



Advancing Health 2030

#NavigatingHealth: Simplifying Complexity

One Day Workshop Tues 16th April



**COLLABORATE +
INNOVATE +
NURTURE =
IMPACT**



THE UNIVERSITY OF
MELBOURNE

Professor Jane Gunn AO

Dean, Faculty Medicine, Dentistry & Health Sciences



**COLLABORATE +
INNOVATE +
NURTURE =
IMPACT**

Collaboration *to* Impact

Professor Tina Brock
Director, Collaborative Practice Centre
Faculty of Medicine, Dentistry, & Health Sciences

Collaborative
Practice Centre

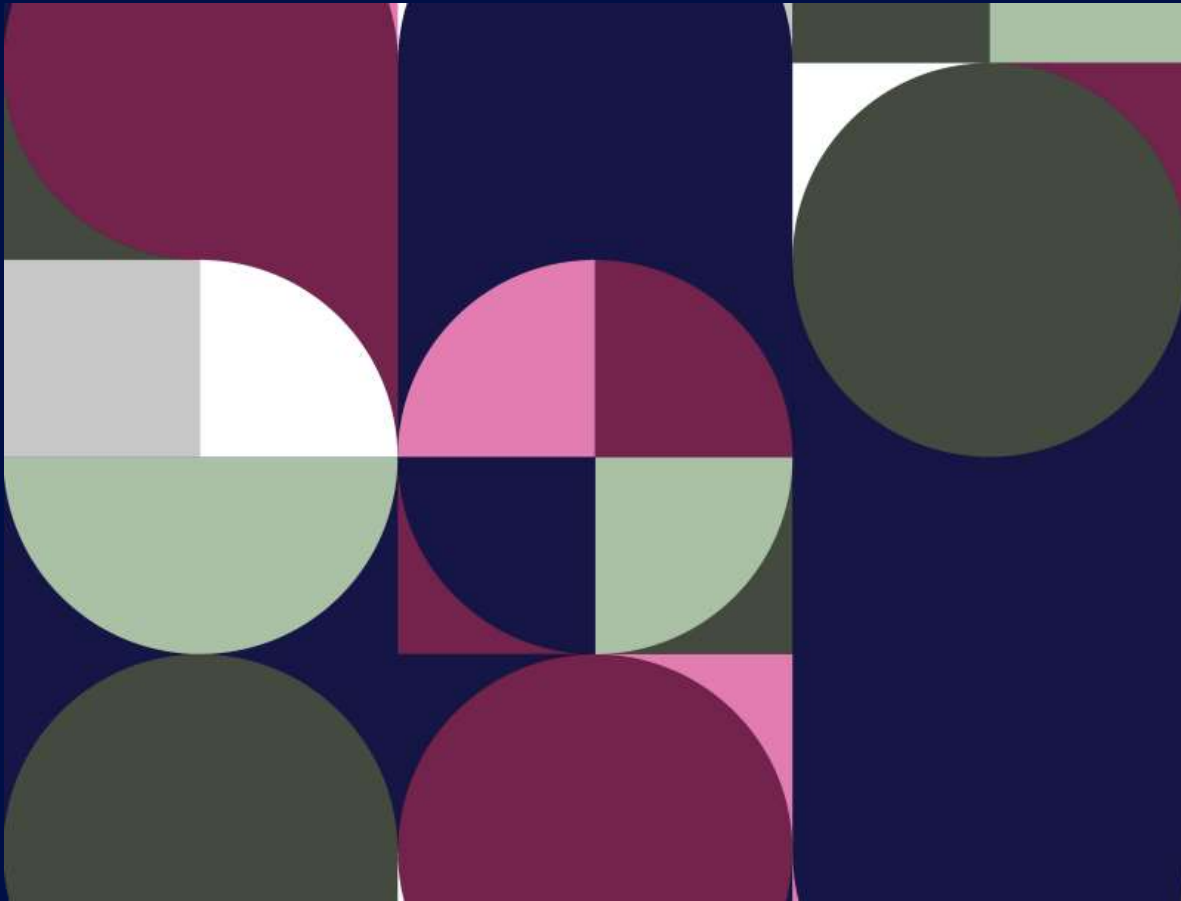
Transforming Health
through Collaboration



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Weaving together



Why does healthcare need skilled teams *now*?



- **Rare alignment*** amongst community, education, government, and practice stakeholders.
- Agreed solutions to **crises** in Medicare, primary care, aged care, mental health, digital health, climate health, et al include **optimising performance of multidisciplinary teams working together at top of scope.**
- Collaborative practice will **improve the consumer journey by decreasing the fragmented, inequitable, and inefficient approaches to healthcare.**
- This is a **key value strategy** for supporting the existing & future health workforce.
- **No specifics about how to achieve this. 😊**

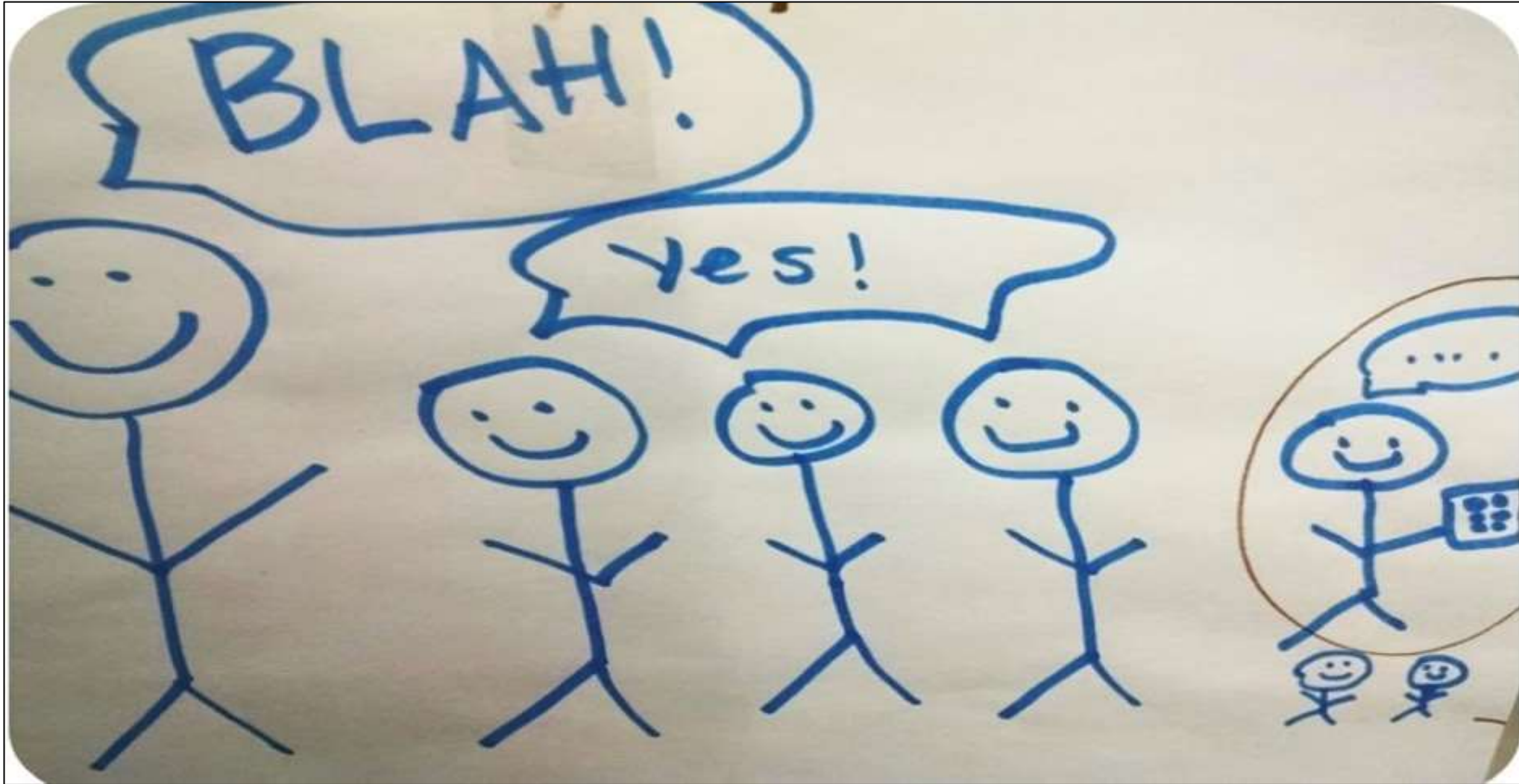
*As described in every modern Australian government report.

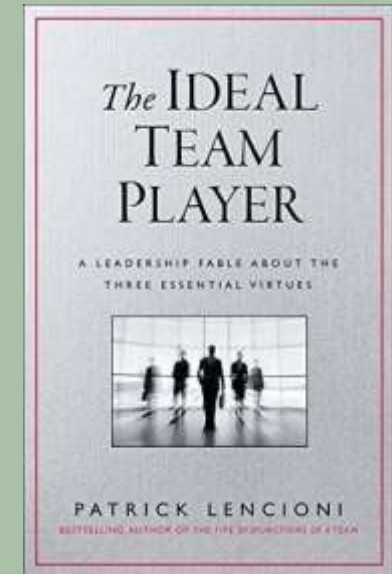


*“Critical gap
in national
healthcare to
be addressed
by new
Collaborative
Practice
Centre”*

*“New Centre devolves into
chaos at first team
challenge...
forming the letters C-P-C
with pillows”*

What does teamwork look like?





- ✓ **Humble**
- ✓ **Hungry**
- ✓ **Smart**

Follow us on Instagram at @cpc4health



Coming soon!



**Ways of
knowing,
learning,
& leading
*together***



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Collaboration *for* Impact

Today's objectives:

1. Gain knowledge/
perspectives
2. Connect to others
3. Take away at least
ONE action







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Tim Cooper & Professor Frederic Hollande

Fireside Chat : Our Journey



**COLLABORATE +
INNOVATE +
NURTURE =
IMPACT**



**Too Complex to Navigate?
What's Stopping Us?**



Implementing Navigable Systems

Mei Krishnasamy
Professor of Nursing (Cancer)
Department of Nursing
School of Health Sciences, University of Melbourne



NAVIGATION

A strategy for overcoming barriers to reduce disparities and to improve access and outcomes



Why is navigation important in cancer care?



01

2023: 165,000 cases of cancer in Australia
An increase of 66,000 cases from 2000¹
3 in every 10 deaths is attributable to cancer

02

Around 86% of the estimated increase between 2000-2023 is attributable to population increase and ageing population¹

03

The number of cancer survivors continues to increase (71% 5-year survival)² due to prevention and screening programs, and new treatments¹

CHALLENGE 01

First Nations people (39%) and those living in the most disadvantaged areas (33%) report higher incidence, mortality, and lower survival than other Australians and those living in the least disadvantaged areas.⁴

CHALLENGE 02

Due to population size and ageing - estimated there will be 47.4% (males) and 54.4% (females) increase in new cancer cases between 2020-2044²

CHALLENGE 03

The resources and workforce available to respond is diminishing^{4,5}

The need for navigation

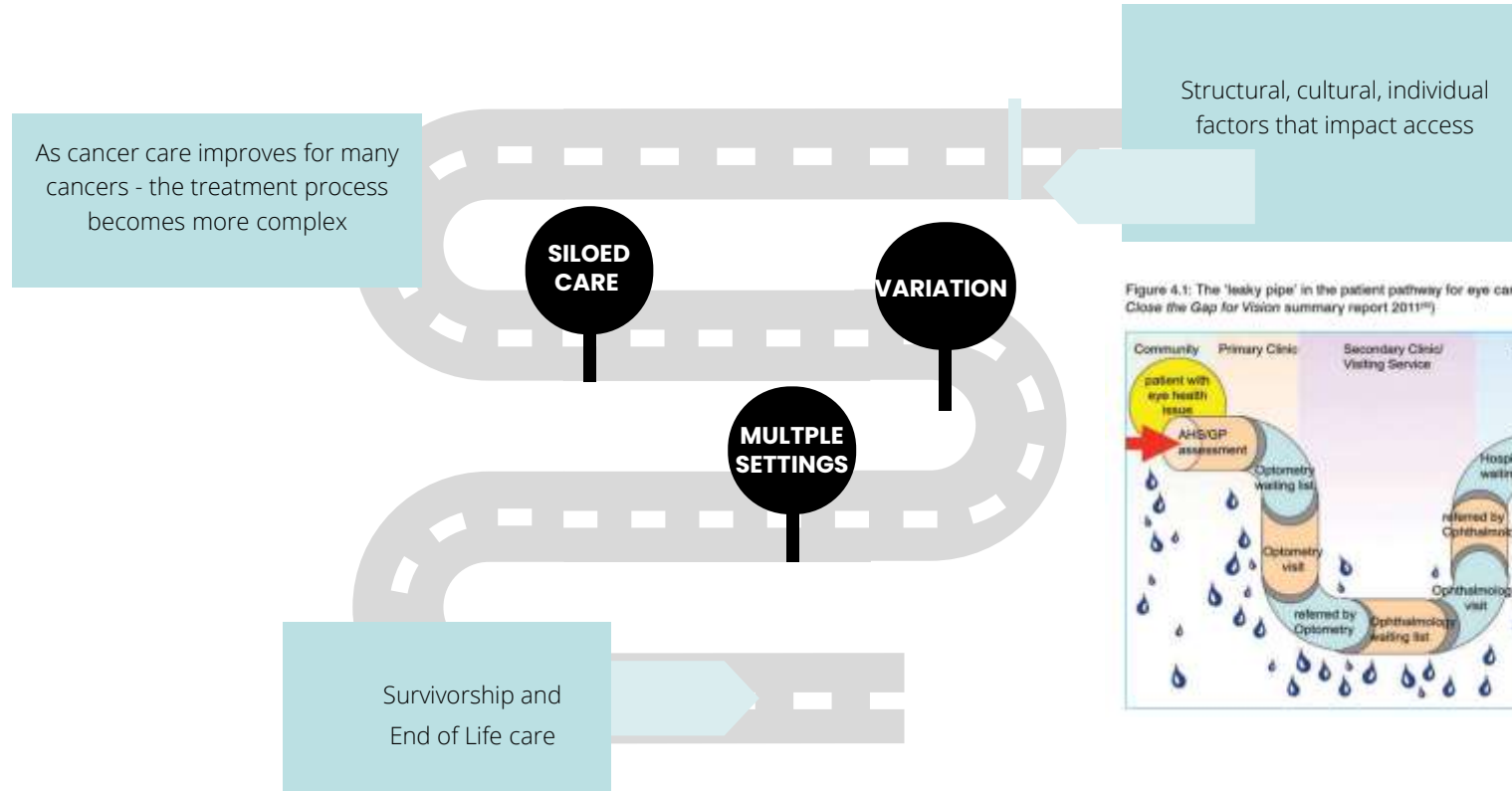
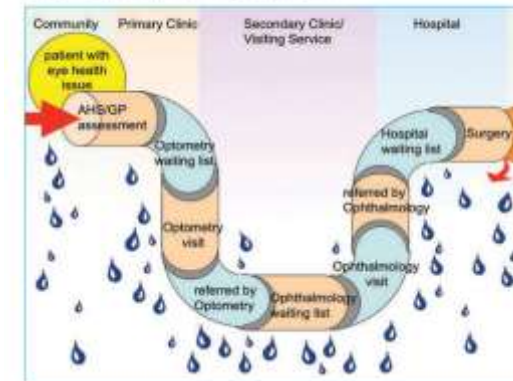


Figure 4.1: The 'leaky pipe' in the patient pathway for eye care (from *The Roadmap to Close the Gap for Vision* summary report 2011¹⁰)



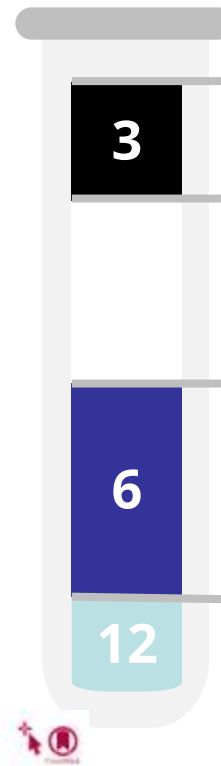
COVID 19 and Colorectal Cancer

COVID-19 pandemic - delays in cancer detection, diagnosis, and treatment.²

Data estimate that there would be a total of 19 975 colorectal cancer deaths during the period of 2020 to 2044 in the absence of the COVID-19 pandemic effects.

Cancer incidence and mortality in Australia from 2020 to 2044 and an exploratory analysis of the potential effect of treatment delays during the COVID-19 pandemic: a statistical modelling study

Qingwen Luo, Darren L O'Connell, Xue Qian Yu, Clare Kahn, Michael Carsons, Francesco Petrosi, Peter Satsky, Paul P Gregori, Sanyas Anand, Chahel J Chahing, Isabelle Sengjarnatarn, Julia Strinberg*, Karen Corfield*



SCENARIO 1

Health-care system disruption for 3-months and each colorectal cancer patient had a treatment delay of 4 weeks, there would be an estimated total of 96 additional colorectal cancer deaths that would occur earlier than expected (2020-2044).

SCENARIO 2

Where disruptions lasted for 6 months and patients had a treatment delay of 16 weeks, this could result in 897 additional deaths occurring earlier than expected.

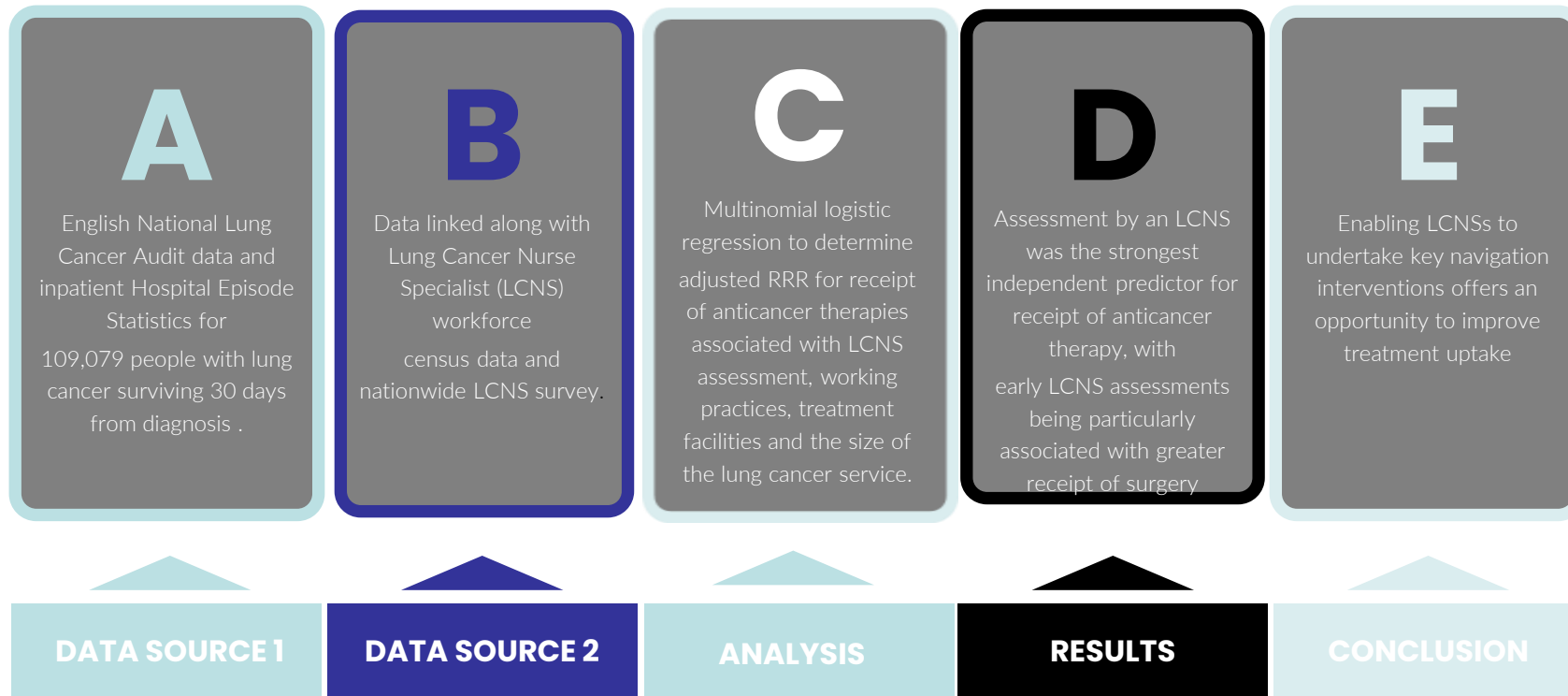
SCENARIO 3

With disruptions lasting 12 months and patients' treatments being delayed by 26 weeks, this could result in a total of 3345 deaths occurring earlier than expected.





An example from lung cancer⁷





Navigation: What's happening in cancer care⁶?

2023-2024-2025-2026

OUTCOME	RATING	COMMENTARY
EARLY DETECTION		
Cancer Screening Rates	●	Strong evidence that patient navigation improves rates of cancer screening.
DIAGNOSIS		
Diagnostic resolution	●	Strong evidence that patient navigation reduces the time to diagnosis.
TREATMENT		
Treatment Initiation	●	Some evidence that navigation reduces the time from diagnosis to initiation of primary treatment.
Treatment Completion	●	Evidence on the impact of patient navigation on treatment completion is inconclusive.
Hospital Readmission	●	Strong evidence that patient navigation reduces hospital readmissions.
Enrolment & Adherence to Clinical Trials	●	Limited evidence that patient navigation improves clinical trial enrolment and adherence.
SURVIVORSHIP		
Adherence to Surveillance	●	Strong evidence that patient navigation increases adherence to surveillance appointments.
Decision-making and Treatment Knowledge	●	Strong evidence that navigation improves the decision-making and treatment knowledge of cancer survivors.
Return to work	●	Evidence on the impact of patient navigation on return to work is inconclusive.
Communication	●	Limited evidence that patient navigation improves communication.
Fatigue	●	Limited evidence that patient navigation reduces cancer-related fatigue.
Patient Satisfaction	●	Strong evidence that patient navigation improves patient satisfaction with care.
Quality of Life	●	Strong evidence that patient navigation improves cancer survivor QOL.
Emotional Distress	●	Evidence on the impact of patient navigation on emotional distress is inconclusive.
Legend ● = Strong evidence of effectiveness ● = Some evidence of effectiveness ● = Limited evidence of effectiveness ● = Evidence not conclusive		

Navigation Roles

Received: 27 November 2022 | Revised: 30 March 2023 | Accepted: 31 March 2023
DOI: 10.1002/1465-1959.21799

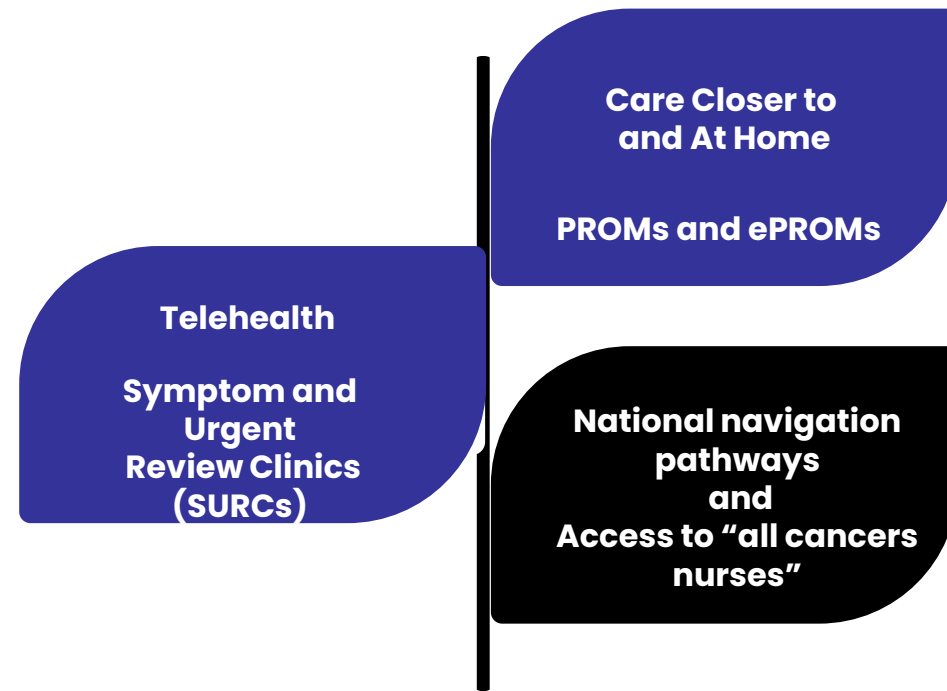
REVIEW ARTICLE

Patient navigation across the cancer care continuum: An overview of systematic reviews and emerging literature

Raymond J. Chan RN, PhD^{1,2} | Vivienne E. Milch MBBS(Hons), MHPol^{1,3,4} |
Fiona Crawford-Williams PhD¹ | Oluwaseyifunmi Andi Agbejule BRadTherapy¹ |
Ria Joseph MNutrDiet¹ | Jolyn Johal BND(Hons)¹ | Narayane Dick BSc(Hons)¹ |
Matthew P. Wallen PhD^{1,5} | Julie Ratcliffe PhD¹ | Anupriya Agarwal MBBS^{1,6,7} |
Larissa Nekhlyudov MD⁸ | Matthew Tieu PhD¹ | Manaf Al-Momani BPharm³ |
Scott Turnbull PhD³ | Rahul Sathiaraj MPH³ | Dorothy Keefe MBBS, MD^{3,9} |
Nicolas H. Hart PhD^{1,2,10,11,12}



Taking care to where the patients are/where the need is





- **Navigation in cancer care**

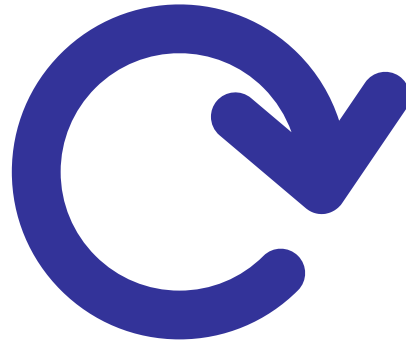
- Navigation is not a role – it's a system level solution
- Navigation needs are different at each step of the cancer continuum
- The skills and knowledge needed to enable effective navigation is different at each step of the journey and often across cancer groups
- Using our workforce efficiently is critical to achieving equitable navigation support

How can we apply what's happening in cancer more broadly across the life course?



● START WITH AN EQUITY LENS

- Rethink health workforce preparation
- Build a system for the most disadvantaged
- Digital solutions/PROMs
 - NB these may compound as well as target inequity



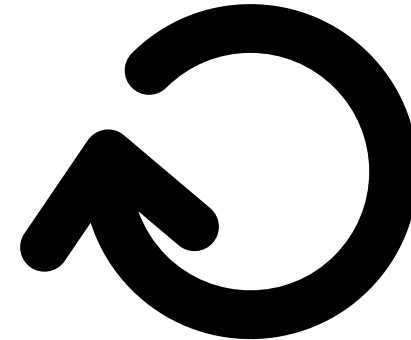
● END TO END THINKING

- Systems level thinking
- Funding re-design
- Community and peer navigation



CO-DESIGN

- Cross disciplinary and cross sector (to include public and private solutions)
- Think about the system not the problem



● SUSTAINABLE CHANGE

- We need an implementation orientation
- Re-think evaluation e.g., **value generation** rather than money saved – a cheaper service is not necessarily a safer or more equitable service



- a. <https://www.australiancancerplan.gov.au/welcome>
1. <https://www.aihw.gov.au/reports/cancer/cancer-data-in-australia/contents/overview-of-cancer-in-australia-2023> (accessed 13/04/2024)
2. [https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(22\)00090-1/fulltext](https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(22)00090-1/fulltext)
3. <https://www.cancer.org.au/health-professionals/resources/inequalities-in-cancer-outcomes>
4. https://ahha.asn.au/sites/default/files/docs/policy-issue/ahha_position_statement_-_health_workforce_3.pdf
5. https://www.who.int/health-topics/health-workforce#tab=tab_1
6. Chan RJ, Milch VE, Crawford-Williams F., et al. Patient navigation across the cancer care continuum: An overview of systematic reviews and emerging literature. CA Cancer J Clin. 2023 Nov-Dec;73(6):565-589. doi: 10.3322/caac.21788.
7. Stewart I, Khakwani A, Hubbard R, et al. Are working practices of lung cancer nurse specialists associated with variation in peoples' receipt of anticancer therapy? Lung Cancer. 2018 Sep;123:160-165. doi: 10.1016/j.lungcan.2018.07.022.



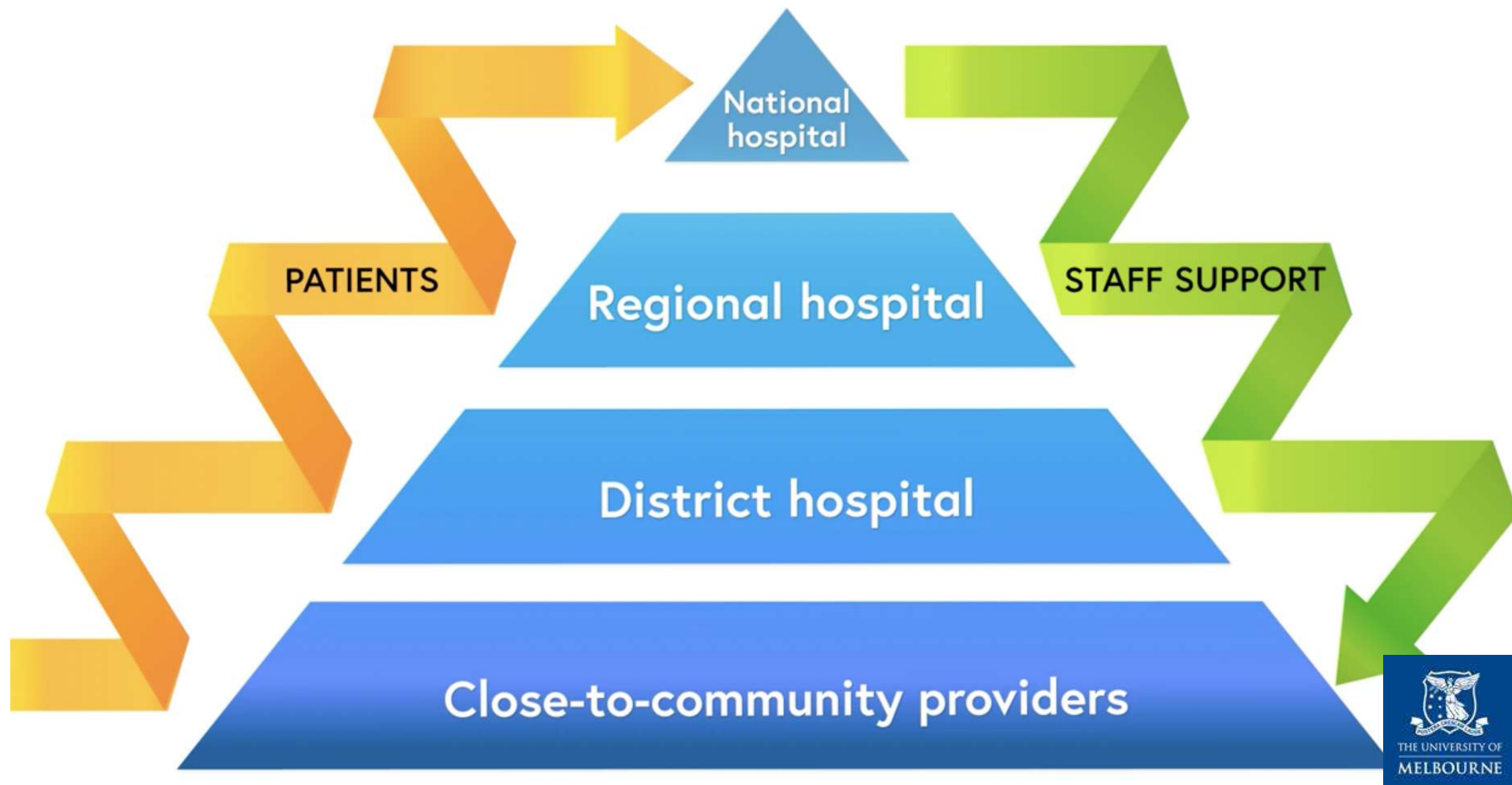
Health Financing, Referral Systems & Navigation

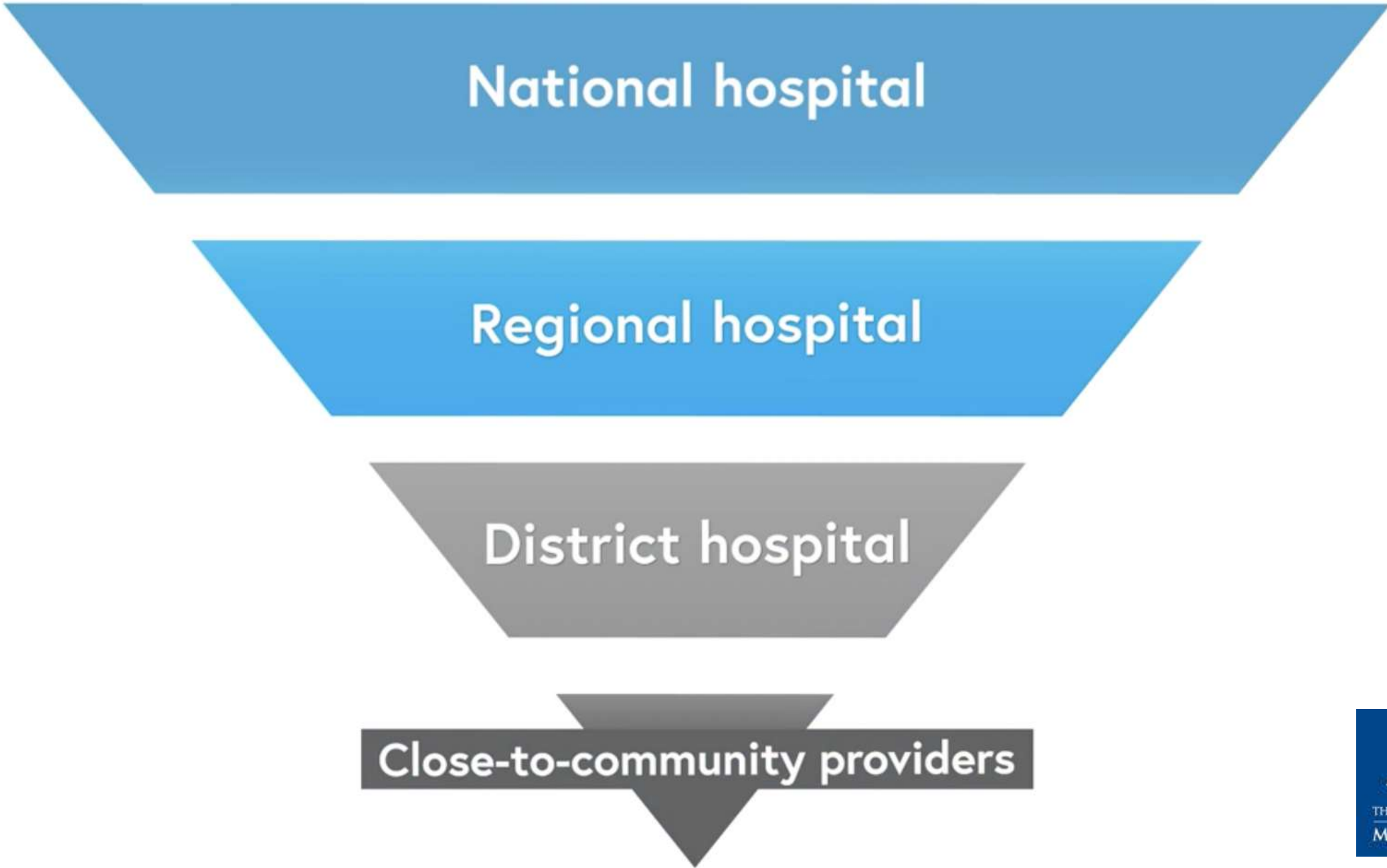
Professor Barbara McPake
Director of Global Health,
Nossal Institute for Global Health,
University of Melbourne

Navigating health systems: the example of the pyramid

Professor Barbara McPake,
Nossal Institute for Global Health,
Melbourne School of Population and Global Health,
University of Melbourne





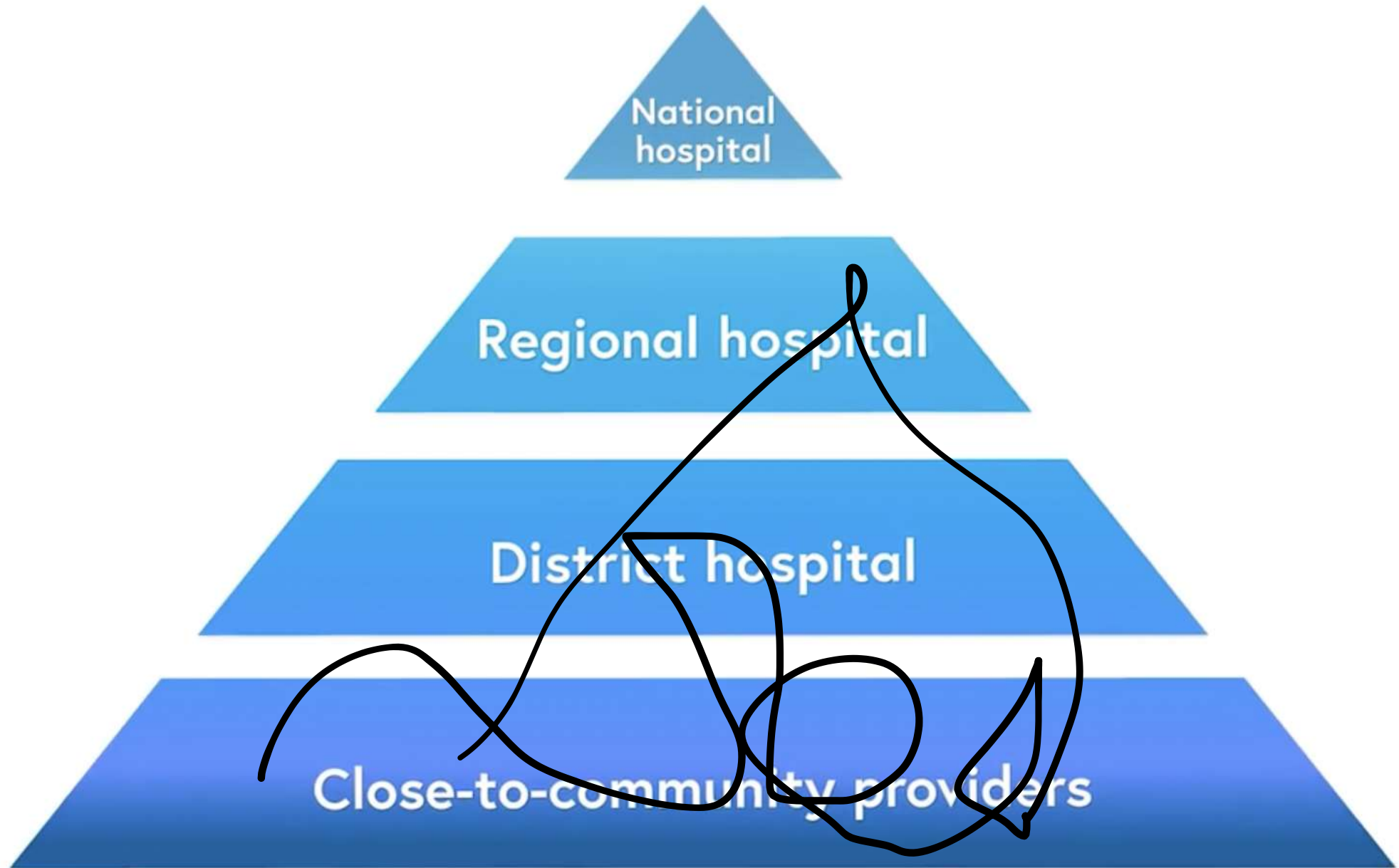


National hospital

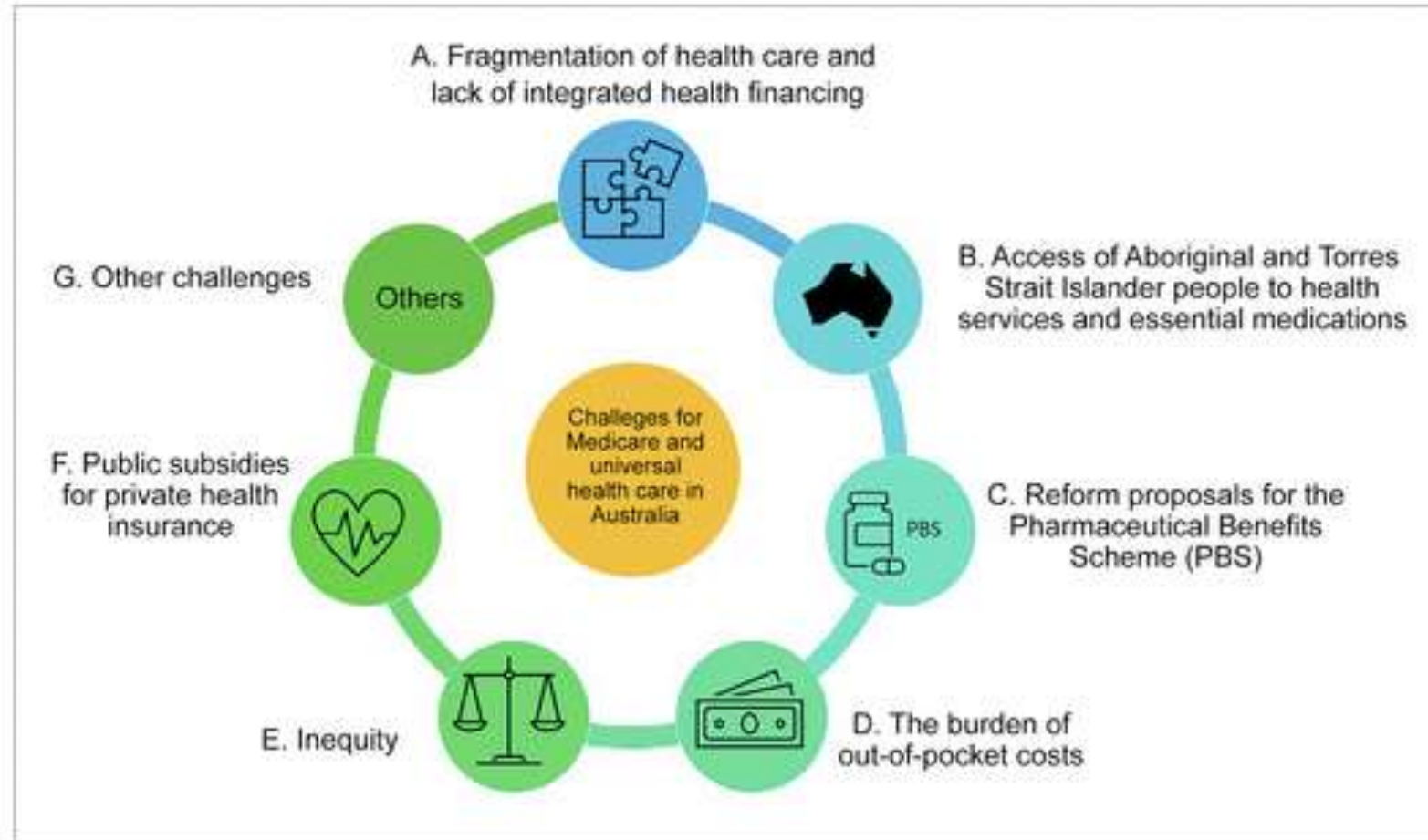
Regional hospital

District hospital

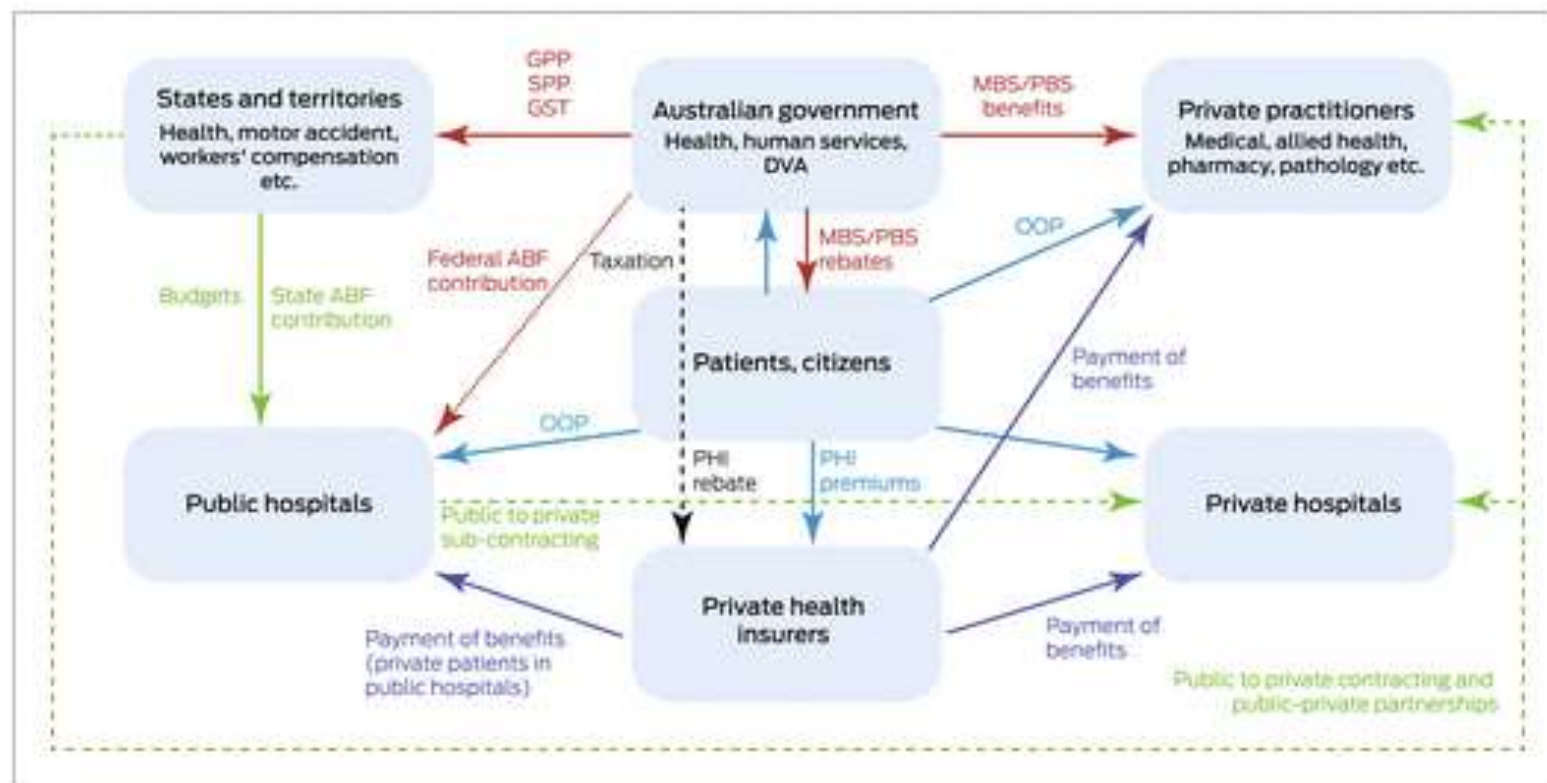
Close-to-community providers



Box 3. The seven major themes identified in 76 articles on universal health care in Australia



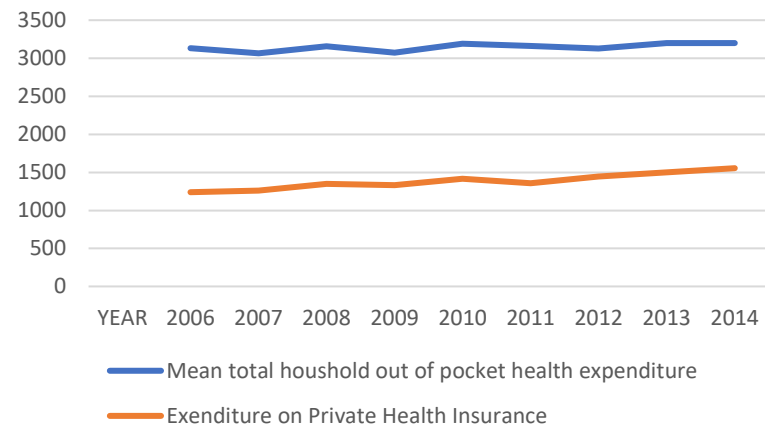
Box 1. Simplified schematic depiction of health care financing in Australia



ABF = activity-based funding; GPP = general purpose payments; GST = goods and services tax; MBS = Medicare Benefits Schedule; OOP = out-of-pocket expenses; PBS = Pharmaceutical Benefits Scheme; PHI = private health insurance; SPP = specific purpose payments.

Catastrophic and Impoverishing Health Expenditure

TOTAL OUT OF POCKET HEALTH EXPENDITURE AND EXPENDITURE ON PHI



Callander et al. Health Economics Review (2019) 9:10
<https://doi.org/10.1186/s13561-019-0227-9>

Health Economics Review

RESEARCH

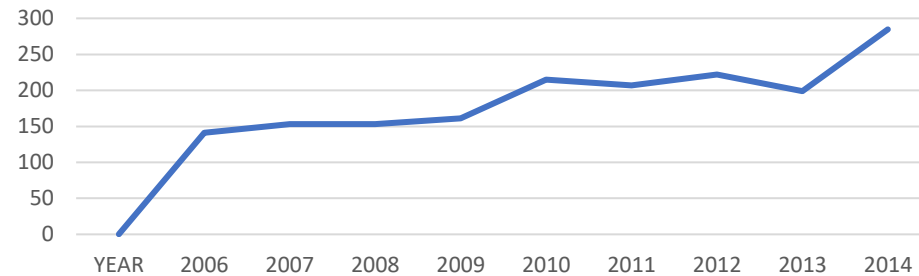
Open Access

Out-of-pocket healthcare expenditure in Australia: trends, inequalities and the impact on household living standards in a high-income country with a universal health care system

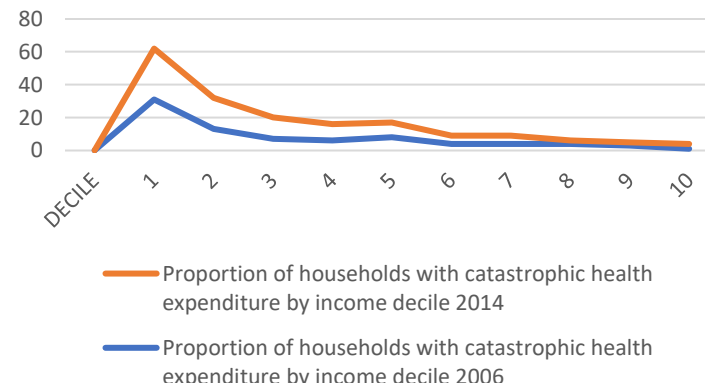
Emily J. Callander^{1*}, Haylee Fox¹ and Daniel Lindsay²

2017

Additional number of people in income poverty after household income adjusted for health care expenditure (000)



PROPORTION OF HOUSEHOLDS WITH CATASTROPHIC HEALTH EXPENDITURE (>10% OF REGULAR MONTHLY INCOME)



DISCUSSION AND DEBATE

Commentary: The Consequences of Private Involvement in Healthcare – The Australian Experience

Commentaire : Conséquences du volet privé dans les services de santé – l'expérience australienne

STEPHEN DUCKETT, PhD, DSc
Director
Health Program at Grattan Institute
Honorary Professor
University of Melbourne
Melbourne, Australia

HEALTHCARE POLICY Vol.15 No.4, 2020

2020

“Private provision, Public waiting”

More private provision has been associated with prolonged waiting. Do longer waits in public sector create demand for private care or does private care thrive by stifling public provision, creating longer waits?

Elasticity of supply of human resources

Given limitations on supply of surgeons, expansion of demand for private care will often result in a reduction in availability of surgical time in the public sector.



**Australia's Health Insurance System and
Its Two-Level Hospital System—A Result
of Muddled and Contested Objectives**

Stephen Duckett



2022

Government foots a large share of the PHI bill to try to make it more attractive (peaked at A\$65.9bn/year in 2012)

Private hospitals engage in ‘cream skimming’ referring out complex patients to public hospitals and selecting patients that yield higher profit margins

Analysis suggests private hospitals less efficient than public ones

Labor tolerates PHI subsidies – possibly because it fears PHI capacity to mobilize voters

“Unfortunately, unlike belief in the Easter bunny and Father Christmas, people tend not to grow out of the belief that supporting PHI benefits the public sector....Subsidies once introduced, are hard to withdraw, no matter how irrational they are.”



Conclusions

- Globally, navigating the health system is not just technically difficult – it involves negotiating issues of culture, power and incentives at every level
- In Australia, the particular difficulties involve fragmentation of health financing with consequences for management of out-of-pocket payments and an unregulated private sector, with impacts for Aboriginal and Torres Strait Islander access to the system, catastrophic and impoverishing expenditures for lower income Australians and inequities more generally - financial outcomes
- From a health outcome perspective, the inherent financial incentives can undermine rational health care journeys in multiple ways



Centre for Digital Transformation of Health

CONNECTING
DIGITAL INNOVATION
TO HEALTH

Connected Care

Professor Wendy Chapman

Associate Dean of Digital Health & Informatics, Director of the Centre for Digital Transformation of Health

University of Melbourne

Fiona

12-year-old girl

Plays soccer

Loves reading

Has asthma





Fiona is 12, she has a history of episodic asthma. During a thunderstorm she becomes breathless and her parents take her to the emergency department



After her consultation she is discharged from the ED with a management plan



She continues to use her inhaler but management of her asthma is sub-optimal, she is not using the correct technique. She is finally referred back to her GP



There's nothing on the record here about your visits to the ED

The visits to the ED may have coincided with days when there was high pollen count

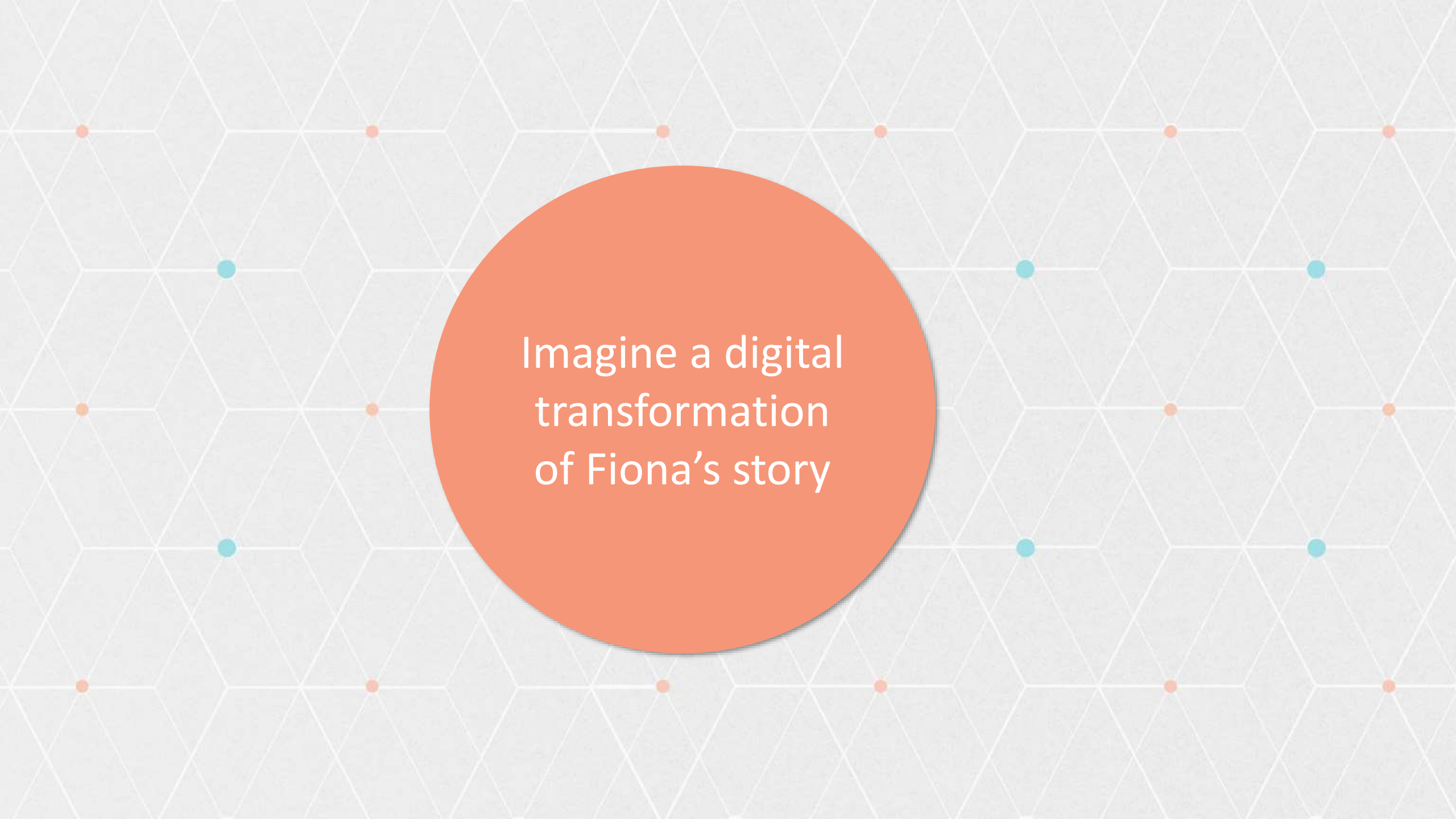
I don't know what I did with the plan they gave me at the hospital



We're just going to have to start again...develop a new plan

OH NO!!

.....3 months later



Imagine a digital
transformation
of Fiona's story



Sprint 3G 9:53 AM 93%

eAsthmaTracker

4. Once this week

5. Not at all

5) How would you rate your asthma control?

1. Not controlled at all

2. Poorly controlled

3. Somewhat controlled

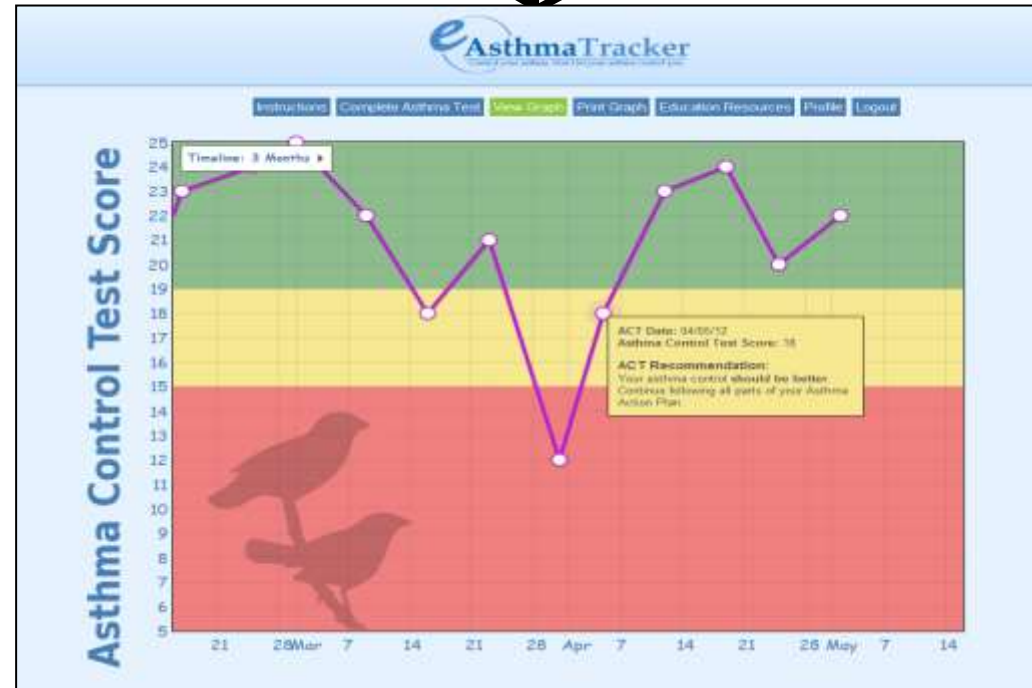
4. Well controlled

5. Completely controlled

Next

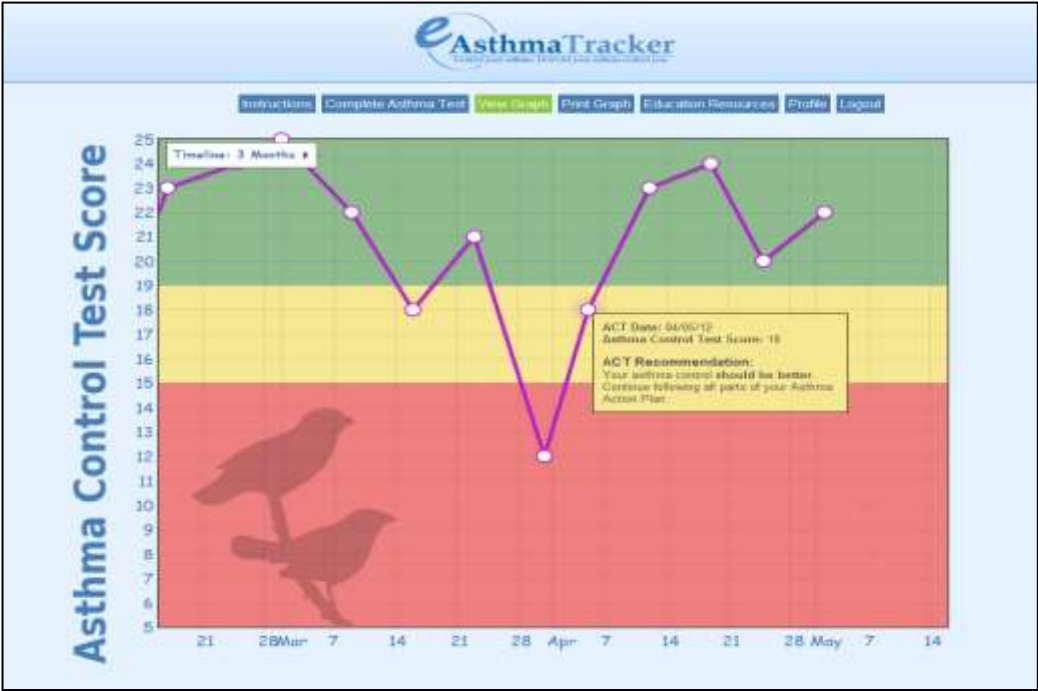
© 2011 Terms & Conditions

Fiona at Home



Fiona

Health care team



Status
Trends

Reminders
Education
Alerts

AsthmaTracker
Control your asthma. Don't let your asthma control you.

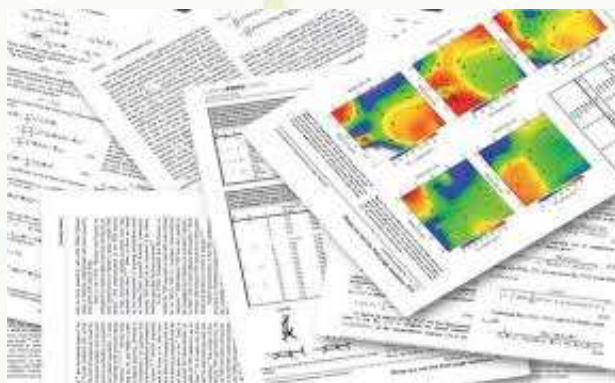
Patients | Flagged Patients | Low Score Patients | Low Compliance Patients | Clinic Users | Manage Clinic | Logout

Search Create Patient

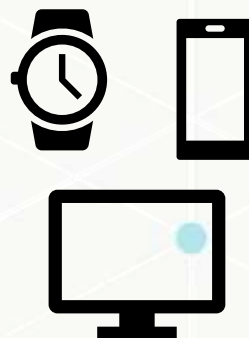
Email	First Name	Last Name	Last 20 Days	Notes
eunhea.kim1@gmail.com	Tinker	Beil	- 24 24 25	add view (1) view graph edit remove
eunhea.kim@hsc.utah.edu	John	Doe	- - - - -	add view (3) view graph edit remove
eunhea.kim@hsc.utah.edu	Jane	Doe	- - - - -	add view graph edit remove
eunhea.kim1@gmail.com	Donald	Duck	- 18 11 16	add view (3) view graph edit remove
eunhea.kim@hsc.utah.edu	Goofy	Goof	- - - - 18	add view (2) view graph edit remove
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eunhea.kim@hsc.utah.edu	Snow	White	- 17 23 25	add view (1) view graph edit remove

Participatory health

The technology exists, so what's the problem?



10,000 AI manuscripts a year



Over 300,000 health apps

Most digital
tools are not
implemented
in real settings



Drug Development Process

Discovery and development



Pre-clinical research
Animal testing, safety
assessment



Clinical Research
Phase I-IV
clinical trials



Review by government
regulatory agency
TGA, FDA review



Post-marketing safety
monitoring

Digital Health Innovation Process



Discovery and development



Review by government
regulatory agency



Post-marketing safety
monitoring

There is a gap in
implementing
and evaluating
digital health
innovations

Connected care requires a connected system



The vision of the National Digital Health Strategy is *'an inclusive, sustainable and healthier future for all Australians through a connected and digitally enabled health system.'*

CHANGE ENABLERS



Policy and regulatory settings that cultivate digital health adoption, use and innovation



Secure, fit-for-purpose and connected digital solutions



Digitally ready and enabled health and wellbeing workforce



Informed, confident consumers and carers with strong digital health literacy



Digital Health Validitron – University of Melbourne

Focus on implementability and evidence generation

Pragmatic expertise

Implementation science, evidence generation, HTA, codesign, HCI/UX, technical FHIR, etc.

Digital sandbox

Virtual environment for prototyping, testing and test bed projects.

Human factors simlab

Immersive physical space for workflow co-design and scenario-based user studies.





What is the state of evidence for this innovation area?

What would a model of care built around this innovation look like?

How do we integrate and demonstrate safety?

Exploration

Design and
prototyping

Development and
Validation

Evaluation

What is a feasible payment model for this innovation?

What regulatory frameworks will it need to operate within?

What outcomes evidence is needed and how does this scale?













Centre for Digital Transformation of Health

Enabling connected healthcare



Collaboration: Enabling Person-Centred Systems

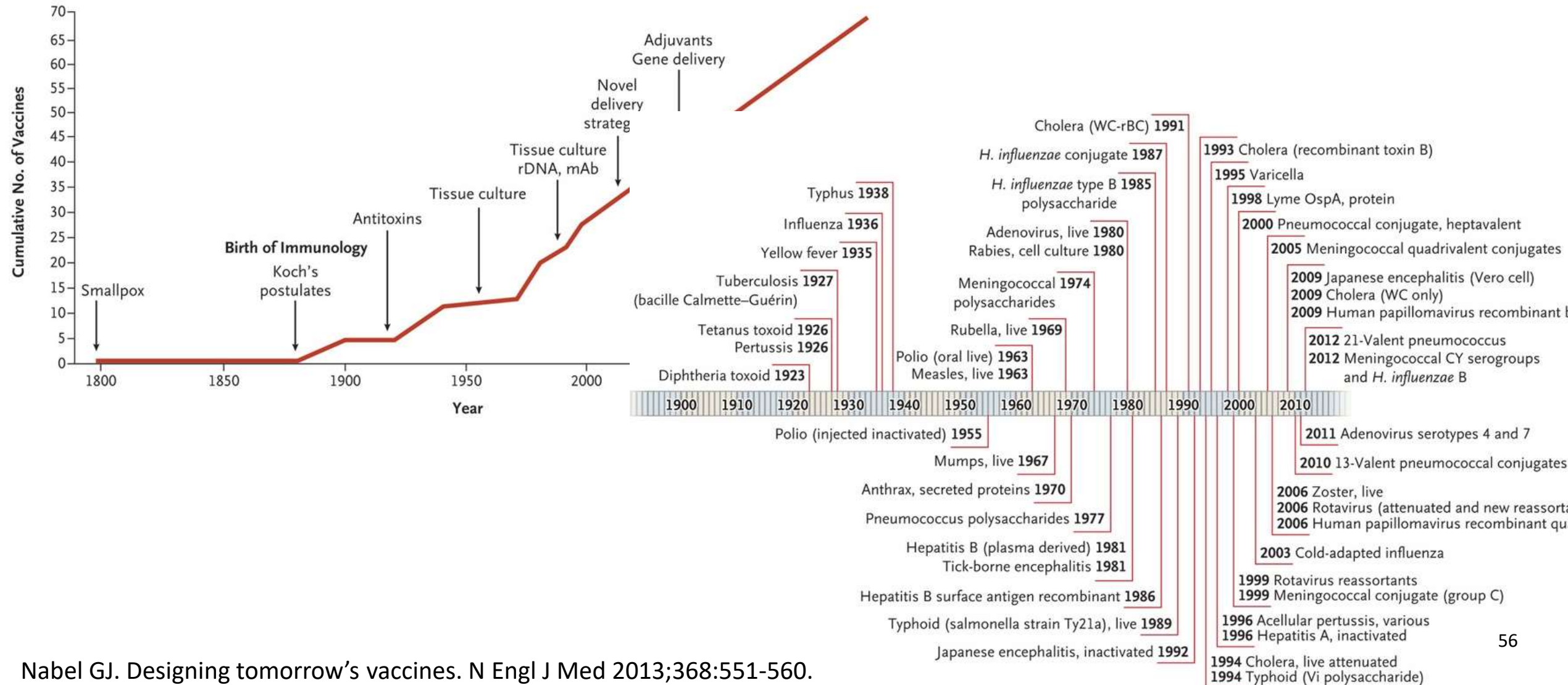


Collaboration: Enabling Person-Centred Systems

Value: Equity, Economics, Evaluation

Associate Professor Natalie Carvalho
Melbourne Health Economics
School of Population and Global Health
#NavigatingHealth: Simplifying Complexity
16 April 2024

Motivation





Measuring value in Health Technology Assessment (HTA)

- Concerns about increases in health care expenditure have led to the development of initiatives to measure the value of health care technologies
- Value traditionally defined as health benefit relative to the cost
- Comparison to explicit or implicit willingness-to-pay threshold

HTA decision-making

- Budgets are limited
- Other health priorities
- Alongside clinical efficacy and safety, economic evaluation typically used as the tool to quantify health benefits, and costs, and consider value for money of new drugs, technologies, interventions etc.
- Patient engagement

Patient/Citizen involvement in HTA

Relevance	Fairness	Equity	Legitimacy	Capacity building
Patients have knowledge, perspectives and experiences that are unique and contribute to essential evidence for HTA.	Patients have the same rights to contribute to the HTA process as other stakeholders and have access to processes that enable effective engagement.	Patient involvement in HTA contributes to equity by seeking to understand the diverse needs of patients with a particular health issue, balanced against the requirements of a health system that seeks to distribute resources fairly among all users.	Patient involvement facilitates those affected by the HTA recommendations/d ecision to participate in the HTA; contributing to the transparency, accountability and credibility of the decision-making process.	Patient involvement processes address barriers to involving patients in HTA and build capacity for patients and HTA organizations to work together.

Consideration of patient preferences in HTA

There are two main methods for incorporating patient preferences:

1. Participation: patient preference input refers to the inclusion of patients and/or their representatives in discussions at different stages of the HTA process e.g., committee meetings, calls for written comments, inclusion of patient representatives on advisory groups, testimonials, focus groups, organisation of a patient panel.
2. Patient-based evidence: the collection of patients'/patient representatives' values and experiences. This includes studies collecting data using a systematic method (e.g., survey, qualitative interviews), where data are analysed for reporting. For example, data collected from patients for valuation of health states to be used in the calculation of QALY weights. Similarly, data collected through qualitative interviews may be informative in setting the context for HTA decision-making or in framing value propositions of otherwise unquantified domains (e.g., impacts on convenience, autonomy, changes in the process of care).



Consumer engagement in HTA

Consumer engagement can provide critical insights to address gaps in the evidence, and information about local health settings gained from the lived experience of disease. A number of countries (including Australia) have formally incorporated consumer/community representation in HTA processes.

However, consumer engagement in HTA has historically lacked consistency and transparency.

Barriers: limited willingness to involve patients, need for confidentiality and possible conflicts of interest, finding the 'right' patient representative, lack of resources to support patient involvement, and needing guidance on how to involve patients. From the patient perspective barriers include the lack of understanding of the processes, the data and evidence required to inform input, and guidance on how to represent a patient community.

There is emerging research focused on articulating best-practice design, implementation and evaluation.

Value considerations

In Australia, health costs are borne by both individuals and the public, through the funding governments provide for public hospitals and health services, Medicare, the Pharmaceutical Benefits Scheme (PBS) and other government-supported health resources.

Therefore, the concept of value must be considered both in terms of personal value (therapeutic benefits of a technology for patients), and broader public (or societal) value.

Methodological challenges:

- Perspective (health care system/payer v societal – time costs, caregiver costs, NDIS, etc...)
- Discount rates (Australia's highest in world at 5%)
- How QALYs are valued
- Guidelines provide little or no reference to highly specialised therapies, such as cell and gene therapies, or new and emerging technologies that represent medical advancements in personalised treatments and treatment pathways e.g., gene therapies, precision medicines
- Impact on equity



Valuing health benefits

The most widely used approach in economic evaluation is to value health benefits using quality adjusted life years (QALYs). Patient-reported outcome measures (PROMs) and patient reported experience measures (PREMs) can embed the patient voice within the evidence considered by HTA, facilitating a more patient-centred approach to reimbursement decision-making.

BUT, questions remain:

- Different weights for children vs adults?
- Patient-reported outcomes are very context specific
- What about non-QALY benefits? (ex “value of hope”)
- A QALY is a QALY is a QALY?

This approach has been criticised for not sufficiently aligning with a patient-centric approach, neglecting societal preferences that may prioritise certain individual groups health gains over others, thereby overlooking considerations of equity.



Equity and Economics

As well as maximising health gains, a key goal of health systems is the reduction of health inequalities.

New methods are being developed to analyse equity in the distribution of costs and health outcomes, led by the University of York. These methods allow for explicit consideration of equity impacts of health technologies and programs, as well as the trade-offs that sometimes arise between equity and efficiency.

Distributional cost-effectiveness analysis (DCEA), has been explored in the literature but is yet to be implemented in practice. The feasibility of incorporating DCEA within HTA processes is currently being explored in England and Wales (NICE), however challenges arise from a lack of consistency in how equity concerns are defined and how data are collected or reported.

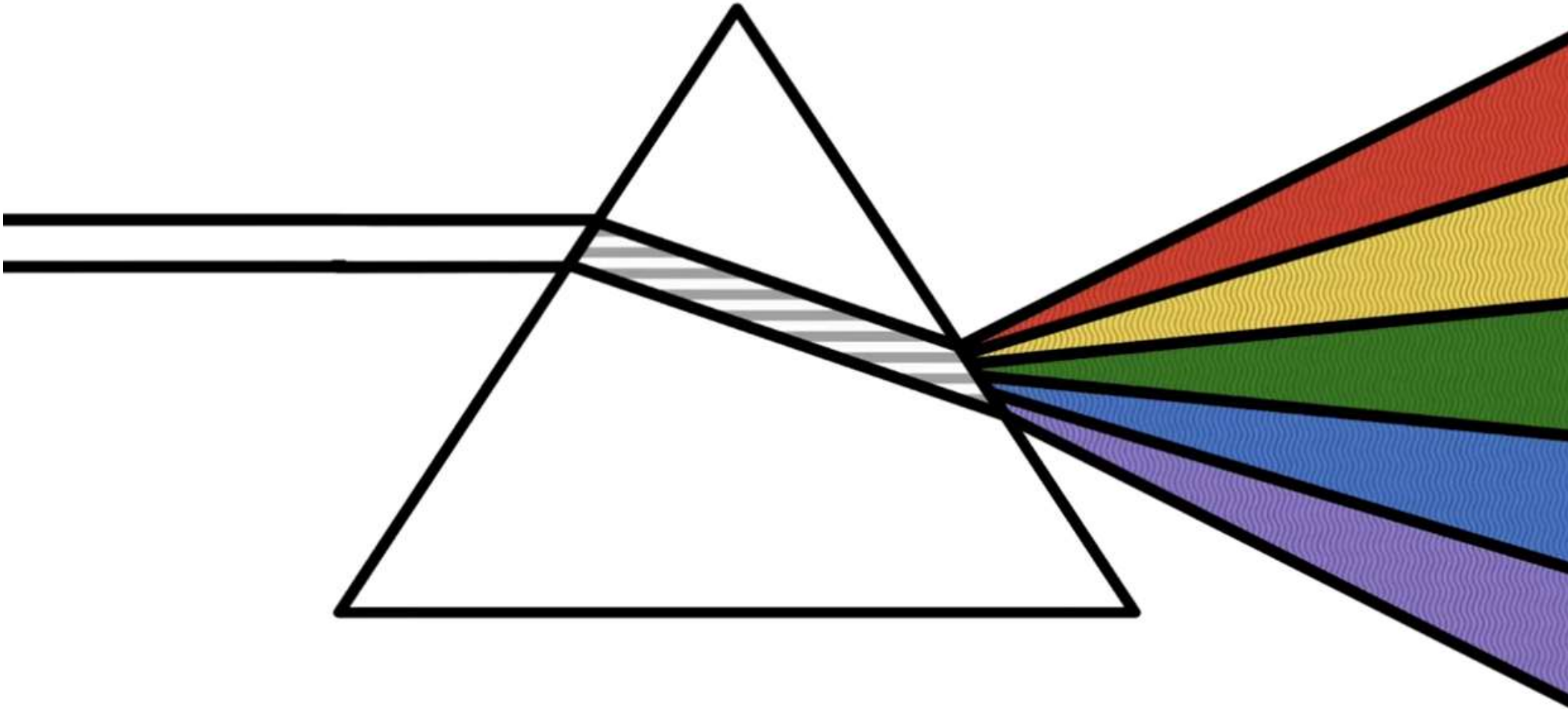
Indirect equity weighting approach, ie, quantifying an overall social value for each policy by using a social welfare function with an equity parameter, which reflects degree of concern for the worse off and indirectly implies equity weights. Application of DCEA methods to whole of population programs can inform targeted policies and interventions to address health inequality across Indigenous and non-Indigenous populations, different socioeconomic strata, and varied geographic regions.

Equity-informative economic evaluation



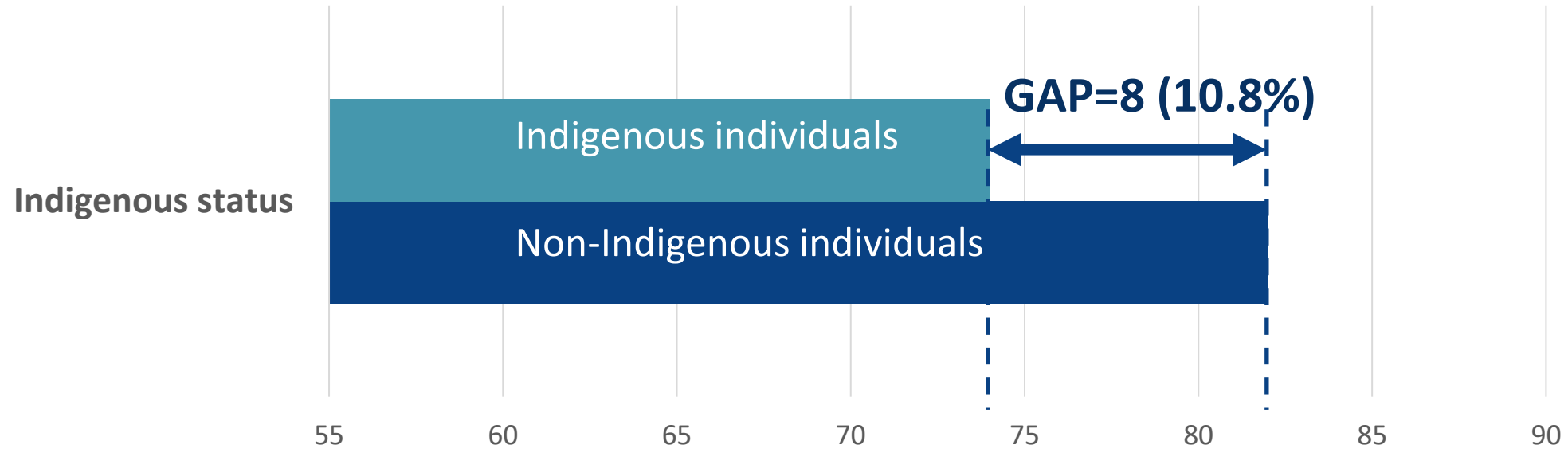
Contact details

Richard Cookson
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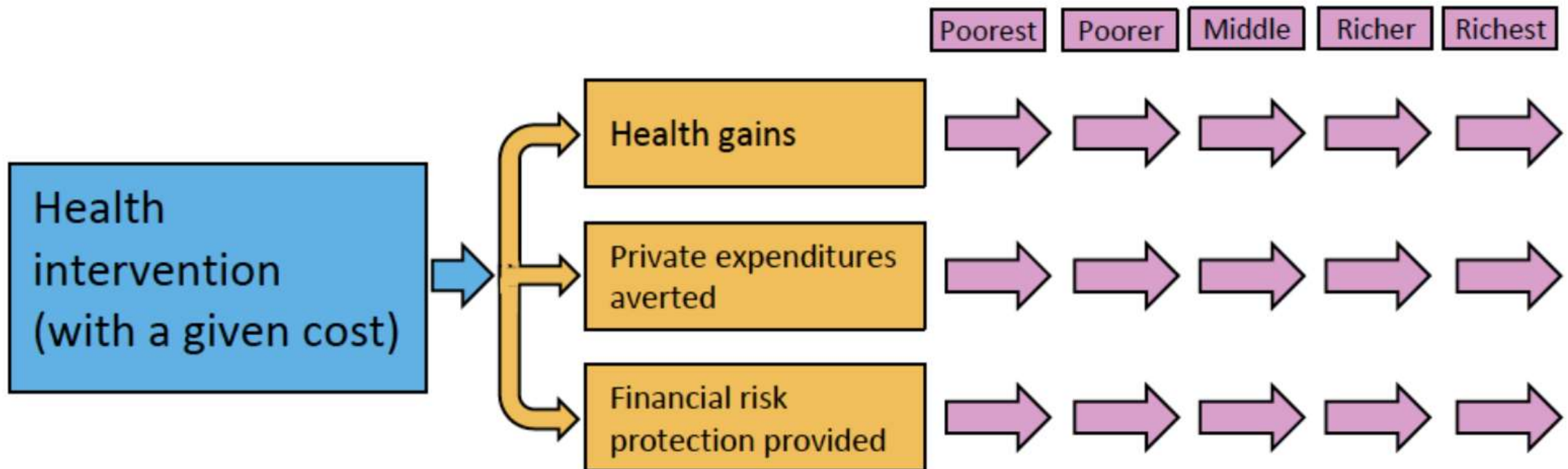
Health Equity

Life expectancy at birth of Australians by Indigenous status¹

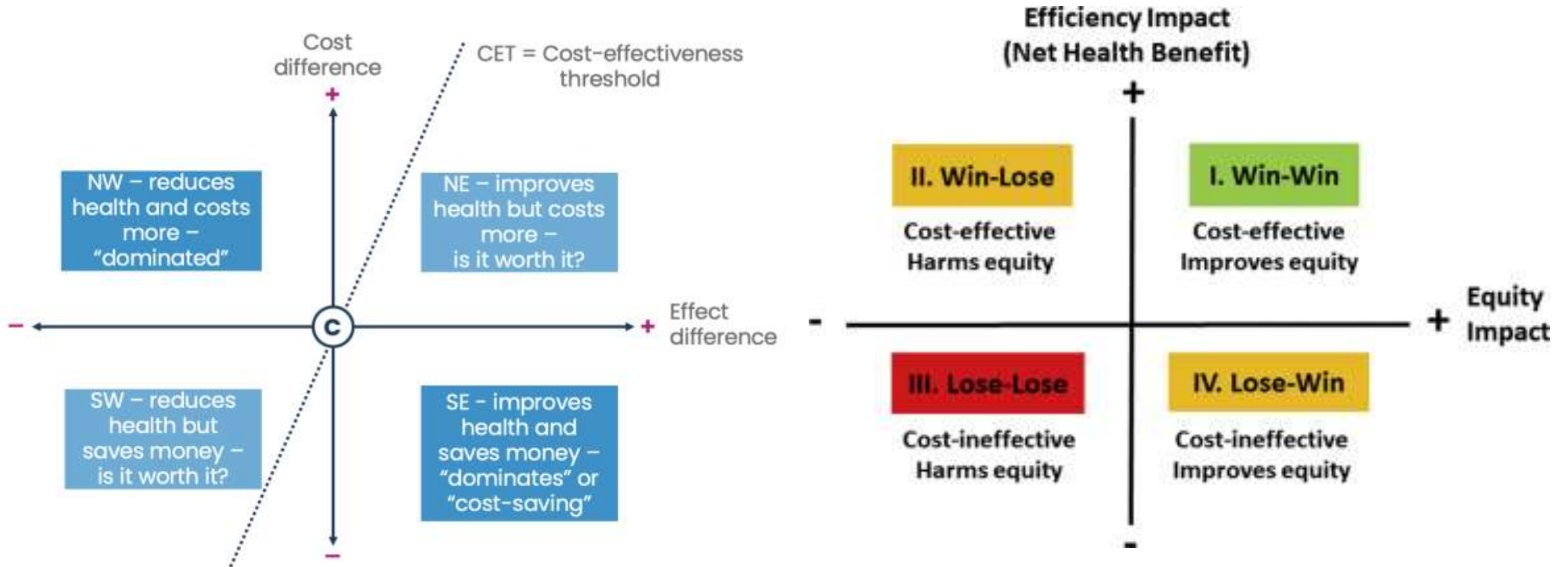


¹ Australian Institute of Health and Welfare 2022. Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2018. Australian Burden of Disease Study series no. 26. Cat. no. BOD 32. Canberra: AIHW.

Extended cost-effectiveness analysis



From traditional “Cost-effectiveness plane” to “Equity-efficiency impact plane”



Building blocks for Australian DCEA

PhD student Boujaoude M.A. has recently estimated inequality aversion parameters for Australia by surveying over 3000 members of the Australian population.

An overwhelming majority of respondents exhibited positive inequality aversion (>84%).

Preliminary results imply that the public is willing to weight incremental health gains to the poorest fifth 5 times more than to the richest fifth, 6 times for Indigenous versus non-Indigenous, and 4 times for people living in rural and remote areas compared to major cities.

Public preferences for reducing health inequality



[Health Inequalities - Trade Offs](#) from [Centre for Health Economics](#) on [Vimeo](#).

Research in this area investigates the strength of public concern for reducing health inequality as opposed to improving total population health – sometimes known as “equity-efficiency trade-offs”. The aim is to provide economically meaningful estimates of the magnitude of inequality aversion in different contexts, to help inform policy decisions. The research is based on questionnaires that present respondents with hypothetical policy dilemmas involving equity-efficiency trade-offs, administered in both face-to-face and online settings.

Equity in HTA: Where are we at?

A limited number of HTA guidelines explicitly mention that equity implications of technologies (unmet clinical need, vulnerable and disadvantaged populations) are important and should be considered (Australia (MSAC/PBAC); Canada (CADTH); England and Wales (NICE); Korea (HIRA); Scotland (SMC); Spain (HTAA); Taiwan (CDE)). In each case, consideration of equity occurs alongside cost-effectiveness analyses with all guidelines recommending equal weighting of QALYs for the base case analysis, regardless of the characteristics of people receiving, or affected by, the intervention in question.

Three agencies (England and Wales (NICE); the Netherlands (ZIN); Norway (NoMA/NIPH)) have operationalised the practice of applying equity weights to specific population subgroups as a means of increasing the effective cost-effectiveness threshold for some new health technologies. In other jurisdictions, qualitative deliberation is the method in which factors for equity are considered.

In light of higher burdens of disease and challenges in accessing health care services among Aboriginal & Torres Strait Islander and Maori populations respectively, Australia and New Zealand have adopted special authority ethnicity criteria for some medications (and vaccines).



Flexibility in the decision-making process

Unlike England and Wales (NICE), the lack of an explicit cost-effectiveness threshold in Australia allows for such factors to be considered qualitatively rather than quantitatively.

“While quantitative assessment can assist in making the health equity impacts of funding decisions explicit and shed light on such considerations in HTA deliberative processes, experts caution that flexibility is pivotal, and that quantitative forms of equity-informed economic evaluation should not be used as an algorithm for decision-making.”

Incorporating emerging quantitative methods, such as DCEA, could improve transparency and consistency in how such factors are weighted during the decision-making process. However, this is currently hampered by a lack of consistency in how equity concerns are defined and how data are reported and collected. Therefore governments and HTA agencies must be explicit about which equity concerns are of most interest and recommend or develop generic indices to best capture them.



Applying the learnings: “The Leaky Pipe”

Andrea Boudville
Teaching Specialist, Master of Public Health,
Melbourne School of Population & Global Health, University of Melbourne

The University of Melbourne acknowledges the Traditional Owners of the unceded land on which we work, learn and live: the Wurundjeri Woi-wurrung and Bunurong peoples (Burnley, Fishermans Bend, Parkville, Southbank and Werribee campuses), the Yorta Yorta Nation (Dookie and Shepparton campuses), and the Dja Dja Wurrung people (Creswick campus).

The University also acknowledges and is grateful to the Traditional Owners, Elders and Knowledge Holders of all Indigenous nations and clans who have been instrumental in our reconciliation journey.

We recognise the unique place held by Aboriginal and Torres Strait Islander peoples as the original owners and custodians of the lands and waterways across the Australian continent, with histories of continuous connection dating back more than 60,000 years. We also acknowledge their enduring cultural practices of caring for Country.

We pay respect to Elders past, present and future, and acknowledge the importance of Indigenous knowledge in the Academy. As a community of researchers, teachers, professional staff and students we are privileged to work and learn every day with Indigenous colleagues and partners.

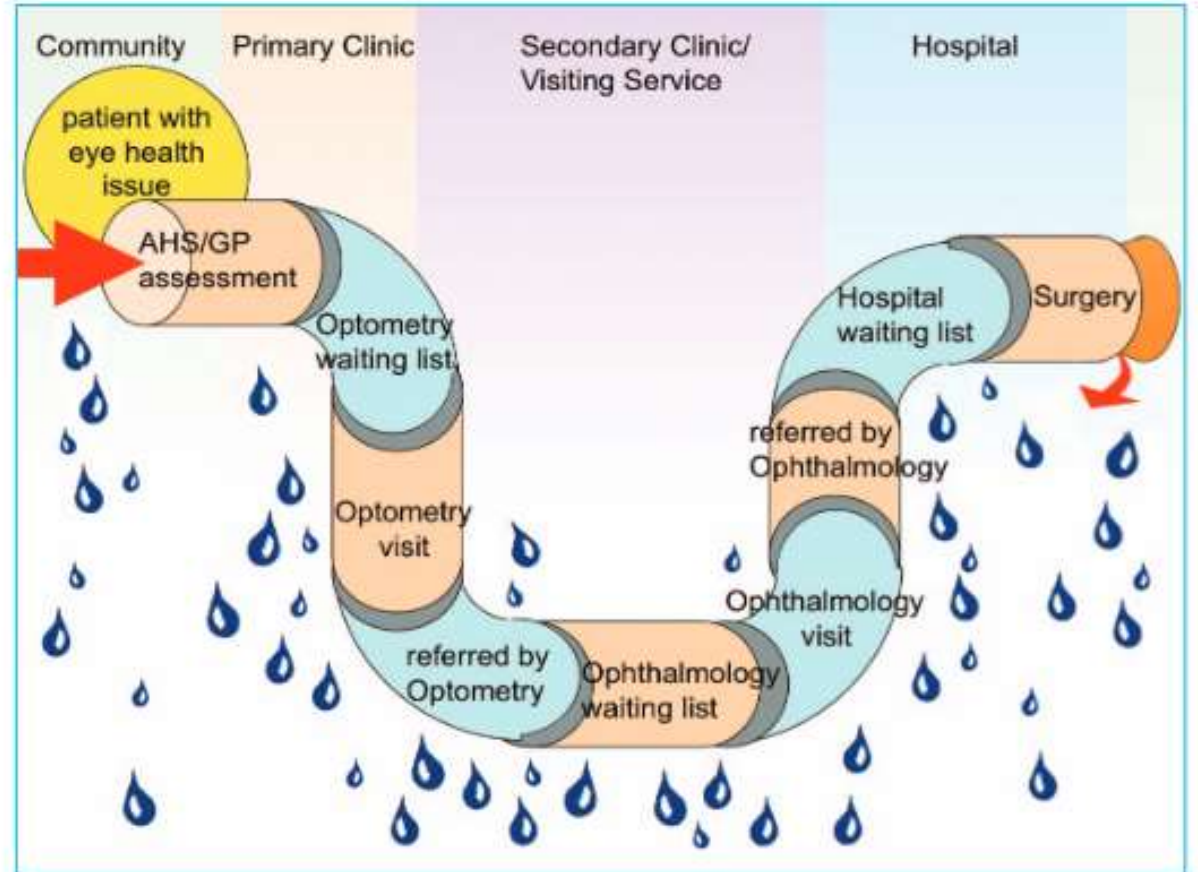
Background and Evidence



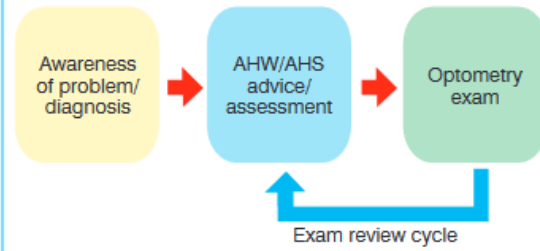
- **Guided by the results of the 2008 NIEHS which determined the extent, distribution and causes of vision loss and blindness in Aboriginal and Torres Strait Islander people.**
 - 4 main causes (94% of all vision loss)
 - 98% of vision loss from these cause was preventable
- **Provided the evidence to determine the Gap in eye health between Aboriginal and Torres Strait Islander people and non- Indigenous Australians.**
 - 6 X more blindness
 - Vision loss accounted for 11% of the health gap
- **Unmet need similar in urban and remote areas**
- **National consultations to investigate the barriers and enablers to eye care**
- **Roadmap to close the gap for Vision recommended policy changes to improve the quality and sustainability of eye care services.**

The Leaky Pipe

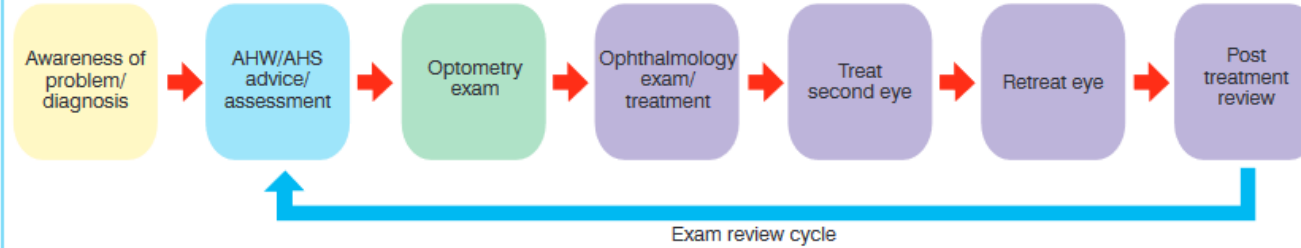
- The pathway is difficult – entering, travelling through each step, exit
- Time taken to get treatment is too long or complex logistics = patient drops out of the system
- Dysfunctional and too hard – prevents some from returning and others from entering
- Back pressure – few end up receiving treatment
- Aim is to stop the leaks – each section must fit smoothly with the next segment and remove the stopper and create negative pressure



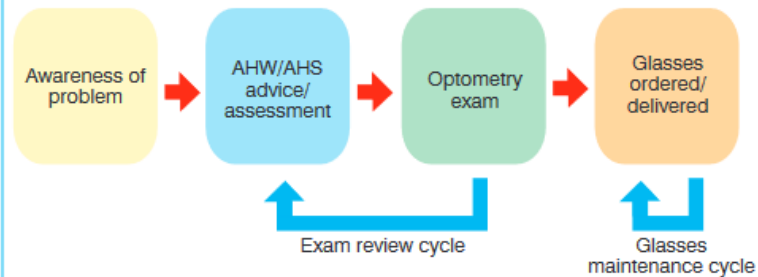
Diabetes (one specialist visit)



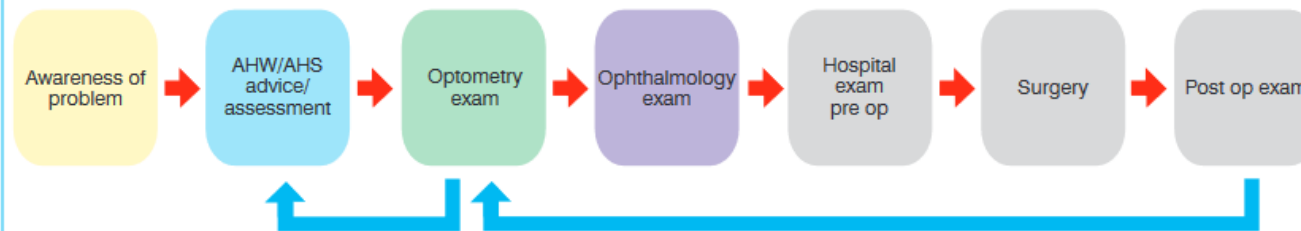
Diabetic retinopathy (5 specialist visits)



Refractive Error (one specialist visit plus dispensing)



Cataract (5 specialist visits)

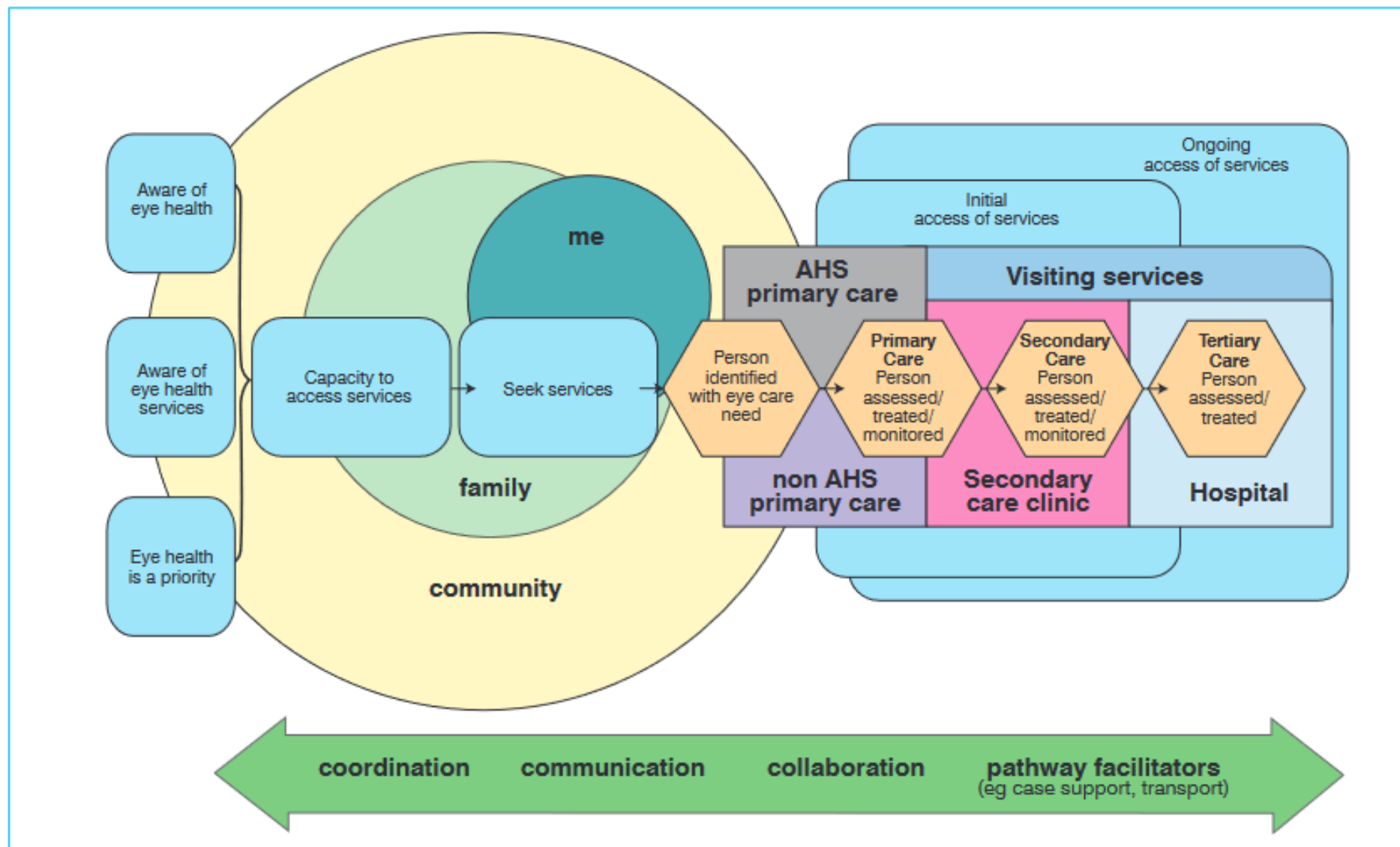


Person centred care



- The Roadmap consists of 42 specific recommendations to strengthen local service systems and increase service utilisation
- Eye services need to be increased in remote areas and their utilisation increased in all areas
 - Sharing positive experiences and building on these to improve pathway in other areas (creating negative pressure in the pipe)
- Model of care to prioritize primary health care and community control
 - Focus on understanding the pathway (for both service providers and patients)
- Requires co-ordination along the pathway of care to improve efficiency and patient outcomes
 - Strengthen the eye care workforce and build local and regional networks
- Eye services require monitoring and evaluation of agreed performance indicators by a nationally accountable body

Patient pathway

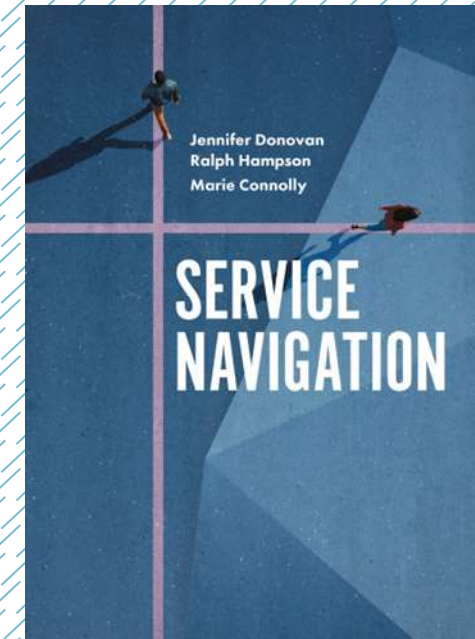




Service Navigation Relational Autonomy Framework (SNRAF)

A framework for practice and research

Dr Jennifer Davidson



Davidson, J., Hampson, R. & Connolly, M. (2019)
*Service Navigation: research and practice in health
and human services*. Macmillan International

SNRAF Domains and Relational Autonomy

- **Four domains** provide structure to navigation practice across different service systems



- **Relational autonomy** provides a lens to SNRAF and each domain
 - Agency and autonomy is exercised in the context of relationships
 - Autonomous decision-making should be supported through understanding individual relational dynamics and encouraging individuals to decide which relationships they want to support/guide their decisions

Questions to guide practice....

Mobilising service systems

- Has mapping of the service sector been undertaken?
- How can fractured and/or complex sector boundaries and issues be managed?
- Are risk management procedures in place to support the provision of services?
- How is service provision monitored and evaluated?

Questions to guide practice....

Fostering self-determination

- How are decisions being negotiated? Is autonomous decision-making central to the process?
- Is the client and/or family role being unintentionally undermined?
- Where does the navigator's practice sit along the autonomy/dependency continuum?
- How is the navigator role being evaluated? Do power dynamics influence client feedback?

Questions to guide practice....

Supporting trajectories and wellbeing

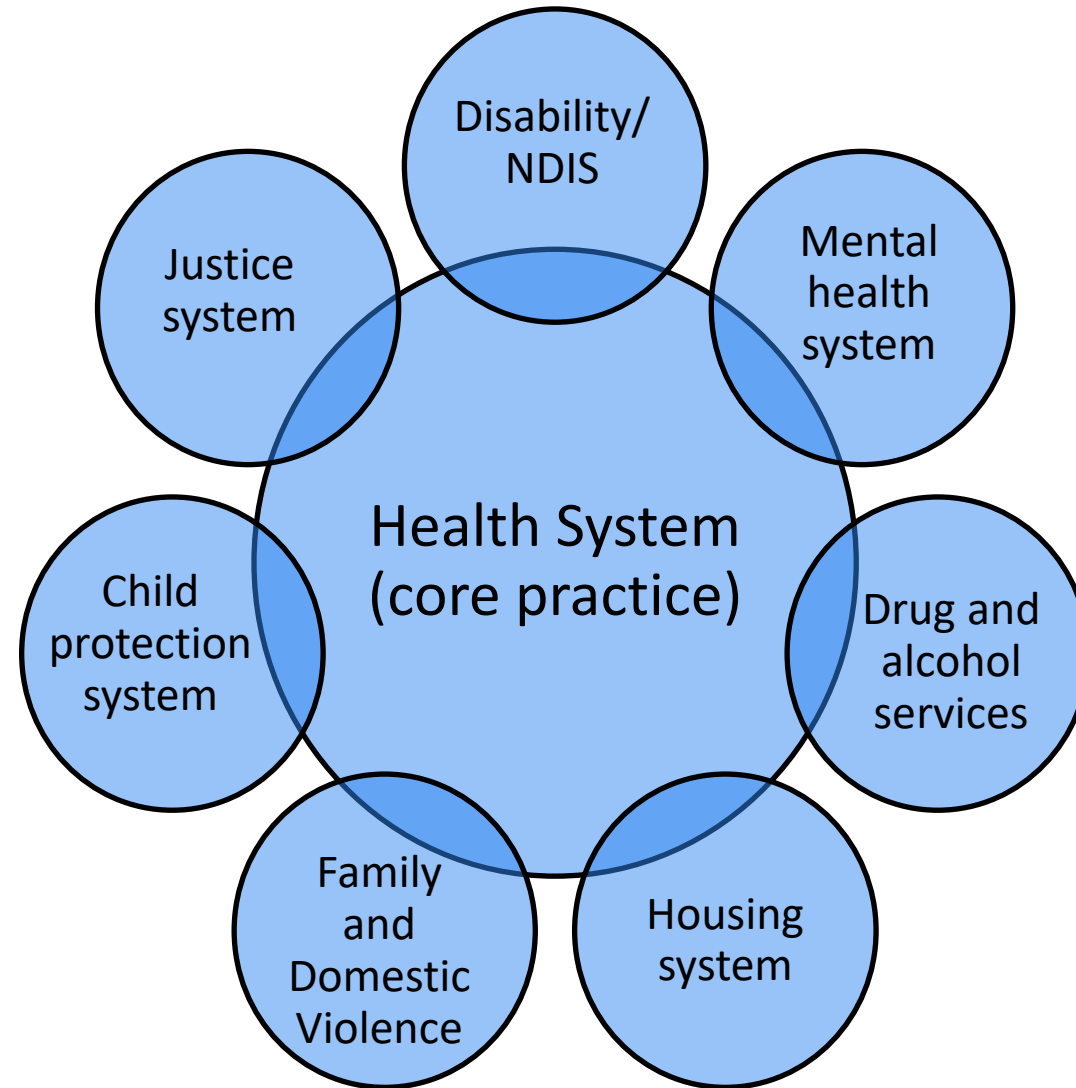
- How are developmental and cultural issues being perceived and factored into the work?
- How might the navigator support transitions? How might they be affected by the transitions?
- Are there any concerns about abuse - emotional, physical, financial?
- How is 'wellbeing' being understood and supported over time?

Questions to guide practice....

Reinforcing ethical practices

- Are the roles and responsibilities of the navigator clear?
- Is an efficient and effective use of client resources underpinning any contracting?
- Are power influences transparent? How are they being responded to?
- How are these dynamics affecting your engagement, contracting and ongoing work?

Mapping a services system: *complex/ fractured service system boundaries*





The Water Well Project

Culture, Communication & Impact

Dr Linny Kimly Phuong

Paediatric Infectious Diseases Physician, Founder & Board Director



@drlinnykp
@thewaterwellau



drlinnykp
thewaterwellproject



Everyone has a right to good health



The Water Well Project



The Water Well Project

Vision

For individuals from migrant, refugee and asylum seeker background to achieve equitable access to health.

Mission

Improve the physical and mental wellbeing of individuals from migrant, refugee and asylum seeker background by improving health literacy.



The Water Well Project



Image credits:

<https://unsplash.com/@dexswaggerboy>

<https://nwmpn.org.au/news/covid-19-vaccination-clinical-champions-program/>



The Water Well Project

What are the barriers to achieving good health in these communities?



Indicators of poor health literacy

- Inappropriate presentations to the emergency department
- More hospitalisations
- Longer length of stays
- Poor uptake of preventative health services
- Poor adherence to treatment regimens

.....



The Water Well Project

How do we bridge this gap?

Community participants

- Interactive health education sessions
- Topics requested by community
- Facilitated by AHPRA registered healthcare professionals
- Delivered in the community
- Community led Q&A
- Work with interpreters

Healthcare system

- First-hand experience:
 - working with communities from CALD backgrounds
 - facilitating group education
 - working with interpreters*
- Interdisciplinary learning



The Water Well Project

Our sessions



Our Partnerships



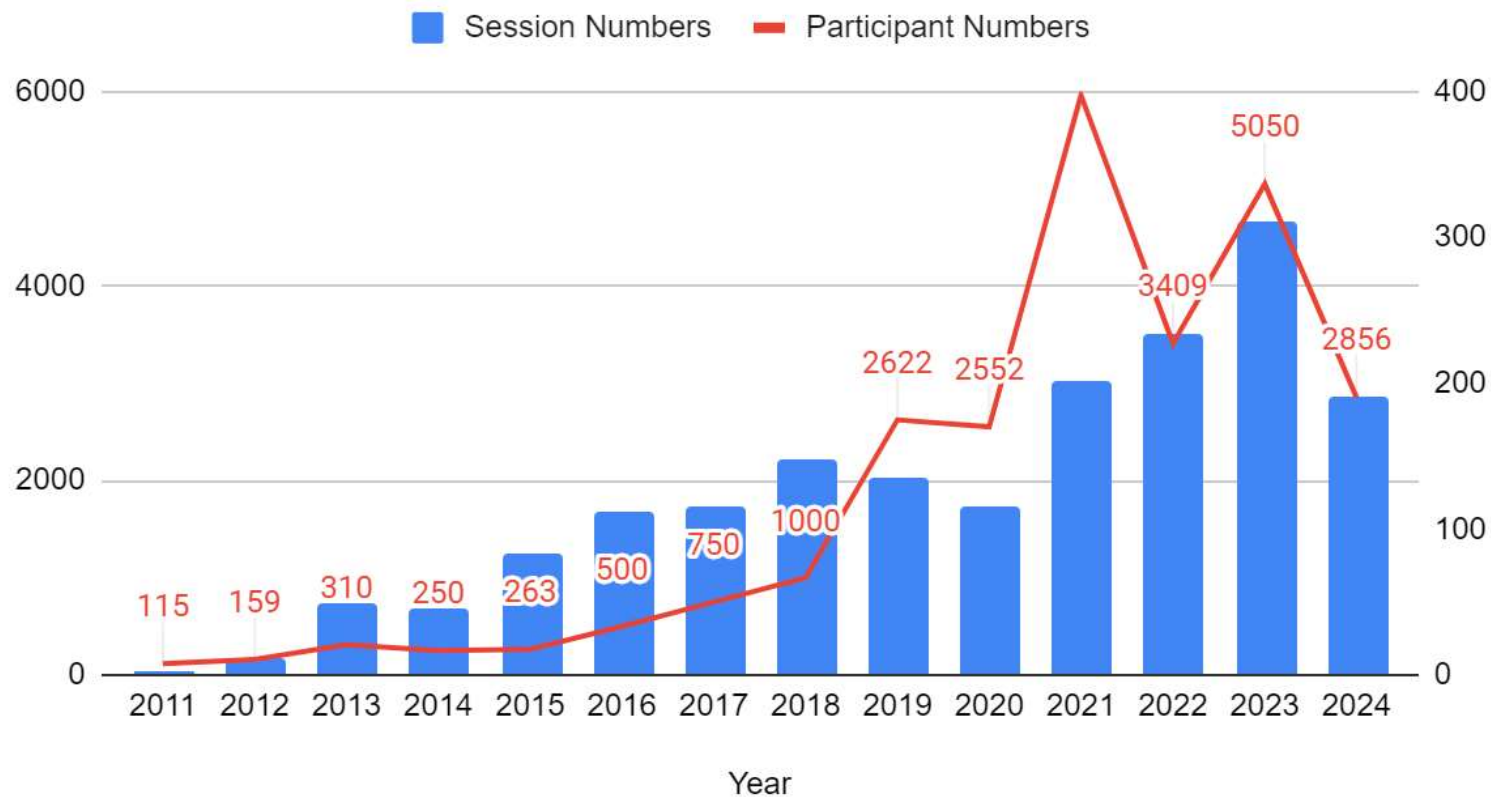


The Water Well Project

Building momentum



- Facilitated **>1,700 sessions** and reached **~25,000** community participants
- Over \$240k donated in volunteer time per annum





Melbourne Awards 2018

Winner - Contribution to Multiculturalism by a Community Organisation



Australian Migration and Settlement Awards 2019

Finalist - Settlement Innovation



Victoria Day Awards 2019

Winner - Community Organisation of the Year



HESTA Impact Awards 2021

Finalist – Outstanding Organisation

HESTA Excellence Awards 2021

Finalist – Community Service

Recognition



Victorian Multicultural Commission Health Award for Excellence 2022

High Commendation



Victorian Public Healthcare Awards 2023

Winner- Excellence in Culturally Diverse Health



The Water Well Project

Our supporters



- . 100 Women
- . 10x10 Philanthropy
- . John and Miriam Wylie Foundation
- . Lord Mayor's Charitable Foundation
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- . City of Brimbank
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- . City of Melbourne
- . City of Melton
- . Hume City Council
- . Knox City Council
- . Manningham City Council
- . Wyndham City Council

- . Federation of Ethnic Communities' Councils of Australia (FECCA)
- . Australian Government- Dept of Health & Aged Care
- . Translating Interpreting Services (TIS) National
- . Victorian Government
- . NSW Government
- . Tasmanian Government

- . Maddocks Lawyers
- . Nous Consulting
- . Greater Western Water
- . Metro Trains
- . Shifra

Our staff, volunteer board & committee
Our healthcare professional volunteers



@thewaterwellau
@drlinnykp



thewaterwellproject
drlinnykp

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GETTING IT RIGHT: ENABLING OUR CHILDREN TO LIVE THEIR BEST LIVES

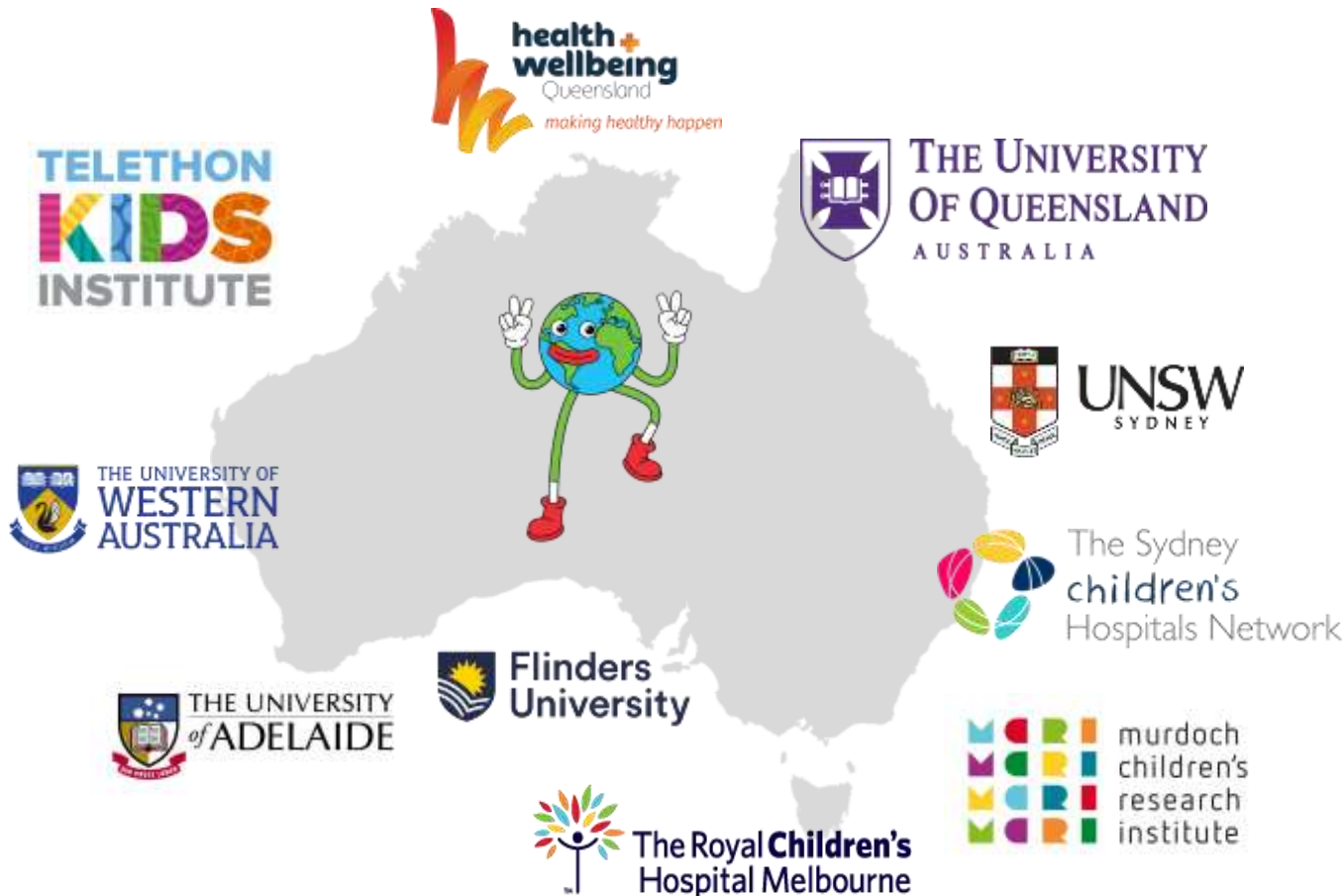
Kris Pierce

MHealthSc (Health Prom & Health Ed), MWellness, Nursing

CHILD UnLIMITED

Unleashing the potential of chronically ill children

Who is Child Unlimited?



We are a network of researchers, clinicians, advocates and families with a shared vision - to improve the whole-of-life care and quality of life of the **1.2 million** Australian children, adolescents and young adults living with a chronic illness or disability.

1ST OF ITS KIND IN THE WORLD



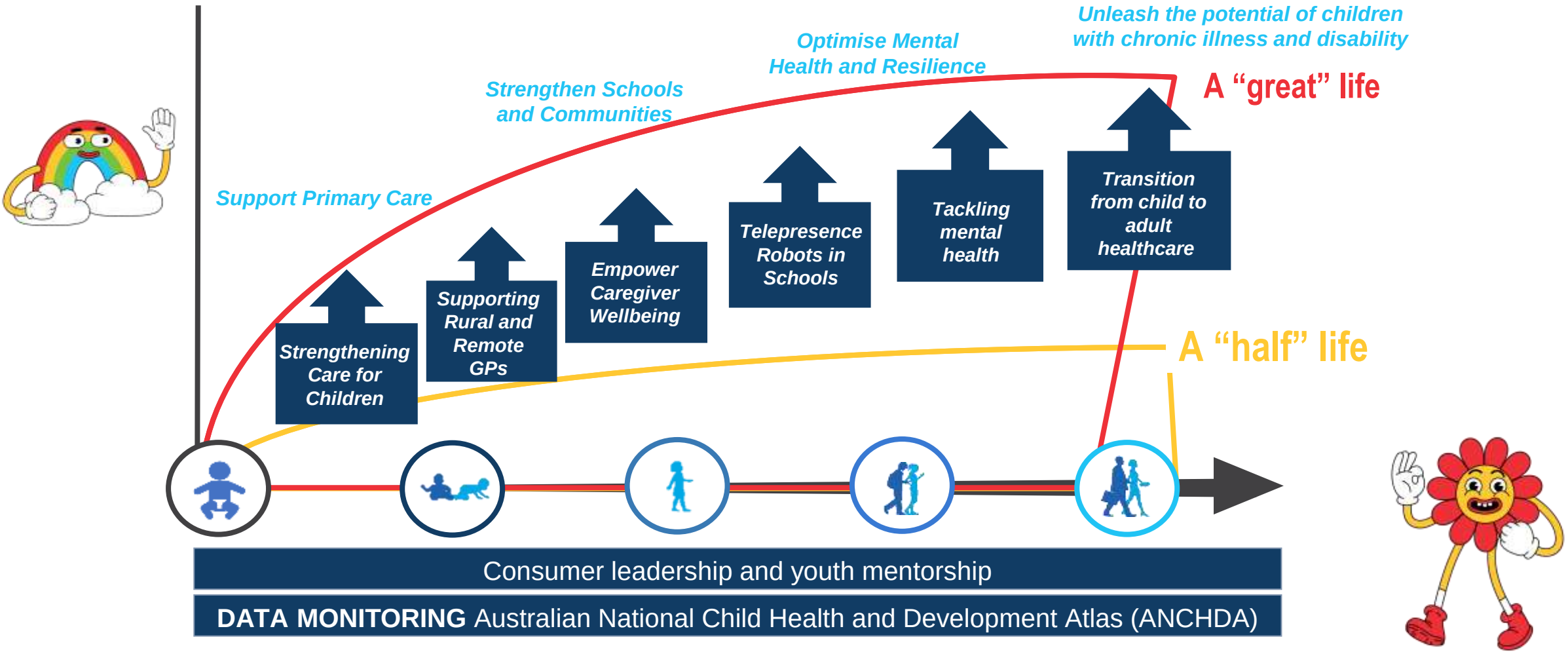
What are our objectives?

- Priorities and research are driven by children, YP and families.
- Reduced burden and variance in care across conditions
- Cost-effective models of care to improve outcomes.
- Children are empowered and supported to achieve their academic potential.
- Resilient and well-informed families
- Actively engaged government & policy partners



Co-Creating National Solutions

Our Mission



Unleashing the potential of children with chronic illness or disability





Will Pierce - WillRockU Highlands



Thank you

CHILD **Un**LIMITED

Unleashing the potential of chronically ill children



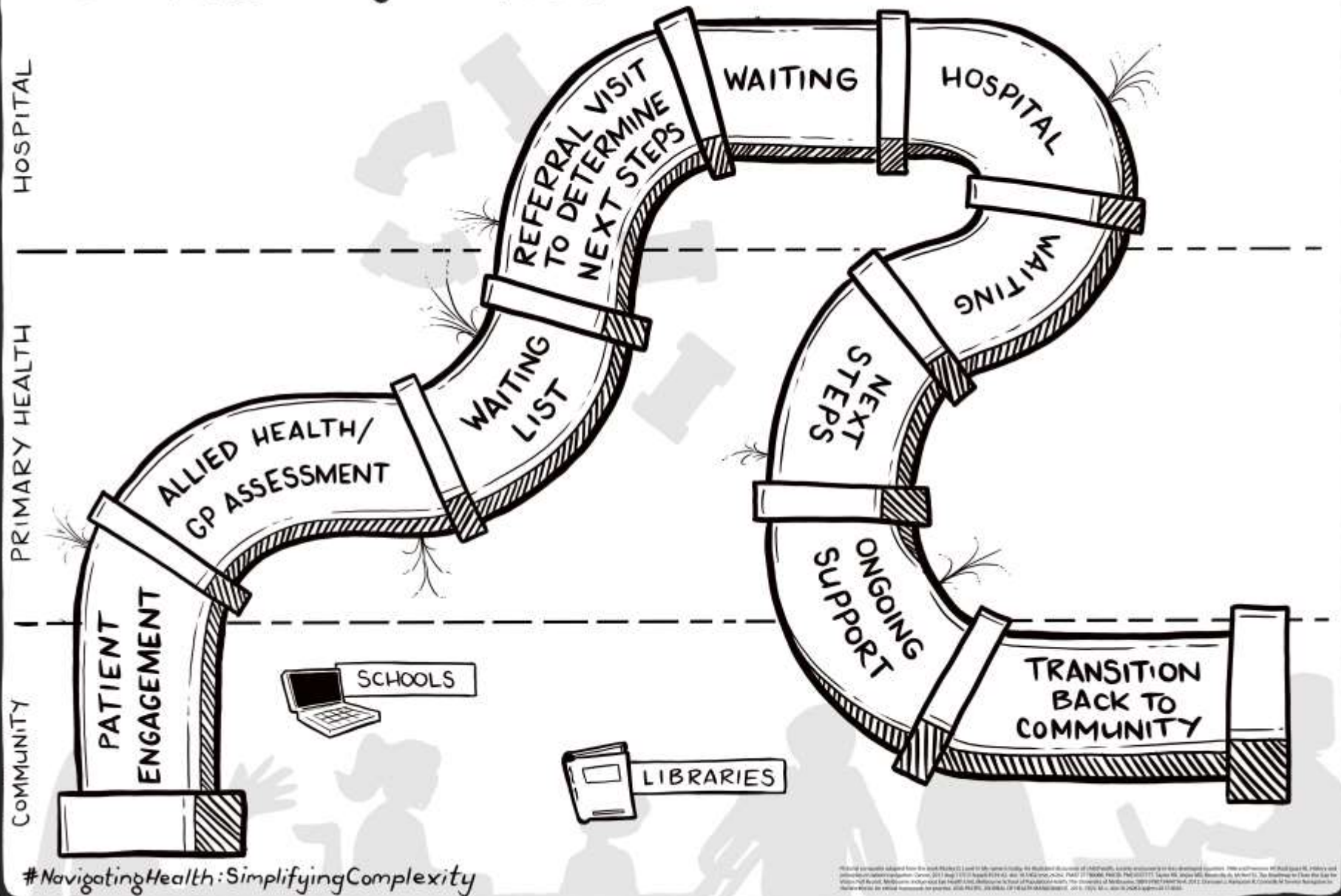
THE UNIVERSITY OF
MELBOURNE

Workshop Pipes



**COLLABORATE +
INNOVATE +
NURTURE =
IMPACT**





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