



Health Research at Medibank 2026

Medibank Better Health Research Hub



Medibank acknowledges Aboriginal and Torres Strait Islander peoples as the First Peoples of Australia and recognises Elders past and present as the Traditional Owners and Custodians of the lands on which we work and live. We are committed to reconciliation, supporting self-determination and valuing Aboriginal and Torres Strait Islander knowledge, perspectives and approaches to health and wellbeing. Aboriginal and Torres Strait Islander peoples are advised that this report may contain the images and names of people who have passed away.

Contents

Contents	3	How an Aboriginal breast cancer service aims to close the survival gap	14	Case studies	28
Foreword	4	Program on sex differences in heart health can help doctors better identify cardiovascular disease in women	16	Case study: Proactive primary care helps lower patients' risk of hospitalisation	29
Introduction	5	Online trial brings low back pain prevention directly to patients	18	Case study: Westmead Institute for Medical Research brings affordable genomic testing into breast cancer care	31
Who we are	6	Reducing progression to type 2 diabetes for women at high risk	20	Case study: Helping patients find the best ways to manage persistent pain	33
Key achievements	7	Speeding up COPD diagnosis in general practice	22	Research perspectives	35
Research pillars	8	Virtual clinic aims to widen access to diabetes care in rural Victoria	24	Acknowledgements	37
Research projects	9	Advanced Recovery Room Care: enabling reduced complications after major surgery	26		
Investigating how digital platforms can improve mental health services for young people	10				
How early mental health support could affect wellbeing in adolescence	12				

Foreword

Research has the greatest value when evidence leads to action. That is why the Medibank Group continues to champion research that informs health policy, strengthens clinical practice and helps improve the way healthcare is delivered.

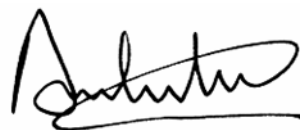
The Medibank Better Health Research Hub committed more than \$930,000 to research, including nine new projects this year, bringing the total number of active projects it supports to 28.

These projects are examining important and practical questions across the health system, from prevention and mental health to new models of care.

The breadth of research featured in this report reflects what can be achieved when researchers, health services, advocacy groups and industry partners bring their expertise, experience and commitment to a shared challenge.

Just as important, the Research Hub supports research that can build knowledge, guide further investigation and inform decisions affecting the health and wellbeing of customers, patients and communities across the country.

I want to thank the universities, research leaders, industry partners and advocacy groups for their collaboration throughout the year, as well as the members of the Health Research Governance Committee for their contribution during the year. Their commitment helps ensure our investment in research remains relevant, robust and connected to the needs of everyone in Australia.



Dr Andrew Wilson
Group Chief Medical Officer





Introduction

The Medibank Better Health Research Hub supports research into Australia's current health needs, with a focus on evidence that can improve healthcare, shape policy and inform how services are delivered.

In 2025, the Medibank Better Health Research Hub took on a new strategic direction to drive our research program forward. This move enables Medibank to play a more active role in building evidence for healthcare and supporting research that tackles some of Australia's biggest health challenges.

As a GP, I know how important good evidence is to the health system, patients and their families, and how research needs to inform clinical services if it is going to improve care. This understanding guides the kinds of research we support and the partners we work with.

In the 2026 financial year, we focused on community mental health and wellbeing, prevention strategies in primary care, and care models for the future.

The types of research we fund address a genuine problem and have the potential to be implemented. If successful, the projects must be able to reach and benefit a wide population. We ask our research partners to connect their work with clinical practice, which is not always easy to do.

Our partnerships are key to making this possible. We work with research organisations, clinicians and professional bodies that can help translate research findings into changes in policy and care.

The projects featured in this report address several health priorities. These include women's health, young people's mental health and models of care after surgery, as well as the Proactive Primary Care project in three Myhealth clinics in Western Sydney. The findings from the Proactive Primary Care project were used in a pre-budget submission to the Australian Government as evidence that multidisciplinary teams in general practice are effective and should be funded.

Health equity is an important factor we account for when assessing research proposals. Researchers are asked to consider vulnerable communities, access to care and workforce pressures when they submit a proposal. Our Health Research Governance Committee then assesses proposals against these criteria and others to enable partnerships with robust, equitable and impactful projects.

As we set our direction for the next two years, we have listened to more than 600 customers. Their feedback showed strong support for Medibank's funding of research, which contributes to the evidence base and reflects our role as a health company. Our new research pillars will place greater emphasis on prevention at every life stage, including healthy ageing, innovative care models and mental health in the community. They will guide our investment and partnerships throughout this period.

My sincere thanks go to the researchers and clinicians featured in this report for their work to strengthen the evidence needed for better care. I look forward to seeing their work inform practice and policy in the coming years.

Dr Shona Sundaraj

Group Medical Director



Who we are

The Medibank Better Health Research Hub (Research Hub) is committed to addressing areas of health and health system need in Australia.

Through partnerships with researchers, health services and other organisations, we support projects that address the quintuple aim of healthcare: improving health outcomes, affordability, patient experience, health equity and the wellbeing of healthcare workers.

The Research Hub prioritise projects that strongly align with our research pillars and principles, and where there is a clear path to translating research outcomes into health policy or clinical practice.

We have allocated funding of more than \$12 million to research since 2013, starting out under the umbrella of the Medibank Better Health Foundation. Renamed in 2025 to reflect the central role we play, the Research Hub continues to champion health research to support the Medibank Group's 2030 vision to create the best health and wellbeing for Australia.

Health Research Governance Committee

The Health Research Governance Committee oversees our funding program, reviewing research proposals to ensure they align with the Research Hub's priorities and support high-quality, ethical research with the potential to improve Australia's health system.

Comprised of team members with diverse professional and academic backgrounds across the Medibank Group, the committee rigorously assesses research proposals against agreed criteria so that the research we support is ethical, patient-centred, robust and impartial.



Committee members for 2025–26 were:

Dr Shona Sundaraj
Group Medical Director
and Chair

Dr Andrew Wilson
Group Chief Medical Officer

Dr Dariush Etemadmoghadam
Translational Research Lead

Bridget Colussa
MBHRH Projects Manager

Nicola Ivory
Head of Partnerships,
Amplar Health

Sarah Trainor
Head of Partnerships and Sales,
Overseas Partnerships

Annie Makar
Health Policy Manager

Tracey Marriner
Senior Health Evaluation Lead

Amanda Bartley
Head of Diversity & Inclusion,
Sustainability & Community

Julia Schulz
Head of Product Portfolio,
Amplar Health

Yash Sodhi
Hub Lead, Group Strategy
& Chief Strategy Officer



Key achievements

\$930k

total funding
allocated to research
(1 July 2025 – 30 June 2026)



8

peer-reviewed
publications

9

New partnerships

\$335k

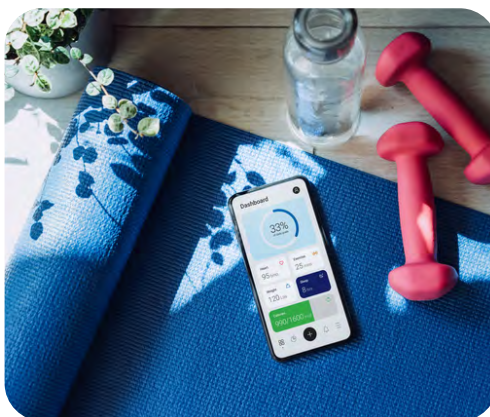
Prevention strategies
in primary care

\$50k

Indigenous health

28

active projects



\$245k

Care models for
the future

\$300k

Community mental
health and wellbeing

Research pillars

We review our research priority areas and the strategic priorities of the broader Medibank business every two years to inform the research pillars that will guide the projects we support.

Our research pillars for the 2025 and 2026 financial years were:



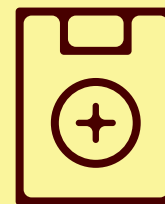
Community mental health and wellbeing

Research will inform evidence-based, co-designed and tailored approaches to enable and promote good mental health and wellbeing in community settings.



Prevention strategies in primary care

Research will focus on interventions in primary care to improve prevention, early detection and management of complex or chronic illness to better support patient health and wellbeing.



Care models for the future

Research will focus on implementation of care models for the future that improve equity of access, patient experience and personalised care.



Medibank's long-standing commitment to reconciliation includes funding and support for community-led, place-based research in Aboriginal and Torres Strait Islander health.

Research supported under this commitment aims to improve the delivery of culturally safe healthcare, strengthen trust within communities, and address systemic barriers to better health equity and outcomes in alignment with the principles of self-determination.

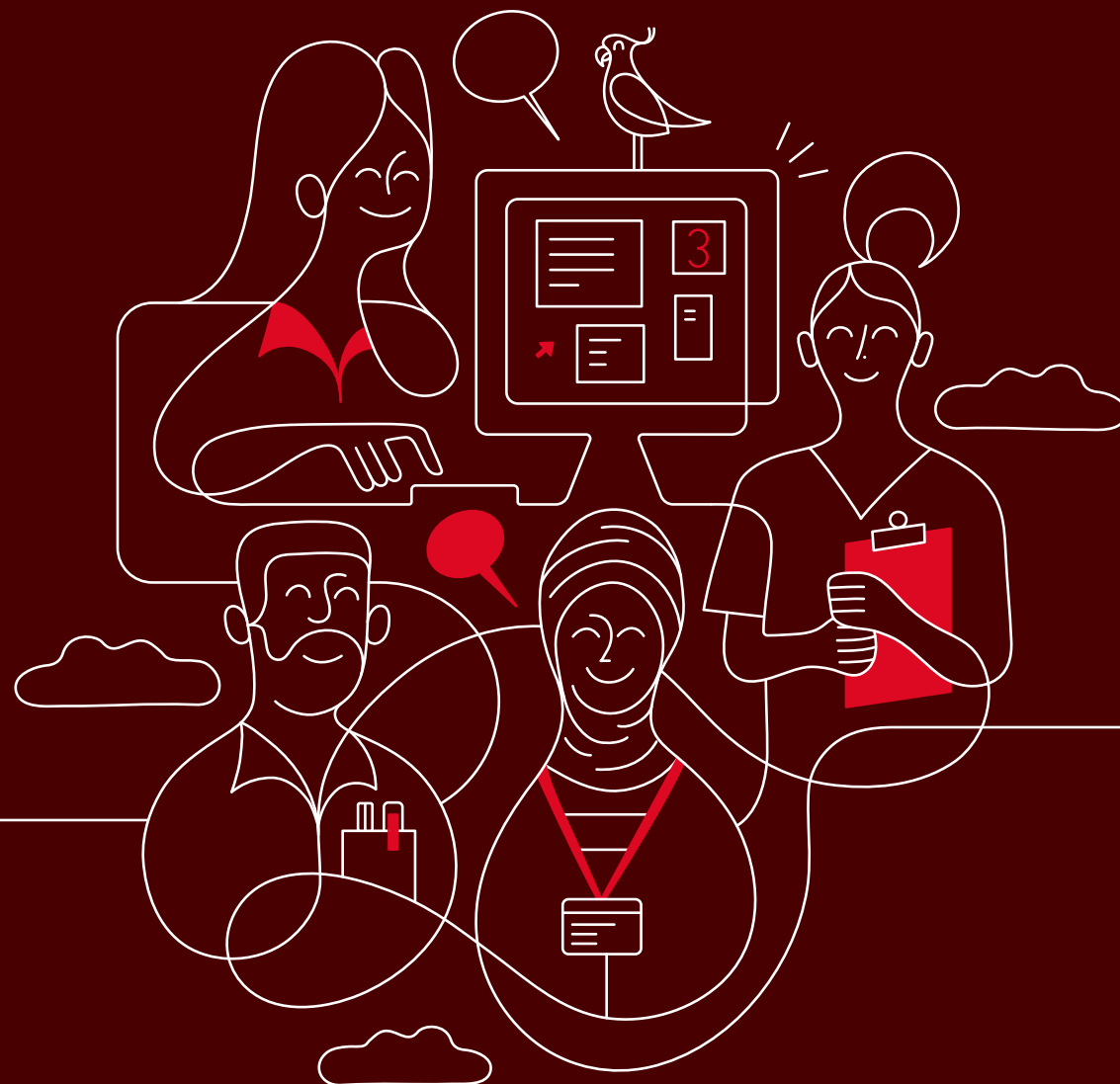
Our research pillars for the 2027 and 2028 financial years are:

- prevention across life stages
- innovative care models
- mental health in the community.

To find out more about our research pillars and principles, visit: [Medibank Better Health Research Hub](#).



Research projects





Lead investigator:
Dr Lee Valentine, Research Fellow in Digital Youth Mental Health, Centre for Youth Mental Health (Orygen), University of Melbourne
Research partnership grant:
\$100,000



Research project

Investigating how digital platforms can improve mental health services for young people

Researchers from not-for-profit organisation Orygen are assessing how the digital platform MOST could help youth mental health services meet rising demand for care.

A young person in Australia referred to a youth mental health service may wait months before seeing a clinician. Because these services are under enormous pressure from workforce shortages and rising demand, they can't always provide support when a person needs it.

"When a young person or their family makes that step to approach a service for treatment, they may already be at a breaking point," says Dr Lee Valentine, Research Fellow in Digital Youth Mental Health at the University of Melbourne's

Centre for Youth Mental Health (Orygen). "But then they could be told, 'You're going to have to wait one to three months before we can even talk to you'."

Demand for services continues to rise: 39% of young people in Australia reported experiencing a mental disorder in 2022, up from 26% in 2007.¹

Dr Lee Valentine and their colleagues are investigating how digital mental health support can work in tandem with these services to respond to demand sooner. Their research is looking at whether MOST changes how these services provide care, including how quickly clinicians can see young people and how much face-to-face care they need. MOST is a digital mental health platform developed by Orygen for people aged 12 to 25.

If successful, the model could help services support young people sooner and make better use of their existing operational capacity.

Integrating MOST into routine care

MOST has been integrated into youth mental health services across Australia since 2020. The platform is now available through around 500 clinics, and more than 22,000 young people have signed up. It is available for free through the Google Play and App Store, and by referral from participating youth mental health services.

Young people using MOST can access online therapy tools at their own pace. For example, a teenager experiencing anxiety might use the platform to learn and practise strategies such as mindfulness. They can also join an online community and get one-on-one professional or peer support.

Research has shown² that using this digital service has reduced depression and anxiety among young people. Dr Valentine and their colleagues at Orygen wanted to find out how MOST affected the way youth mental health services delivered care, including how quickly they receive clinical support.





With a grant from the Research Hub, Dr Valentine's team is evaluating the use of MOST at five headspace centres in Victoria to see what happens when it is integrated into routine care. headspace is a national network of services that provides early intervention mental health support to young people. The team's project will run until December 2027.

"Our research is focused on the question of engagement and how young people and services can engage with digital mental health products, and what we can do to ethically strengthen that engagement so that we can see more

of the positive benefits that we know are really possible through the medium of digital intervention," says Dr Valentine.

Measuring changes to youth mental health services

Dr Valentine and their colleagues will look at how MOST influences four parts of service delivery: how long young people wait for support, how much clinical care they receive, how they move between different levels of care, and whether digital support provides access for those who would otherwise struggle to attend services.

The researchers will use administrative data from the youth mental health centres to compare service activity before and after MOST was introduced. They will look at waiting times, referral patterns, clinical contacts and changes in the level of care that young people receive.

Supporting young people while they wait

Young people can use MOST at different points in their mental healthcare journey. Under the model that Dr Valentine's team is studying, a person referred to a headspace service can be offered MOST while they wait for their first appointment with a clinician.

A young person facing a three-month wait, for example, could be referred to MOST and connected with a clinician within about a week.

Dr Valentine says clinicians describe this period as a 'head start'.

"They're not just being added to a wait list, but they can start working with a clinician and working through therapeutic content on MOST," they add.

Once a young person starts face-to-face care, they can continue using the platform together with their treatment. They can also keep accessing it afterwards as ongoing support.

The study aims to examine whether using MOST at these different stages changes how young people engage in face-to-face care and how long they stay with the service. For instance, a person might need fewer face-to-face appointments or a shorter period of care. In some cases, support through MOST could be enough to meet their needs.

The team also want to find out if using the platform between appointments can help clinicians maintain contact with young people without adding more face-to-face sessions.

Informing decisions about digital mental healthcare

Findings from the study could give youth mental health services evidence about what MOST can do for their operations, including how it affects their capacity to provide face-to-face care.

More broadly, the results could also inform decisions about how youth mental health services integrate digital mental healthcare.

"It could support ongoing funding, partnerships and policy reform," says Dr Valentine.

Applying the findings to other areas of healthcare

The next stage of the study is to analyse service data and compare patterns of care before and after MOST was rolled out.

"Where we're headed and what I'd love to see is that digital supports can provide earlier, more continuous, more efficient and more equitable care at scale," says Dr Valentine.

The team also hopes their findings will be useful in other parts of healthcare, as well as in schools and services that support young people with education or employment.

Dr Valentine wants the research to give mental health services evidence they can use when deciding where digital support fits into their care and how they can adopt it.

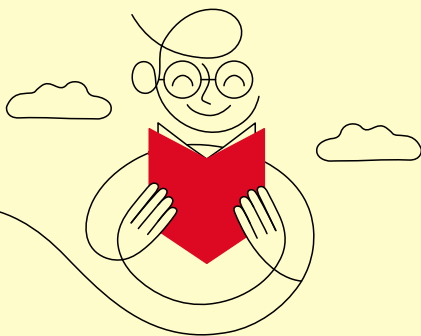
"For me, it's just about getting clear evidence that digital intervention can add value at a service level," says Dr Valentine. "Right now it's MOST, but we hope that what we learn from MOST can inform digital intervention more generally."

1. AIHW (Australian Institute of Health and Welfare). Australia's health 2026. AIHW. 2026;Cat. no. AUS 256:1-99. <https://www.aihw.gov.au/reports/australias-health/australias-health-2026/contents/key-findings>

2. Orygen. World-first digital mental health intervention shows outstanding engagement rates, bridges gaps in healthcare system. Orygen, Revolution in Mind. September 2024. <https://www.orygen.org.au/About/News-And-Events/2024/World-first-digital-mental-health-intervention-sho>



Lead investigator:
Dr Simone Darling, Principal
Research Fellow, Murdoch
Children's Research Institute
Research partnership grant:
\$200,000 over two years



Research project

How early mental health support could affect wellbeing in adolescence

Does providing mental health support in primary schools improve wellbeing in adolescence?

Almost 600,000 Australian children and adolescents experience mental health challenges each year¹. Many of them wait for months to see a paediatrician or psychologist.

With specialist services under pressure, schools are often left to support these children.

"Teachers are dealing with this off the side of their plate," says Dr Simone Darling, Principal Research Fellow at Murdoch Children's Research Institute. "After school, parents would stop teachers and try to talk to them about their children's mental health, which teachers told us left them struggling with what to say and do to help."

The Mental Health in Primary Schools (MHIPS) initiative was developed by Murdoch Children's Research Institute and the University of Melbourne in 2020, working closely with the Victorian Department of Education, to help schools better support mental health. The initiative equips schools to identify concerns early, provide timely support and link students and their families with health and community services when needed. It brings early identification and support into schools, instead of leaving it to the health system alone.

Now, with funding from the Research Hub, a longitudinal study will follow students who took part in the first MHIPS pilot. Researchers want to find out whether children who received support in primary school show differences in their mental health and require fewer services in adolescence.

"We don't have any information on the long-term impact," says Darling, who leads the longitudinal study. "If we can invest early and put something like this into primary schools, what does that mean for the long-term outcomes for these children?"

Creating mental health support inside schools

The idea behind MHIPS grew from conversations with educators, principals, government and educational organisations in 2019. Schools were seeing more children struggling with mental health, and teachers

were taking on the burden to help, often with no additional training, and on top of their teaching load.

To strengthen schools' response, MHIPS introduced a Mental Health and Wellbeing Leader role in each participating school. These experienced educators receive training from the MHIPS team and spend time away from the classroom to focus on supporting students' mental health.

Depending on the size of the school, they spend from two days a week up to full time in the role.

These leaders do not offer clinical care. Instead, they upskill teachers to recognise concerns early and connect families with the right support, which may include local health and community services.



¹The Kids Research Institute Australia. Prevalence of mental disorders. Young Minds Matter: The second Australian Child and Adolescent Survey of Mental Health and Wellbeing. <https://youngmindsmatter.thekids.org.au/our-research/prevalence-of-mental-disorders/>.

They also guide schools in choosing mental health programs that address their local needs and are backed by evidence.

“Prevention, promotion and early intervention really have to be a big part of the solution,” says Darling.

MHiPS was piloted in 10 Victorian primary schools in 2020, 26 schools in 2021 and 100 schools in 2022. After evaluation of the pilot, the Victorian Government invested \$200 million over four years and \$93.7 million annually to expand the initiative throughout the state. All government and low-fee non-government primary schools in Victoria have been funded to implement MHiPS.

The initiative is now in more than 1,900 Victorian schools, and pilot initiatives are also underway in regional Queensland.

Improving how schools respond

When researchers evaluated MHiPS, they found that schools put greater emphasis on students’ mental health and teachers felt better supported when concerns arose. They described feeling less isolated now that they had a dedicated colleague who could help students get the support they needed.

“A principal once told us, ‘I wouldn’t have a school nowadays without a mental health and wellbeing leader,’” shares Darling.

Schools are also becoming more selective in choosing mental health programs and are looking for those backed by research.

Following children into adolescence

The new longitudinal study will look at whether the benefits seen during the pilot continue as participating students go through secondary school.

Researchers will follow around 600 students who participated in the pilot in 2020–2021 and who are now in Years 8 to 10. The study will use surveys and interviews with students and their families to understand how their mental health and experiences at school have changed.

The study will also look into school engagement, resilience, emotional regulation, relationships and use of health services.

“We’re really interested in what types of supports the kids who were in MHiPS schools were accessing compared to kids who weren’t in MHiPS schools,” says Darling. “Were the kids in MHiPS schools being really well supported by their school because the staff felt more confident?”

The researchers also want to know if children who received support earlier at school need less support from health services later in adolescence.

Gathering evidence for early mental health support

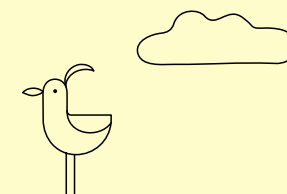
Funding from the Research Hub is enabling the research team to collect long-term evidence on what happens after schools introduce dedicated mental health support.



Data collection is expected to start in 2027 after ethics approval, with early findings anticipated from the middle of the year. The team will share findings with schools, families, policymakers and others involved in child health and education.

Darling hopes the evidence from the study will strengthen the case for continued investment in preventative mental health in Victoria and other states. She sees the project’s biggest success as cultivating school communities where mental health is openly discussed and students and their families know where to get help.

“Mental health is no longer just a specialist problem,” she says. “It’s everyone’s business.”





Lead investigator:
 Leanne Pilkington, Honorary
 Senior Cancer Research
 Associate, Harry Perkins
 Institute of Medical Research



Co-investigators:
 Andrew Redfern, Associate
 Professor and medical
 researcher, Harry Perkins
 Institute of Medical Research;
 and Dr Katie Meehan, Senior
 Research Officer, Harry Perkins
 Institute of Medical Research
Research partnership grant:
 \$100,000

Research project

How an Aboriginal breast cancer service aims to close the survival gap

A new model of breast cancer care tailored to Aboriginal women integrates clinical and cultural considerations into treatment planning.

Aboriginal women in Western Australia are more likely to die from breast cancer than non-Aboriginal women. Research from the Harry Perkins Institute of Medical Research found that their breast cancer survival was about 30% lower.¹

“When we removed other things that might cause that gap, like other illnesses and age, we still found the difference was around 20%,” says Associate Professor Andrew Redfern, who conducted the research with his colleague Leanne Pilkington, an honorary research associate at the institute.

Together, Pilkington and Redfern have investigated cancer outcomes of Aboriginal people in WA since 2008 and found that several factors contribute to the difference in breast cancer survival. They are now using their research to pilot an Aboriginal Breast Cancer Advisory Service, with a grant from the Research Hub supporting the recruitment of an Aboriginal Cancer Journey Coordinator.

The service will provide individualised advice so that each patient receives care tailored to her needs and, where possible, closer to home. It will help the care team consider factors such as where a patient lives, her family and cultural responsibilities and any obstacles that could affect her treatment.

“It’s about knowing what each woman wants, what’s important to her, and how do we support her to treatment if she needs it while respecting her wishes and working within the evidence-based treatment options recommended by her treating team,” says Pilkington, a Bindjarep and Palyku woman who comes from Bindjarep Country south of Perth and Palyku Country in the Pilbara. “How can we enable that to be the best journey for her, whichever way it goes?”

Impact of individual circumstances on care

In their earlier research, Pilkington and Redfern studied remoteness, socioeconomic disadvantage, access to services and delays in care, as well as differences in breast cancer types, treatment responses and side effects to understand what was contributing to the disparity in survival.

They found that no single factor explained the poorer breast cancer outcome among Aboriginal women. Most of the factors they investigated contributed to the disparity.



The advisory service will use these findings when a woman is diagnosed, so her care team can consider the circumstances that might affect her care and build them into her treatment plan. The statewide pilot will be based at Fiona Stanley Hospital, where an Aboriginal Cancer Journey Coordinator will collect information about each patient to provide to a multidisciplinary team of clinicians.

Having worked in Aboriginal health for decades, Pilkington saw how access to information could affect treatment decisions, and how difficult it could be for some women to travel to Perth for care.

A woman diagnosed in Kununurra, for example, might need to go to Perth for a biopsy and diagnosis before returning home and then making more journeys for treatment.

“She’s away from Country, she’s away from her family, she’s away from her support system,” says Pilkington. “So she’s scared, she’s worried that she’s going to have breast cancer and that no one’s there to support her.”

The coordinator can help with these issues along with the clinical side of care. They can support a patient to prepare questions for her doctor and arrange accommodation or other support while she is in Perth.



Treatment closer to home

The service will consider local treatment options when suitable for a patient. WA now has video chemotherapy services in Port Hedland, Broome and Narrogin, where local clinicians administer chemotherapy with specialist support from Perth.

The researchers will look at what happens after the initial treatment plan. About three-quarters of women with breast cancer need hormone therapy, often for five years or longer, according to Redfern.

“We’re finding that about three times as many Aboriginal women do not finish their hormone tablets,” he says. “It’s about 30% compared to 10% for non-Aboriginal patients.” Aboriginal women can also experience more severe side

effects from some cancer treatments, which raises the possibility that different medicines could be more suitable for some patients. The pilot will include a review three months after diagnosis to identify problems with treatment or side effects, and address them.

Accepting traditional healing

Traditional healing practices, including bush medicine, will be discussed as part of the service. Together with an expert clinical pharmacist, the research team will explore potential interactions between traditional medicines and cancer drugs as part of treatment planning.

According to Redfern, it is important that people don’t feel they have to choose between traditional healing and cancer drugs. “We can be integrative with the approach,” he says.

Pilkington points out that some Aboriginal people might be reluctant to disclose their use of traditional medicine because of concerns about how their knowledge could be used by others.

“There’s still that distrust of how the provider will respond if I tell them that I am taking bush medicine,” she says.

The service will ask patients about the traditional medicines they use without the need to give up those practices or their cultural knowledge.

Adapting the model to other types of cancer

The first year of the pilot project is expected to involve about 20 to 25 Aboriginal women with breast cancer. The researchers will investigate whether patients engage with treatment plans developed through the service and if plans are still being followed at six months.

Based on related studies on head and neck, lung cancer and bowel cancer currently underway, Redfern believes the model can be applied to other types of cancer.

Their longer-term ambition is to make the service part of standard cancer care. Because the pilot is embedded in existing care, Redfern says it could continue in much the same form if evidence from the pilot supports wider adoption.

The team also wants the service to create opportunities to improve prevention and early detection. According to Redfern,

the survival rate of Aboriginal women whose breast cancer is detected through screening is similar to that of the wider population. However, the survival gap is much larger among Aboriginal women whose cancer is found after they notice a lump or other symptoms.

“The main outcome obviously is that, firstly, we close the gap in breast cancer survival rates,” he says. “So, both Aboriginal and non-Aboriginal people survive and survive well, and have a well-informed journey, with choices that are right for them.”

They also hope the model can support culturally safe care of Aboriginal people with other cancers throughout WA.

“Thanks to Medibank for the financial support to create this help, to germinate the seed into a sapling of service,” says Redfern, “but also for their interest in seeing how it could be built into routine service and made more widespread if it works.”

1. Spalding LJ, Lee EYC, Redfern CF, Pilkington L, Bulsara M, Trevithick R, Meehan K. Aggressive tumour biology contributes to poor breast cancer outcomes for indigenous Australians. *Cancer Res* 2020;80(4_Supplement):P2-10-09. doi: 10.1158/1538-7445.SABCS19-P2-10-09. https://aacrjournals.org/cancerres/article/80/4_Supplement/P2-10-09/646467/Abstract-P2-10-09-Aggressive-tumour-biology



Lead investigator:
Professor Cassandra Szoeki,
Director, Women's Healthy
Ageing Program, Monash
Centre for Health Research
and Implementation,
Monash University

Research partnership grant:
\$100,000



Research project

Program on sex differences in heart health can help doctors better identify cardiovascular disease in women

A new training program can help doctors better recognise signs of cardiovascular disease in women.

Cardiovascular disease remains a leading cause of illness and death in women globally. In Australia, it claims the lives of around 20,000 women each year.¹

Decades of research have shown that women can develop heart disease differently from men.² However, medical education has traditionally focused on studies that enrolled mostly male participants, and medical schools still don't extensively teach the sex differences in cardiovascular disease.

"Medical students are certainly not told a woman's heart is different from a man's heart or how heart disease develops differently in women," says Professor Cassandra Szoeki, Director of the Women's Healthy Ageing Program at Monash University.

With funding from the Medibank Better Health Research Hub, Professor Szoeki and her colleagues have partnered with Women's Health Victoria to design Australia's first national education program to help clinicians better recognise cardiovascular disease in women. Their pilot will train doctors to apply the evidence on sex differences in heart disease in their practice.

Why women's heart disease is different

A leading physician and neurologist, Professor Szoeki has spent 30 years studying how disease manifests differently in women. Her research has investigated differences in heart, brain and bone health, as well as ageing.

But much of this evidence was not included in medical education because women were often excluded from clinical trials. This began to change after the United States passed legislation in 1993 to increase the inclusion of women in clinical research, which was subsequently mandated.

Since the turn of the century, most clinical trials have captured data on biological sex, although sex differences were not consistently examined or reported. This has changed in the last two decades, with research into sex differences doubling in the last 10 years.

Australia is also addressing this research gap. From January 2026, most National Health and Medical Research Council and Medical Research Future Fund grant programs require researchers to consider sex, gender, variations of sex characteristics and sexual orientation in their research where relevant.





While there is now a wealth of research showing sex differences in symptoms, treatment response and management strategies, it remains in the medical literature and has not translated to clinical guidelines or medical school teaching. Several reviews of medical education in Australia have found that students are still rarely taught sex differences outside reproductive health. Women's health has traditionally been viewed through a narrow reproductive lens, instead of considering how sex differences affect other parts of the body, including the brain, heart and musculoskeletal system.

Heart disease offers a good example, according to Professor Szoeki.

"Women's hearts are different to male hearts, and the way we get heart disease is different," she explains. "Around 80% of women develop disease in the heart's small blood vessels, while around 80% of men develop it in the larger

coronary arteries. Most of our treatments were developed for the larger vessel disease because that's what the studies focused on."

Small blood vessel disease can manifest very differently from the large artery disease that men typically experience. Instead of angina or the sudden crushing pain of a heart attack, a woman might experience fatigue, breathlessness or a general feeling that something is not right. These symptoms can be easy to dismiss or attribute to other causes.

Because of this, cardiovascular disease in women might not always be detected as quickly as in men.

Using evidence in medical education

Professor Szoeki's project came out of feedback from Australian women. In a national survey on gender bias in healthcare, participating women said that they wanted doctors to understand women's health instead of just doing more research.

"They don't listen to me. I'm telling them I'm not right, and then I had a heart attack," says Professor Szoeki, recalling some of the concerns raised by women in the survey.

Working with clinicians, medical educators, community organisations and former patients, the research team is designing a learning module around the questions doctors typically encounter during consultations. The learning module aims to help clinicians recognise the symptoms of heart disease in women and know when to recommend further investigation or a referral.

The online course will first be rolled out to doctors through continuing professional development before being adapted for other health professions and later for community education.

The course will also feature content addressing the needs of the 10 priority groups identified as being at higher risk of poor health outcomes. They include Aboriginal and Torres Strait Islander women, women from culturally and linguistically diverse communities, LGBTQIA+ people, veterans, people serving in the military and women living in regional and remote areas.

Measuring what doctors learn

Researchers will evaluate how many doctors complete the course and compare their knowledge before and after the training. The research team will use the findings to improve future versions of the program.

The team will also measure how participating doctors use what they have learned in their practice.

Funding the project and future plans

Aside from the grant from the Medibank Better Health Research Hub, the project received funding, staff time and other

in-kind support from community groups, clinicians, researchers, health services and professional bodies.

Professor Szoeki says funding from the Research Hub helped get the project off the ground. "Without Medibank, we wouldn't have had a starting place."

The pilot is planned as the first step in a much larger program. Although the team chose heart disease because the evidence is well established, Professor Szoeki believes the model can be used for other conditions where women and men experience disease differently.

"What I'd really like to see is a recognition of women's health outside reproductive health, moving past what's called 'bikini medicine,'" she says. "We've got to start looking holistically at how healthy ageing and good mental health are connected, and how chronic disease can holistically affect these."

Professor Szoeki points out that dementia has been the leading cause of death in Australian women for over a decade, while depression is a leading cause of morbidity. She believes a broader approach to women's health should place greater emphasis on brain, heart and bone health, where women experience poorest health outcomes.

Taking this broader approach also means recognising the importance of both biological sex and gender in health and medical research. The course draws on the growing body of knowledge about biological sex differences, enabled by the recording of biological sex in clinical trials since the turn of the century. But as researchers increasingly consider sex, gender, variations of sex characteristics and sexual orientation, Professor Szoeki hopes the growing evidence base will enable the course to expand its teaching in these areas.

1. AIHW (Australian Institute of Health and Welfare). Heart, stroke and vascular disease: Australian facts. Canberra: AIHW; 2026. <https://www.aihw.gov.au/reports/heart-stroke-vascular-diseases/hsvd-facts/contents/disease-types>

2. In this article, references to women and men refer to biological sex recorded at birth.



Lead investigator:
Dr Tash Pocovi, Research Fellow, School of Health Sciences and Nursing, Spinal Pain Research Centre, Macquarie University

Research partnership grant:
\$100,000



MACQUARIE
University
SYDNEY · AUSTRALIA

**SPINAL PAIN
RESEARCH CENTRE**

WalkBack

Research project

Online trial brings low back pain prevention directly to patients

WalkBack Online will test if a self-directed walking and education program can help prevent low back pain from recurring without physiotherapy.

Low back pain is Australia's leading cause of disability. Around 4 million people in Australia have back problems, the vast majority of which involve pain in the lower back.¹

Despite the toll of this condition, healthcare is mostly reactive, treating flare-ups instead of preventing future ones.

"In usual clinical care, we almost exclusively focus on treatments," says Dr Tash Pocovi, Research Fellow at Macquarie University's Spinal Pain Research Centre. "We rarely take a preventive approach with low back pain, because we actually weren't certain of how frequently back pain recurred."

Pocovi's research has shown that walking and education can reduce the likelihood of low back pain recurring. Now, with a grant from the Research Hub, she is testing WalkBack Online, a self-directed program that could make prevention available to more people.

Tackling a common problem differently

Before developing an intervention, Dr Pocovi and her colleagues wanted to understand how often low back pain recurred after recovery. They followed around 250 patients for 12 months after they had been discharged from care from either physiotherapists or chiropractors.

"We saw that 70% of that cohort had a new episode of back pain in the 12-month period following discharge," says Dr Pocovi.

This finding prompted her team to look at how people could prevent new episodes of low back pain instead of returning to their clinician whenever pain recurred. Programs of regular exercise and education about safely resuming activities are known to help prevent low back pain. However, such programs can require regular appointments or classes that some patients cannot afford or attend.

"We started looking for accessible, low-cost, safe exercise formats to try and pursue and see whether they could actually be effective in preventing low back pain," says Dr Pocovi.

Walking offered a familiar and inexpensive exercise option that's available to almost anyone.

In 2019, Dr Pocovi and her team created the WalkBack program, an individualised

walking and education regime delivered over six months by specially trained physiotherapists. Participants received six consultations to gradually increase their walking and confidence in self-managing their low back pain.

A trial of WalkBack, published in the medical journal The Lancet in 2024, found the program reduced recurrences of low back pain that limited daily activities by up to 28%, compared with usual care. Episodes serious enough to make people seek care were reduced by 43%.

"When you think about the simplicity, you're actually getting quite substantive benefit," says Dr Pocovi.

Helping people stay active when pain returns

Although walking is the visible part of the program, Dr Pocovi says education is what helped trial participants understand how to respond when their pain returned.

Many people assume pain signals further damage, leading them to stop moving altogether. WalkBack taught participants that they could continue their activities but should adjust how much they did when they were in pain.

1. Australian Institute of Health and Welfare. Back problems. 2024. Last updated 17 June 2024. Australian Government. <https://www.aihw.gov.au/reports/musculoskeletal-conditions/back-problems>

“We had several participants state that the program really changed how they felt,” says Dr Pocovi. “They said, ‘I actually found that if I reduced how much I was walking because I was a little bit sore, but kept at it instead of stopping walking altogether, I recovered much more quickly and the episode was not as severe.’”

The education also addressed common fears about exercise and back pain, including the idea that pain necessarily means damage. Participants were encouraged to keep up their usual activities where possible, while reducing the amount of walking if they became sore. They also learnt about gradually increasing the load on their body rather than going from very little activity to too much too quickly.

The education also helped participants understand how to increase their activity safely and not do too much too soon. The program gradually increases their walking according to their starting level of activity.

Each participant starts with a tailored walking plan based on factors such as their current activity level, age and other health conditions. The program can then be adjusted to suit their circumstances.



Bringing the program to more people

The new WalkBack Online trial aims to test whether the walking and education program can work without regular face-to-face sessions with a clinician.

The walking component will gradually increase participants' activity from their starting level. For example, someone doing very little intentional walking may start with around 20 minutes three times a week, and a person who cannot set aside a 20-minute block may break that time into shorter walks across the day. Meanwhile, the education will help address common fears about exercise and back pain, including the idea that pain necessarily means damage. It will also teach them how to stay active when pain returns.

“We wondered how much of a key ingredient clinician involvement is, or are we able to take people through a similar behaviour change journey and get them more active and provide education in an online format,” says Dr Pocovi.

The research team is converting the program into an online format that patients can use independently. Making the program available online could help address some of the geographical and workforce barriers that make care harder to access in rural and regional areas. People would be able to take part without needing to live near a trained physiotherapist. Although internet access can still be a barrier in some rural areas, the online format removes the need for regular travel to appointments.

Dr Pocovi's team is developing the program with input from patients and clinicians who participated in the original trial. Co-design workshops will help the team decide how the content should work online and what support participants need to stay engaged.

The team expects to complete the workshops and pilot testing by early 2027 before launching a randomised controlled trial involving around 220 participants. The trial will test whether WalkBack Online reduces the recurrence of low back pain and if it is safe, acceptable and cost-effective for participants.

“Ultimately, it's about effectiveness: does delivering the WalkBack program in this online format still yield a preventive effect against low back pain recurrence?” says Dr Pocovi.

Testing if walking improves general health

The new trial will also investigate benefits that were not formally measured in the original WalkBack trial.

For example, during follow-up interviews, many WalkBack participants described other improvements such as sleeping better and feeling less stressed. Some appreciated having regular time to themselves, and others joined local walking or hiking groups.

Dr Pocovi says the team is interested in whether these social connections are part of the broader benefits of becoming more active, together with possible changes in mood and anxiety. The team will investigate these outcomes in the new trial instead of assuming the original program caused them.

“The initial focus was definitely back pain, but we feel that this [new] trial provides an opportunity to look at additional outcomes,” says Dr Pocovi. “Does it actually improve people's mental health, their quality of life?”

Backing the new trial

Funding from the Research Hub is enabling the research team to test the effectiveness of WalkBack Online. According to Dr Pocovi, the Hub's support is allowing the research team to test WalkBack Online through a rigorous trial, following their efforts to develop an online version of the intervention.

“Medibank's really facilitating the ability to test the efficacy of the intervention, the cost-effectiveness, safety and several other measures we are interested in.

“I'd like WalkBack Online to be developed in a way that's accessible to anyone suffering from recurrent low back pain,” says Dr Pocovi. “We believe this program is incredibly scalable, so we want to explore how the general public can best go about accessing our WalkBack program.”



Lead investigator:
Dr Stephanie Cowan,
Postdoctoral Research Fellow,
Monash Centre for Health
Research and Implementation,
Monash University



Co-investigator:
Professor Lisa Moran, Head,
Healthy Lifestyle Research
Program, Monash Centre
for Health Research and
Implementation, Monash
University

**Co-funded research
partnership grant:**
\$200,000 from the Medibank
Better Health Research Hub
and Diabetes Australia

Research project

Reducing progression to type 2 diabetes for women at high risk

Researchers are developing a primary care model to help more women at high risk of type 2 diabetes receive recommended screening and preventive care.

Women with polyendocrine metabolic ovarian syndrome (PMOS) have up to four times the risk of developing type 2 diabetes compared to women without the condition, and they are often diagnosed at a younger age.¹ This is a significant health concern because type 2 diabetes can lead to serious heart, kidney, nerve and eye complications. Although international guidelines recommend regular diabetes screening and preventive care, many of these women are missing out on these services in Australian primary care.

Formerly known as polycystic ovarian syndrome (PCOS), PMOS is a hormonal and metabolic condition that affects weight, skin, mental health and wellbeing, and the reproductive system. The name was changed to be more aligned with the metabolic and endocrine effects of the condition, including its link to type 2 diabetes.

“We know from international evidence-based guidelines what the best practice screening should be,” says Professor Lisa Moran, Head of the Healthy Lifestyle Research Program at Monash Centre for Health Research and Implementation. “We also know some of the best practice management strategies for primary prevention. The issue is that these aren’t routinely done.”

Moran believes one reason may be that PMOS is often seen mainly as a reproductive condition. “So its metabolic risks can drop down the list in a busy consult unless clinicians are supported to prioritise them,” she says. Other factors can also make it harder for women to receive recommended care, including difficulty accessing services, gaps in healthcare workforce knowledge and losing contact with services over time.

A new research project led by the centre will work with general practices to make recommendations easier to deliver as part of routine care for women with PMOS.

Helping GPs incorporate guidelines into routine care

PMOS affects around one in eight women of reproductive age and increases the risk of impaired glucose tolerance and type 2 diabetes.² But because many women are diagnosed while still young, they are not always considered an immediate priority for screening.



Recognising the metabolic and endocrine effects of PMOS is important because diabetes prevention needs to be part of care from an early age, together with management of its reproductive effects.

The research project will focus on making guideline recommendations easier for general practices to use by understanding the needs of patients and clinicians.

Understanding where women are missing out

The first stage of the research will analyse national women’s health data linked to Medicare claims to understand current practices in preventive care.

Researchers will examine if women with PMOS are receiving recommended diabetes screening, cardiometabolic checks and referrals to allied health services. They also want to find out if care differs across metropolitan and regional communities.

“We hope to gain information on screening practices,” says Moran, co-investigator of the research project. “We hope to also gain some nuance on screening practices for type 2 diabetes, such as where it’s being done better and where it’s being done maybe not quite as well.”

The findings will help identify the improvements needed and will guide the selection of pilot sites.

Researchers will then work with patients, GPs, practice staff, allied health professionals and healthcare organisations to develop a primary care model that can be incorporated into existing general practice systems. This co-design process is intended to make sure the model reflects what clinicians and patients need.

“If we come to a certain healthcare setting without having that on-the-ground knowledge of how it works – from the perspective of healthcare workers, the administrative staff, the managers, the funders or the people attending that service – we’re bringing in an artificial perspective that may or may not meet the realities of day-to-day use,” says Moran.

Supporting prevention in general practices

The researchers will develop tools to support GPs and practice teams. These include electronic medical record prompts, referral pathways, clinician training and shared decision-making resources.

Instead of introducing new systems, adapting existing tools might make implementation easier, according to Moran, citing electronic medical record (EMR) prompts as an example.

“If EMR prompts are already there, and if we can capitalise on them and just use existing prompts and put in different pathways and actions, that might be something that health professionals are already familiar with.”

The researchers will also partner with community prevention programs to help women get lifestyle support, which can be difficult when services are limited or involve out-of-pocket expenses.

Testing what works

The team will pilot the new primary care model in two general practices, one in a metropolitan area and one in a regional area.

Instead of running a long study, the researchers will do the pilot in short ‘Plan, Do, Study, Act’ cycles. Each cycle will let them trial part of the model, learn directly from participating practices and women with PMOS, make improvements and test the changes in the next round.

The pilot will look at changes such as diabetes screening, referrals to lifestyle programs and allied health services, clinician confidence and patient experiences.

Moran says this method helps avoid bringing in a model that does not really work in healthcare environments.

Preparing for wider adoption

Funding from the Research Hub and Diabetes Australia is supporting research to help general practices integrate research-based diabetes prevention into routine care. Moran says it is difficult to obtain funding for this type of research, even though it plays an important role in improving patient care.

“We’re linking national data, we’re running real-world pilots, we’re looking at a type of research that isn’t typically covered by academic grants,” she says.

At the end of the project, the team will create an implementation toolkit that other practices can use to introduce the model in their own clinics. The toolkit will include resources such as EMR prompts, screening workflows, referral guidance and training materials.

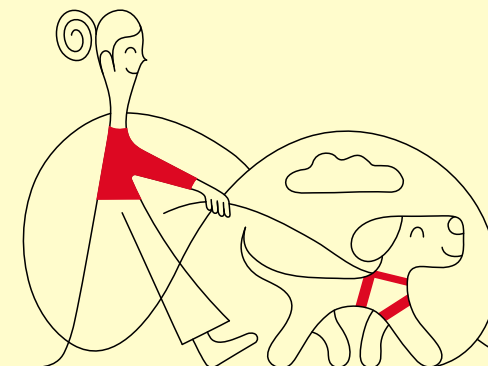
If the pilot shows that the model can be used successfully in general practice, the team hopes to test it on a larger scale with more practices.

Moran also sees potential to use it for other groups at higher risk of type 2 diabetes, such as women with a history of gestational diabetes.

“I want there to be improved knowledge, improved confidence about this process,” she says. “I want healthcare professionals to feel confident that when a person with PMOS turns up in front of them, they’re confident about what they need to do with regards to diabetes screening.”

1. Diabetes Australia. PMOS in spotlight for diabetes prevention. 13 August 2026.
<https://www.diabetesaustralia.com.au/mediarelease/pmos-in-spotlight-for-diabetes-prevention>

2. World Health Organization. Polycystic ovary syndrome. 22 January 2026.
<https://www.who.int/news-room/fact-sheets/detail/polycystic-ovary-syndrome>





Lead investigator:

Professor Charlotte Hespe, Head, General Practice and Primary Care Research, School of Medicine, Sydney, University of Notre Dame Australia

Co-funded research partnership grant:

\$250,000 over two years from the Medibank Better Health Research Hub and the Australian General Practice Research Foundation, a part of the Royal Australian College of General Practitioners



Research project

Speeding up COPD diagnosis in general practice

BREATHE FAST could help GPs detect chronic obstructive pulmonary disease earlier with a simple screening test.

People living with breathlessness often attribute it to getting older, being unfit or overweight, smoking or having asthma. Some assume breathlessness is something they have to live with, not realising that it could be a sign of chronic obstructive pulmonary disease, or COPD.

“There’s a lot of what we call self-attribution,” says Professor Charlotte Hespe, Head of General Practice and Primary Care Research at the University of Notre Dame Australia. “People don’t report it until their symptoms have become quite severe.”

A GP, Professor Hespe has spent much of her clinical and research career looking at what is missing in preventive care and how general practice can step in. “A lot of the big opportunities are around chronic disease, early identification and then intervention to be able to prevent people getting sick,” she says.

Her latest project, BREATHE FAST (Breathlessness Rapid Evaluation and Therapy – Fast Assessment Spirometry Testing), uses digital self-screening before a GP consultation to identify patients with chronic breathlessness. Those who screen positive are offered a one-minute handheld

lung function test (micro-spirometry) before seeing their GP, providing additional information to support earlier identification, assessment and management of possible COPD.

Getting treatment earlier could help patients avoid further loss of lung function and reduce the impact of symptoms on their daily lives.

Asking about symptoms not commonly raised

Supported by the Research Hub and the Australian General Practice Research Foundation (AGPRF), BREATHE FAST is a sub-study of the larger BREATHE research program. The AGPRF is the philanthropic arm of the Royal Australian College of General Practitioners and advances research that strengthens general practice and patient care. Medibank partners with the foundation to help fund this work and improve health outcomes through general practice.

As part of BREATHE, patients complete a short questionnaire through BetterConsult, a digital tool that lets patients tell their GP what they want to discuss before they arrive for their appointment. BetterConsult also prompts patients about symptoms that they might otherwise not mention, such as breathlessness.



“What’s been really powerful about this project is the number of patients who are indeed breathless, who would have never said anything about it to their GPs,” says Professor Hespe.

With this digital screening process, GPs or practice staff members don’t have to remember to ask every patient about breathlessness.

Patients who report breathlessness that lasts longer than four weeks and meet the study’s criteria will be invited to complete the micro-spirometry test when they attend their scheduled GP appointment. BREATHE FAST will focus on rural general practices, where accessing respiratory testing can be difficult.

Introducing lung testing into general practice

Diagnosing COPD usually needs spirometry testing to be done, which measures how much air a person can breathe out and how quickly they can do so. This test was mostly stopped during the COVID-19 pandemic

because of the risk of spreading respiratory and droplet infections. Since then, many general practices have not resumed routine testing.

“Once you’ve de-skilled, it’s actually very hard to skill back up again,” explains Hespe.

Formal spirometry also takes time and requires trained staff. With the high cost of equipment and training, and limited Medicare rebates, many general practices find it difficult to offer this test.

BREATHE FAST will evaluate a handheld PIKO-6 micro-spirometer as a simpler way to screen patients. The test takes less than a minute and can be done by a practice nurse or GP.

Patients taking part in BREATHE FAST will complete a COPD questionnaire and a micro-spirometry test during the same visit. Together, these assessments could indicate if COPD is likely and whether treatment should start while formal spirometry is being arranged.

The study will also evaluate how accurately the digital self-screening questionnaire, combined with handheld micro-spirometry, identifies COPD by comparing the results with diagnostic spirometry, the gold standard test for diagnosing COPD.

“If we’ve picked up your breathlessness, you’ve done a test and it shows you actually fit the diagnostic criterion for having COPD, I can prescribe you a puffer today,” says Hespe. “I don’t have to wait 6 to 12 months to have you back again.”

Detecting COPD early is important because treatment can help slow its progression. As the disease becomes more severe, lung function can decline to the point where some people need portable oxygen.

BREATHE FAST is looking at whether earlier identification and treatment in general practice could help prevent people from reaching these later stages.

Reducing delays in rural communities

Being able to assess breathlessness during a routine GP visit could be particularly valuable in rural and remote areas. In these places, a patient might travel hundreds of kilometres to see a GP.

“If you send them home and then you make a referral to go and do a spirometry test in another centre that’s another two hours away, it’s probably not going to happen,” says Hespe.

Rural communities also have a higher risk of COPD.

“People from lower socioeconomic backgrounds unfortunately have a much higher risk,” adds Professor Hespe. “They often don’t have the same access to regular healthcare and in rural areas, people are more likely to have to pay to see their GP, which makes them more likely to put off seeking care.”

The project will look at the role practice nurses could play in completing the assessments. If nurses can handle much of the screening, it could make it easier for general practices to use the process as part of their routine care.

Testing if the process works

BREATHE FAST is expected to have 20 participating rural general practices. The research team plans to kick off a pilot before recruiting more practices.

Researchers will measure how many patients report chronic breathlessness through the digital screening and how many go on to complete the micro-spirometry test. They will also look at whether this leads to more people being diagnosed with COPD and starting treatment earlier.

The research will likewise investigate how patients, GPs and practice staff use the new screening process, including how practices manage screening, who is best placed to perform it and what might prevent it from becoming part of routine care.

Looking for emerging signs of COPD

The research could help doctors identify people at risk before they meet the current criteria for COPD. Researchers now recognise a stage known as pre-COPD, where early lung damage may already be present even though results from standard tests do not yet meet the threshold for COPD.

Professor Hespe and her colleagues hope to use participants identified through the BREATHE program and BREATHE

FAST to do additional assessments that might detect early signs of lung disease. This proactive prevention creates the opportunity to reduce healthcare costs and the burden of disease on patients.

If BREATHE FAST shows that digital screening and micro-spirometry can be used effectively in routine care, the findings could inform clinical guidance and future policy. Professor Hespe plans to work with organisations such as the Royal Australian College of General Practitioners and Lung Foundation Australia to consider where this type of assessment could fit within preventive care.

Eventually, she would like to see breathlessness screening included in routine health assessments and handheld micro-spirometers become common equipment in GP clinics.

“You have to have the evidence to show that it’s a valid tool to use and that it’s easy to use, and acceptable to both patients and clinicians,” she says. “Then you can start embedding it into general practice.”



Lead investigator:
Dr Tshepo Rasekaba,
Senior Research Fellow,
John Richards Centre for
Rural Ageing Research,
La Trobe Rural Health School,
La Trobe University

Research partnership grant:
\$100,000



LA TROBE
UNIVERSITY

Research project

Virtual clinic aims to widen access to diabetes care in rural Victoria

A virtual clinic pilot could give rural Victorians with type 2 diabetes access to specialist care that's not available locally.

Australians living in rural and regional communities often have limited access to clinicians such as diabetes specialists due to a lack of personnel and geographic isolation. In regional Victoria, many people have to take time off work and pay for transport and accommodation to see a specialist in Melbourne.

"These then end up being barriers to care, which impact clinical outcomes," says Dr Tshepo Rasekaba, Senior Research Fellow at La Trobe University's John Richards Centre for Rural Ageing Research. "People in rural and regional communities, especially, tend to have poorer diabetes outcomes relative to their city counterparts, because they have poor access to services. It becomes a case of one's postcode determines one's health outcomes."

Dr Rasekaba and his colleagues at La Trobe University are testing a virtual diabetes clinic (VDC) that could give people with type 2 diabetes access to specialist care from more convenient locations closer to home.

The pilot, funded by the Research Hub, links rural health services facilities such as local rural hospitals and GP clinics with a multidisciplinary team through telehealth. It will add specialist diabetes care in areas where it is currently unavailable.

"We start from a point of strength – what do you have locally? What don't you have that we can then provide virtually? And that might be different from one community to the next," says Dr Rasekaba, who adds that the virtual service will not replace but will complement local care. "That is why co-design is a vital part of the process we're following in the project."

Giving rural patients access to more specialists

The project builds on previous research by Dr Rasekaba that evaluated a telehealth specialist service in Victoria. This telehealth service connects people in rural and remote communities with specialists in Melbourne, including patients living six to eight hours' drive away.

Dr Rasekaba's evaluation found that patients saved time and money when accessing specialists virtually. It also showed that telehealth services reduced emergency department presentations and hospitalisations by addressing avoidable issues. Yet, the model connected patients

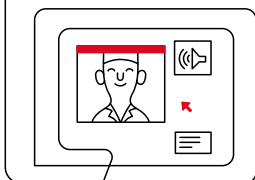
with single specialties, for example, patients with diabetes were only linked with an endocrinologist. However, local care providers identified multidisciplinary care as a gap.

Following these findings, Dr Rasekaba wanted to find out if telehealth could give rural patients access to more diabetes specialists. In addition to endocrinologists, the VDC pilot is designed to connect patients with diabetes educators, dietitians, podiatrists and other health professionals based on their needs. It also connects them with specialists such as cardiologists for conditions related to diabetes.

"What VDC seeks to do is to have a multidisciplinary model," says Dr Rasekaba.

Fitting the needs of each community

The pilot is being co-designed with clinicians, service managers and people with lived experience of diabetes. This process ensures that the clinic complements each community's existing services instead of rolling out the same model everywhere.



Local health professionals will continue to provide in-person care, with nurse facilitators helping patients access their virtual appointments and coordinating their care.

Dr Rasekaba says local support will be important because some people might not be confident using digital technology.

“We may need to look into a concierge model where there’s a local person that helps them navigate the technology and connects them to the specialist they need to see,” he adds.

Assessing suitability and access

The pilot is first testing how well the VDC model runs within rural health services and how patients and clinicians respond to it. Researchers will track patient referrals and participation and gather feedback from patients and health professionals.

They will also look at patients’ use of diabetes services previously unavailable to them, including changes in relevant Medicare activity and referrals.

The researchers will monitor clinical outcomes, though Dr Rasekaba says that the pilot might be too short or too small to show significant changes in diabetes control. Specifically, they will track HbA1c, a standard measure of diabetes control over time, together with emergency department presentations and hospitalisations related to diabetes.

“If we can see that it does impact those clinical outcomes, great. If not, that’s okay, because that’s a secondary outcome,” says Dr Rasekaba. “This pilot is really aimed at enabling people in rural and regional areas of Australia to receive multidisciplinary diabetes care that’s personalised and accessible locally.”

The project will also test factors that could affect the virtual service’s viability as part of routine care. For instance, bulk billing, Medicare rebates and out-of-pocket costs could affect patients’ ability to use specialist services. Some rural health services might also need better facilities for virtual consultations.

Moving the model to a larger trial

If the pilot shows that the model is feasible and acceptable to patients and clinicians, Dr Rasekaba wants to expand it into a larger study focused on the effectiveness of virtual multidisciplinary care for controlling diabetes and reducing the need for hospital care.

He also sees potential for the model to be used in metropolitan communities where access to specialist care can be a challenge. His longer-term goal is for virtual multidisciplinary diabetes care to become part of routine health services, primarily as an enabler in underserved communities.

“We will look to scale up and move into the clinical effectiveness–implementation as pathways to normalising this service in type 2 diabetes care,” says Dr Rasekaba.



Funding from the Research Hub has enabled the research team to co-design and test a model that Dr Rasekaba had wanted to pursue for several years. The evidence generated through this study will be important in securing further funding for a larger study to measure clinical outcomes and implement as well as scale the model.

“Until Medibank came along, I didn’t have the financial means to be able to really test it,” he says. “Their funding has provided that opportunity.”

The pilot started in February 2026 and is expected to run until February 2027.



Lead investigator:
Professor Guy Ludbrook,
Professor of Anaesthesia,
Adelaide University and the
Royal Adelaide Hospital

Research partnership grant:
\$95,000



ANZCA
FOUNDATION

Research project

Advanced Recovery Room Care: enabling reduced complications after major surgery

The ARRC Network is helping hospitals enhance postoperative care to speed up recovery after major surgery.

Patients are in significant physical stress in the first hours after major surgery. As anaesthesia wears off, the body reacts to the surgical trauma, which can cause unstable blood pressure, breathing difficulties, kidney problems or severe pain.

But despite these risks, patients typically spend only two hours in a recovery room before being moved to a general ward where staff check them less frequently.

“There’s a lot happening to your body in terms of recovery and changes as a result of the surgery and anaesthesia,” says Guy Ludbrook, Professor of Anaesthesia at Adelaide University and the Royal Adelaide Hospital (RAH). “When we looked more deeply, it’s clear that two hours is not enough.”

Professor Ludbrook and his colleagues investigated what happens after patients leave the recovery room and found that some were being sent to general wards with unresolved clinical problems. Their research led to Advanced Recovery Room Care (ARRC), an approach that extends close monitoring and treatment for up to 18 hours after surgery.

The ARRC research project, undertaken by the ANZCA Foundation and Adelaide University, is now extending this initiative to other hospitals through the related ARRC Network. With funding from the Research Hub, the network helps hospitals establish ARRC services and share evidence as more facilities adopt the model.

Fewer complications and shorter hospital stays

A specialist anaesthetist at RAH, Guy Ludbrook first became concerned about postoperative care in 2004, after asking a colleague to spend three months observing patients in the recovery room.

“What he saw was concerning,” he says, as patients with unresolved problems were being sent to the ward.

A small overnight trial followed in 2018–19, initially using three beds and nursing staff. RAH gradually expanded the service as positive clinical outcomes accumulated.

ARRC is intended for medium-risk patients who might need more care than a general ward can provide but do not require intensive care. Patients are screened using the American College of Surgeons National Surgical Quality Improvement Program (NSQIP) risk tool, which takes into account factors including older age, infections, surgical-site complications and reduced

function of the heart, kidneys or other internal organs. Those who NSQIP scores as at ‘medium risk’, or those who become unstable during or soon after surgery, are eligible for the service, where specialist doctors and nurses care for them from arrival in the recovery room until the morning after surgery. After this ‘golden 24 hours’ of postoperative care, most are then suitable to be transferred for ward care.

According to the latest annual report of RAH and its ARRC registry, major complications have been reduced among ARRC patients compared with those directly transferred to a ward. This translates to major reductions in length of stay and hospital readmissions, and the need for nursing home care. Registry results which are to be published suggest patient mortality at four years follow up has fallen by 35%, which is estimated to equate to 250 lives saved per year at RAH’s 10-bed ARRC unit, giving patients a higher chance of surviving major surgery. They also spend more days at home after surgery, that could free up as many as 6,000 RAH hospital bed days each year, creating capacity to care for more patients.¹

“From a patient perspective, they are getting better outcomes,” says Professor Ludbrook. “From a hospital perspective, of course, patients getting better is terribly important. But the fact that we can save our precious resources and use them to treat other patients is also incredibly important.”

Helping hospitals roll out the model

The success of the home-grown ARRC model at RAH has led to global collaboration through the ARRC Network. This collaboration brings together hospitals with ARRC units and those considering them so they can share research and implementation strategies.

“It’s like a society where we share experiences, we share data, we learn together,” says Professor Ludbrook.

The ARRC Network now includes hospitals in Australia, New Zealand, the Netherlands and the United Kingdom, plus a new centre in the United States. Two hospitals in Hong Kong have also opened ARRC units after their teams visited RAH. In Australia, several public hospitals are preparing to establish similar units.

The network is helping hospitals assess what they need to create an ARRC service, including space, staffing, costs and the types of patients those units should care for. Adapting the model to local circumstances means hospitals can introduce the service without major changes to existing layouts or infrastructure. One hospital created space by walling off a corridor and others have used existing recovery rooms that were not occupied overnight.

By sharing experiences, hospitals learn from one another instead of starting from scratch. For example, the RAH team has shared clinical protocols with hospitals overseas and at the same time has adopted ideas from them.

Funding a common registry

A grant from the Research Hub is helping the network build the infrastructure needed to collect and share information. It funds the network’s website, nurse education programs and a data manager to build a registry.

The registry will provide a common source of information on how well patients recover and how much hospital space they use. This data will enable researchers to compare results from various facilities and use the findings to improve care.

Evaluating patient experience is also part of the project. RAH collects feedback from patients and their carers, and monitors how ARRC impacts recovery. For example, a recent patient in the hospital’s ARRC unit had major kidney surgery and an epidural for pain relief. With the close monitoring and care he received, the patient was already up and walking with nurses the next morning.

“I wouldn’t have imagined that a patient having that surgery could do that,” says Professor Ludbrook.

Making ARRC a standard in more hospitals

Professor Ludbrook and his colleagues are now preparing a national summit on enhanced postoperative care and writing a white paper with international experts. Their aim is to bring clinicians and healthcare leaders together to discuss the evidence and how the ARRC model can grow.

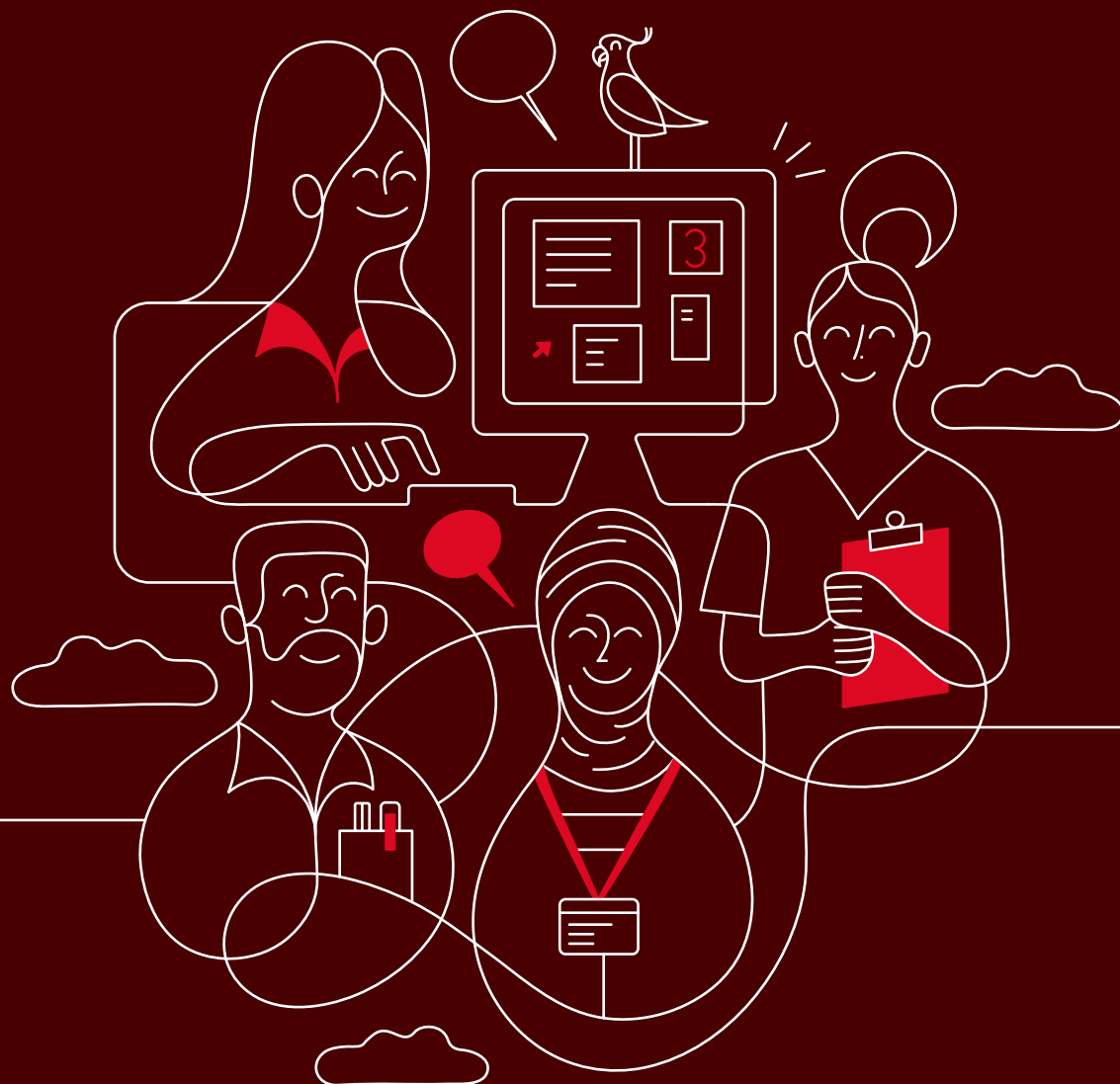
Professor Ludbrook hopes ARRC will become standard care where suitable. “I expect that we’ll have data from hospitals all over Australia and internationally that will help guide us into better practice.”

He has a personal reason for wanting ARRC units to be available more broadly. “I may well be a patient in five years,” he says. “If any of us have to become a patient, I would want this type of care to be available for everyone in Australia.”





Case studies



Case study

Proactive primary care helps lower patients' risk of hospitalisation



AUSTRALIAN INSTITUTE
OF HEALTH INNOVATION



Lead investigator:
Dr Mohammed Hasan,
Chief Medical Officer,
Myhealth

Research partnership grant:
Multiyear evaluation with
Myhealth Medical Group
and Macquarie University's
Australian Institute of
Health Innovation

A new model of general practice uses case reviews to help patients get on top of their health issues before they need hospital care.

People are often time poor and have to prioritise how to use the limited time they have for their health. They might put off preventative care, even when those services are readily available. Short GP appointments can also make it difficult to discuss and plan for all of a patient's needs.

Myhealth's Proactive Primary Care (PPC) project is trialling a new model of care at three clinics in Western Sydney. Myhealth operates more than 100 GP clinics in New South Wales, Victoria and Queensland. The PPC pilot, launched in 2024, brings together GPs, nurses, social workers, mental health practitioners and

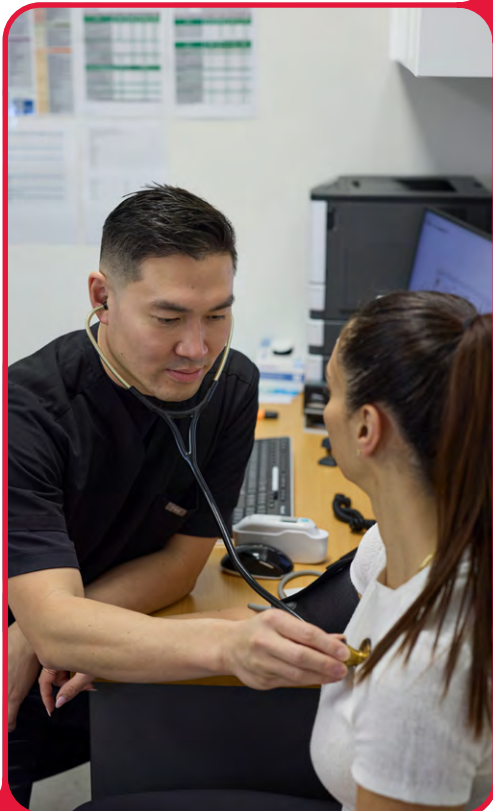
pharmacists to review patients who are at high risk of hospitalisation and follow up on care they may have missed.

"We want to deal with things while they're still under control and not wait for a complication," says Dr Mohammed Hasan, Chief Medical Officer at Myhealth. "We want to keep people healthy and well for as long as possible."

The evaluation is supported by a grant from the Research Hub, and Medibank also holds a majority ownership interest in Myhealth.

The Australian Institute of Health Innovation at Macquarie University is independently evaluating the model's impact, sustainability and scalability.





Lowering the risk of hospitalisation

A key component of the model is case review. The GP-led multidisciplinary team (MDT) comprising of a registered nurse, social worker and clinical pharmacist reviews the records of patients who are at high risk of hospitalisation and checks if they are up to date with recommended care. Following discussion with the GP in the case review, the MDT contacts the patient to discuss their care, identify any gaps and support the completion of recommended care. This may include overdue

screening, vaccinations, chronic condition management, and social supports among other services. Patients are reviewed again around 12 months later to see if the care has been completed or identify any ongoing care needs.

Results to date have been promising: by the end of the second year of the case review intervention, about 40% of patients had a lower hospitalisation risk score. Around one-fifth of patients who initially had a medium hospitalisation risk score (10–19% risk) moved into the low category (below 10% risk).

Among clinically eligible patients, rates of vaccination also increased. Shingles vaccination rose from 30% to 57%, pneumococcal vaccination from 32% to 51% and influenza vaccination from 33% to 52%. Screening rates also went up, including cervical cancer from 9% to 34% and bowel cancer from 16% to 43%.

According to Dr Hasan, these results show it's not enough just to make preventative services available. "You still need to push to actually increase their uptake," he says.

Helping patients with issues that affect their health

As part of the case review, registered nurse Aysu Kaya worked with patients to help them complete care and follow up issues recommended during their reviews.

One patient was identified during case review as needing an over-75 health assessment but during the follow-up assessment with the patient, Ms Kaya learned about several issues that needed attention.

"He was going to be homeless," she says. "He was struggling with housing applications and that whole process. There were also issues with his specialist appointments."

Ms Kaya referred the patient to the team's social worker who addressed the patient's housing instability and followed up on his missed specialist appointments.

Providing more support to GPs

GPs reported throughout the program that their involvement in the PPC program had a positive influence on their job satisfaction and was closely linked to their perception of feeling supported to deliver care to their expected standard.

Data from the case review intervention showed that the PPC nurse and social worker delivered 276 and 492 hours of proactive care, respectively. This was work that otherwise would have been done by GPs or not at all.

"For a GP to work to the top of their scope, you need to reduce the admin work," says Dr Hasan.

Case reviews also drove more referrals to pharmacists for home medicine reviews, which are assessments of patients' medicines and how they are being used. These referrals more than doubled following the addition of the pharmacist to the MDT in the second year, with 98 case review-identified referrals in the first year compared to 205 in the second year. These reviews can help GPs identify medicines that may no longer be needed, or problems that may arise when patients are taking multiple medicines.

Rolling out the model to more patients

A second PPC intervention, patient flow and segmentation, focused on making sure patients were connected with the right

support around their GP appointment by capturing the reason for their visit and enabling GPs to refer patients for further support. The intervention was implemented at one clinic and reached 4,398 patients between June 2025 and June 2026. Of these, 2,120 received care from a PPC mental health nurse, chronic care nurse or social worker. Other patients were directed to existing practice nurses.

Feedback has been positive. Almost all patients surveyed (97%) said they were definitely satisfied with how their care was arranged and provided, and 97.4% said they definitely felt confident in and trusted the health professionals they spoke with.

The PPC model is currently being evaluated by the Australian Institute of Health Innovation, with the findings expected to guide the next phase of the project expanding to new geographies and a new cohort focused on the first 2,000 days of life.

Dr Hasan sees potential to expand the model to the first 2,000 days of life so children can receive preventative care early. He says this period is important for future health and could give GPs more opportunities to support parents and carers with their children's health from the start. He also wants the model to become available in more general practices. "If we want something greater than what we already have, we need to invest accordingly," he says. "We need greater support for different multidisciplinary team members to work to the top of their scope."

Meanwhile, Ms Kaya would like case reviews to become standard practice. "The format is something that should be expanded to every general practice."

The final evaluation report is expected to be delivered by the end of 2026.

Case study

Westmead Institute for Medical Research brings affordable genomic testing into breast cancer care



Lead investigator:
Dr Dinny Graham, Senior
Research Fellow, Westmead
Institute for Medical Research

Research partnership grant:
\$260,000 over two years



A low-cost genomic test could help more breast cancer patients avoid unnecessary chemotherapy.

Every year, the Westmead Breast Cancer Institute treats 500 to 600 women diagnosed with early breast cancer in Western Sydney. Breast cancer is a very diverse disease, and treatment planning takes into account the estimated risk that it will return after surgery, with women at high risk of relapse recommended chemotherapy. Many have breast cancers that belong to an intermediate risk group, where it is hard to know if chemotherapy is needed and will provide enough benefit to justify its side effects.

Around 70% to 80% of breast cancers are hormone receptor positive, meaning the cancer grows in response to hormones such as oestrogen or progesterone.¹ Endocrine therapy is the standard treatment for this type of breast cancer, but some patients may also benefit from chemotherapy. Identifying which patients will likely benefit is a major challenge.

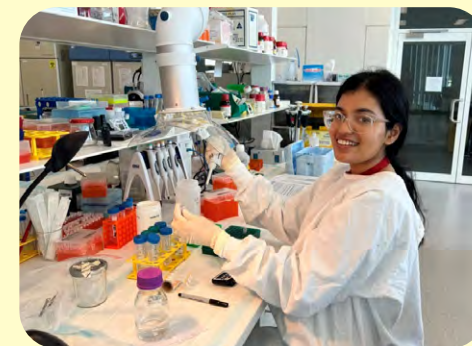
“In cases where the clinical team is concerned the breast cancer has features of a quite aggressive type, they recommend adjuvant chemotherapy and endocrine treatment,” says Dr Dinny Graham. Adjuvant chemotherapy is additional treatment given after surgery.

“What we find is that there’s a subset of patients in that intermediate risk group, where it’s a little equivocal whether or not chemotherapy is warranted,” adds Dr Graham.

Existing pathology tools such as Ki-67, which estimates how quickly tumour cells divide, help doctors predict how aggressive the cancer is. But these assessments can differ between laboratories and even between pathologists. This makes the results less reliable for patients in the intermediate risk group. For this reason, the clinical team takes a conservative approach and may recommend chemotherapy although it might not be needed.

“Clinicians would rather recommend a course of chemotherapy than find that the patient experiences a recurrence,” says Dr Graham.

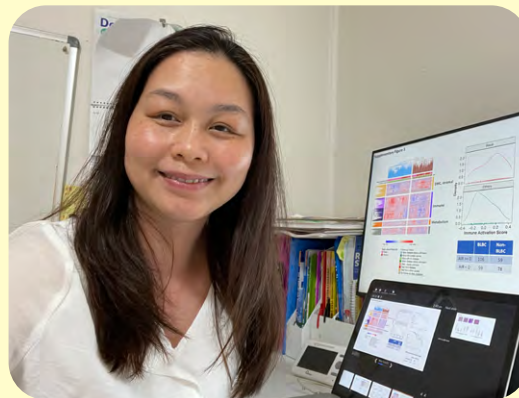
Commercial genomic tests provide a more accurate estimate of recurrence risk than standard pathology assessments. But the



cost can be prohibitive for many patients. One commonly used test receives only a partial Medicare subsidy, while another has no Medicare rebate and costs more than US\$5,000. It also requires tissue samples to be sent overseas for analysis, resulting in delays to the patient’s treatment journey.

To make genomic testing more affordable, Dr Graham and her colleagues at the Westmead Institute for Medical Research developed the PROSPER: Providing Affordable Precision Medicine Care for Breast Cancer Patients Program. They are creating a low-cost genomic test that could deliver the same clinical information as expensive commercial alternatives.

1. Breast Cancer Network Australia. Hormone receptor positive breast cancers. Breast Cancer Network Australia.
<https://www.bcna.org.au/resources/about-breast-cancer/types-and-subtypes-of-breast-cancer/hormone-receptor-positive-breast-cancers>



Developing an affordable alternative

The researchers first investigated how often commercial genomic testing changed treatment decisions. They used the commercial genomic test EndoPredict and compared the recommendations of a multidisciplinary team before and after clinicians received each patient's result.

Treatment recommendations changed in around 10% of all cases. For patients in the intermediate risk group, the treatment plan changed in about one in four cases.

"We really demonstrated the need for the test," says Dr Graham.

However, genomic testing could not be offered to every patient due to high costs. The team developed a low-cost alternative to make the test available to more breast cancer patients.

The PROSPER test measures tumour growth potential using routine pathology samples at a much lower cost. Early laboratory studies suggested that the test could eventually cost less than current routine pathology tests funded by Medicare.

"Our retrospective validation test showed that PROSPER could predict the risk of

recurrence as accurately as the EndoPredict results previously gathered from the same cohort of patients," says Dr Graham.

With the Research Hub's support, the team completed the validation studies and has moved into prospective clinical testing.

Preparing the genomic test for hospital use

The researchers are partnering with Australian biotechnology company SpeedX to convert the PROSPER test into a clinical PCR test that can be used on routinely collected breast cancer tissue samples. NSW Health Pathology at Westmead Hospital is evaluating the test as part of its clinical validation.

The research team aims to have the test done in local pathology laboratories instead of sending samples interstate or overseas.

"We would like to be providing the reagents in a kit, ready to use, and sending them to NSW Health Pathology centres across New South Wales," says Dr Graham.

Current commercial tests can take two to four weeks to come back, while the PROSPER test can now produce a result

within two days. The team aims to reduce this wait even further.

Getting the result earlier enables multidisciplinary teams to review the data before finalising treatment plans after surgery.

Helping patients decide about chemotherapy

Dr Graham believes the biggest benefit of the test is helping patients decide if chemotherapy is right for them. As she says, "It allows patients to feel confident and reassured in the decision that they make about their treatment."

Women whose results show chemotherapy is not expected to provide clinical benefit can avoid unnecessary treatment. Those likely to benefit can proceed with treatment knowing that the recommendation is backed by personalised genomic information.

Dr Graham also expects more affordable genomic testing to ease pressure on the healthcare system by reducing unnecessary chemotherapy.

"The vast majority of changes in treatment recommendation that we saw being made

when these types of tests were available were de-escalation of treatment," she says. "A significant number of patients could forgo chemotherapy, which would represent a considerable saving to the healthcare system."

Making the test available through Medicare

The team is continuing clinical validation with NSW Health Pathology and preparing its application for Therapeutic Goods Administration approval. It will then apply for a Medicare rebate so the test can be offered through the public health system.

"Seeing patients across Australia receiving the test for free, that's what success looks like for us," says Dr Graham. "We want to see widespread uptake of the test and keep it available free to patients through the public health system."

"Without the generous support from the Research Hub, this project could not have gone forward. The funding has helped us to move forward to providing an affordable test that will improve quality of life for thousands of Australians going through treatment for breast cancer."

Case study

Helping patients find the best ways to manage persistent pain



Lead investigator:

Associate Professor Nancy Sturman, General Practice Clinical Unit, The University of Queensland Medical School

Co-funded research partnership grant:

\$125,000 from the Medibank Better Health Research Hub and the Australian General Practice Research Foundation, a part of the Royal Australian College of General Practitioners

This pilot of a self-management app provided some valuable lessons for GPs and patients trialling non-drug treatments for persistent pain.

Persistent pain affects around 3.4 million people in Australia and is a challenging condition for patients and GPs to manage.¹

Many people live with pain for years. Doctors and patients often don't have a simple way to tell if an intervention – such as exercise or another non-drug treatment – is working.

Associate Professor Nancy Sturman from The University of Queensland and her team aimed to change this by giving patients and GPs a structured way to test non-drug treatments.

Supported by the Medibank Better Health Research Hub and the Australian General Practice Research Foundation, her team piloted a mobile app that helps patients self-manage treatment experiments. The StudyU app helps patients work with their GP to pick an activity and monitor its

effects over several weeks, so patients can decide whether to continue or try something else.

"I've always been attracted by this idea that an individual patient could trial an intervention themselves and compare how they go with or without it," says Associate Professor Sturman.

Learning what works for each patient

Associate Professor Sturman's team conducted a pilot study in a large Brisbane general practice. The study invited participants to choose from non-drug activities such as chair yoga, changes to swimming routines, online cognitive therapy and affordable activities available in the local community. Each activity required patients to actively manage their own condition.

The app prompted participants to complete daily ratings, which helped them stay with an activity long enough to see if it was making a difference. The app recorded daily pain scores and tracked over several weeks how pain affected sleep and overall quality of life. Patients could then bring the information



collected by the app into conversations with their GP to discuss what was or wasn't working.

"One of the problems for patients with persistent pain is they can get all this advice about things that, in general, people believe may help," says Associate Professor Sturman. "But you need to know whether it helps you or not."

Even if an activity did not help, patients still learned something useful.

"If you're trialling something consistently and at the end of those days you look at the graphs and you think 'Actually I'm worse off swimming', I think that's also really helpful," says Associate Professor Sturman. "It's being able to go to the GP and say, 'Look, it actually isn't working; let's try something different.'"

1. Painaustralia. Working Together to Address Chronic Pain: Painaustralia Budget Submission 2021 to 2022. January 2021. https://treasury.gov.au/sites/default/files/2021-05/171663_pinaustralia_0.pdf



Six patients completed structured self-experiments using StudyU. One of them said the experience encouraged them to start a second experiment right after finishing the first.

Understanding the realities of persistent pain

The pilot helped show why introducing new self-management options can be difficult for people living with persistent pain.

Many participants were managing several health conditions with family

responsibilities, financial pressures and uncertainty over being able to continue working. GPs described consultations that were filled with urgent priorities, making it tough for patients to find the headspace to embark on something new.

The research challenged some of the team's assumptions.

"We were offering GPs a tool that might help patients do more self-management, but that was quite a tough ask for patients and also for GPs," says Associate Professor Sturman.

The study's findings suggest patients may need to build trust with a GP over many consultations before being ready to commit to a structured non-drug treatment.

Lessons for general practice

Although the number of participants was lower than originally planned, the study offered important lessons about introducing digital health tools into busy GP clinics.

GPs and practice staff strongly supported the idea of helping patients manage their pain using non-drug options. But they also identified barriers for clinicians such as competing priorities and limited opportunities for GPs to receive feedback about patients' progress.

One unexpected finding came after a chiropractor within the practice started referring patients to the study. Because patients had regular consultations with the chiropractor for persistent pain, recruitment was more successful than through general practice appointments. This experience showed that allied health professionals within the same practice could add value to future studies.

The project also produced resources that continued to benefit the practice after the pilot ended. Researchers created a directory of affordable local activities and support services, giving GPs a place to find non-drug treatments they could recommend to patients.

Continuing the research

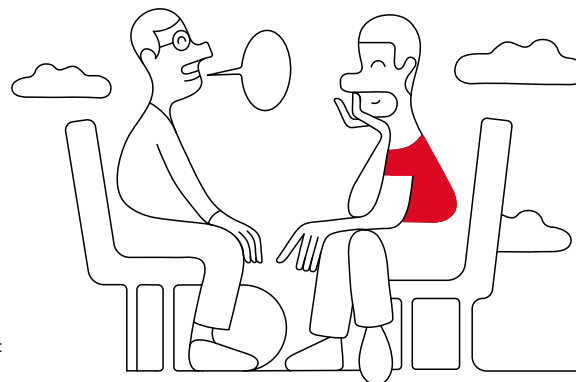
The pilot is now informing the next stage of research. Associate Professor Sturman and members of the StudyU team are contributing to a new project involving patients on a waitlist for hospital pain clinics, where waiting times can reach several years.

The team plans to apply what they learned from StudyU to further investigate how personalised self-experiments can support people living with persistent pain.

"I'm excited about the future of digitally enabled n-of-1 [single person] studies, where individual patients test if a treatment works for them," says Associate Professor Sturman. When carefully designed, these single-person studies can produce statistically robust results, helping provide greater confidence about whether a treatment works for an individual.²

She believes the lessons from this project will also help future research in general practice.

"Continuing to dissect the challenges and find ways to meet them is going to mean that patients are ultimately better off," she adds. "We're going to have a health system that better accommodates what works for each individual patient."



2. Sturman N, Nikles J, Worthy P, et al. Evaluating digitally-enabled self-experiments in general practice to support patients managing persistent pain. medRxiv. <https://doi.org/10.1101/2024.12.20.24319270>

Research perspectives



Associate Professor Adam Culvenor, Sport and Exercise Medicine Research Centre at La Trobe University

Associate Professor Adam Culvenor recognises that generating evidence is only part of the research challenge. Just as important is understanding what helps – or prevents – that evidence from changing healthcare.

Culvenor and his team are investigating why so many young people in Australia with anterior cruciate ligament (ACL) injuries undergo knee reconstruction surgery despite evidence that active rehabilitation can produce comparable outcomes for many patients. Their research examines the beliefs and healthcare pathways that influence

treatment decisions, to improve access to evidence-based care.

Partnering with the Research Hub has expanded the scope and direction of their work. An industry-funded PhD created dedicated research capacity. The team also gained access to a national dataset of ACL reconstruction patients, allowing them to investigate post-surgical complication risk at a level traditional data collection could not achieve.

The research has since contributed to the team securing a further \$2.7 million MRFF grant for the KOBRA (Knee Osteoarthritis outcomes in young adults with a BRace) trial, with support from Medibank. The trial will investigate whether a low-cost knee brace can improve outcomes for young adults with post-traumatic knee osteoarthritis following ACL reconstruction.

Regular input from Medibank stakeholders has also helped the team refine the research as evidence-to-practice gaps emerged.

“We can have strong evidence about the treatments that work, but we also need to understand what influences patients’ treatment choices,” says Culvenor.

Turning evidence into clearer treatment pathways can reduce barriers to recommended care and prevent unnecessary surgeries, ultimately improving outcomes for patients and the health system.



Jessica Payne, Nursing and Midwifery Research Assistant and Critical Care Nurse

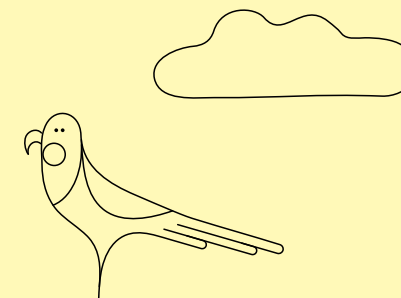
For Jessica Payne, meaningful research involving First Nations people depends on community leadership, cultural knowledge and self-determination.

Payne is leading work at Grampians Health to co-design, implement and evaluate a culturally safe emergency department care pathway for Aboriginal and Torres Strait Islander people. The project brings together First Nations and Western research methodologies to develop a model that better represents and serves local communities.

Support from the Research Hub and Western Alliance Academic Health Research Centre has resourced community-led participation and culturally safe co-design of the care pathway. It has also created the capacity for meaningful engagement with First Nations co-researchers and community members, grounded in reciprocity and accountability. Their knowledge, experience and cultural wisdom have guided the work throughout the project.

The experience has confirmed for Payne that translating research into important change cannot be rushed. She says the biggest lesson has been “slowing down to ensure dedication to engagement and connection with all knowledge users” throughout the research cycle.

With community leadership and research partners collaborating, the project is building an evidence-based pathway that could help clinicians provide culturally safe care and promote health equity.





Research perspectives



Dr Simone Darling, Principal Research Fellow at Murdoch Children's Research Institute

Simone Darling has seen first-hand how industry partnerships can give researchers the time and support needed to explore and answer important questions.



Dr Darling leads a longitudinal study examining whether the benefits of the Mental Health in Primary Schools initiative endure as children move into adolescence, including their impact on mental health, wellbeing and demand for health services.

Support from the Research Hub has enabled Dr Darling's team to undertake long-term data collection and build research capability to support the project. Just as importantly, she says, the partnership has brought a broader health system perspective, including insights into consumer behaviour and the realities that influence how healthcare is delivered and accessed.

This broader perspective can challenge assumptions, strengthen research questions and help ensure findings are relevant to real-world priorities.

"When researchers and industry partners work together well, the result is not simply better research. It is evidence that is more relevant, easier to act on and more likely to improve outcomes at scale," says Dr Darling.

This leads to stronger research that is better positioned to be translated into standard healthcare practice.



Acknowledgements

We wish to acknowledge the contribution of the Medibank Better Health Research Hub Research Governance Committee 2025–26.

Dr Shona Sundaraj

Group Medical Director and Chair

Dr Andrew Wilson

Group Chief Medical Officer

Dr Dariush Etemadmoghadam

Translational Research Lead

Bridget Colussa

MBHRH Projects Manager

Nicola Ivory

Head of Partnerships, Amplar Health

Sarah Trainor

Head of Partnerships and Sales,
Overseas Partnerships

Annie Makar

Health Policy Manager

Tracey Marriner

Senior Health Evaluation Lead

Amanda Bartley

Head of Diversity & Inclusion,
Sustainability & Community

Julia Schulz

Head of Product Portfolio, Amplar Health

Yash Sodhi

Hub Lead, Group Strategy
& Chief Strategy Officer

Partner organisations

Adelaide University

ANZCA Foundation

Australian General Practice
Research Foundation

Diabetes Australia

Harry Perkins Institute of
Medical Research

La Trobe University

Macquarie University

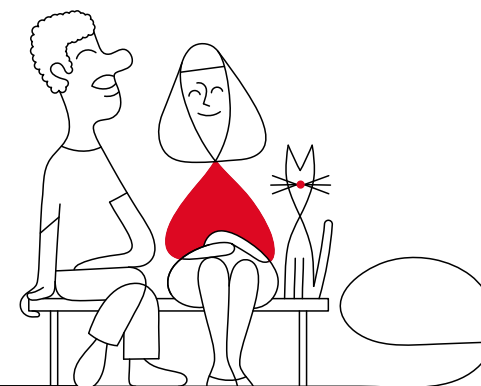
Monash Centre for Health and
Research and Implementation

Murdoch Children's
Research Institute

Orygen

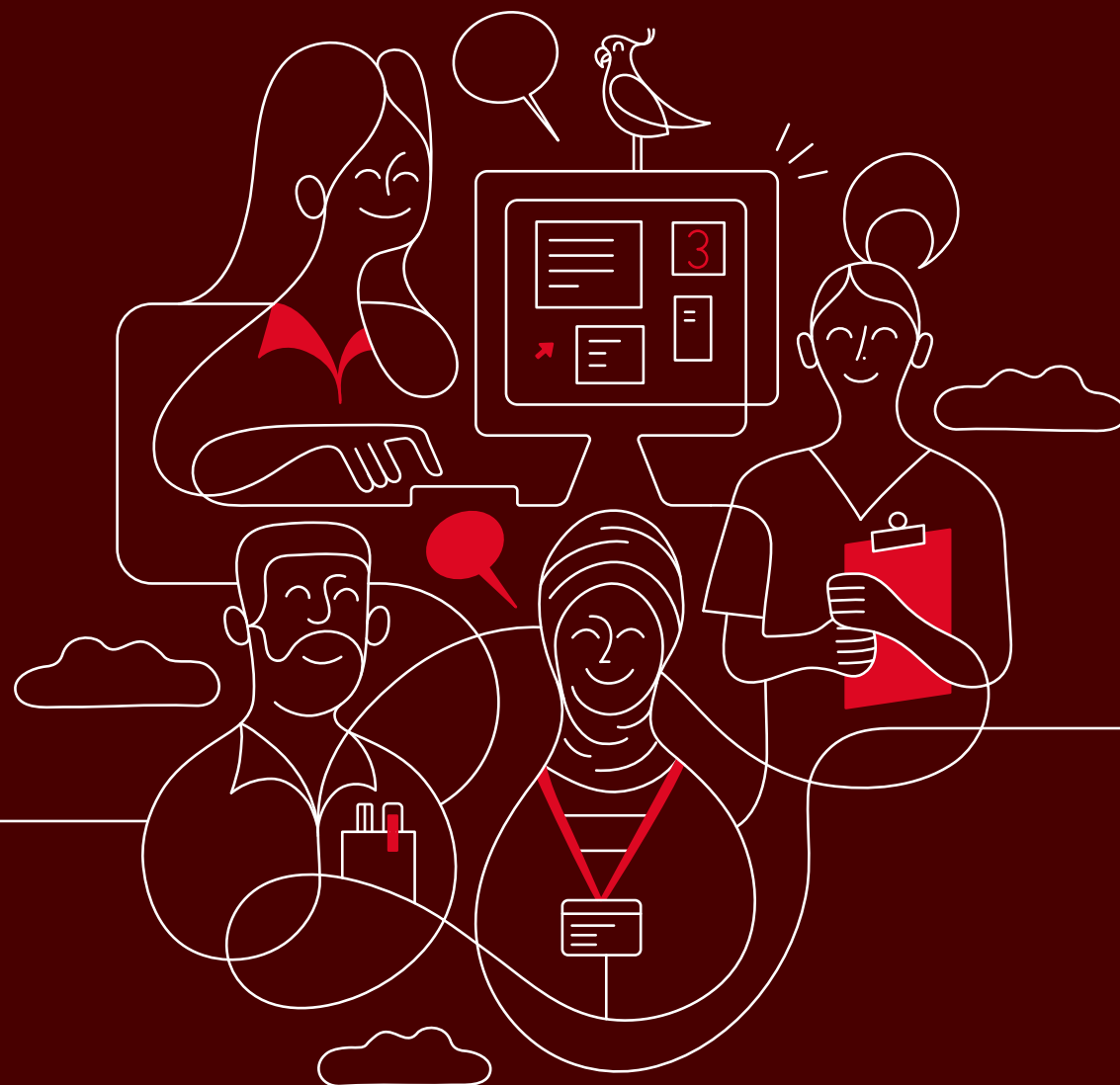
University of Notre Dame

Women's Health Victoria





While Medibank hopes that you find this information helpful, please note that it is general in nature. It is not health advice, and is not tailored to meet your individual health needs. You should always consult a trusted health professional before making decisions about your healthcare. While we have prepared the information carefully, we can't guarantee that it is accurate, complete or up to date. And while we may mention goods or services provided by others, we aren't specifically endorsing them and can't accept responsibility for them. For these reasons we are unable to accept responsibility for any loss that may be sustained from acting on this information (subject to applicable consumer guarantees).



**medibank
group**

Medibank Private Limited
ABN 47 080 890 259