Health Research at Medibank 2025

Medibank Better Health Research Hub

Medibank acknowledges Aboriginal and Torres Strait Islander peoples as the First Peoples of this nation. We proudly recognise Elders past, present and emerging as the Traditional Owners of the lands on which we work and live. We're committed to supporting Indigenous self determination and envision a future where all Australians embrace Aboriginal and Torres Strait Islander histories, cultures and rights as a central part of our national identity. Aboriginal and Torres Strait Islander peoples should be aware that this report may contain the images and names of people who may have passed away since publication.

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Foreword

Medibank's support for research reflects our Better Health for Better Lives purpose.

Medibank's investment in research is a reflection of our Better Health for Better Lives purpose. It is one way we are looking to make a longstanding contribution to the health and wellbeing of everyone in Australia.

During the year we launched the Medibank Better Health Research Hub (MBHRH), the next iteration of how we bring research to life. This builds on the legacy of the Medibank Better Health Foundation, which has championed health research at Medibank over the past decade.

While some things have changed, the mission has not.

We continue to partner with leading researchers and organisations across the health sector to address areas of health and health system need.

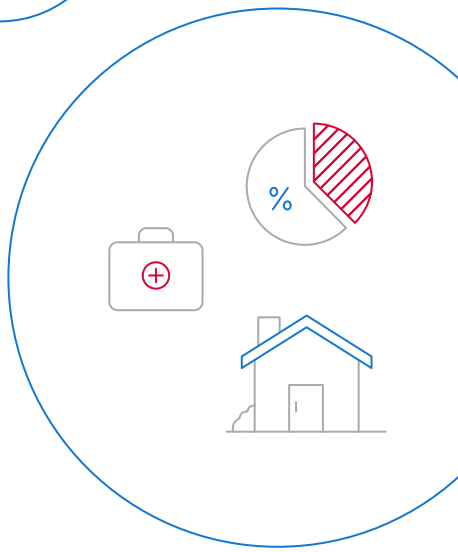
We continue to be guided by the quintuple aims of healthcare: improving health outcomes, affordability, patient experience, health equity, and the wellbeing of health workers.

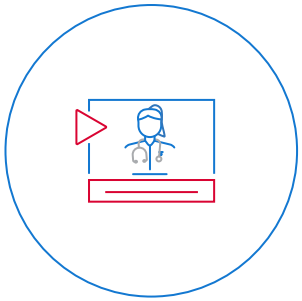
And we remain just as focused on transforming research into insights for the benefit of our customers, community and the long-term sustainability of the health system.

During the year we committed almost $1 million to support six new projects to deliver on this mission, adding to another 18 active projects already underway.

I'd like to extend my appreciation to the universities, research leaders, industry partners and advocacy groups who collaborated with us during the year. I also wish to acknowledge the dedicated team at Medibank, including the members of our Health Research Governance Committee. Their commitment is reflected on every page in this report, and in the exciting future ahead for the MBHRH.

Dr Andrew Wilson
Group Chief Medical Officer





Introduction

The Medibank Better Health Research Hub (MBHRH) supports partners who build the evidence vital in shaping health policy and health service delivery for the benefit of all Australians.

The MBHRH represents an exciting new chapter in Medibank's ongoing commitment to improving health outcomes for everyone in Australia. For more than a decade, the Medibank Better Health Foundation supported high-quality research to enhance the delivery of health services nationwide. This year, to better achieve our goal, we have relaunched with a new name and a refreshed set of priorities.

As part of this strategic shift, we are committed to supporting research projects that will positively influence health policy or improve how clinical services are delivered.

This has led us to change how we work with our research partners, making sure their projects strongly align to our research pillars and support our broader strategic and advocacy priorities. We ensure our investment in research meets the needs of the Australian population and healthcare system by reviewing our pillars every two years.

Our current pillars are:

- Community mental health and wellbeing
- Prevention strategies in primary care
- Care models for the future.

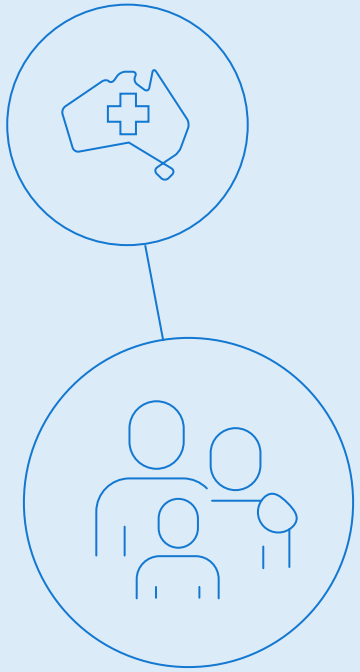
We also require that projects align with our research principles, which reflect our values and ambition to maximise healthcare outcomes. These principles ensure that research projects are person-centred, address health inequity and inclusion, promote collaboration and consider how knowledge can be translated into policy and practice. Additionally, they establish priorities that meet the healthcare needs of the population.

Health needs are vast and diverse. The research showcased in this report and supported by the MBHRH, is also diverse across areas of need in the health system. This year, funded projects include evaluating a new non-surgical intervention to improve outcomes after anterior cruciate ligament injury and creating culturally safe care pathways for First Nations people in a regional emergency department.

Other projects include gaining a better understanding of higher education students' health and wellbeing needs and the barriers to accessing services, and investigating the impact of price transparency initiatives on price variation and out-of-pocket costs. We are excited to see how the results of these initiatives will drive system-level changes in the future.

Once again, I sincerely thank all the researchers and clinicians who have contributed to our projects this year. Your hard work, insight and dedication to advancing evidence-based care continue to drive meaningful improvements in health outcomes in Australia.

Dr Shona Sundaraj
Group Medical Director



Who we are

The newly-named Medibank Better Health Research Hub (MBHRH) was established in 2013 as part of Medibank's corporate social responsibility strategy. Since then, the MBHRH has allocated more than $11 million in funding to health research projects that aim to benefit not only customers but everyone in Australia.

We partner with researchers, health services and other organisations across the health sector on projects that address the quintuple aims of healthcare: improving health outcomes, affordability, patient experience, health equity and the wellbeing of healthcare workers. We prioritise research projects that strongly align to our research pillars and principles, and where there is a clear path to the translation of research outcomes into health policy or clinical practice.

In FY25, we committed $976,000 to fund six new research projects bringing the total number of active projects supported by the MBHRH to 24.

Health Research Governance Committee

The Health Research Governance Committee (HRGC) is made up of Medibank team members with diverse professional and academic backgrounds from across the organisation's various business units. The HRGC reviews all research proposals to make sure they align with the MBHRH's agreed research focus areas, as well as Medibank's strategic health priorities.

All proposals are rigorously assessed against agreed criteria to ensure that the research we support is ethical, robust and impartial, addresses the consumer voice and is likely to positively impact the Australian health system. We actively support research that will help us achieve Medibank's 2030 vision of the best health and wellbeing for Australia.

The Health Research Governance Committee members for 2024–25 were:

Dr Shona Sundaraj	Group Medical Director and Chair
Dr Andrew Wilson	Group Chief Medical Officer
Dr Dariush Etemadmoghadam	Translational Research Lead
Katrina Weir	MBHRH Projects Manager
Nicola Ivory	Head of Partnerships, Amplar Health
Sarah Trainor	Head of Partnerships and Sales, Overseas Partnerships
Sophie Dutton	Health Policy Manager
Tracey Marriner	Senior Health Evaluation Lead
Amanda Bartley	Squad Lead, Diversity & Inclusion, Sustainability & Community
Kaitlin Varrica	Executive Assistant (Observer)

Key achievements

$976k

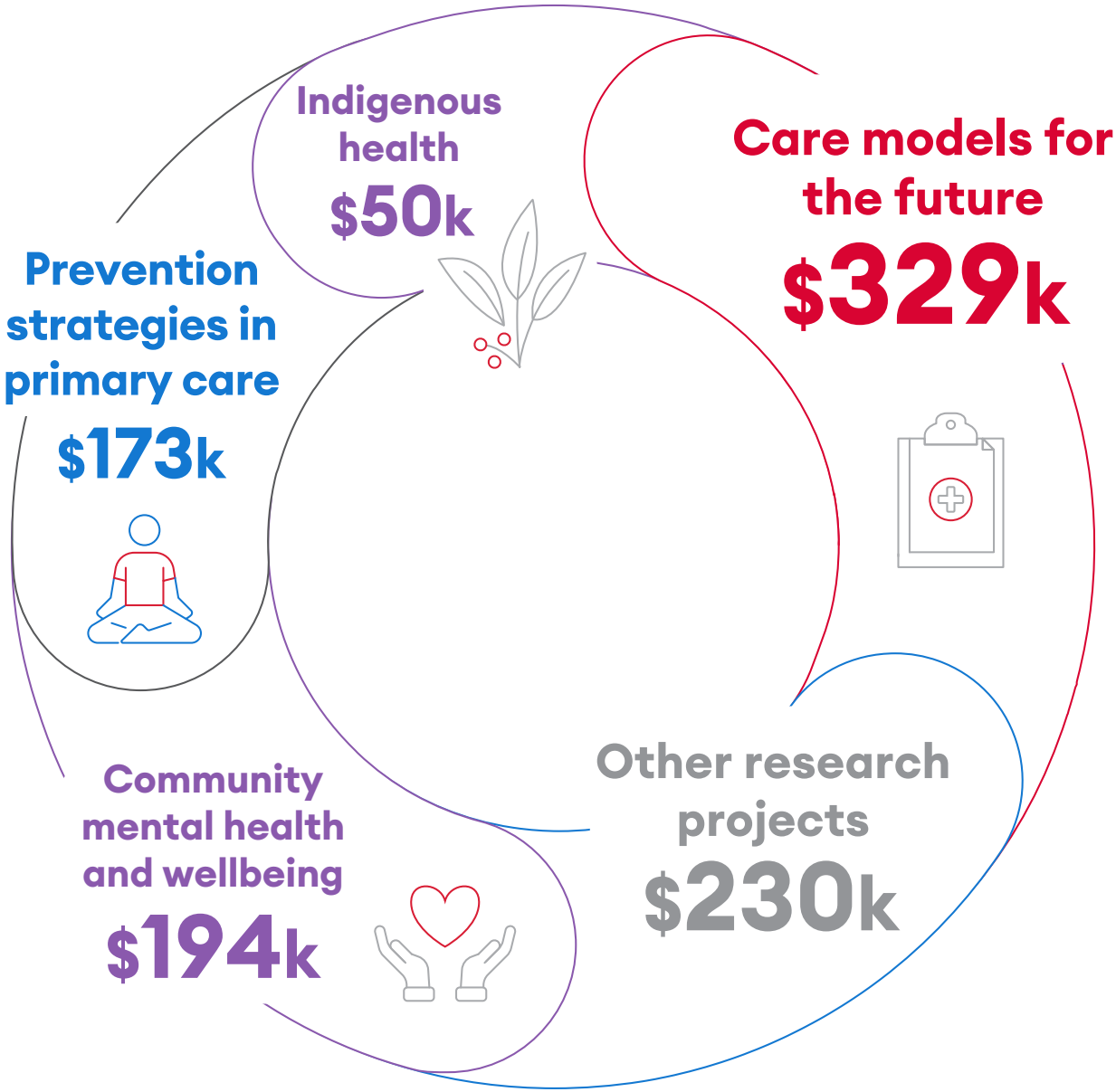
total funding allocated to research

1 July 2024 to 30 June 2025

24 active projects

16 organisations partnered with

9 publications



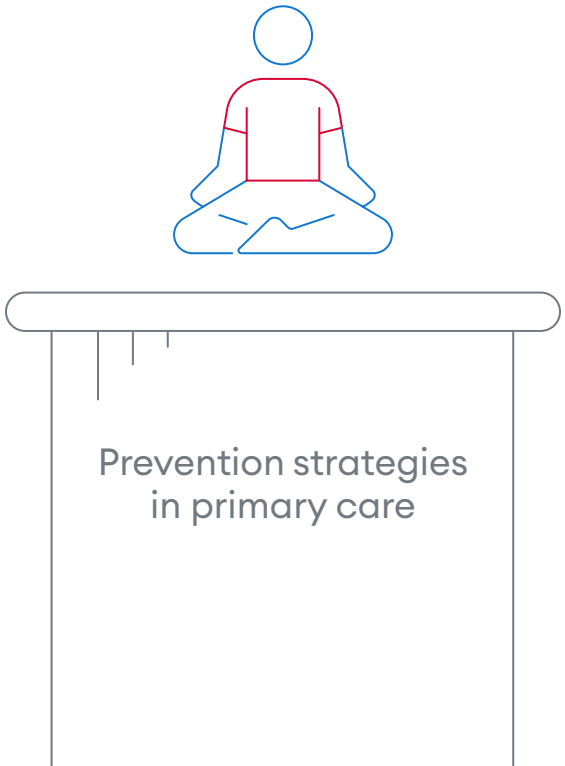
Research pillars

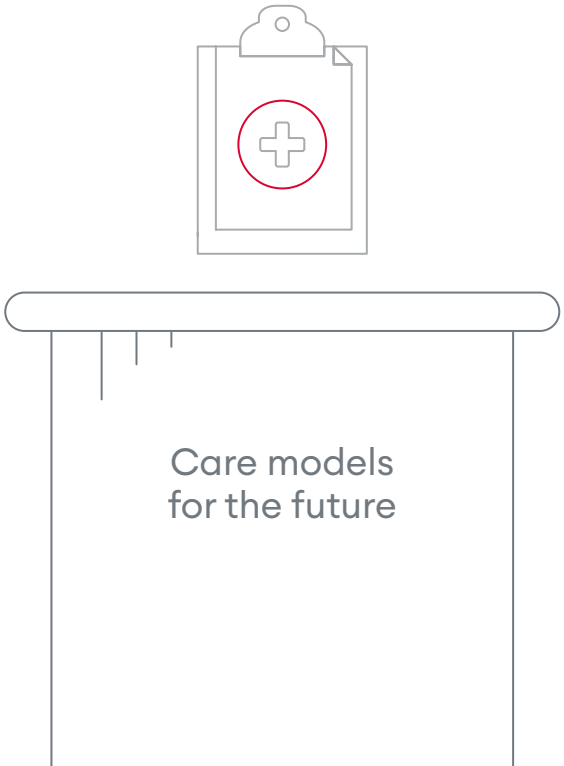
Every two years, we review our research priority areas and the strategic priorities of the broader Medibank business and agree on the research pillars that will guide the projects we support; whether our partners are seeking funding or in-kind support, such as access to data or brand and marketing expertise.

Our research pillars for the 2024-25 and 2025-26 financial years are:

- Community mental health and wellbeing
- Prevention strategies in primary care
- Care models for the future

We also have an annual commitment to support community-led research in Aboriginal and Torres Strait Islander health.





Medibank Better Health Research Hub hosts inaugural Primary Care Symposium

On 20 June 2025, Medibank convened its inaugural Primary Care Symposium (Symposium) hosted by the Medibank Better Health Research Hub, bringing together more than 70 healthcare stakeholders from across Australia.

The event provided a national platform for dialogue and collaboration on the future of primary care, with a focus on developing practical, patient-centred solutions to support reform.

Participants included senior health leaders, general practitioners, nurses, allied health professionals, researchers and policymakers. Together, they shared their insights, experiences, and evidence to shape a vision for a stronger, more sustainable and equitable primary care system.

The Symposium centred on the urgent need to modernise Australia's primary care model to meet the evolving health needs of the community.

Discussions acknowledged the existing pressures facing primary care – including workforce capacity, funding limitations, care fragmentation, and inequities in access – and explored evidence-based solutions to address these challenges.

The key outcome of the Symposium was the development of a communiqué that outlines areas of consensus among participants and presents recommendations to guide future policy and reform efforts.

Key recommendations included:

- **Strengthening team-based care** by supporting all clinicians to work to their full scope of practice, and encouraging active patient participation in care planning and decision-making.
- **Embedding change management** and continuous improvement processes into reform rollouts, including support for clinicians, practice teams and community partners during transition.
- **Modernising funding models** to promote quality, equity and innovation–such as blended funding approaches that enable more proactive, personalised care.
- **Investing in digital infrastructure and data-sharing** to ensure more coordinated, connected and transparent care across the system.

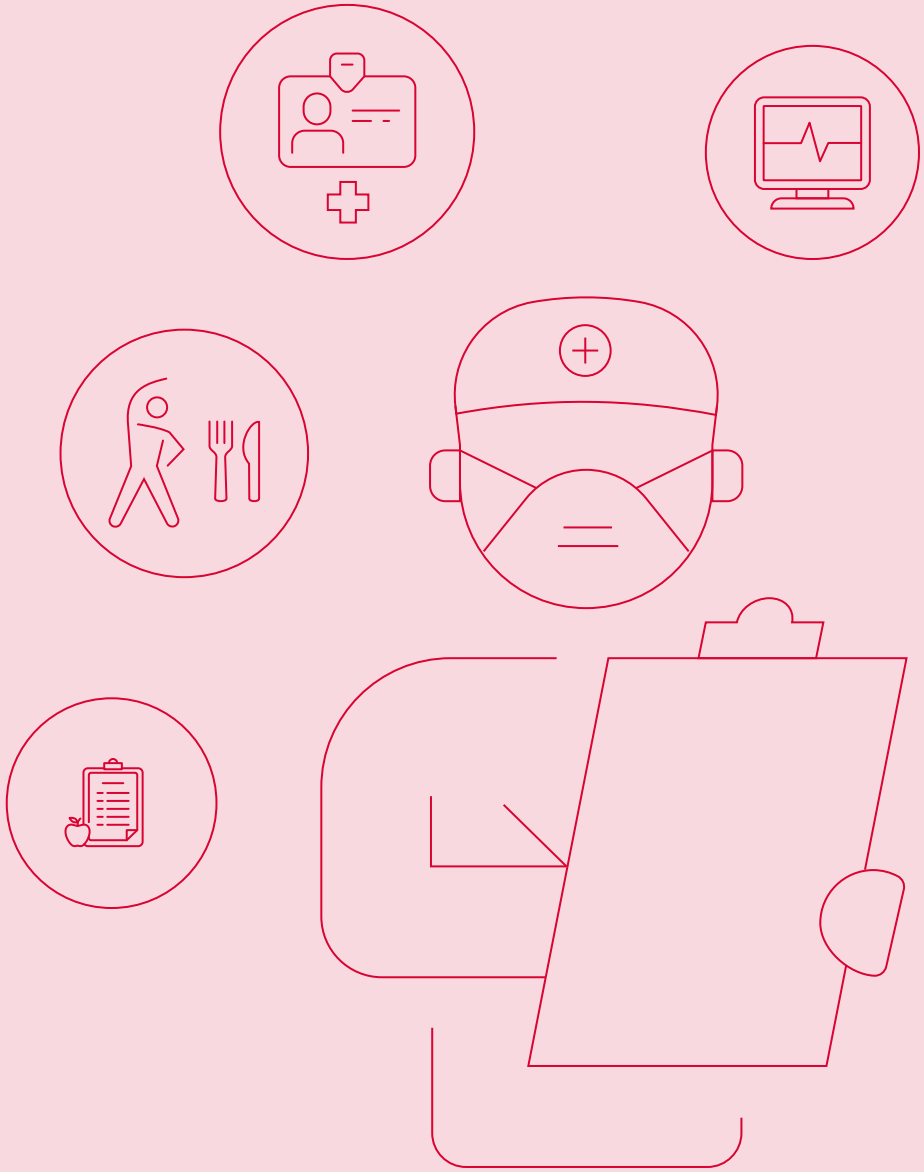
The communiqué also highlights the need for inclusive care models that reflect the lived experience of patients, carers and communities, while addressing longstanding inequities related to geography, culture and access.

Participants agreed that successful reform will require sustained collaboration between all parts of the health system. Building trust, leadership capability, and a shared vision were identified as essential foundations for reform to succeed.

Left to right: David Koczkar, Chief Executive Officer, Medibank; Dr Nigel Lyons, Health Advisor; Professor Harriet Hiscock, Consultant Paediatrician, The University of Melbourne; Dr Shona Sundaraj, Group Medical Director, Medibank; Dr Walid Jamal, General Practitioner

The Symposium underscored a sector-wide appetite for change, offering a practical, frontline perspective to support ongoing reform. The communiqué signals a readiness across the sector to work together with government and communities to implement sustainable improvements in primary care.

Research projects



Lead investigator:

Associate Professor Stephanie Filbay

Principal Research Fellow, NHMRC Fellow, Dame Kate Campbell Fellow, University of Melbourne

Research partnership grant:

$150,000

over three years

The EMBRACE trial: Evaluating a new non-surgical intervention to improve outcomes after anterior cruciate ligament injury

Could a non-surgical treatment designed to facilitate healing of ACL rupture be more effective than ACL surgery?

Australia has the highest rate of anterior cruciate ligament (ACL) injuries globally, with young athletes most at risk.[1] More than 90% of these patients undergo ACL reconstruction surgery, at enormous cost to the healthcare system. The cost of ACL surgery and postoperative rehabilitation in Australia is expected to reach $315 million per year by 2030.[2] This high rate of surgery is despite evidence that many people experience poor long-term health outcomes after ACL surgery.

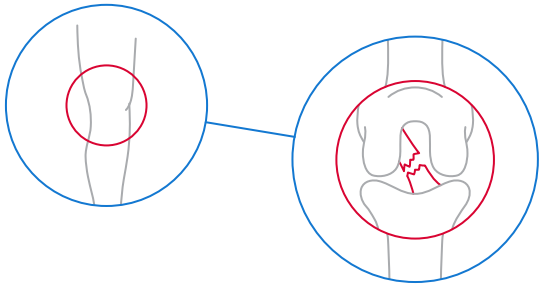
Current treatments to manage ACL injuries are based on the idea that ruptured ACLs do not heal. However, a 2023 study led by Associate Professor Stephanie Filbay from The University of Melbourne in collaboration with researchers from Lund University, University of Southern Denmark, and Boston University School of Medicine, found that 30% of people who underwent rehabilitation alone for a full ACL rupture, had an intact ACL (considered to reflect ACL healing) after two years. Furthermore, these individuals reported better outcomes compared to those who had undergone ACL reconstruction or had a non-healed ACL.[3]

This led the researchers to consider whether there was a way to treat ACL injuries that would encourage natural healing and offer better health outcomes for patients. The result?

A new bracing intervention known as the 'cross bracing protocol'. Developed by a surgeon and sports doctor, this intervention could prove to be a safer, more effective and lower-cost alternative to ACL surgery. Having shown early positive results, its effectiveness will now be tested in a multicentre randomised controlled trial known as the Evaluating Non-surgical Management of Acute Anterior Cruciate Ligament Rupture With a Novel BRACE Protocol Versus Early

A high-level hockey player on day 1 of the Cross Bracing Protocol

Surgical Reconstruction (EMBRACE) comparative effectiveness randomised controlled trial. The trial is supported by the Medibank Better Health Research Hub and a Medical Research Future Fund Clinical Trials Activity grant.



1 Zbrojkiewicz D, Vertullo C, Grayson JE. Increasing rates of anterior cruciate ligament reconstruction in young Australians, 2000-2015. Med J Aust 2018;208(8):354–58. doi: 10.5694/mja17.00974
2 Maniar N, Verhagen E, Bryant AL, et al. Trends in Australian knee injury rates: an epidemiological analysis of 228,344 knee injuries over 20 years. Lancet Reg Health West Pac. 2022;21:100409. doi:10.1016/j.lanwpc.2022.100409
3 Filbay SR, Roemer FW, Lohmander LS, et al. Evidence of ACL healing on MRI following ACL rupture treated with rehabilitation alone may be associated with better patient-reported outcomes: a secondary analysis from the KANON trial. Br J Sports Med. 2023 Jan;57(2):91–8. doi:10.1136/bjsports-2022-105473

A new approach to treating ACL injuries

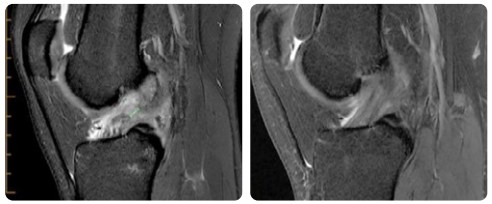
Until now, ACL reconstruction has been the most common treatment for ACL injuries. It typically involves surgically removing the torn ACL and replacing it with a tendon from somewhere else in the body, holding it in place with screws.

According to Associate Professor Filbay, the surgery is invasive and delivers mixed results. "Some people will recover well, but others will have poor long-term outcomes after surgery," she says.

Another approach is to treat the injury with rehabilitation alone, which, based on the long-held belief that ACLs cannot heal, aims to restore stability to the damaged knee by strengthening the knee muscles so they can function without an ACL.

With both treatments, outcomes can include ongoing pain, instability, an inability to return to sport, limitations on work and poor quality of life. Roughly half of those with ACL injuries will be dissatisfied with their outcome,[4] and develop knee osteoarthritis within 5–15 years after the initial injury.[5]

"Our approach involves holding the knee in 90 degrees of flexion for the first four weeks using a brace. At this angle, the two



MRI showing an acute ACL rupture (left), and a 12-week follow-up MRI (right) demonstrating signs of ACL healing after the Cross Bracing Protocol

torn ends of the ACL are positioned closest together, and we hypothesise that this helps the body to naturally heal the ACL," says Associate Professor Filbay.

"After four weeks, the knee brace is adjusted to allow more and more movement, until the patient has full movement at 10 weeks and the brace is taken off at 12 weeks. This is also combined with physiotherapist-supervised rehabilitation throughout the treatment period."

Results from the pilot research show that 95% of patients using the protocol had regained an intact ACL after 12 weeks and reported excellent outcomes after 12 months. Based on these positive results, the team is moving forward with a full-scale trial involving multidisciplinary clinicians and 180 patients across Melbourne, Sydney, Gold Coast, Brisbane and Perth.

Drawing on lived experience

The clinical trial was designed in partnership with multidisciplinary clinicians, including surgeons, sports physicians and physiotherapists, as well as people with lived experience of ACL injury – including Associate Professor Filbay herself.

"I tore my ACL as an 18-year-old soccer player and have had two failed reconstructions since then," she recalls. "Once you tear the graft, you have a very poor prognosis. I then developed osteoarthritis in my mid-20s."

This lived experience is a key reason Associate Professor Filbay is investigating treatment options for patients. She would also like to see patients receive more information about the evidence regarding treatments and outcomes.

"We know from two studies that most patients aren't accurately informed about non-surgical treatment options," she says. "Most patients are told that surgery results in better outcomes than nonsurgical treatment, which doesn't reflect the clinical trial evidence."

Delivering more options and better outcomes

Although the team doesn't plan to start analysing data from the trial until late 2027, clinicians and medical bodies worldwide are already showing interest in it.

"It's a bit of an 'a-ha' moment," says Associate Professor Filbay. "Learning that ACL ruptures can heal has opened a door of opportunity for potentially answering other questions that have persisted for years, such as how to predict who needs surgery and who doesn't. This paradigm shift has triggered a lot of additional studies in this area."

If it is deemed successful, the Cross Bracing Protocol may become a mainstream model of care for ACL injury.

"We're not suggesting that it will be a suitable treatment for everyone," says Associate Professor Filbay. "But there is potential for triaging patients so that those patients with a greater chance of healing naturally can be directed towards this treatment. Ultimately, it's about giving people with ACL injuries more options that will hopefully lead to better outcomes in the long term."

4 Roos EM, Boyle E, Frobell RB, Lohmander LS, Ingelsrud LH. It is good to feel better, but better to feel good: whether a patient finds treatment 'successful' or not depends on the questions researchers ask. Br J Sports Med. 2019 Dec;53(23):1474-1478. doi: 10.1136/bjsports-2018-100260. Epub 2019 May 9. PMID: 31072841.

5 Cheung EC, DiLallo M, Feeley BT, Lansdown DA. Osteoarthritis and ACL reconstruction – myths and risks. Curr Rev Musculoskelet Med. 2020 Feb;13(1):115–22. doi:10.1007/s12178-019-09596-w. PMID: 31894466; PMCID: PMC7083996.

Lead investigator:

Associate Professor Chris Pearce

Research Director,
Outcome Health

Research partnership grant:

$98,104

Personalising treatment recommendations for patients with depression

Testing a digital tool that supports GPs to make more personalised, data-driven treatment recommendations for depression.

General practitioners (GPs) are on the front line of treating depression and anxiety, prescribing more than 85% of antidepressants.[1] Finding the right treatment is crucial for improving patient outcomes[2], but with many GPs already struggling with heavy workloads and short appointments, it isn't always realistic to expect them to consider all options.

Instead, GPs will often choose from two or three familiar 'go-to treatments', without detailed personalisation as they relate to each patient.[3] This can lead to poor management of symptoms, adverse reactions, loss of trust, non-compliance with treatment plans and trial-and-error prescribing.

To tackle this problem, a team from Melbourne-based Outcome Health, in collaboration with Monash Partners, primary care GPs and Western Victoria Primary Health Network, has developed a digital tool to help GPs make more personalised, data-informed treatment recommendations for patients.

Known as the Clinical Antidepressant Recommendation Engine (CARE), this tool evaluates treatment options at the point of care, using the patient's circumstances and clinical guidelines to make real-time recommendations. Currently being beta tested with a small group of GPs, the team is working towards rolling it out nationally in late 2026, with the support of the Medibank Better Health Research Hub.

1 Wallis KA, Moncrieff MDJ. Antidepressant prescribing in general practice: a call to action. Aust J Gen Pract. 2021 Dec;50(12):1060–6.
2 Goldberg D. The heterogeneity of "major depression". World Psychiatry. 2011 Oct;10(3):226–8. doi:10.1002/j.2051-5545.2011.tb00061.x
3 Bayes A, Parker G. How to choose an antidepressant medication. Acta Psychiatr Scand. 2019 Mar;139(3):280–91. doi:10.1111/acps.13001

Personalised treatment recommendations in real time

"There are over 250 subtypes of depression and around 25 designated antidepressants in the Australian market, along with several other drugs that can be used as antidepressants, and they all come with about 30 pages of guidelines," says the project lead, Associate Professor Chris Pearce, Outcome Health's Research Director.

"GPs don't have time to read all that information at the point of care, so they will prescribe a treatment they're familiar with. Our solution sorts through all those treatments and guidelines in real time, considering the patient's medical history, to come up with a personalised recommendation and, just as importantly, a reason for making it."

The tool considers the patient's symptoms, existing medications and other health issues before making its recommendation. This enhances the selection of an optimal antidepressant and avoids contraindications. For instance, knowing that an adolescent patient has a history of acne might prompt CARE to recommend a treatment that doesn't affect hormone levels, which can influence oil production in the skin.

In addition to saving GPs time and removing the uncertainty of trial-and-error antidepressant selection, the team hopes that CARE will improve GPs' understanding of drug effectiveness, enrich health literacy conversations with patients and improve outcomes for patients taking antidepressants.

"One of the issues we see with these medications is compliance," says Associate Professor Pearce. "Patients will often stop taking medications if they experience side effects. By matching patients with the right treatment, we can hopefully minimise side effects. We can also provide patients with more information about what those side effects might be, so they are prepared. This project is partly about giving patients more control over what's happening."

It is also hoped that finding the right medication earlier will help reduce the cost of mental health services. According to the Australian Institute of Health and Welfare, $13.2 billion was spent on mental health services in Australia in 2022–23.[4]

Supporting GPs to make more informed decisions

CARE is designed to integrate seamlessly into the GP desktop environment and deliver results during a standard consultation, says Associate Professor Pearce. Updates will ensure it considers newly approved antidepressants and changes to clinical guidelines.

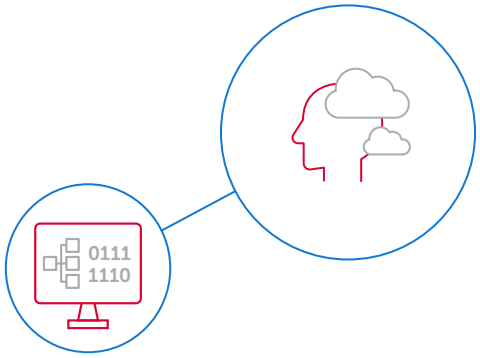
While the tool is still being tested, it will be powered by Outcome Health's GP-centric interactive analytics suite, POpulation Level Analysis and Reporting (POLAR), which is used in more than 1,600 GP practices across eight primary health networks across Australia.

The team will use an adapted health IT usability model to evaluate the solution's impact, including changes in prescribing habits over time, the variety of antidepressants prescribed, the number of mental health plans implemented and patient outcomes.

"For us, success would be widespread adoption and measurable changes in care patterns," says Associate Professor Pearce.

More broadly, the team believes the solution could serve as a prototype for a new model of personalised prescribing that could be used for other conditions.

"This model could be used for just about anything. For example, recommending diabetic or cardiovascular drugs," says Associate Professor Pearce. "What it really comes down to is a way of delivering personalised care based on individual patients' circumstances. Personalised care is already being used in niche areas like intensive care and oncology, but we believe individualised care should be applicable to everybody."



4 Australian Institute of Health and Welfare. Expenditure on mental health services. https://www.aihw.gov.au/mental-health/topic-areas/expenditure#exp_mhs

Lead investigator:

Jessica Payne

First Nations Health Advisor, Grampians Health

Research grant:

$50,000

Creating culturally safe care pathways for First Nations people attending a regional emergency department

Grampians Health

How a participatory action research model combining First Nations research methodologies with Western ones is helping create a culturally safe model of care.

Aboriginal and Torres Strait Islander people are more likely than non-Indigenous Australians to leave emergency departments before being seen or completing treatment, in both urban and rural Australia. The higher rate of "leave events" stems from a combination of individual and systemic factors, including experiences of racism and a sense of insufficient cultural safety within the healthcare environment.[1]

Given the higher burden of disease and lower life expectancy experienced by Aboriginal and Torres Strait Islander people, these early departures can have significant consequences for health outcomes.[2] For example, they can often result in incomplete or delayed care, increasing the likelihood of re-presentation and potentially leading to more serious health issues or hospital admission.

It can also lead to feelings of disempowerment and distrust that can alienate individuals and the community and damage the health service's reputation.

Grampians Health, supported by Western Alliance and the Medibank Better Health Research Hub, hopes to address this issue by working with the Aboriginal and Torres Strait Islander community to co-design and test a culturally safe care pathway for use in a regional emergency department. Grampians Health is the primary public referral health service for the largely rural Grampians region of Victoria, serving over 250,000 people.

Veronica Furnier Grampians Health Chief Redevelopment, Infrastructure Officer with Aunty Deb and Makayla Rumler GH Aboriginal Hospital Liaison

"A recent Grampians Health quality improvement project revealed that Aboriginal and Torres Strait Islander patients are twice as likely to leave the emergency department with incomplete treatment compared to the general population," says Jessica Payne, First Nations Health Advisor, Grampians Health, and lead investigator for the project. This highlights the pressing need for targeted initiatives to address these disparities."

1 Wright L. "They just don't like to wait" – A comparative study of Aboriginal and non-Aboriginal people who did not wait for treatment or discharged against medical advice from rural emergency departments: Part 1. Australas Emerg Nurs J. 2009 Aug;12(3):78–85.
2 Davison M, Chan J, Clarke M, Mitchell C, Yan A, Henaway E. Yarning to reduce take own leave events in First Nations patients presenting to the Emergency Department – presenting the qualitative themes and co-design of the Deadly RED project. Health Promot J Austr. 2024 Oct;35(4):1060–6.

Understanding barriers to culturally appropriate emergency department care

Through a series of collaborative steps – including co-design workshops and community-led consultations – the Grampians Health project team aims to develop, implement and evaluate a culturally responsive emergency department care pathway over an 18-month period.

The project team is basing its approach on a participatory action research model that combines First Nations research methodologies, such as dadirri (deep listening) and ganma (knowledge sharing), with Western ones. The model puts Aboriginal and Torres Strait Islander leadership and consumers at the project's core,[3] with Indigenous co-researchers embedded in every phase.

"We want to ensure we reflect local priorities and build on community knowledge, cultural strengths and lived experience," explains Karina Demasson, Research Assistant.

The team is also reviewing evidence from metropolitan-based, culturally safe emergency care models and adapting these to a regional context. Projects include the Stay'n Deadly and Stay'n In program at St Vincent's Health Sydney and MOB ED at Queensland Children's Hospital. Both programs reduced Did Not Wait rates through interventions like flexible clinic hours, an Indigenous health worker presence during the evenings and cultural safety training for staff.

Once the care pathway has been co-designed, the research team will pilot it at the Ballarat Base Hospital emergency department, with plans to expand to other Grampians Health sites if it is successful.

"Evaluation will focus on the pathway's feasibility, acceptability and impact, including whether it changes the number of people who feel safe to self-identify as Aboriginal and/or Torres Strait Islander and reduces incomplete treatment rates," says Ms Payne. "The findings will inform policy and practice change locally and could potentially support broader implementation in emergency departments and urgent care centres across rural and regional Australia."

Grampians Health Emergency Department

Creating a trust-based, culturally safe ED environment

Ms Payne says extensive community consultation still has to occur, so it is too early to predict what the culturally safe pathway pilot will cover. But features may include increased presence of Aboriginal health professionals in the emergency department, with extended hours and roles for Aboriginal Health Liaison Officers and strengthened referral pathways to Aboriginal Community Controlled Health Organisations.

Emergency department staff taking part in the pilot may also receive enhanced cultural safety training to address racism and unconscious bias, while visual cues, such as Aboriginal artwork and signage, may be used to help create a more welcoming environment.

Additionally, the pilot will aim to embed community governance and data sovereignty to ensure the model is led by, and accountable to, the communities it serves.

According to Ms Payne, the support of the Medibank Better Health Research Hub has been invaluable. "It has enabled critical aspects of the project including hiring research staff, supporting meaningful community engagement and the co-design process, and helping ensure we can carry out genuinely community-led research. It means Aboriginal voices can be privileged throughout the whole research process, which is central to the project's goals," she says.

"Ultimately, we want to create a more respectful, trust-based and responsive emergency department environment – where over time, Aboriginal and Torres Strait Islander patients are more likely to remain engaged with care, feel culturally respected and experience better health outcomes."

3 Bateman, S., Arnold-Chamney, M., Jesudason, S., Lester, R., McDonald, S., O'Donnell, K., ... & Kelly, J. (2022). Real Ways of Working Together: co-creating meaningful Aboriginal community consultations to advance kidney care. *Australian and New Zealand Journal of Public Health, 46*(5), 614-621

Lead investigator:

Associate Professor Sanjeevan Muruganandan

Research and Pleural Lead for the Department of Respiratory Medicine at Northern Health; Clinical Associate Professor Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne

Research grant:

$98,497

Evaluation of a digital health model of care for the management of adults with symptomatic malignant pleural effusion

Northern Health

How digital solutions are restoring a sense of control and dignity for cancer patients.

Malignant pleural effusion (MPE) is a buildup of fluid in the chest cavity that commonly affects people with advanced cancer. MPE is estimated to affect 10,000 people in Australia every year, and is a complication of most types of cancer.[1] MPE causes severe breathlessness and chest pain and often recurs following initial drainage.

Managing MPE remains a significant challenge in cancer care. Most therapies used in Australian health services rely heavily on inpatient procedures such as chest drainage via a chest tube or surgical procedures such as thoracoscopic pleurodesis. This adheres the lung to the chest wall so that fluid no longer builds up between the layers. Repeat interventions and extended hospital stays are common due to complications around such treatments.

Researchers from Northern Health are leading a project to address this challenge by testing a novel, ambulatory model of care. It aims to reduce hospital time and improve quality of life for people living with MPE by enabling safe, effective home-based management, supported by digital health tools, including telehealth and tele-ultrasound.

"MPE typically signals advanced cancer, with life expectancy ranging from three to 12 months," says Associate Professor Sanjeevan Muruganandan, Clinical Associate Professor, Pleural Lead for the Department of Respiratory Medicine at Northern Health, and lead investigator for the project. "Current MPE management often involves invasive procedures and patients may require repeated interventions. As a result, they can spend much of their remaining time in hospital, contrary to many patients' preference to remain at home."

The research focuses on a model of care to support people with MPE who have undergone a definitive procedure to stop the fluid from returning. One such procedure, is inserting an indwelling pleural catheter (IPC) under local anaesthetic to drain fluid from the chest cavity. When fluid builds up, the IPC allows drainage at home – typically with support from a carer or community nurse.

"We're investigating this model of care to allow better access and use of IPCs as an option for managing MPE that may result in lower reintervention rate and require significantly less time in hospital compared to traditional inpatient procedures," Associate Professor Muruganandan explains.

Launched in September 2023, the model is being trialled at Northern Health in Victoria. With support from La Trobe University, HCF Foundation, the Victorian Nurses and Midwives Trust, Melbourne Academic Centre for Health (MACH) and the Medibank Better Health Research Hub, the trial is expected to conclude in December 2025. Successful outcomes may also support the development of a regional service to improve access to specialised pleural care for people with MPE.

1 V. Duong, K. Tirant, U. Raza Khan, et al., " Evaluation of a Digital Health Model of Care for the Management of Adults With Symptomatic Malignant Pleural Effusion," Respirology Case Reports 13, no. 6 (2025): e70194, doi.org/10.1002/rcr2.70194.

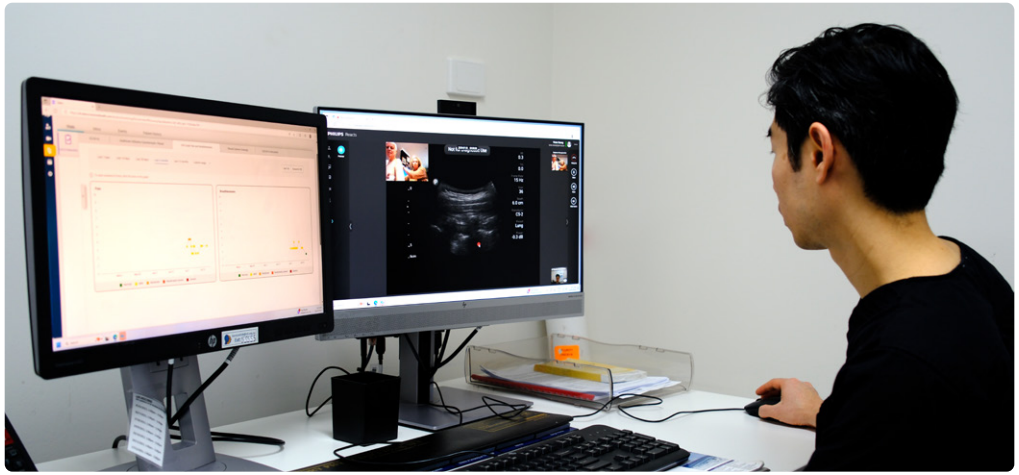
Managing MPE within a home-based environment

By increasing access to IPCs for managing MPE, the research team is seeking to establish a care model that maximises symptom control within a more person-centred, home-based environment.

In line with this approach, the project uses the Specialised Ambulatory Pleural Service at Northern Health to deliver care to people with MPE. This incorporates regular telehealth reviews along with tele-ultrasounds performed by a community nurse. Here, a hospital physician remotely guides the nurse through the ultrasound procedure and results are interpreted jointly. A digital care pathway has also been introduced so that each patient's symptoms can be regularly monitored.

The research team is evaluating the feasibility, cost-effectiveness and acceptability of this nurse-led, digitally enabled model for both patients and carers, while exploring its potential for wider adoption. Employing a mixed-methods design, the program combines qualitative insights with clinical outcomes and health economic data.

Results from the Northern Health site are being benchmarked against outcomes from three control sites – Melbourne Health, Eastern Health and Grampians Health – where conventional inpatient care for MPE is standard.



A clinician performing a virtual consultation with tele-ultrasound and digital care pathway where patient reported outcome measures (PROMs) are recorded and reviewed for a person with malignant pleural effusion

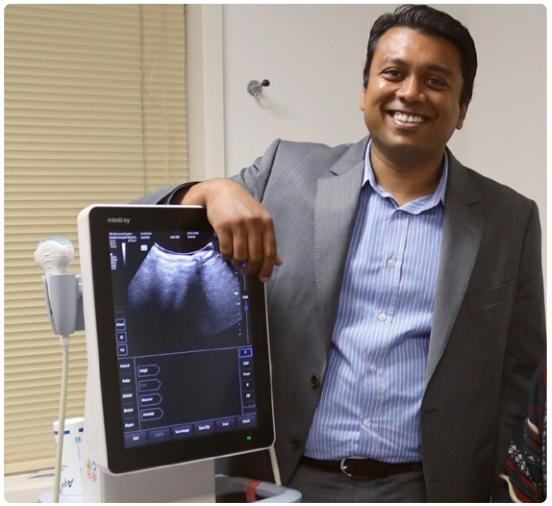
Creating a strong foundation for success

With the program attracting positive feedback, the team has begun formally evaluating patients and other stakeholders' participation, with the support of La Trobe University and the Medibank Better Health Research Hub.

"The evaluation involves gathering data from patients on issues like how acceptable the model is for them, and their quality of life while they're engaging with it," says Associate Professor Muruganandan. "Community nurses' feedback and insights from clinicians and health system stakeholders – including oncologists, thoracic surgeons and palliative care teams – are also being captured to inform future improvements.

"Our project's success hinges on strong partnerships with institutions like Medibank and MACH, which is providing critical support and momentum. Without such collaboration, scaling models like this beyond the pilot stage would be difficult."

If the project's results are promising, the next step will be a 'stepped-wedge' trial to gradually roll out the model across other sites while tailoring it to each local system.



Dr Muruganandan alongside a point of care ultrasound

As Associate Professor Muruganandan points out, the model has particular potential for regional and remote areas, as it helps ensure patients receive consistent, high-quality care regardless of geography. Its approach – combining remote monitoring, telehealth and empowered community care – could also be adapted to other chronic conditions such as heart failure, liver disease and pneumothorax.

"Even modest improvements, like reducing hospital time by 10%, can be hugely meaningful for someone with only a few months to live – that's potentially a few extra weeks at home," he says.

"Ultimately, this model is about restoring a sense of control and dignity for patients at a time when so much feels uncertain and out of their hands."

Lead investigator:

Associate Professor Kevin McNamara

Deputy Director (Research) at Deakin Rural Health, School of Medicine, Deakin University

Research partnership grant:

$80,000

Putting mental health peer support into practice in rural and regional emergency departments: feasibility and pilot testing

Peer support plays a vital role in ensuring that people with mental illness have a voice in their own care.

People experiencing a mental health crisis often seek help from hospital emergency departments (EDs). However, when people have negative experiences of ED care or do not receive appropriate support, it can exacerbate their mental illness burden. Providing the care that people with mental health issues need is a particular challenge for overstretched rural and regional EDs.

A new research project, led by Associate Professor Kevin McNamara, Deputy Director at Deakin Rural Health, is aiming to change that. The project, which is being run in partnership with Western Alliance, will evaluate the impact of integrating a 'lived experience' workforce in the ED in Victoria's largest rural and regional health service, Grampians Health.

A first stop for mental health care

EDs are designed to handle acute and urgent illnesses and injuries, not complex psychological issues. Yet for many people in Australia, they are the first point of care when a mental health crisis hits, due to a lack of readily accessible alternatives. This is especially true in rural and remote parts of Australia, where there is a shortage of mental health professionals, after-hours services and options for accessing ongoing care.

According to the Australian Institute of Health and Welfare, about 3.7% of all ED presentations in Australia are related to mental health[1].

"People often arrive at the ED because they don't have anywhere else to go," says Associate Professor McNamara. "But EDs are fast-paced, busy environments that are frequently under a great deal of stress. It's difficult in this pressured environment for ED staff to address patients' underlying mental health needs.

ConnectED Project Team

Added to this, mental health clinicians are often not part of the ED team in many rural and regional settings due to chronic workforce shortages."

Deakin Rural Health and Grampians Health are collaborating on the development and implementation of an innovative model of care, ConnectED, to support both patients and staff in ED. ConnectED will involve people with lived experience of mental illness being embedded alongside clinical staff in EDs to provide peer support. These team members will draw on their experiences with mental illness to connect with patients, provide practical and emotional support as they navigate the healthcare

1 Australian Institute of Health and Welfare. Mental health services provided in emergency departments

system, and help connect them with ongoing support to promote recovery and mental wellbeing. Importantly, peer support doesn't replace clinical care – it complements it.

"Peer support is a key mechanism for ensuring that people with mental illness have a voice in their own healthcare and that healthcare is an empowering experience which supports mental illness recovery," says Associate Professor McNamara.

The research team expects that introducing a peer support model will also benefit clinical staff members working in EDs by reducing their workload and by increasing ED capacity to deliver person-centred mental healthcare.

Co-designing a model of care

The ConnectED model is being developed through a collaborative co-design process, which will incorporate patients' needs and preferences in the service model, and determine how best to integrate lived experience workers into regional ED settings.

The ongoing process involves engaging stakeholders – including patients, peer workers, mental health professionals, ED clinicians and hospital administrators – through interviews and workshops to understand their perspectives and experiences. The research team is also reviewing existing literature, case studies and models in use across Victoria and nationally.

Key questions the process will seek to answer include 'What should the role and scope of the peer worker be?', 'How do we ensure the safety and wellbeing of both the peer worker and the patient?', 'How do we integrate lived experience workers into existing teams?' and 'Which patients and scenarios should peer workers prioritise?'

It is expected that this approach will help ensure that the final model is safe, person-centred and sustainable. A pilot is anticipated to be up and running by early 2026, with continuous improvement part of the plan.

"We're adopting a rapid-cycle approach," says Associate Professor McNamara. "What we want to do is to be constantly debriefing, constantly learning. This will enable us to continue to improve the model throughout the course of the pilot."

Measuring the project's impact

While the project is still in its early stages, the team is optimistic that the ConnectED model will deliver a range of benefits, including improved patient experience, support for and improved confidence among emergency department staff members in their roles, stronger connections to ongoing care and recovery pathways, and fewer unnecessary visits to EDs.

"Different stakeholders will seek a variety of outcomes from this model" says Associate Professor McNamara. "But I am confident that all stakeholders want consumers to have more positive ED experiences, and if peer workers contribute to that, that will be a positive outcome."

Associate Professor McNamara credits the Medibank Better Health Research Hub for helping to bridge the gap between theoretical health research and more practical, purposeful research such as the work being completed by his team.

Lead investigator:

Associate Professor Samantha Hocking

Associate Professor Diabetes Australia, and Senior Staff Specialist Endocrinologist, The University of Sydney and Sydney Local Health District

Research partnership grant:

$75,085

A new approach to early detection and virtual care for diabetes prevention

THE UNIVERSITY OF SYDNEY | Sydney HealthPartners

How can we more effectively identify and manage prediabetes to help prevent type 2 diabetes in our community?

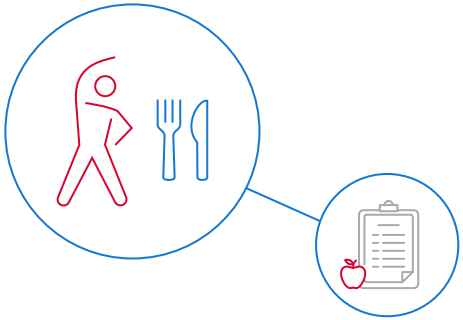
Prediabetes is a precursor to type 2 diabetes that affects around 1 in 6 adults in Australia with the number rising up to 1 in 4 in areas with a lower socio-economic profile.[1] If no preventative measures are taken, about a third of people with prediabetes will develop type 2 diabetes within a decade, with a lifetime risk of 73%.[2 3]

This makes prediabetes a significant public health concern. However, there is currently no national screening program to identify individuals with prediabetes. Nor is there a national program to help people with prediabetes make lifestyle changes that could help them manage their condition and prevent them from developing type 2 diabetes.

To address this issue, researchers from Sydney Health Partners' Diabetes and Obesity Clinical Academic Group, led by Associate Professor Samantha Hocking, are exploring whether early detection and a virtual care diabetes prevention program featuring a low energy diet can help manage prediabetes.

A new clinical pathway for managing prediabetes

"Prediabetes is a condition where people have abnormal blood glucose levels, but they aren't high enough to meet the diagnostic criteria for type 2 diabetes," says Associate Professor Hocking. "But it is not a benign condition. People with prediabetes also have higher cardiovascular risk.



"We know that if you can identify people with prediabetes early and reduce their blood glucose levels through lifestyle interventions like weight loss and exercise, you can reduce the risk of them developing type 2 diabetes and other cardiometabolic conditions. It's a golden opportunity for prevention."

However, lack of access to affordable diet and exercise counselling often prevent people from taking advantage of this opportunity.

The Sydney Health Partners' study will see the team working with primary care doctors in the Central and Eastern Sydney Primary Health Network and the Nepean Blue Mountains Primary Health Network to identify patients with prediabetes.

1 Meyerowitz-Katz G, Seelan S, Gaur P, Francisco R, Ferdousi S, Astell-Burt T, et al. Detecting the hidden burden of pre-diabetes and diabetes in Western Sydney. *Diabetes Res Clin Pract*. 2019 May;151:247–51. doi: 10.1016/j.diabres.2019.04.019.
2 Ligthart S, van Herpt TT, Leening MJG, Kavousi M, Hofman A, Stricker BH, Franco OH. Lifetime risk of developing impaired glucose metabolism and eventual progression from prediabetes to type 2 diabetes: a prospective cohort study. Lancet Diabetes Endocrinol. 2016;4(1):44-51. doi:10.1016/S2213-8587(15)00362-9
3 Bell K, Shaw JE, Maple-Brown L, Ferris W, Gray S, Murfet G, Flavel R, Maynard B, Ryrie H, Pritchard B, Freeman R, Gordon BA. A position statement on screening and management of prediabetes in adults in primary care in Australia. Diabetes Res Clin Pract. 2020;164:108188. doi:10.1016/j.diabres.2020.108188

The team will use the Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK) to identify individuals at high risk of prediabetes. This is a validated questionnaire that assesses an individual's risk based on factors such as their age, gender, family history of diabetes, history of high blood glucose levels, smoking status, physical activity levels and dietary habits. Individuals at high risk will then be given a blood test to confirm the diagnosis.

Once an individual is diagnosed, they will be offered a choice of two lifestyle interventions. "Our approach is to provide a virtual care intervention that uses low-energy meal replacements for rapid weight loss, along with personalised support," says Associate Professor Hocking. "We know from a previous study that using meal replacements for just 10 weeks is highly effective for weight loss and restoring glucose levels to normal.

"Or patients can use the Get Healthy Service, which is a telephone health coaching service offered by NSW Health."

Patients who choose the virtual care intervention will monitor and track their progress in a diary app. They will also receive personalised support, based on their needs and preferences.

"One of the important things for us is to provide people with what they believe will help them achieve their health goals, not what we believe will help them," says Associate Professor Hocking. "We'll have coaches to help people troubleshoot, but as much as possible, we want the intervention to be self-directed.

"So, we'll be asking patients what that support should look like. Do they want someone to call them once a month to check they are on track? Do they want more regular calls? Or do they want to go back to their GP?"

Evaluating clinical outcomes and patient experience

After 12 months, the team will evaluate and compare the results achieved by patients using the virtual care intervention and those using the Get Healthy Service coaching.

"We're interested in knowing what is happening with people's prediabetes after 12 months," says Associate Professor Hocking. "For instance, how many of them reverted to normal glucose tolerance, and how many of them developed type 2 diabetes.

"But we also want to know how people found our intervention. Did they like it? Did they find the digital program as engaging as seeing a clinician in person? Did it impact their quality of life? There's no point having an intervention that successfully reduces prediabetes if people are miserable doing it."

Although the study is still in its early stages, Associate Professor Hocking anticipates that the virtual care intervention will result in substantial weight loss and glucose normalisation for patients, providing a strong case for its widespread adoption. It could also improve equity of access for those from socio-economically disadvantaged backgrounds and in rural and remote areas of Australia – groups in which diabetes rates are highest.[4]

"If we can create a simple, scalable digital intervention that's easy for GPs to refer patients to, we can significantly improve patients' health outcomes," says Associate Professor Hocking. "The partnership with Medibank Better Health Research Hub has been critical for starting the ball rolling."

4 National Rural Health Alliance. *Diabetes in rural Australia: fact sheet – February 2025* [Internet]. Canberra (Australia): National Rural Health Alliance; 2025.

Case studies

Lead investigator:

Professor Meredith Makeham

Associate Dean, Community and Primary Health Care, Faculty of Medicine and Health, The University of Sydney

Research partnership grant:

$75,000

(of a $125,000 joint grant from the Medibank Better Health Research Hub and the Australian General Practice Research Foundation, formerly RACGP Foundation)

Optimising virtual care technologies to link general practice and residential aged care

THE UNIVERSITY OF SYDNEY

Could virtual care improve access to high-quality GP services for people living in residential aged care homes?

Australia's rapidly ageing population is driving increased demand for aged care services, including residential care. More than 190,000 Australians currently live in residential aged care homes (RACHs), up from 179,000 in 2017.[1] Australia's declining general practitioner (GP) capacity means that many of these homes struggle to access timely, high-quality general practice services for residents. This issue has been linked to delays in accessing healthcare, avoidable hospitalisations and poorer health outcomes.

Researchers led by Professor Meredith Makeham, Associate Dean, Community and Primary Health Care, Faculty of Medicine and Health, The University of Sydney[2], have been working to address this issue. They have been exploring whether virtual care, and especially video-telehealth, could help people living in RACHs access high-quality GP services.

The study, launched in 2023, was made possible by a Digital Health Grant from the Medibank Better Health Research Hub and the Royal Australian College of General Practitioners Foundation (now known as the Australian General Practice Research Foundation).

Improving GP access for residents of aged care homes

Having emerged as a viable alternative to in-person care during the COVID pandemic, video-telehealth enables GPs to provide timely care remotely, observe patients, guide remote examinations by nursing staff or carers, and support acute or unplanned care needs. When integrated with compatible technology, GPs can also access real-time vital signs such as a patient's temperature, heart rate and oxygen saturation during a consultation, and undertake remote examinations with a digital stethoscope and camera.

This approach could potentially enhance the ability of people living in RACHs to access GP services. However, general practices seeking to incorporate virtual care into their model of care for people living in RACHs need support.

"We believe virtual care is an important adjunct to in-person visits for GPs caring for people living in RACHs," says Professor Makeham. "It could potentially enable more timely care that might prevent residents from being transferred to a hospital when acute issues arise. But more evidence is needed to understand the factors that impact how GPs and RACHs take up high quality virtual care".

In particular, more information is required about what is needed to enable person-centred consultations, the usability of virtual care in aged care and general practice settings, and its integration into processes and workflows.

1 Australian Institute of Health and Welfare. People using aged care.
2 Co-investigators and team: Dr Adeola Bamgboje-Ayodele, Professor Melissa Baysari, Associate Professor Fiona Robinson, Professor Sue Kurrle, Pan Teng, Margaret Watkiss and Tamasha Dilani Jayawardena.

Examining virtual care through a 'human factors' lens

To explore these issues, Professor Makeham and her team worked with Sydney North Health Network to study their new virtual care service that used an innovative platform, HealthTeams, which was designed specifically for the RACH setting.

Using a human factors approach, the team conducted a cognitive walkthrough analysis to examine how easy HealthTeams was to learn and use. This involved simulating a virtual consultation and observing each action from the user's perspective.

Interviews with GPs and residential care nurses provided further qualitative insights into how HealthTeams supported communication and care delivery.

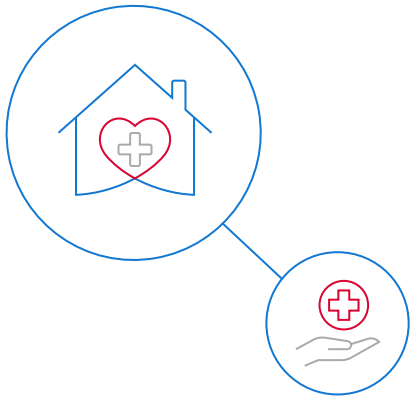
"Poor system integration between the aged care homes' systems and general practice systems was a challenge," says Professor Makeham. "There were a number of technical issues that stopped people from being able to initiate or conduct a consultation."

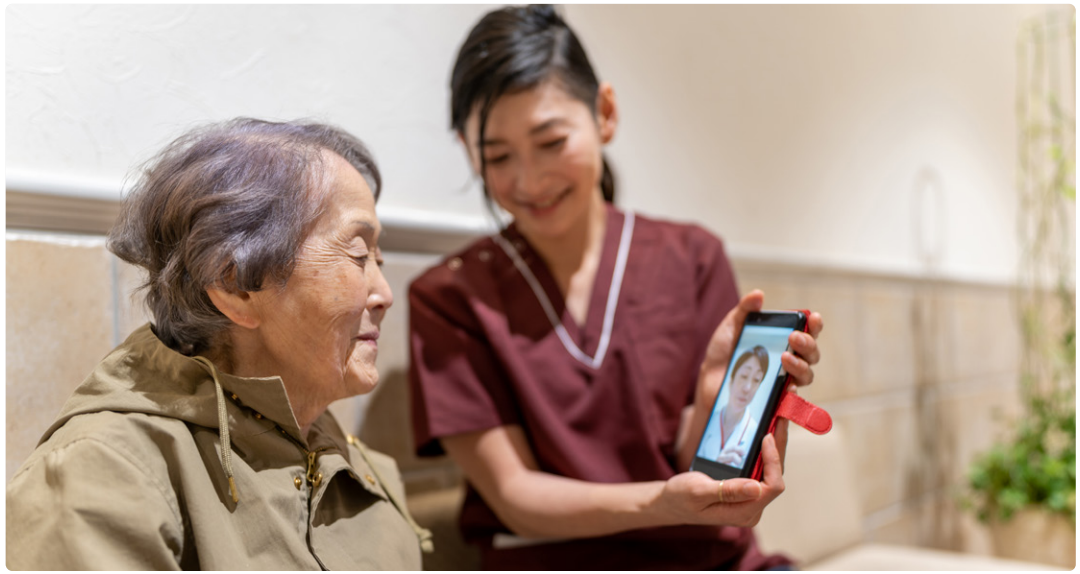
Other factors included the availability and training of aged care staff to support virtual consultations. When staff were present and comfortable with the technology, the calls were more effective and efficient.

Translating research into real-world impact

While further evaluation is ongoing, the team has highlighted that usability issues are a common challenge in clinical information systems. Addressing these requires improved training for end users and structured feedback to software designers so virtual care platforms can be refined and better support care delivery.

More critically, the research indicates that workflow barriers in aged care are likely to be the biggest determinant of whether virtual care succeeds. Ensuring staff availability, aligning technology with day-to-day routines, and embedding new processes into existing systems will be essential to realising the potential of virtual care in RACHs.





Video-Telehealth can be used to support high quality general practice care for people living in Residential Aged Care Homes

Professor Makeham believes that understanding more about the factors impacting GPs' uptake of virtual care technology in RACHs will help lead to real-world change. The team will provide evidence to guide investment in new virtual care models, technology, and education and training for GPs and aged care staff.

Two larger, related studies launched in early 2025 will explore the issue further, including developing best practice models for using new technologies like video-telehealth to support new models of care.

"The ultimate aim is to enable GPs to provide better, person-centred care in RACHs that is supplemented by the effective use of video-telehealth technology," says Professor Makeham. "We're also hoping that this work will help guide policy change as Australia continues to deal with an ageing population and decreasing capacity of our general practice workforce to meet the needs of people living in RACH settings."

Lead investigator:

Professor Adam Elshaug

Director, Centre for Health Policy, Melbourne School of Population and Global Health, The University of Melbourne

Research partnership grant:

$664,275

over four years

The impact of price transparency on price variation and out-of-pocket costs

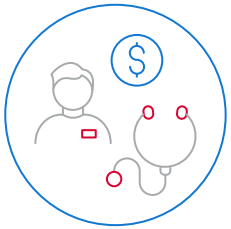
Australians spent $33.7 billion on out-of-pocket costs in 2021–22. Researchers want to know why.

When researchers from The University of Melbourne began looking at the impact of price transparency on price variation and out-of-pocket costs, the figures were startling. In 2021–22, Australians spent $33.7 billion on out-of-pocket healthcare costs[1]. Out-of-pocket costs for some common procedures had surged by as much as 300% in five years[2]. Furthermore, almost a million people miss out on specialist care each year due to cost[3] [4].

"Clearly, healthcare costs, particularly out-of-pocket costs, were a significant barrier to patients accessing healthcare," says the research's lead investigator, Professor Adam Elshaug, Director of the Centre for Health Policy at the Melbourne School of Population and Global Health.

"We were interested in trying to understand the factors influencing how fees are set and whether price transparency websites could be a solution."

Fast-forward almost five years, and the team is nearing the end of a comprehensive research program investigating the variation in specialists' fees and the factors influencing how they set their fees. The initial phases of the work have looked at specialists' willingness to participate in price transparency initiatives and the effect of these types of initiatives on patient costs. More recently, the researchers have been exploring how collaboration between providers, such as surgeon-anaesthetist teams that work together regularly, affects pricing for private hospital treatment and health outcomes.



Exploring the factors influencing how fees are set

"We interviewed 27 medical specialists to understand how they set their fees," recalls Dr Khic-Houy Prang, Senior Research Fellow at the Centre for Health Policy at The University of Melbourne. "We found several factors at the patient, specialist and system levels that influence fee setting.

"At a patient level, these include the patient's characteristics and circumstances, the complexity of a patient's case and the patient's assumptions about the value of the care they receive. At the specialist level, factors include specialists' perceived experience and skill, how long a surgery is and ethical considerations. System-level factors include the Australian Medical Association's recommended price list, practice location and the cost of running a practice."[5]

1 Australian Institute of Health and Welfare, Health expenditure Australia 2021–22.
2 Private Healthcare Australia. Health funds call for 'surprise billing law' as new data reveals soaring out-of-pocket costs for medical procedures.
3 Duckett S, Stobart A, Lin L. Not so universal: how to reduce out-of-pocket healthcare payments. Melbourne: Grattan Institute; 2022
4 Patient Experiences, 2023-24 financial year. Australian Bureau of Statistics.
5 Sabanovic, H., La Brooy, C., Méndez, S. J., Yong, J., Scott, A., Elshaug, A. G., & Prang, K. H. (2023). "It's not a one operation fits all": A qualitative study exploring fee setting and participation in price transparency initiatives amongst medical specialists in the Australian private healthcare sector. *Social Science & Medicine, 339*, 116353. https://doi.org/10.1016/j.socscimed.2023.116353

The interviews also revealed that female specialists often charge less than their male counterparts due to a combination of personal values and societal and systemic biases about gender and competence. For instance, many female specialists felt that male specialists overvalued their services, while they were driven by empathy, ethical considerations and concern for patients' financial circumstances. Unspoken expectations also played a role, with some female specialists feeling pressured to set lower fees. Patients' and GPs' subconscious biases also contributed to the fee disparity.[6]

"Despite tending to have better outcomes than their male counterparts, patients assume female specialists are not as skilled as male specialists and therefore they shouldn't be charging as much as male specialists," says Dr Prang. "Female specialists are also subject to referral bias, where GPs tend to refer patients that require greater support, interaction and information to female specialists because women are perceived to be better communicators than men. GPs tend to refer patients who require surgery to male specialists.

"Female specialists also spend more time in consultations with patients than male specialists."

Creating a more transparent system for patients and GPs

In a second research phase, the team analysed millions of de-identified and anonymous Medibank-funded procedure claims data to complement and deepen their understanding of the interviews.

"We found that, contrary to common beliefs, patient complexity accounts for little variation in prices and out-of-pocket costs,"[7] says Dr Susan J. Méndez, Senior Research Fellow at the Melbourne Institute of Applied Economic and Social Research, The University of Melbourne.

A market with a wide variation in prices can indicate low competition. When information is lacking, patients find it hard to shop around or make informed decisions. This leads to the question on whether price transparency could impact patients' costs. Initial evidence shows that introducing price transparency initiatives, without including information about quality, may lead to unintended consequences such as price increases. For patients, publicly reporting prices alone may not be enough to eliminate uncertainty about the quality of service and the skills and experience of providers.

Researchers are investigating how provider collaboration may impact out-of-pocket pricing

The team's research also indicated that most specialists are opposed to participating in price transparency websites. Barriers to participation include the complexity of setting prices for surgery, fears that patients will choose specialists based on price alone, and concerns about the lack of transparency in other areas of the healthcare system.

Specialists' reluctance to participate in these types of initiatives is evident in the response to the Department of Health, Disability and Ageing Medical Costs Finder website. Launched in 2019, the website was designed to showcase the average cost of common specialist consultations and services, alongside individual specialists' fees. By the end of 2022, just seven out of 11,000 Australian specialists had chosen to voluntarily load their fees to the website.

By early 2025, this had only increased to 70 specialists[8].

While the government has announced plans to overhaul the website, including shifting from voluntary to mandatory reporting of the average fees of all eligible non-GP specialists,[9] Professor Elshaug and his team would like to see future initiatives link price transparency with the quality of care patients receive.

"What we're proposing is publishing fees with quality of care metrics," says Dr Méndez. "Patients often think higher fees mean better quality care and outcomes, but that isn't always the case. Making this information available would help patients make better decisions about their care."

Ultimately, the research team hopes its work will continue to guide future policy change in this area.

"Price transparency holds enormous promise for improving the healthcare market," adds Professor Elshaug. "But equally, it has enormous potential for unintended negative consequences. Our work is to try to understand and mitigate the latter and bolster the former."

6 La Brooy, C., Sabanovic, H., Méndez, S. J., Yong, J., Scott, A., Elshaug, A. G., & Prang, K. H. (2025). 'Charge what you think you're worth': a qualitative study exploring the gender pay gap in medicine and the role of price transparency. *Internal Medicine Journal*. https://doi.org/10.1111/imj.16649
7 Yong, J., Elshaug, A. G., Mendez, S. J., Prang, K. H., & Scott, A. (2024). Sources of specialist physician fee variation: Evidence from Australian health insurance claims data. *Health policy, 147*, 105119. https://doi.org/10.1016/j.healthpol.2024.105119
8 Butler M. Strengthening Medicare more transparency on patient medical fees [media release]. Canberra: Australian Government Department of Health; 2025 Mar 17.
9 ibid.

Lead investigator:

Professor Rachael McDonald

Director, MedTechVic Hub, Swinburne University of Technology, Melbourne

Understanding access to health and wellbeing for students in higher education

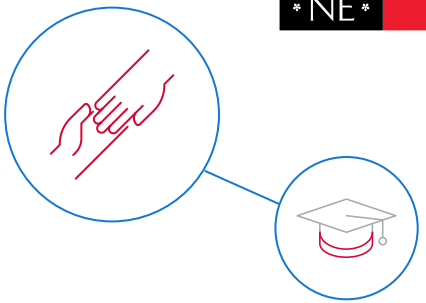
As international students navigate challenges around social connection and mental health, how can universities enhance service accessibility to better support their wellbeing?

University life offers students opportunities for intellectual growth and social connection. However, there is growing evidence to suggest that many students in Australia are unable to make the most of these opportunities, due to challenges with their physical and mental health. Studies indicate increased issues in areas including mental health, substance abuse, physical inactivity, sexual behaviour and decreased food security. These studies also show that university students may frequently struggle to access suitable health services, which can have a lasting impact on their health.[1]

Additionally, the evidence suggests that international students in particular are less likely to access available health services, are at increased risk of adverse health outcomes and are less likely to seek help.

Researchers from the MedTechVic Hub at Swinburne University of Technology in Melbourne are leading a 12-month project to better understand and address these challenges, with support from Medibank's Overseas Student Health Cover (OSHC) team and the Medibank Better Health Research Hub. Since July 2024, the research team has been examining the post-pandemic health, wellbeing and service use of higher education students at Swinburne, and their perceptions of access to healthcare. The team is using its findings to support the co-development of solutions with undergraduate and postgraduate students to improve the students' health and wellbeing.

"University life is about more than getting a degree – it's about building resilience and lifelong skills, and health is central to that. The evidence suggests that mental health, in particular, remains a concern," says Professor Rachael McDonald, Director, MedTechVic Hub, Swinburne University of Technology.



"Many students also struggle to navigate the complexities of Australia's health system – especially international students – with a clear gap in transparency around access, costs and support."

Understanding student health and access needs

The research team is delivering the project in two phases. Phase one focused on understanding student health and access needs, while a second stage, still ongoing, revolves around co-producing solutions with students. The team has taken a mixed-method approach, combining surveys, focus groups and eight co-design workshops.

A total of 274 students from across all schools at Swinburne completed the initial surveys. Findings revealed that students generally reported better physical than mental health, with no significant differences by gender or education level.

1 Sanci L, Williams I, Russell M, Chondros P, Duncan AM, Tarzia L, et al. Towards a health promoting university: descriptive findings on health, wellbeing and academic performance amongst university students in Australia. BMC Public Health. 2022;22:1.

Mental health emerged as students' top concern. The most sought-after services were mental health supports (58% of respondents), while barriers to care included affordability (50%), timely access to healthcare professionals (35%) and uncertainty about when to seek help (28%). Nearly half (48%) of students showed moderate levels of stigma toward mental health.

Students also displayed limited health literacy, particularly around nutrition and physical activity. Qualitative data from focus groups and workshops highlighted difficulties in navigating a complex and opaque health system – especially among international students. Issues included confusion about costs, access pathways and medical language. Many international students also expressed uncertainty about insurance, service eligibility and self-advocacy in a foreign system, and a need for culturally informed care.

"A key finding is that there is a broad, ongoing trend of students having real difficulties navigating the health system," says Professor McDonald. "The students didn't know how much services cost, how to pay or what they'd need – and for international students, the transparency gap was even wider."

Co-designing solutions to improve students' health and wellbeing

In response to the challenges it identified, the research team has come up with a series of recommendations for the university's student health services to consider. These include streamlining service delivery and improving health service access and health literacy by making communication with students more transparent.

These recommendations have guided the development of two solutions, co-designed with Swinburne students. The first focuses on ways the university can streamline health service delivery by establishing additional access points and a centralised system, and introducing clearer communication about services, costs and feedback mechanisms.

Students working in small groups

Students brainstorming solutions to difficulties accessing health services

A second solution focuses on the university and its partners developing a more health-literate and engaged student population by conducting health education campaigns and incentives to improve literacy and reduce stigma. Peer-support initiatives, such as mentorship and ambassador programs, will also be included.

The research team plans to pilot the solutions with student involvement, including during orientation week, and conduct evaluations based on student feedback and engagement.

"The solutions are designed on principles-based frameworks, which makes them adaptable and scalable beyond Swinburne," says Professor McDonald.

"We'll also be presenting our findings at university conferences and in peer-reviewed publications to support broader adoption of this kind of approach."

According to Professor McDonald, the support of the Medibank Better Health Research Hub has been vital to the project's success. "Tackling complex health challenges takes more than just adding a service – it requires collaboration, innovation and deep understanding," she says. "Collaborating with Medibank has been crucial in helping us move beyond one-size-fits-all solutions to co-design approaches that truly reflect students' needs."

As Professor McDonald also points out, the co-designed recommendations present a strategic opportunity to enhance student health outcomes, mitigate systemic barriers and promote long-term engagement with healthcare.

"We want students to have clear, easy access to the care they need, and the health literacy to navigate it confidently. It's about more than just better health outcomes – it's about equipping students to thrive, so they graduate not just with a degree, but with the resilience and wellbeing to succeed in life beyond university."

We wish to acknowledge the contribution of the Medibank Better Health Research Hub Research Governance Committee 2024–25.

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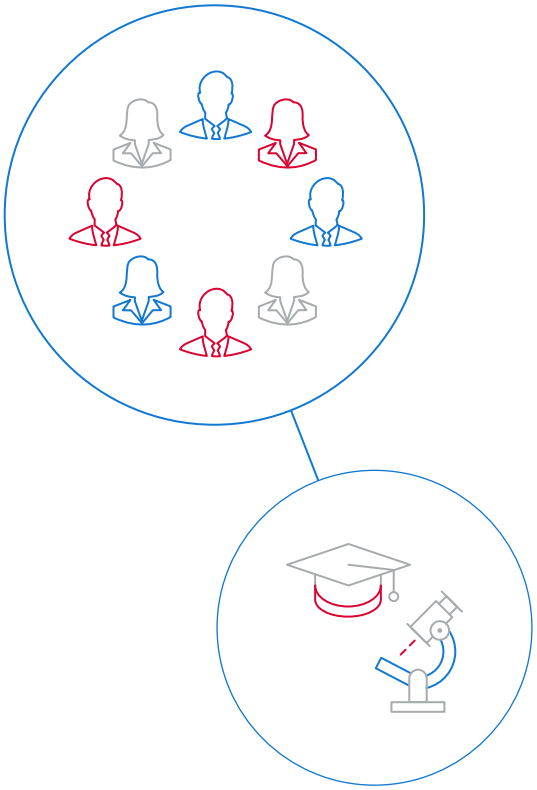

Partner organisations

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Grampians Health

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Northern Health

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Swinburne University of Technology, Melbourne

Sydney Health Partners

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