royal Melbourne Hospital, The Royal Victorian Eye and Ear Hospital, St Vincent's Hospital

The Victorian Integrated Cancer Services are supported by the Victorian State Government

Overview

Project Title:	Advancing Equitable, Patient-Centred Care at Peter Mac
Project Lead(s):	Kate Ioannou, WCMICS
Lead Health Service(s):	Peter MacCallum Cancer Centre
Executive Sponsor:	Geri McDonald, Director Patient Experience & Wellbeing – Peter Mac Kath Quade, Program Director - WCMICS
Commencement date:	April 2026
Completion date:	June 2026
Author(s):	Kate Ioannou

Acknowledgements:

WCMICS respectfully acknowledges Australia's Aboriginal and Torres Strait Islander communities pay respects to their Elders past and present. WCMICS is committed to honouring Aboriginal and Torres Strait Islander peoples as Australia's first peoples and as the Traditional Owners and custodians of the land and water on which we rely.

Recommended citation:

Ioannou, K. 2026. *Advancing Equitable, Patient-Centred Care at Peter Mac*. Western and Central Melbourne Integrated Cancer Service (WCMICS), Melbourne, Australia.

Disclaimer:

© WCMICS 2026.

This material *Advancing Equitable, Patient-Centred Care Across Cancer Pathways* has been prepared by the Western and Central Melbourne Integrated Cancer Service (WCMICS), a member of the Victorian Integrated Cancer Services (VICS), to inform and guide activities related to cancer service improvement within Victoria.

Generative AI was used to support aspects of the analysis conducted in the project and preparation of this report. No new concepts, findings or recommendations were generated through the use of AI tools.

The material and data are intended for Victorian Integrated Cancer Services (VICS) member organisations and health professionals to support cancer service planning, quality improvement, and system integration.

All VICS materials – including data products, protocols, methods, analyses, documentation, and tools – are protected by copyright and remain the intellectual property of the Victorian Integrated Cancer Services (VICS) and the State of Victoria (Department of Health).

Contents Page

Abbreviations 4
Project Summary 5
Main Messages 6
Project Report 7
Section 1: Introduction 7
Section 2: Project Design and Approach 8
Section 3: Implementation 9
Section 4: Results 12
Section 5: Discussion 14
Section 6: Future Directions 15
References 17
Appendices 18
Appendix A: Population Definitions and Data Basis 18
Appendix B: Prioritisation Matrix 19
Appendix C: Criteria Definitions and Scoring 20
Sign off 21

Abbreviations

Abbreviation	Term
AIHW	Australian Institute of Health and Welfare
COSA	Clinical Oncology Society of Australia
DEI	Diversity, Equity and Inclusion
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and Other Sexually or Gender Diverse People (LGBTI+ where a source uses that term)
M&E	Monitoring and Evaluation
PCXS	Patient and Carer Experience Strategy
Peter Mac	Peter MacCallum Cancer Centre
RACI	Responsible, Accountable, Consulted, Informed
VCCC Alliance	Victorian Comprehensive Cancer Centre Alliance
WCMICS	Western and Central Melbourne Integrated Cancer Service

Project Summary

Context and Aim

Significant inequities in cancer outcomes persist across population groups in Australia due to a range of social, cultural, economic and structural determinants of health.[1] Addressing these inequities requires equitable, culturally responsive and accessible cancer care that meets the diverse needs of all people throughout the cancer care continuum.[2]

Peter MacCallum Cancer Centre's (Peter Mac's) Patient and Carer Experience Strategy applies an equity lens across all strategic priorities.[3] However, while the strategy identified equity objectives focused on navigation, communication and access to wellbeing and support services, there were no agreed actions to support implementation. The Advancing Equitable, Patient-Centred Care at Peter Mac project was established to translate this strategic intent into a practical, co-designed Diversity, Equity and Inclusion (DEI) Action Plan, supported by governance and measurement, ready for Peter Mac to implement as business as usual by September 2026.

Phase 1 of the project (this report) aimed to develop and apply a transparent, repeatable method to decide where focused equity action should begin.

What Was Done

Western and Central Melbourne Integrated Cancer Service (WCMICS) was engaged by Peter Mac to lead the development of a DEI Action Plan, supported by an implementation plan, equity measures and a governance structure. Conducted between April and June 2026, Phase 1 aimed to identify the population groups experiencing significant inequity with limited or fragmented responses at Peter Mac.

A working group compiled four sources of evidence for each priority population named in the Victorian Cancer Plan:[4] patient activity data, a rapid literature review, an environmental scan and strategic alignment mapping. Each population was then assessed against six equally weighted criteria using a structured scoring approach and assigned to one of three response tiers. This provided a transparent and evidence-informed basis for prioritising future action.

Key Results

- A structured, evidence-informed methodology was developed to defined, assessed and score all 12 priority populations outlined in the Victorian Cancer Plan.
- Three populations received the highest score, 2.8 out of 3: people from regional and rural communities, people experiencing mental health issues and people experiencing socioeconomic disadvantage.
- Ranked by size alone, older people (53% of patients) would have come first and people experiencing socioeconomic disadvantage (17%) seventh of 12.
- Every population was given a recommended response: foundational equity redesign (three populations), equitable service scaling (four) or embedded equity practice (five).

Impact and Value

- Peter Mac has a documented, evidence-informed reason for where its equity work begins.
- The method uses information most cancer services already hold and can be reused by other health services.

Next Steps

Peter Mac should review the prioritisation at agreed intervals and extend the approach to Tier 2 and Tier 3 populations through established programs. WCMICS will share the method with member health services, including at the Clinical Oncology Society of Australia (COSA) Annual Scientific Meeting in November 2026.

Main Messages

- A transparent, criteria-based method showed where Peter Mac should begin its equity work across 12 priority populations.
- Population size alone would have pointed elsewhere. Considering severity, system gaps and existing responses moved attention to the groups for whom the system currently does least.
- Every population received a recommended response. Tiers describe the kind of response needed, not the importance of a population.
- The method is simple and transferable, but it rests on judgement. Its value is that the reasoning can be read, questioned and repeated.

Project Report

Section 1: Introduction

1.1 Problem Statement

The Victorian Cancer Plan 2024–2028 names 12 priority populations and aims for equitable outcomes for all Victorians.[4] Cancer services are expected to act on equity for all of them, but cannot redesign care for 12 groups at once. Peter Mac needed to decide where focused improvement should begin. Choosing by population size favours the largest groups, and it says nothing about how severe an inequity is or whether services already respond to it. Without a structured approach, decisions may overlook groups experiencing severe inequity and limited system support.

1.2 Background

Peter Mac is a public cancer treatment, research and education centre with six patient-facing campuses across Victoria. In 2025–26 it cared for 47,823 patients: 52% were aged 65 years or older, 31% were born overseas, 27% lived outside metropolitan Melbourne and 0.9% identified as Aboriginal or Torres Strait Islander.

Peter Mac's Patient and Carer Experience Strategy (PCXS), launched in 2026, applies an equity lens to all of its goals. One objective in each of its three priority areas is directed at priority population groups: objective 1.2 (strengthen navigation), objective 2.4 (provide more support for patients who need assistance communicating) and objective 3.2 (connect priority population groups with the wellbeing and support services they need).[3] In developing its implementation plan, Peter Mac committed to priority population assessments to identify targeted actions.

Achieving equity requires responses based on need, not the same response for everyone. The VCCC Alliance Cancer Equity Framework distinguishes equity from equality and asks organisations to assess inequities, address them and make equity a sustained commitment.[2] The Australian Cancer Plan asks services to take an intersectional approach to priority population groups.[1] Phase 1 was the first step of a six-month project, from April to September 2026, in which WCMICS was engaged by Peter Mac to lead the development of a DEI Action Plan, with an Implementation Plan, equity measures and a governance structure.

1.3 Aim Statement

To develop and apply a transparent, repeatable method for deciding where a cancer centre should begin its equity action across 12 priority populations.

Phase 1 delivered the first of the project's five objectives: to review existing data to identify and understand priority population groups for patients and carers at Peter Mac.

Section 2: Project Design and Approach

2.1 Change Initiative

Phase 1 was a decision-support activity. Its intended output, as set in the program logic, was a documented set of Peter Mac priority population groups for the focus of the DEI Action Plan. Its short-term outcome was an agreed definition of the priority population groups for PCXS-related DEI work. It did not set out to change care directly. This report therefore presents the method and the decision as its results.

2.2 Scope

Table 1 sets out the scope of Phase 1, drawn from the project plan.

Table 1. *Scope of Phase 1*

In scope	Out of scope
• The 12 priority populations named in the Victorian Cancer Plan • Peter Mac patients and carers, across all six campuses • Internal Peter Mac documents and datasets, supplemented by data accessible to WCMICS • Alignment with PCXS objectives 1.2, 2.4 and 3.2 and the VCCC Alliance Cancer Equity Framework	• Consultation with consumers (Phase 2) • Design of actions (Phases 3 and 4) • External datasets or benchmarking (see Section 3.4) • Changes to clinical care pathways or direct service delivery • Policy, resourcing or budget decisions

2.3 Assumptions

- No ethics application was required, because the work was a quality improvement activity.
- Peter Mac could provide timely access to data, and the data would be sufficient to identify priority populations.
- Equity concepts, including intersectionality, were understood across the project team and stakeholders.
- Peter Mac governance bodies would review and endorse outputs within planned timeframes.

2.4 Governance

Project governance followed the governance of the PCXS. The project sponsor was Peter Mac's Director, Patient Experience and Wellbeing. A working group met weekly and made day-to-day decisions. It comprised the WCMICS project lead, Peter Mac's Manager, Patient Experience, and a Peter Mac diversity and inclusion project officer, with subject-matter experts and Peter Mac's business intelligence unit consulted as needed. WCMICS endorsed the project plan on 9 April 2026, and Peter Mac's Community Advisory Committee received a project update on 27 May 2026. The three initial priority populations were formally endorsed by the executive sponsor in June.

2.5 Stakeholder Management

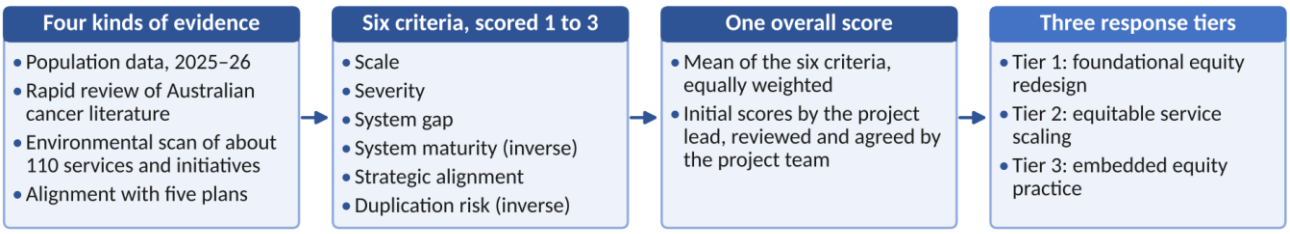
Twelve subject-matter experts helped define each population in data. Peter Mac's business intelligence unit extracted and checked the patient data. The project lead led a structured walk-through of frontline services for the environmental scan. Consumers were not involved in Phase 1 scoring; their input began in Phase 2, when the three Tier 1 populations became the focus of co-design.

Section 3: Implementation

3.1 Key Activities and Inputs

Phase 1 ran from April to June 2026, after pre-scoping discussions in March. Figure 1 summarises the method. Its inputs were in-kind staff time, Peter Mac patient data, published evidence, Peter Mac's service information and existing strategies and plans.

Figure 1. *The Phase 1 prioritisation method*



Applied to each of the 12 priority populations in the Victorian Cancer Plan. Tiers describe the response needed, not the importance of a population.

Step 1. Gather four kinds of evidence

- **Population data.** Unique Peter Mac patient counts for 2025–26, extracted on 18 May 2026 (44,948 patients), using definitions agreed with 12 subject-matter experts. Three populations could not be identified within Peter Mac data and were therefore estimated using published sources provided by subject-matter experts from the respective priority populations (Appendix A).
- **Rapid literature review** of Australian, cancer-specific evidence on barriers, experience and outcomes. It informed the severity and system gap scores.
- **Environmental scan** of about 110 existing Peter Mac services and initiatives, drawn from a desktop review and a structured walk-through of frontline services (a Gemba walk), each mapped to the populations it serves. It informed the system maturity and duplication risk scores.
- **Strategic alignment mapping** of PCXS objectives 1.2, 2.4 and 3.2 against the VCCC Alliance framework,[2] the Victorian[4] and Australian[1] cancer plans, the Parkville Precinct Strategic Cancer Service Plan[5] and Peter Mac's Disability Accessibility Plan.[6] It informed the alignment score.

Step 2. Score each population

The project team scored each population using an equally weighted multi-criteria matrix: scale, inequity severity, system gap, system maturity (inverse), strategic alignment and duplication risk (inverse). Each criterion was scored 1–3 based on the evidence (Table 2). The overall score is the mean of the six criteria.

The project lead assigned initial scores, and the project team reviewed the evidence and agreed the final scores. Multi-criteria methods suit decisions of this kind because they involve several considerations that cannot be reduced to one number.[7] Scores were judgement-based and were not intended to represent a statistically derived measure of need.

Table 2. *The six prioritisation criteria*

Criterion	What was assessed	Scoring
Scale	Size of the population group at Peter Mac	Larger scores higher
Severity	Degree of inequity and its effect on outcomes and experience	More severe scores higher
System gap	Extent of structural or system-level failure to meet need	Larger gap scores higher
System maturity	Level of existing response at Peter Mac	Inverse: less mature scores higher
Alignment	Fit with PCXS objectives 1.2, 2.4 and 3.2	Stronger fit scores higher
Duplication risk	Overlap with existing initiatives	Inverse: less overlap scores higher

Each criterion was scored 1, 2 or 3. Appendix C gives the criteria in full.

Step 3. Assign response tiers

Populations were grouped into three tiers that describe the kind of organisational response needed: foundational equity redesign, equitable service scaling and embedded equity practice. Tier assignment considered the score pattern alongside the evidence on existing services, so a small numerical difference was not treated as a complete account of need.

Each population was scored separately, so the matrix does not capture intersectionality. Carers were considered alongside patients. Data from Peter Mac's Carer Support Program (about 461 carers, 2021 to 2026) were too incomplete to define carer priority groups, so carers were aligned with the patient groups.

3.2 Key Milestones

Table 3 compares planned and delivered milestones for Phase 1.

Table 3. *Phase 1 milestones, planned and delivered*

Milestone	Planned	Delivered
Project kick-off; project plan endorsed by WCMICS	Week 2	6 April and 9 April 2026
Population data extracted	Not specified	18 May 2026
Community Advisory Committee update	Not specified	27 May 2026
Priority populations identified	Week 6 (mid-May)	June 2026
Prioritisation final report	Not specified	August 2026

Week 1 began on 6 April 2026.

3.3 Deliverables

Table 4 lists the Phase 1 deliverables.

Table 4. *Phase 1 deliverables*

Output or deliverable	Appendix reference
Documented definitions and data basis for the 12 priority populations	A
Weighted prioritisation matrix	B
Criteria and scoring definitions	C
Tier classification of all 12 populations	Section 4 and Appendix B
Prioritisation final report (June 2026)	This report

3.4 Adaptations and Changes

- **Prioritisation method.** The working group first rated need as high, medium or low from a narrative summary. It replaced this with the scored matrix to make the reasoning explicit. The change moved the priority population milestone from mid-May to June.
- **External data estimates.** External datasets were out of scope, but published national estimates were used for three populations that Peter Mac data could not identify.
- **Carers.** Carer priority populations were to be defined separately. Because carer data were incomplete, carers were aligned with the patient groups.

3.5 Issues Encountered

Table 5 summarises the main issues and how they were managed.

Table 5. *Issues encountered and how they were managed*

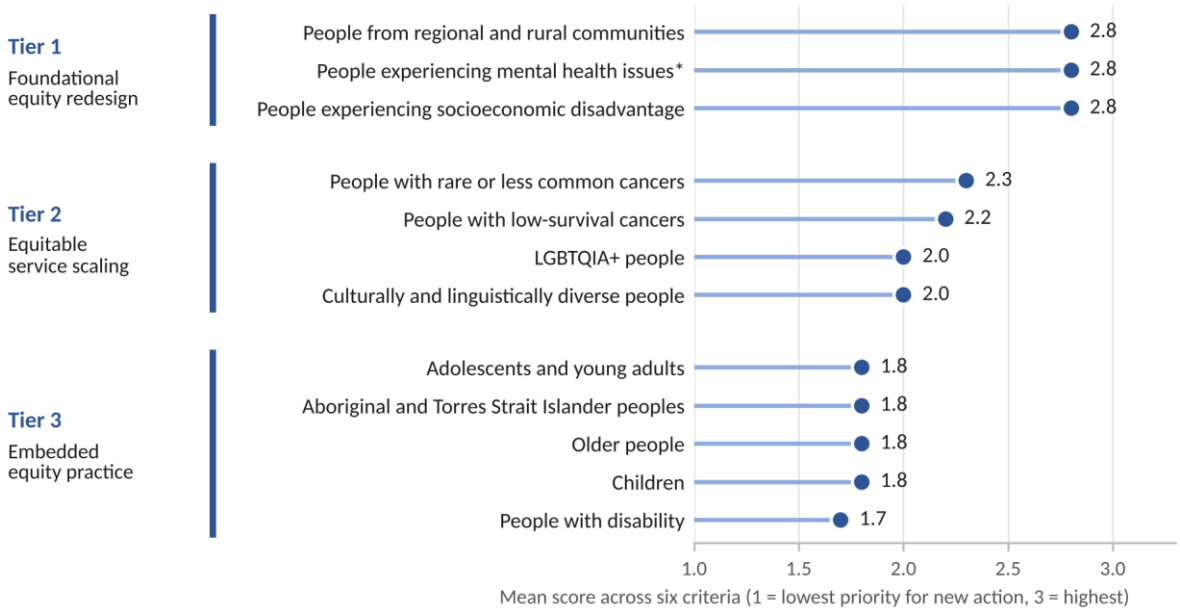
Issue encountered	Management strategies	Outcome
Peter Mac patient activity data could not identify some populations	Definitions agreed with subject-matter experts and data analysts; published estimates used; limits documented	All 12 populations assessed; three on published estimates
Initial approach did not make the reasoning explicit	High, medium and low rating replaced by a scored matrix	Method transparent and repeatable; milestone moved to June
Carer data incomplete	Carers aligned with the patient groups and invited into later engagement	Carers named as a cross-cutting group in later phases

Section 4: Results

4.1 Outcome Measures

Phase 1's results are its outputs: the scored matrix, documented population definitions and the tier classification. Three populations received the highest score, 2.8 out of 3: people from regional and rural communities, people experiencing mental health issues* and people experiencing socioeconomic disadvantage (Figure 2). All three scored 3 for severity, system gap, alignment and low duplication risk.

Figure 2. *Prioritisation scores for the 12 priority populations, by tier*



Population names are those used at the prioritisation stage. *Named 'people experiencing emotional or psychological distress' in the Diversity, Equity and Inclusion (DEI) Action Plan.

The matrix changed the order of priority. Ranked by size alone, older people (53% of patients) would have come first and people experiencing socioeconomic disadvantage (17%) seventh of 12. Considering severity, system gap and existing response moved attention to the groups for whom the system currently does least.

Every population received a recommended response (Table 6). The tiers reflect the current system response, not the importance of any population. Aboriginal and Torres Strait Islander peoples, for example, scored 3 for both severity of inequity and alignment. They sit in Tier 3 because dedicated roles, programs and strategies already exist, so the recommended response is to embed and strengthen equity within that work rather than create a parallel response.

Table 6. *Response tiers and the populations in each*

Tier	Populations	Recommended response
1. Foundational equity redesign	People from regional and rural communities (2.8) People experiencing mental health issues* (2.8) People experiencing socioeconomic disadvantage (2.8)	Significant inequity with limited or fragmented responses. New work is needed on how care is designed and coordinated.
2. Equitable service scaling	People with rare or less common cancers (2.3) People with low-survival cancers (2.2) LGBTQIA+ people (2.0) Culturally and linguistically diverse people (2.0)	Existing services partly address need. Targeted improvement and scaling are needed.
3. Embedded equity practice	Adolescents and young adults (1.8) Aboriginal and Torres Strait Islander peoples (1.8) Older people (1.8) Children (1.8) People with disability (1.7)	Established programs, roles or governance exist. Equity effort is best integrated within them.

Scores out of 3 in brackets. *Named 'people experiencing emotional or psychological distress' in the Diversity, Equity and Inclusion (DEI) Action Plan.

What this enabled. The three Tier 1 populations became the initial focus of Peter Mac's DEI Action Plan, where they are named people experiencing socioeconomic disadvantage or financial toxicity, people experiencing emotional or psychological distress, and people from regional and rural communities.

Table 7 reports the outcome measure for Phase 1 from the project plan.

Table 7. *Outcome measure*

Measure	Baseline	Target	Result	Descriptive summary
Priority populations defined and agreed (populations agreed / populations identified)	No agreed definitions	100%	12 of 12 (100%)	Met. All 12 defined and assessed; three selected as the initial focus. Three definitions rely on published estimates.

4.2 Process Measures

Table 8 reports process measures counted for this report.

Table 8. *Process measures*

Measure	Baseline	Target	Result	Descriptive summary
Evidence sources assembled for each population	0	4 of 4	4 of 4 (100%)	Derived for this report. Population data, rapid review, environmental scan and strategic alignment were completed.
Criterion scores completed (12 populations × 6 criteria)	0	72	72 of 72 (100%)	Derived for this report. Every population was scored on every criterion.
Priority populations milestone delivered on time	Not applicable	Week 6 (mid-May)	June 2026	Derived for this report. Not met on time; delayed by the change of method (Section 3.4).

Section 5: Discussion

5.1 Summary of Key Findings

The matrix strengthened the consistency and transparency of the prioritisation. It changed the order of priority from the one population size alone would have produced. It does not remove judgement. Scores were assigned on a three-point scale, the criteria were equally weighted, and a single point on one criterion separates the lowest Tier 2 score from the highest Tier 3 score. Its contribution is that the reasoning can be read, questioned and transferred to other health services.

Different kinds of evidence answered different questions. Activity data showed how many people were affected but could not see three of the 12 populations at all. Published evidence showed where inequities exist and how severe they are. The environmental scan showed what Peter Mac already does. No single source would have produced the same decision.

Tiers made a focus possible without excluding anyone. Every population has a recommended response, and the Tier 2 and Tier 3 populations remain priorities, to be addressed by scaling existing services and embedding equity in established programs.

The method is transferable. It uses population data, published evidence, a service scan and strategic plans that most cancer services already hold. Other services would need to apply their own data; the scores reported here are specific to Peter Mac.

5.2 Achievement of Project Aim

Project aim: To develop and apply a transparent, repeatable method for deciding where a cancer centre should begin its equity action across 12 priority populations.

Achievement met: Met.

Key factors influencing achievement:

- Four kinds of evidence were assembled for all 12 populations, with subject-matter experts and the business intelligence unit supporting definitions and data.
- A scored matrix replaced a narrative rating, making the reasoning explicit and repeatable.
- The change of method delayed the decision by about a month.

5.3 Assessment of Value

No financial analysis was undertaken. Phase 1's value is qualitative. It gave Peter Mac a defensible starting point for its DEI Action Plan, focused the later co-design on three groups, and gave every other priority population a recommended response. The method can be adapted by other health services.

5.4 Challenges and Limitations

- **Scores rested on judgement.** The project lead assigned initial scores and the project team reviewed them. Scoring was not blinded or independently replicated, and the effect of different scores or weights was not tested.
- **Thresholds were not written down.** The thresholds used to convert evidence into a score of 1, 2 or 3 were not documented.
- **Populations were scored one at a time,** so intersectionality is not captured.
- **Data were incomplete.** Three populations were sized from published estimates, and socioeconomic disadvantage was measured by area of residence, which does not identify individuals or capture financial toxicity caused by cancer.
- **Consumers did not take part in scoring.** Their input began in Phase 2.
- **The scan is a snapshot.** System maturity and duplication reflect the services identified at the time and may change.

5.5 Lessons Learned

- **Settle the prioritisation method before collecting evidence.** Changes to the approach during Phase 1 caused a delay of about one month, which reduced preparation time for the Think Tanks (Phase 2).
- **Record scoring anchors and the reason for each score as you go.** It makes the decision easier to explain and to repeat.
- **Combine evidence types.** Routine data alone could not see several populations, and could not show what services already exist.

Section 6: Future Directions

6.1 Sustainability Planning

The prioritisation is sustained through the DEI Action Plan, which sits under the PCXS and reports through its governance.

6.2 Monitoring and Evaluation (M&E) Plan

The prioritisation reflects the evidence and services available in 2026 and should be reviewed as data, services and community priorities change. Better data will strengthen the next review. The DEI measures will identify regional and rural patients by residential locality using the Modified Monash Model,[8] and propose person-level screening for financial toxicity and distress, which would allow two of the Tier 1 groups to be identified directly.

6.3 Recommendations

These recommendations are subject to endorsement by Peter Mac and WCMICS.

For Peter Mac

1. Keep the three Tier 1 populations as the initial focus, and use the tiers as response pathways, not as a ranking of importance.
2. Review the prioritisation at agreed intervals, and sooner if patient need, services or data change.
3. Extend the approach to Tier 2 and Tier 3 populations, working through established programs and with the communities concerned.
4. Strengthen person-level equity data, collected safely and voluntarily, so that more populations can be identified directly.
5. For the next cycle, agree scoring anchors before reviewing evidence, include consumer and community validation, use more than one independent scorer and test how results change under different scores or weights.

For WCMICS

1. Share the method and tools with member health services and other Integrated Cancer Services.

References

1. Cancer Australia. Australian Cancer Plan [Internet]. Surry Hills (NSW): Cancer Australia; 2023 [cited 2026 Oct 5]. Available from: https://www.australiancancerplan.gov.au
2. VCCC Alliance. Cancer Equity Framework: full report [Internet]. Melbourne: VCCC Alliance; 2024 [cited 2026 Oct 5]. Available from: https://vcccalliance.org.au/assets/Cancer-Equity-Framework-Full-Report_Final.pdf
3. Peter MacCallum Cancer Centre. Patient and Carer Experience Strategy: leading through the human experience [Internet]. Melbourne: Peter MacCallum Cancer Centre; 2026 [cited 2026 Oct 5]. Available from: https://www.petermac.org/patients-and-carers/support-and-wellbeing/patient-and-carer-experience-strategy
4. Department of Health. Victorian cancer plan 2024–2028 [Internet]. Melbourne: Victorian Government; 2024 [cited 2026 Oct 5]. Available from: https://www.health.vic.gov.au/victorian-cancer-plan
5. Peter MacCallum Cancer Centre, The Royal Melbourne Hospital, The Royal Women's Hospital. Parkville Precinct Strategic Cancer Service Plan 2025–2035 [Internet]. Melbourne: Parkville Precinct partners; 2025 [cited 2026 Oct 5]. Available from: https://www.thermh.org.au/about/strategies-plans/parkville-precinct-strategic-cancer-service-plan
6. Peter MacCallum Cancer Centre. Disability Accessibility Plan 2025–2030: towards better care, inclusion, and experience for people with disabilities [Internet]. Melbourne: Peter MacCallum Cancer Centre; 2025 [cited 2026 Oct 5]. Available from: https://www.petermac.org/document/disability-accessibility-plan-digital/viewdocument/1448
7. Baltussen R, Niessen L. Priority setting of health interventions: the need for multi-criteria decision analysis. Cost Eff Resour Alloc. 2006;4:14. doi:10.1186/1478-7547-4-14
8. Department of Health, Disability and Ageing. Modified Monash Model [Internet]. Canberra: Australian Government [cited 2026 Oct 5]. Available from: https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm
9. Mitchell AJ, Chan M, Bhatti H, Halton M, Grassi L, Johansen C, et al. Prevalence of depression, anxiety, and adjustment disorder in oncological, haematological, and palliative-care settings: a meta-analysis of 94 interview-based studies. Lancet Oncol. 2011;12(2):160–74. doi:10.1016/S1470-2045(11)70002-X
10. Australian Institute of Health and Welfare. Cancer data in Australia [Internet]. Canberra: AIHW; [updated 2026 Jun 29; cited 2026 Oct 5]. Available from: https://www.aihw.gov.au/reports/cancer/cancer-data-in-australia/contents/overview
11. Australian Bureau of Statistics. Remoteness Structure. Australian Statistical Geography Standard (ASGS) Edition 3, July 2021 – June 2026 [Internet]. Canberra: ABS; 2021 [cited 2026 Oct 5]. Available from: https://www.abs.gov.au/statistics/standards/australian-statistical-geography-standard-asgs-edition-3/jul2021-jun2026/remoteness-structure
12. Australian Bureau of Statistics. Socio-Economic Indexes for Areas (SEIFA), Australia, 2021 [Internet]. Canberra: ABS; 2023 [cited 2026 Oct 5]. Available from: https://www.abs.gov.au/statistics/people/people-and-communities/socio-economic-indexes-areas-seifa-australia/latest-release
13. Australian Bureau of Statistics. Estimates and characteristics of LGBTI+ populations in Australia, 2022 [Internet]. Canberra: ABS; 2024 [cited 2026 Oct 5]. Available from: https://www.abs.gov.au/statistics/people/people-and-communities/estimates-and-characteristics-lgbti-populations-australia/latest-release

Appendices

Appendix A: Population Definitions and Data Basis

Table A1 gives the working definition, share of Peter Mac patients and data basis for each population. Unique patient counts are for 2025–26, extracted on 18 May 2026 (44,948 patients).

Table A1. *Definitions and size of the 12 priority populations*

Priority population	Definition used	Share of patients	Basis
Older people	Aged 65 years or older, or 50 years or older for Aboriginal and Torres Strait Islander people	53%	Counted
People experiencing mental health issues*	Published estimate that about 35% of people diagnosed with cancer experience clinically significant psychological distress[9]	35%	Estimate
People with rare or less common cancers	Australian Institute of Health and Welfare definitions of rare and less common cancers[10]	28%	Counted
People from regional and rural communities	Residence in a local government area classified as non-metropolitan[11]	27%	Counted
Culturally and linguistically diverse people	Born in a country where English is not the main language	24%	Counted
People with disability	Published estimate that 21.4% of Australians have disability, as cited in the Disability Accessibility Plan[6]	21%	Estimate
People experiencing socioeconomic disadvantage	Residence in a local government area in the most disadvantaged 20% on a Socio-Economic Indexes for Areas index[12]	17%	Counted (area level)
LGBTQIA+ people	Published estimate that 4.5% of Australians aged 16 years and over are LGBTI+[13]	4.5%	Estimate
People with low-survival cancers	Cancers with the lowest five-year survival, as identified in the Victorian Cancer Plan[3]	2.8%	Counted
Adolescents and young adults	Aged 15 to 25 years	2%	Counted
Children	Aged 18 years or younger	1.5%	Counted
Aboriginal and Torres Strait Islander peoples	Patients who identify as Aboriginal and/or Torres Strait Islander	0.9%	Counted

Population names are those used at the prioritisation stage. *Named 'people experiencing emotional or psychological distress' in the DEI Action Plan. A person can be counted in more than one population, so shares do not add to 100. The age ranges for children and for adolescents and young adults overlap.

Limits of the population data. Three populations (mental health issues, disability and LGBTQIA+ people) are not reliably recorded in routine data, so national estimates were applied. These show likely scale, not the number of Peter Mac patients. Socioeconomic disadvantage was measured by area of residence, which does not identify individuals or capture financial toxicity caused by cancer.

Appendix B: Prioritisation Matrix

Table B1 gives every criterion score. Darker shading shows a higher score; every value is also printed. The overall score is the mean of the six criteria.

Table B1. *Weighted prioritisation matrix*

Priority population	Scale	Severity	System gap	System maturity (inverse)	Alignment	Duplication risk (inverse)	Score	Tier
People from regional and rural communities	3	3	3	2	3	3	2.8	1
People experiencing mental health issues*	3	3	3	2	3	3	2.8	1
People experiencing socioeconomic disadvantage	2	3	3	3	3	3	2.8	1
People with rare or less common cancers	3	2	2	2	2	3	2.3	2
People with low-survival cancers	1	3	2	2	2	3	2.2	2
LGBTQIA+ people	1	2	2	2	2	3	2.0	2
Culturally and linguistically diverse people	2	2	2	2	2	2	2.0	2
Adolescents and young adults	1	2	2	2	2	2	1.8	3
Aboriginal and Torres Strait Islander peoples	1	3	2	1	3	1	1.8	3
Older people	3	2	1	1	2	2	1.8	3
Children	1	2	2	2	1	3	1.8	3
People with disability	2	2	2	1	2	1	1.7	3

Shading: light = 1 (low), medium = 2, dark = 3 (high). For the two inverse criteria, a higher score means a less mature existing response or a lower risk of duplication. *Named 'people experiencing emotional or psychological distress' in the DEI Action Plan.

Appendix C: Criteria Definitions and Scoring

Each criterion was scored 1 (low), 2 (medium) or 3 (high) from the evidence, and all six were equally weighted. Table C1 describes each criterion and the evidence that informed it.

Table C1. *The six criteria*

Criterion	What was assessed	Main evidence used	Scoring direction
Scale	Size of the population group at Peter Mac	Population data	Larger scores higher
Severity	Degree of inequity and its effect on outcomes and experience	Rapid literature review	More severe scores higher
System gap	Extent of structural or system-level failure to meet need	Rapid literature review; environmental scan	Larger gap scores higher
System maturity (inverse)	Level of existing response at Peter Mac	Environmental scan	Less mature scores higher
Strategic alignment	Fit with PCXS objectives 1.2, 2.4 and 3.2	Strategic alignment mapping	Stronger fit scores higher
Duplication risk (inverse)	Overlap with existing initiatives	Environmental scan	Less overlap scores higher

Calculation. Overall score = (scale + severity + system gap + system maturity + alignment + duplication risk) ÷ 6, rounded to one decimal place. Observed scores ranged from 1.7 to 2.8.

Response tiers. Tier 1, foundational equity redesign: significant inequity with limited or fragmented responses; new work is needed on how care is designed and coordinated. Tier 2, equitable service scaling: existing services partly address need; targeted improvement and scaling are needed. Tier 3, embedded equity practice: established programs, roles or governance exist; equity effort is best integrated within them.

Sign off

Executive Sponsor approved by:

Name:	Kath Quade
Position:	Program Director, Western & Central Melbourne Integrated Cancer Service
Date approved:	13/10/2026

WCMICS approved by:

Name:	Kath Quade
Position:	Program Director, Western & Central Melbourne Integrated Cancer Service
Date approved:	13/10/2026