

The Health Advocate

Your voice in healthcare

Value Based Health Care

Reflections from the
Australian Centre for Value-
Based Health Care Advisory
Group Chair

2025 Value-Based Health Care
Award Winners

What Makes Genuine
Co-Design Verses Tokenistic
Co-Design?

Rethinking the Health
Workforce

North Brisbane Safe Space
Network



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INSIDE**

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SUSAN MCKEE
Chair, Australian Centre
for Value-Based Health
Care Advisory Group
CEO, Dental Health
Services Victoria

Reflections from the Australian Centre for Value-Based Health Care Advisory Group Chair

Thank you to everyone who attended the AHHA congress earlier this month. We had an amazing line up of speakers and panels which sparked great questions and audience participation.

I was reflecting with a few colleagues who have been on this journey with the AHHA over a number of years that the case studies and conversations have come a long way in the past few years with implementation of the principles of Value-based health care changing the way health care is delivered and making real life impact improving outcomes for patients.

In saying that however, my option is we have only just begun to imbed these principles across the health and care system in Australia.

A recent experience with the hospital system with my amazing 90 year old mum suggests we

have a long way to go before we have a Health 'System'. My mum was admitted to hospital following a TIA, she is otherwise fit and well and lives independently. She should have been in and out in a few days but it just so happened to coincide with Easter so she was there for 10 days as apparently it is not possible to discharge patients on weekends and public holidays. She could have been at home with the support of our family and follow up with her GP.

We need to do better. Hospitals are fantastic if you are injured or very unwell but no place if you are not.

As we continue to face challenges of increasing chronic disease, continued silos and ever increasing expenditure to name a few we need to relentlessly pursue health care reform to improve those



outcomes that matter to patients and build a Health and Care System that focuses on prevention and early intervention to keep people well, support people to recover and works with the whole health sector to replace the current output based, break fix model that is no longer fit for purpose.

The Australian Centre for Value-based health care will continue to advocate for this much needed reform and to support you in your journey implementing value based health and care. 

**“We need to do better.
Hospitals are fantastic if you
are injured or very unwell but
no place if you are not.”**

Australia's health system is world class—but big reform is essential

By nearly every international measure, Australia has one of the best performing health systems in the world. Yet most Australians remain largely unaware of this.

That's understandable. Health care is deeply personal, and when care is delayed, disjointed or something goes wrong, no amount of positive statistics offers comfort. And while it's right that inquiries and investigations follow serious failures, there's a risk that we lose sight of the broader truth: most of the time, for most people, the system works, and it works well.

But excellence is not immunity. We cannot allow our strong performance to become an excuse for inertia. Like any complex system, Australian health care faces massive structural and financial challenges that threaten its sustainability, its equity and its ability to deliver outcomes that truly matter to people.

Australia's health system has its roots in post-war innovations from Western Europe and Scandinavia, with universal access as a founding principle.

We've embraced global medical advances, and championed some of our own, with our hybrid model of public and private care reflecting both our history and our values. Values that prioritise care that is universal in access, person-centred and aligned with community expectations.

But what once made us a leader won't necessarily keep us there.

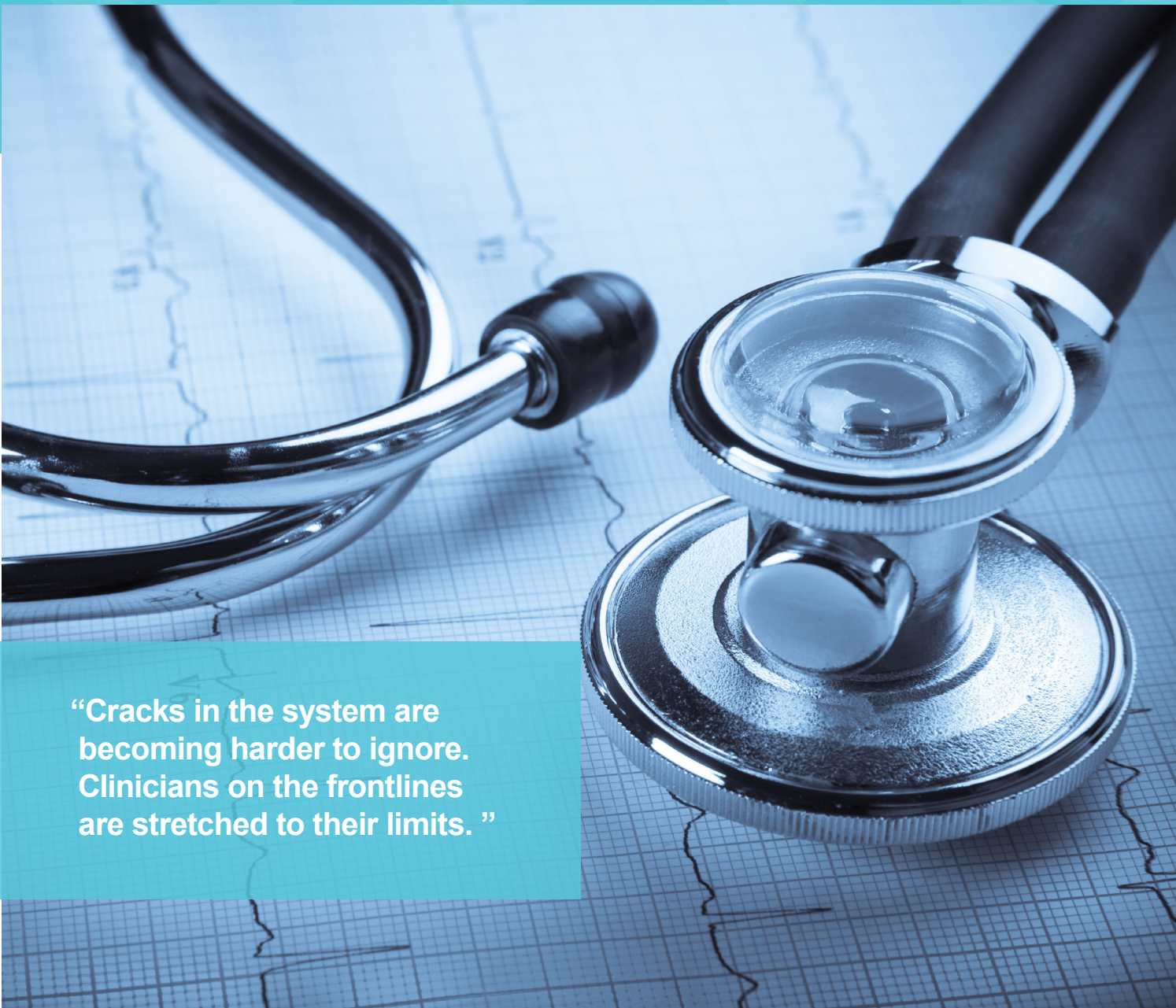
Cracks in the system are becoming harder to ignore. Clinicians on the frontlines are stretched to their limits. They routinely cite duplicated roles, siloed services, fragmented data systems and outdated funding mechanisms as barriers to better care.

Consumers, too, are speaking up, frustrated by long wait times, high out-of-pocket costs, and the confusion of navigating a system that often feels designed without them in mind.

Both offer practical solutions, but too often their voices are lost within a bureaucratic maze or drowned out by vested interests. Reform is frequently resisted, not because people deny the problems, but because change is uncertain, and the status quo feels safer.

Leaders who take up this challenge will need to be able to balance the short- and medium-term of consequences that can include career-limiting criticisms, intensive and transparent processes of consultation and co-design, and the inevitable barriers to building a broad consensus that leads to lasting change.

Australians expect governments to deliver high-quality health care, regardless of who's in power. They want the same in aged care, disability and



“Cracks in the system are becoming harder to ignore. Clinicians on the frontlines are stretched to their limits.”

education. But we can't keep asking for more while insisting on paying less. We need an honest national conversation about what it takes to fund and maintain world-class services, what trade-offs we're willing to make and where we can come together in compromise to achieve this.

That conversation must be respectful, inclusive and grounded in reality. Turning health care into a political football only serves short-term interests. In an era of polarised debate and manufactured

outrage, we've lost the art of consensus. But the future depends on rebuilding it.

That means elevating the voices of those who deliver and receive care, being honest with the public about choices, and creating space for leadership that embraces change, rewards outcomes and measures success by the value we deliver, rather than maintaining the status quo.

The time for that work is now. 

AHHA in the news

12 MARCH 2025



Australian Health Review: New collection – Aboriginal and Torres Strait Islander health

The *Australian Health Review* released a new collection of articles focused on the health and wellbeing of First Nations Australians, ‘Beyond Closing the Gap’.

‘This collection highlights the pressing health challenges facing Aboriginal and Torres Strait Islander communities, while also showcasing policy and service innovations aimed at improving health outcomes and equity,’ says Dr Sonj Hall, Editor-in-Chief of *Australian Health Review*.

Featured Policy Reflections explore key issues, including the ongoing failure to address the impacts of social determinants of health for First Nations Australians. 

24 MARCH 2025



Alliance model delivering tangible population-based outcomes

Released by AHHA Ltd’s Deeble Institute for Health Policy Research, the Evidence Brief ‘Delivering tangible population-based outcomes via an alliance model: South West Primary Health Care Alliance Queensland’ examines the alliance governance model as a strategy for achieving person-centred population health outcomes, particularly in the context of increasing chronic conditions and an ageing population.

Established in 2022, the Alliance brings together local healthcare stakeholders, including communities, government, and service providers, to collaboratively design and deliver integrated healthcare services.

The Alliance has demonstrated positive progress towards its core objectives, particularly in workforce stabilisation, access to services, and continuity of care. 

HAVE YOUR SAY...

We would like to hear your opinion on these or any other healthcare issues.
Send your comments and article pitches to our media inbox: communications@ahha.asn.au

1 MAY 2025

VBHC leaders gather in Melbourne to turn value-based care into reality

On the eve of Australia's Federal Election, hundreds of Australia's leading health thinkers met in Melbourne to explore the opportunities within Australia's healthcare systems to shift the focus from the volume of services delivered, to the outcomes that matter to people and communities, through a range of transformative programs, policies and consumer experiences.

Opened by the Hon Mary-Anne Thomas, Minister for Health, Minister for Ambulance Services, Victoria, the 2025 Value-Based Health Care (VBHC) Congress ran from Thursday, 1 May to Friday, 2 May at ZINC at Fed Square. 

6 MAY 2025

Re-election brings fresh momentum for health reform, says AHHA Ltd

The Australian Healthcare and Hospitals Association Limited (AHHA Ltd) congratulated the Australian Labor Party on its re-election and welcomed returning Prime Minister Anthony Albanese.

Health was a central issue throughout the 2025 Federal Election campaign, and voters made clear their expectations for a healthcare system that is fair, accessible, and responsive to the needs of individuals and communities.

AHHA Ltd welcomed the Government's commitment to reaffirm the founding principles of Medicare and is calling for action through systemic reform that prioritises equity, sustainability, and innovation. 

27 MAY 2025



Healthscope receivership prompts AHHA Ltd call for health system reform

The Chief Executive Officer of the Australian Healthcare and Hospitals Association Limited, Tony Farley said that the announcement about Healthscope's financial troubles should provide governments with the opportunity to think carefully about the sustainability of our health system and how public health care is funded and delivered.

Australians expect high-quality universal services, from health and disability to aged care and early childhood. Delivering on those expectations requires open, honest conversations about sustainability, priorities, and the true cost of excellence.

'The standards expected of public hospitals should be applied in any setting and by anyone providing public health care, regardless of whether they are public or privately owned and run,' said Mr Farley. 

ANCHOR Wins 2025 People's Choice Poster Prize

A national registry giving deaf and hard of hearing children
the best start in life



The Hon Jillian Skinner AM, Valerie Sung, Libby Smith, Kylie Woolcock

The Murdoch Children's Research Institute's Australian National Child Hearing Health Outcomes Registry (ANCHOR) was awarded the 2025 People's Choice Poster Prize at this year's Value-Based Health Care Congress held in Melbourne.

Selected by popular vote from nearly 60 poster entries, with an impressive 1,632 votes cast across all entries, ANCHOR's poster captured attention for its bold vision: to ensure that every deaf

and hard of hearing child in Australia has the opportunity to thrive.

A National Commitment to Better Outcomes

The vision of the Australian National Child Hearing Health Outcomes Registry (ANCHOR) is to give all deaf and hard of hearing children the best opportunities to reach their full potential and live healthy, fulfilled lives.



Australian National Child Hearing
Health Outcomes Registry

VISION

To give all deaf and hard of hearing children the best opportunities to reach their full potential & live healthy, fulfilled lives

MISSION

To collect & connect child hearing health information into a national data system to drive quality improvement, research & value-based care

AIMS 2023-25 Establish the prerequisites of a national data system:

1. Environmental scan of Australia's child hearing services & datasets
2. Develop a prototype data system in 2 states
3. Establish a Core Outcome Set to measure what matters to children, families, services
4. Estimate the costs & benefits of ANCHOR

THE PROBLEM & THE OPPORTUNITY

- Australia has world-class child hearing health services. Universal newborn hearing screening facilitates early detection of hearing loss & early access to interventions, including hearing amplification & cochlear implantation (Fig.1)
- Despite early detection of hearing loss, deaf and hard of hearing children are not reaching their best potentials: almost half of deaf and hard of hearing children have language & academic skills below expected standard at school entry
- Child health services collect vast amounts of data held within disparate electronic data systems - there is opportunity to link routinely collected data into one system to track outcomes

Figure 1: ANCHOR as a Child Deafness Learning Health System



THE INNOVATIVE SOLUTION

A whole-population data resource as a Learning Health System to track outcomes of deaf and hard of children, identify gaps in service provision & inequities in service access, identify effective & ineffective interventions, and create solutions to improve care (Fig.1)

STAKEHOLDER & FAMILY ENGAGEMENT AT THE CORE OF CO-DESIGNING ANCHOR

- Partnerships with >100 child hearing health stakeholders from >49 organisations delivering >300 services across all states/territories (Fig.2)
- Focus groups & interviews with families & young people
- Partnerships with Deaf advocacy groups & Aboriginal and Torres Strait Islander researchers to lead recruitment & conduct data collection (by Auslan using researchers / through yarning circles) in culturally safe environments
- Stakeholders co-design methods through accessible, inclusive online meetings with Auslan interpreters, captioning, & culturally inclusive etiquette
- Recruitment & survey materials accessible through video Auslan interpretation



- Establishment of the parent-led Australian Childhood Deafness Research Community Advisory Group (AusChildDeafness-CAG), to ensure families with lived experience are at the heart of developing a data resource that reflects the needs of children and young people who are deaf and hard of hearing and their families

Figure 2: Collaborating child deafness stakeholders



PRELIMINARY OUTCOMES

AIMS 1 & 4

- > 100 child hearing service providers across >300 services provided information on their data collection, databases, referral pathways & costs of data systems
- Map of services cover all states & territories, includes stakeholders from multiple professional disciplines

AIM 2

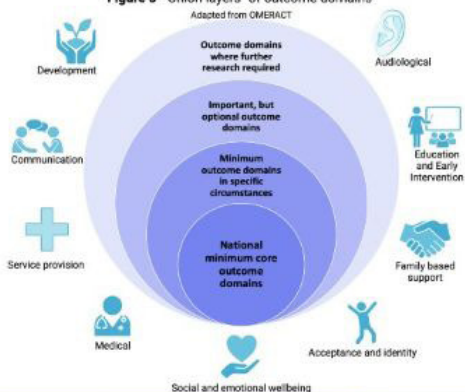
- Priority datasets for data linkage identified, data linkage plan co-designed & developed with data custodians of key stakeholders
- Data custodians co-developed data governance framework, data transfer & management plans
- Legal agreements in process of signing off by data custodians & state data linkage authorities
- Waiver of consent for use of data for linkage approved by Human and Research Ethics Committee

AIM 3

- 39 parents / carers with lived experience & young people who are deaf or hard of hearing expressed their views on what outcomes matter to them in focus groups & interviews
- Lists of outcomes in 9 core outcome domains created from data from focus groups & interviews & literature search (Fig.3)
- AusChildDeafness-CAG developed recruitment video for e-dephi survey
- > 225 stakeholders & families participated in e-dephi survey to rank outcomes
- Workshops scheduled for stakeholders & families to co-design final Core Outcome Set



Figure 3 'Onion layers' of outcome domains



NHMRC

Australian Government
Department of Health
and Aged Care



“ANCHOR’s mission is to collect and connect child hearing health information into a national data system to drive service improvements, creating an enduring Learning Health System and pipeline for research discoveries that single studies cannot address alone.”

ANCHOR’s mission is to collect and connect child hearing health information into a national data system to drive service improvements, creating an enduring Learning Health System and pipeline for research discoveries that single studies cannot address alone.

ANCHOR’s Phase One (2023-2025) program aims to establish the prerequisites of a national database, through:

- Environmental scanning of Australia’s child hearing health services and datasets;
- Developing a prototype data system spanning two states;
- Establishing a national Core Outcomes Set to ensure ANCHOR measures what matters to children, families and services; and
- Estimating costs and benefits of ANCHOR.

ANCHOR’s Phase One program is realising its aims by extensive engagement with families and young people with lived experience, their communities, and over 100 child deafness stakeholders from more than 49 organisations delivering over 300 services across more than 15 disciplines, representing

all states and territories of Australia, including Aboriginal and Torres Strait Islander and Deaf communities. We established the parent-led Australian Childhood Deafness Research Community Advisory Group (AusChildDeafness-CAG), to ensure families with lived experience are co-designing ANCHOR, and are at the heart of developing a data resource that reflects the needs of children and young people who are deaf and hard of hearing and their families. This is paving way to future successful implementation of ANCHOR (Phase Two) beyond 2026.

Recognition by the Health Community

The People’s Choice Poster Prize is unique in that it reflects the voice of the health community itself. Delegates at the VBHC Congress were invited to vote for the poster that most inspired them, and ANCHOR’s message clearly resonated. 

For more information about ANCHOR, visit: www.mcricri.edu.au/research/projects/anchor

The Victorian Virtual Specialist Consults

2025 Winner of the Innovation Award for Value-Based Health Care

“Patients are offered a one-off assessment to enable initial investigations and interventions, while navigation into the most appropriate ongoing care provider is assessed and facilitated.”

The Victorian Virtual Specialist Consults (VVSC) is a first of its kind service in Australia. VVSC utilises video co-consultation with community providers to provide timely and equitable access to specialist expertise across the state.

In short, VVSC provides specialist care differently.

In collaboration with community-based clinicians, specialist expertise is provided when and where it is required. The collaborative consultation supports Victoria’s community and rural-based workforce with partnership development and upskilling to keep patients in their own communities.

In addition, patients seen through the Victorian Virtual Emergency Department (VVED) who experience significant barriers to healthcare access can be booked into a direct consultation with a relevant specialist. Waiting times for appointments are days to weeks, rather than months to years

seen in the traditional hospital specialist services. Patients are offered a one-off assessment to enable initial investigations and interventions, while navigation into the most appropriate ongoing care provider is assessed and facilitated. This allows the care journey to commence and health to be optimised whilst awaiting definitive care.

This service is innovative, aiming to replicate the ‘corridor consult’ that hospital providers leverage when advice is needed. It is transformative, enabling patients to receive care when and where they need it, rather than when it is available. But most importantly it improves equity in healthcare access. In doing so, VVSC reduces demand on overburdened hospital outpatient services, supports patients getting the right care in the right place, and re-establishes value in health for all Victorians.

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“The Victorian Virtual Specialist Consults (VVSC) is a first-of-its-kind service in Australia. VVSC utilises video co-consultation with community providers to provide timely and equitable access to specialist expertise across the state.”

Informed by co-design sessions with consumers, specialists and non-hospital specialist general practitioners (GPs), a dedicated website (vvsc.org.au) enables GPs to book 20-minute appointments with a specialist at a time that works for them, with or without the patient present. Each clinic carefully considers multi-disciplinary input to facilitate robust case discussion.

A pilot to test feasibility focused on General Medicine in January 2023. Early positive feedback led to rapid expansion with further clinics added based on GP requests and specialist enthusiasm to be involved. Partnerships with Victorian Aboriginal Community Controlled Health organisations, rural and regional centres, the Royal Flying Doctors Service and key healthcare providers such as the 1800 line for sexual health have enabled streamlined care pathways for those facing barriers to healthcare access.

A survey after every appointment provides real-time feedback on the value and impact of the service. The VVSC has demonstrated significant improvements in health care utilisation, reduction

in specialty clinic wait lists and a high level of GP and patient satisfaction.

To date, 8233 specialist appointments have been offered, including 2800 GP-initiated co-consults.

The GP satisfaction following co-consult demonstrates 98.5% of the 1676 survey respondents agreeing or strongly agreeing that the consultation made a meaningful change to management. Of those who had an existing referral to specialist clinics, 68% were subsequently cancelled after the co-consult, and of those planning to refer, 75% did not proceed after the consultation.

For those that require ongoing specialist input and referral into a local hospital pathway, early investigations and management enable the patient to feel well prepared for the eventual appointment. This ensures that time spent waiting is productive, contributing positively to the patients care journey and mitigating the risks of delayed care.

Direct patient reviews demonstrate an average patient satisfaction of 4.8/5 (n=136) with 96% likely or highly likely to recommend VVSC to others.



Kylie Woolcock, the Victorian Virtual Specialist Consults team and Dr Melissa Sweet from Croakey Health Media.

This service is centred around a commitment to overcoming the fragmentation between primary and tertiary care.

The traditional outpatient model, whereby a GP will refer to a clinic, has led to long-waiting times and fragmentation of care. Additionally, the reliance on letters or other correspondence which may or may not arrive in time leads to unnecessary investigations and management decisions without all the information.

The VVSC model is the first statewide initiative to provide equitable and accessible specialist care for patients. The service, at its core, aims to

collaborate synchronously with GPs and patients to allow contemporaneous discussions ensuring all stakeholders are heard, all information is available and allowing immediate clarification of missing information or results. The patient is kept at the centre of the care journey.

The VVSC is a leader in the virtual care space, arguing for new funding models that support better collaboration between primary and tertiary care. It stands as one of the most innovative models to defragment care in Australia and will continue to adapt and iterate to feedback to stay at the cutting edge of this progress. 



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Integrated health and social care hubs to address adversities in Australian families

The Centre of Research Excellence (CRE) in Childhood Adversity and Mental Health was awarded the 2025 VBHC Transformation Award in recognition of its exceptional work implementing Child and Family Hubs.

Led by the Murdoch Children's Research Institute (MCRI), the CRE brings together families with lived experience, practitioners, researchers, and policymakers across the health, social care, and legal sectors. Its mission is to prevent the lifelong mental health impacts of adversity in early childhood.

Family Adversity in Australia

Adverse childhood experiences or family adversities are common and significantly increase the risk of poor mental and physical health in children and adults.¹ They include child emotional and physical abuse and neglect, harsh parenting, conflict between parents, bullying and broader issues like food and housing insecurity and poverty. Most interventions target single adversities but adversities often occur in clusters, with 1 in 5 Australian children experiencing three or more adversities, and more than half experiencing at least two adversities by age 11 years.²



Child and Family Hubs: A Holistic Approach

In 2019, we embarked on a project to improve outcomes for Australian children living with adversities. Through our Centre of Research Excellence in Childhood Adversity and Mental Health (www.childhoodadversity.org.au), funded by the National Health and Medical Research Council and Beyond Blue, we aimed to assess the impact of an integrated health and social care ‘one-stop shop’—a Child and Family Hub. Hubs were designed with families and local service providers to address adversities identified by caregivers and respond either through supports and services offered in the Hubs or warm referrals to supports outside the Hubs.³

Learning how to ‘build’ a Hub

We began by examining evidence for effective strategies to mitigate the effects of adversity on child mental health. Using this evidence, we co-designed two Child and Family Hubs in Victoria

and New South Wales with input from families and service providers. Hubs were in existing community health centres because families told us that these were non-stigmatising and they were happy to go there. Key components of these Hubs included:

- Family-friendly Hub entries
- Partnerships with families
- Workforce training on addressing adversities
- Mapped referral pathways to services
- Regular activities to enhance practitioner capabilities
- Parenting support
- Co-location of Hub practitioners where possible

Whilst the centres already had health practitioners working in them (e.g. general practitioners, paediatricians, nurses), we added new roles to create the Hubs. These included financial counsellors, lawyers and wellbeing coordinators to address social issues. We were learning about what services to bring together and how practitioners could work together to identify and address adversities.

>



Kylie Woolcock, the Hon Jillian Skinner AM, Professor Harriet Hiscock.

Testing and Results

Over a 12-month period, we tested the Hubs with a community sample of 234 families who reported high levels of adversities both inside (e.g., family violence, substance abuse) and outside (e.g., financial difficulties) the home. The results were promising:

- The proportion of caregivers reporting no adversities increased from 11% to 20%.
- Families reported more referrals for support with challenges inside and outside the home.
- Consistent Hub attendance led to increased support from practitioners.
- The proportion of children with mental health problems decreased.
- Warm parenting practices increased.

A National Child and Family Hubs Network

The success of these Hubs informed the creation of a National Child and Family Hubs Network (www.childandfamilyhubs.org.au/). This network aims to accelerate learning, coordinate approaches, and build the capacity of over 470 Australian Hubs across various sectors, including early childhood, primary schools, primary care, Aboriginal Community Controlled Organisations, and virtual platforms.

The Network, comprising over 1200 member organisations and individuals, is dedicated to building evidence for Hubs, providing strategic investment advice, conducting national communities of practice, tracking progress, adapting successful strategies, and expanding a virtual e-Hub to support rural and regional areas.

Conclusion

Integrated health and social care Hubs are proving to be effective in detecting and supporting Australian families experiencing adversities. The National Child and Family Hubs Network is successfully scaling these models through funding, advocacy, and collaboration, paving the way for a brighter future for children and families across Australia. 

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Health Care and Social Assistance



Measuring What Matters

How Patient Activation is Personalising Cancer Care at Northern Health

Northern Health's award-winning project *Measuring Patient Activation in Cancer Care: A Step Toward Equitable, Value-Based Healthcare* is a powerful example of how person-centred innovation can drive meaningful change in the health system. Recognised in the Equity category of the 2025 AHHA Value-Based Healthcare Awards, the initiative demonstrates how digital tools, co-design, and culturally responsive care can be combined to improve outcomes and reduce inequity in cancer care.

The 2025 Equity Award for Value-Based Health Care is supported by the Transport Accident Commission (TAC).

Cancer care is becoming increasingly complex. Advances in treatment across multiple settings have enabled more people to live with—and through—cancer, often for many years. But this growing demand is placing significant pressure on healthcare services. Northern Health recognised that better support for patients starts with better understanding—and developed a model of care that responds to individual needs, capabilities and preferences.

At the heart of this work is the Patient Activation Measure (PAM), a validated questionnaire that assesses a patient's knowledge, skills and confidence in managing their health. The PAM assigns each patient a score from 0 to 100, categorised into four levels of activation. Higher scores correlate with better self-management, fewer emergency visits, and improved long-term outcomes.

Northern Health embedded the PAM into a multilingual Digital Care Pathway (DCP), delivered through the *My Health@Northern* app. This digital approach enables real-time outcome collection and the delivery of tailored education and self-management resources. The system is designed to be inclusive, supporting patients with low health or digital literacy, and available in multiple languages to meet the needs of culturally and linguistically diverse (CALD) communities.

This information helps clinicians personalise care plans based on each patient's activation level, ensuring support is directed where it's needed most. Patients with lower activation scores can be prioritised for wrap-around support, while those



Kylie Woolcock, Dr Katharine See (Northern Health), Lidia Stojanovski (Transport Accident Commission (TAC))

with higher scores are empowered to manage aspects of their care independently, often within the community. It's a shift from one-size-fits-all to right care, right time, right person.

Since its launch, more than 1,100 PAM assessments have been completed by nearly 500 patients, with engagement rates exceeding 80%. Importantly, 12% of surveys were completed in languages other than English—highlighting the value of culturally inclusive, accessible design. Patients showed an average eight-point increase in activation at re-assessment, with 70% reporting increased confidence in managing their care.

By measuring outcomes that matter—not just outputs—Northern Health is delivering care that is more equitable, more efficient, and more meaningful to patients. The model demonstrates how insights from activation data can enhance shared decision-making, strengthen clinician-

patient relationships, and guide the effective use of limited resources.

Crucially, this success was built on deep consumer involvement. A dedicated Consumer Advisory Group, including people with lived experience of cancer and members from CALD backgrounds, helped shape every stage of the project. Their insights ensured the pathway was not only accessible, but aligned with what mattered most to patients and families.

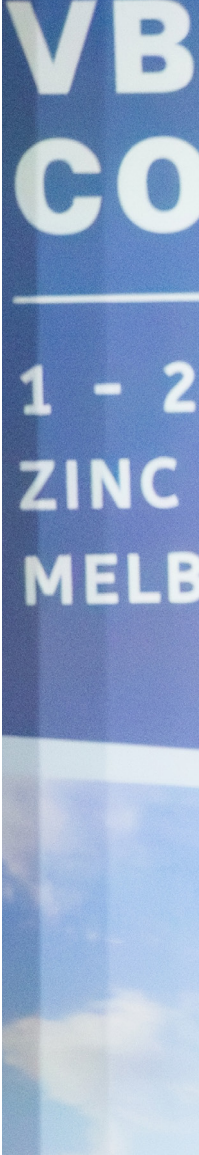
Northern Health's project offers a practical blueprint for services looking to embed value-based care across diverse communities. By combining digital tools, strong consumer partnerships, and a focus on what matters most, it is helping to build a more equitable and person-centred health system—one that empowers patients and delivers better outcomes for all. **ha**



DR ELISSA ELVIDGE
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Research Institute



Dr Elissa Elvidge is currently participating in the Deeble Institute Scholarship Program and recently presented at the 2025 Value-based health care Congress in Melbourne. Her presentation explored the critical role of cultural safety in delivering equitable and effective care.



Cultural Safety

An essential foundation for Value-Based Health Care

Value-based health care, with its focus on patient outcomes and cost-effectiveness, holds immense promise for transforming service delivery. At its heart is the promotion of healthcare engagement and clinical efficacy through the consideration of individual's priorities and preferences in relation to care. For many Indigenous Australians, the failure of health services to provide care in such a manner, including ensuring that care is culturally safe, is reflected in later clinical presentation, reduced adherence to therapy, and poorer clinical outcomes. In turn, this is reflected in disparities in health outcomes and substantially increased care costs. Rather than viewing the process of establishing cultural safety and equity in service delivery as issues that can be addressed as add-ons to existing models of care, it is essential that

we recognise that these considerations are the essential underpinnings of Value-based health care.

For Aboriginal and Torres Strait Islander peoples, concerns about cultural safety in relation to healthcare are paramount. Where people feel unsafe, unheard, and under-served, they are much less likely to seek care. Where individuals do engage with services, clinical benefits can be undermined by experiences that can leave patients feeling traumatised and undervalued. Addressing this problem requires acknowledgment of the historical and continuing impacts of colonisation, the systemic racism that exists within the healthcare system, and the fact mainstream services have been designed according to cultural norms that may differ considerably to those of Indigenous communities.



Similarly, equity is not just a social imperative but a factor that is critical in achieving value in healthcare. Inherent to considerations of equity is a recognition that communities have different needs and face different barriers to accessing quality healthcare.

A value-based system that ignores the considerable disparities in the circumstances of those accessing care, including racism, housing insecurity and reduced educational opportunities will inevitably fail to deliver optimal outcomes. However, with a focus on outcome measurement, we can understand who is achieving outcomes and who is not, bringing visibility to the underlying determinants of access and experience that influence outcomes, and allow initiatives to

be better targeted. Ensuring cultural safety in Value-based health care requires a multi-pronged approach:

1. Data Collection and Analysis:

Robust collection and disaggregation health outcome data by ethnicity and other social determinants allows disparities to be identified, the progress of reforms to be tracked, and services to be tailored to the specific needs of all members of the community. Essential to this is the collection of care experiences from the perspectives of those accessing services and doing so in a manner that is transparent, reproducible, and allows the benchmarking of performance.

>

“Fulfilment of our responsibility to provide effective and equitable health services for all can be achieved through the integration of cultural safety and equity into all aspects of service design and delivery.”

1. Culturally Responsive Models of Care:

Healthcare delivery models should be tailored to meet the unique cultural needs of diverse communities. This can include incorporating cultural practices into service design, providing culturally appropriate health information, and ensuring access to Indigenous health professionals and other support mechanisms. Co-design of services with Aboriginal and Torres Strait Islander communities is critical to achieving models of care that are genuinely culturally responsive.

1. Workforce Development:

Healthcare professionals need training in cultural safety, anti-racism, and equitable service delivery. This process goes beyond the promotion of cultural awareness and understanding of different cultural practices and requires the development of self-awareness and interpersonal skills necessary to build trust and rapport with patients from diverse backgrounds. Training must also address the impacts of healthcare provider bias and systemic racism within the healthcare system.

1. Workforce well-being:

Indigenous health professionals are members of both health service organisations and disadvantaged communities, and often have their own lived experiences of racism and culturally unsafe care. It is essential not only that these health professionals are supported and listened to, but that they are not placed in harm's way by being asked to act as intermediaries between community members and culturally unsafe services.

1. Community Engagement:

Meaningful engagement with Aboriginal and Torres Strait Islander communities and other priority populations is essential. This involves actively listening to community voices, ensuring that these voices reflect the diversity of opinions within communities, and partnering with community-controlled health organisations. In addition to establishing services that produce better clinical outcomes, demonstrating responsiveness to community priorities and perspectives is critical in ensuring that communities feel listened to and that the views of community members are truly valued.

1. Accountability and Transparency:

Clear accountability mechanisms are needed to ensure that healthcare providers meet safety and quality standards, including in relation to cultural safety. These may include setting targets, monitoring performance, and publicly reporting on progress. Ensuring transparency promotes the building trust with community members and allows measures that are effective in addressing disparities to be identified.

Fulfilment of our responsibility to provide effective and equitable health services for all can be achieved through the integration of cultural safety and equity into all aspects of service design and delivery. In doing so, we can create a system that not only delivers better health outcomes, but that reflects the entitlement of all Australians to the highest standards of care. 

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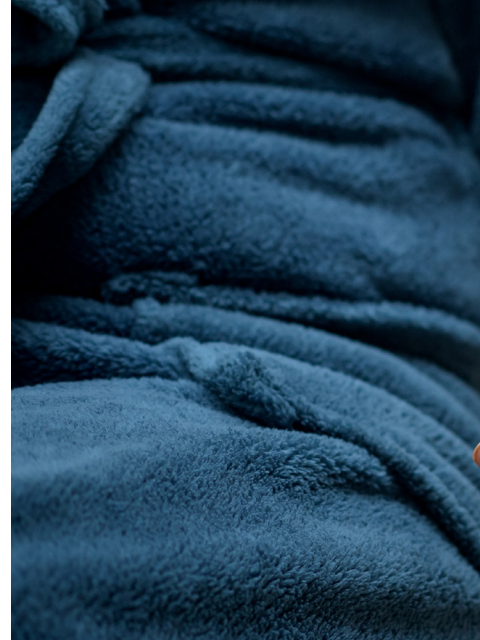
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SIMON RADMORE
Executive Director,
Strategy & Office of
the Chief Executive
Northern Sydney Local
Health District



Simon Radmore is currently participating in the Deeble Institute Scholarship Program and recently attended the 2025 Value-Based Health care Congress in Melbourne. He was also accepted into the International Hospital Federation Young Executive Leaders (YEL) Program for 2025.



Why value-based healthcare must become the norm, not the exception

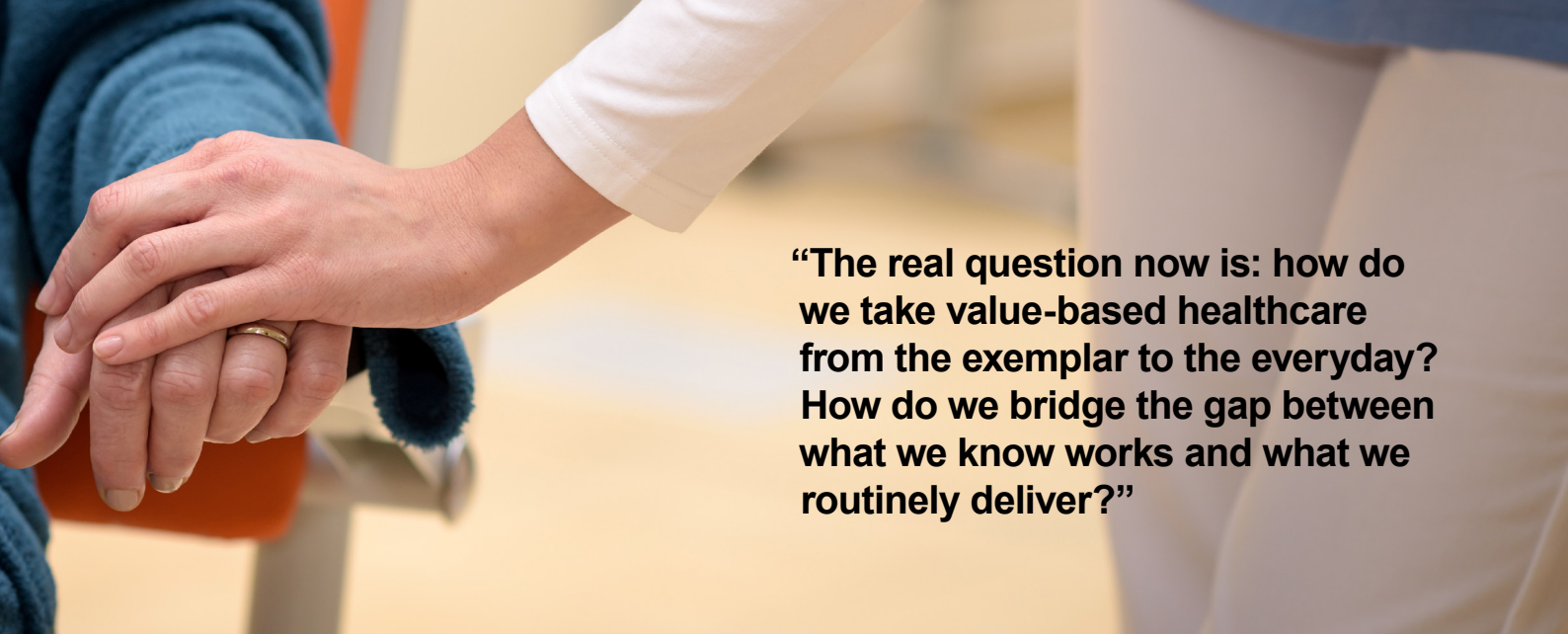
You'll be hard pressed to find a bigger advocate of value-based healthcare. It just so happens that my first non-clinical role in health was as a project officer implementing the Leading Better Value Care program in NSW. As I sat in the audience at the 2025 AHHA Value-Based Care Congress I was both inspired by the incredible work underway, and a bit frustrated. I fully support the principles of value-based healthcare, but I must admit that I find it frustrating that we still treat 'value' as an add-on, something separate and elusive, rather than integral and non-negotiable.

Calling out value-based healthcare and striving for high-value care acknowledges a hard truth: some of the care delivered today is not optimised for value. According to Braithwaite et al. (2020), as much as 40% of healthcare delivers little to no value (30%) or causes harm (10%). Calling out value-based healthcare means recognising that low-value care – care that does not improve outcomes, that is unnecessary, duplicative, or even harmful

– is still embedded in our systems. And it means accepting that the structures, incentives, and cultures that shape our health system are often misaligned with what truly matters: delivering the best possible care and outcomes for the communities we serve.

At its core, *value-based healthcare* is about delivering on the Quintuple Aim of health, a comprehensive framework that defines what healthcare should do:

- 1. Improve health outcomes** that matter to patients,
- 2. Enhance the care experience** for individuals and their families,
- 3. Support the health workforce**, recognising the critical importance of clinician wellbeing,
- 4. Achieve financial sustainability**, ensuring that resources are used wisely and waste is reduced, and
- 5. Advance equity**, so that no individual or community is left behind.



“The real question now is: how do we take value-based healthcare from the exemplar to the everyday? How do we bridge the gap between what we know works and what we routinely deliver?”

These five aims are not aspirational extras. They should be the baseline. Yet too often, they are treated as ideals pursued in pilot programs, isolated initiatives, or considered the role of only the most exceptional health services. If we truly believe in the promise of value-based healthcare, we must shift our mindset from thinking of it as a new model to recognising it as the *definition* of quality healthcare.

The real question now is: how do we take value-based healthcare from the exemplar to the everyday? How do we bridge the gap between what we know works and what we *routinely deliver*?

Firstly, we need to better understand and scale the lessons from pockets of excellence. High-value care already exists and there are services, teams, and clinicians delivering exceptional care every day. But these lessons too often remain localised. We must invest in sharing what works, understanding why it works, and adapting it to different contexts, not just replicating models, but translating principles.

Secondly, we must make it easy for clinicians to deliver high-value care in every interaction. That means aligning funding models, performance metrics, and data systems with value, not

volume. It means reducing administrative burdens that distract from care. It means working collaboratively to establish and embed learning health systems where evidence informs practice and practice informs evidence. And it means ensuring that the tools, time, and team structures clinicians need to deliver holistic, patient-centred care are in place.

Thirdly, we need leadership. Brave, sustained, and system-wide leadership. Leaders must champion the shift to value, model its principles, and challenge the inertia that keeps low-value care in place. And they must co-design solutions with clinicians, researchers, educators, patients, and communities, because value is something we build *together*.

The future of healthcare must be built around value, not cost alone. Our communities deserve care that delivers better outcomes, a better experience, and better use of every dollar we spend. We need to move towards a world where value-based healthcare isn't innovation, it's simply the healthcare we should already be delivering. The time to stop treating it as a model and start treating it as the expected norm is now. ■



TAN NGUYEN
A/Director Policy, Dental
Health Services Victoria



Tan Nguyen is currently participating in the Deeble Institute Scholarship Program. He recently attended the 2025 Value-Based Health Care Congress in Melbourne and shares his personal reflections. The views expressed are his own.

Where is prevention and health equity for value-based health care?

The 2025 Value-Based Health Care Congress held in Naarm brought together consumers, policy-decision makers, health services managers, and frontline healthcare workers to share knowledge on how much has progressed in delivering outcomes and quality care that matter most to consumers in an optimally efficient way. Many initiatives are supported by enabling digital health technologies and are data driven. For the most part, examples of value-based health care were drawn from disease-specific conditions and consumers who are utilising healthcare. There are excellent examples of value-based health care, which is often constrained by funding existing models, limited resource allocation, and issues on health workforce attraction and retention for regional and remote areas.

It is without a doubt that delivering and partnering with the private sector can achieve outcomes and quality care for consumers. But there is still a resounding concern amongst consumer advocates that genuine consumer

engagement and co-design is lacking, and the need to empower consumers towards health and wellbeing. There was limited discourse on the value of prevention external to clinical care pathways, and measuring whether initiatives are appropriately considering service delivery impacts on health equity across populations. Social prescribing also featured as a way forward to address fundamental social and commercial determinants of health, although it is yet to be truly embedded in healthcare systems.

The NSW Special Commission of Inquiry into Healthcare Funding published in April 2025, makes explicit mention and recommendations to valuing prevention and value-based health care. These two concepts are not new but remains elusive to broadly implement at healthcare system level and organisational level. There was only one mention of consumers within the 41 recommendations made, which relates to consulting, where appropriate, on value-based health care procurement processes. The health sector has historically and continues to

“Measuring costs is easy, measuring what matters is much harder. It is imperative that we need to be clear on what outcomes matter most for consumers and defining ‘value’ for the oral health context.”



weight its efforts mainly on the cost component on the value equation, rather than the outcomes that matter to consumers. Operationalising the value equation, that is, outcomes divided by costs, remains just a theory.

At Dental Health Services Victoria, we commenced the value-based health care journey since 2018. Unlike many value-based health care initiatives in Australia and internationally, we face chronic and severe underfunding of government subsidised public oral healthcare. The responsibility of Dental Health Services Victoria is both population oral health and commissioning of service delivery to over 50 independent community health services. Along with this nuanced complexity, service delivery for Victorian public oral healthcare must take a life course approach to oral health, rather than more clearly defined clinical care pathways for disease-specific conditions.

In 2023, Dental Health Services Victoria defined value-based health care principles for oral health models of care under three principles: Principle 1 – Care is co-designed with the person or population, Principle 2 – Prevention and early intervention are prioritised, and Principle 3 – Consistent measurement of health outcomes and costs are embedded. By going back to basics, I find myself grappling with the need for ‘quick wins’ by policy-

decision makers, while ensuring social justice is preserved through genuine consumer co-design and promotion of health equity. The 2025 Value-Based Health Care Congress underscores the varied perspectives on what is ‘value’, and care delivery must be flexible to accommodate consumer agency through shared-decision making.

Measuring costs is easy, measuring what matters is much harder. It is imperative that we need to be clear on what outcomes matter most for consumers and defining ‘value’ for the oral health context. Arguably, the prevention of oral disease has co-benefits to other non-communicable diseases by addressing modifiable risk factors. Therefore, a common understanding of what constitutes ‘value’ between consumers, policy-decision makers, health services managers, and frontline healthcare workers is necessary to bridge the value-based health care implementation gap. In health economics, improved quality of life is measured in quality-adjusted life years. Fortunately for many disease-specific conditions, there are validated methods to quantify this. Economists acknowledge that quality-adjusted life years is not perfect measure, but unless this possible for oral health in Australia, we will continue to dance around what constitutes as success for Victorian public oral healthcare. 



ALISON BARBER
Queenslanders with
Disability Board Member
Carer's Qld State
Ambassador



What Makes Genuine Co-Design Verses Tokenistic Co-Design?

I have frequently referred to the **Spinal Cord Injury Service Delivery Model** undertaken by Queensland Health as one of the best examples of true codesign that I have ever had the benefit of being involved with. I would like to reflect on what made this project so genuinely 'codesigned', and not just a tokenistic application of the term, which is sadly, commonplace today.

My goals for joining were to encourage collaboration between the private rehabilitation services and the public Spinal Injuries Unit, in addition to emphasising the urgent requirement of upskilling of nurses, both within the public and private sectors, of the potentially life-threatening condition of autonomic dysreflexia.

All levels were involved in the codesign project, from executives, Doctors, clinicians, consumers, families, care and support workers, in addition to peak bodies, such as Spinal Life Australia, Carers Queensland and Queenslanders with Disability Network.

The consumer advocacy group itself was a broad selection of consumers from all over the state of Queensland representing metropolitan, regional, rural and remote experiences. It included a wide range of participants, with an equally wide range of time since their injury and, in fact, levels of injury. I believe this provided a really balanced perspective on different experiences, and yet we found many similarities between us. Natural leaders emerged within the consumer group who encouraged and motivated those members who initially felt less confident, to understand, value and share the power of their own journeys, and to share their experiences as equally valued members of the group. I believe that overall, it has resulted in an incredible model for Spinal Cord Injury Services, which will hopefully be adopted in full. It not only has the required input, but also is generally inclusive of participants' journeys, giving a balanced model of care moving forward.

“I became a fierce advocate for, not only my own children, but for all people living with invisible disabilities. Through this journey as a carer I have had the opportunity to be involved in many codesign projects over a long period of time.”

I personally have been involved in the world of disabilities for over 26 years, since my two sons were born with communicating hydrocephalus requiring VP Shunts, and grew up with gastrostomies, in addition to being on very different parts of the autism spectrum. They were both PEG fed for about 20 years of their lives, and between them have undergone approximately 30 brain surgeries. I became a fierce advocate for, not only my own children, but for all people living with invisible disabilities. Through this journey as a carer I have had the opportunity to be involved in many codesign projects over a long period of time.

However, I sustained my own spinal cord injury, approximately 5 years ago, becoming a C2 Incomplete tetraplegic. To say this was unexpected is an understatement. It really does show that none of us knows what lies ahead in life. Investing in genuine codesign, in any projects you undertake, is invaluable, as you never know when your own life experiences may change, and you yourself might become one of the clients that you currently represent.

I have become involved with Queenslanders with Disability Network, and I am now proud to be a member of the board of QDN. I am a Carer Ambassador for Carers Queensland, a Group

Convenor for our local Peer Support Group, and have recently been chosen as a member of the Disability Reform Codesign Team with QDN for the next 3 years. I have been involved with numerous NDIA codesign opportunities through their Participant First projects. Nevertheless, this Spinal Injuries Project, in my opinion, has by far been the best codesign project I've been involved with. It was not just tokenistic involvement, it was genuine codesign that was fully collaborative. From commencement to completion, there was equal input from all parties.

We initially separated the consumer and clinician groups to build trust, comfort and understanding of the goals of the project, and then we proceeded with joint meetings, including breakout rooms where clinicians genuinely valued the participants' challenges and input.

The consumer group were made to feel equal, and very much valued members of the project. Not only that, we were actually made to feel like the experts, and because of our own individual and unique journeys, our experiences were genuinely not only listened to, but we could see that we were collaboratively involved in the entire project design. It was a very empowering experience for all involved.

>



“I witnessed my co-participants grow in their own confidence, and participating in the process led to more awareness of their own rights on ways they could navigate the health system and how to better empower our peers moving forward.”

Following each meeting, data collation took place and summaries were distributed to all participants prior to the next meeting. This enabled all participants to reflect on the progress of the project to date and prepare for the next stage prior to the following meetings. This cyclic feedback loop was an excellent way to keep all involved, up to date and focused on the overall goals of the project in addition to the next stage to be worked on. It enabled reflection and genuine collaboration for all involved.

I witnessed my co-participants grow in their own confidence, and participating in the process led to more awareness of their own rights on ways they could navigate the health system and how to better empower our peers moving forward.

Unexpected bonus outcomes were achieved, such as a participant from a rural area being involved in an opportunity to up-skill the staff at his local hospital in his specific unique needs as a spinal injury client. Another region adopted a new policy on support workers being allowed to continue managing their client’s complex bowel care routines during hospitalisations as nurses are generally not trained or comfortable with digital rectal stimulation!

When Co-design is done well, with total inclusion from the start of a project, right through to the end, not only is the end product improved but many additional benefits are included for all involved. 



ANTHONY SCOTT
Professor and Director
of the Centre for Health
Economics, Monash
Business School

Rethinking the Health Workforce

Addressing shortages through smarter policy and local solutions

The health workforce is the cornerstone of any healthcare system. As global health systems grapple with increasing demand, the workforce's role becomes even more critical in delivering care and shaping how that care is accessed, experienced, and sustained. In Australia, this challenge is particularly pressing. The healthcare and social assistance sector has become the largest industry in the country, employing over 2.1 million people, which accounted for 15% of the total workforce in 2022.

Between 2013 and 2022, the health and care workforce expanded by 50%, significantly outpacing the 21% growth in the working population. Despite this significant growth, shortages remain persistent, particularly among registered nurses and doctors, with national forecasts continuing to predict ongoing shortages.

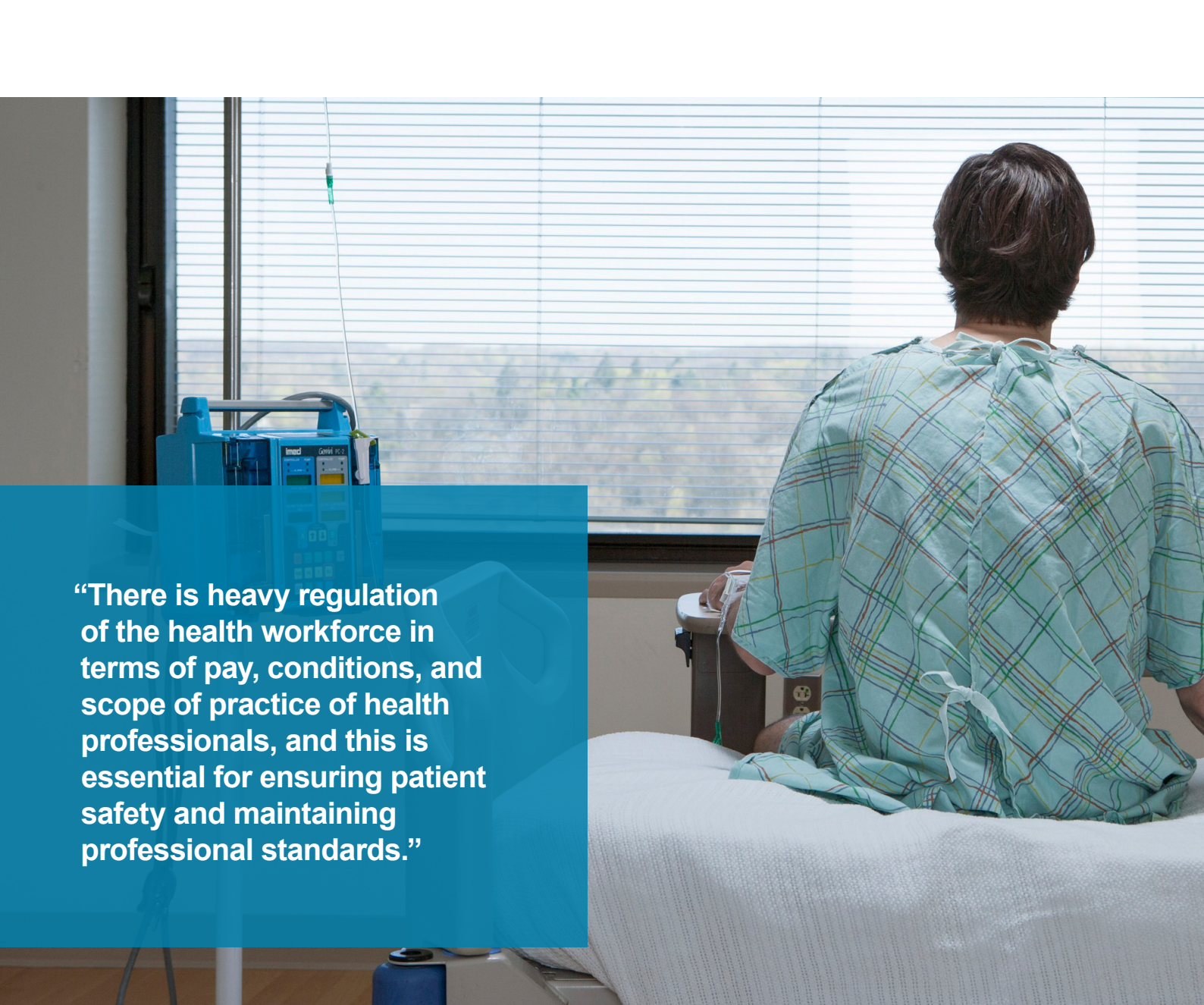
These shortages are not merely statistical. They have tangible consequences for patients. Shortages can harm patients as they disrupt care pathways and care episodes, delay access to diagnosis and treatment, and compromise the quality of care. The issue is not solely about the number of workers available, but their skills and scope of practice, and how they are distributed across

different regions, specialties, and sectors, such as public versus private healthcare.

Shortages impact two critical stages of the care pathway. The first is access to care, or the initial point of contact. Here, insufficient workforce numbers and uneven geographic distribution create significant barriers. Patients may also face financial obstacles, such as out-of-pocket costs, which further exacerbate inequities in access. Even when the need for care is the same across populations, the ability to pay can determine who gets seen and treated and their care pathway.

The second stage affected is the delivery of value-based health care. There is considerable variability in what constitutes an 'appropriate' care pathway, influenced by patient complexity, preferences, and supply-side constraints, such as the skill mix and availability of healthcare professionals.

To effectively address these challenges and reduce shortages, there must be a greater focus on the flexibility of local labour markets. Ideally, these markets should be flexible and responsive, allowing for smooth transitions in and out of the workforce, informed job choices, and competitive employment conditions. However, in practice, >



“There is heavy regulation of the health workforce in terms of pay, conditions, and scope of practice of health professionals, and this is essential for ensuring patient safety and maintaining professional standards.”

several frictions hinder this ideal. Labour mobility is often limited, and workers may lack complete information about alternative job opportunities. Employers, too, face constraints in adjusting pay and working conditions to fill vacancies. Trade unions and the Fair Work Commission determine the same pay for the same work. Minimum wages are important, but pay may not vary across local labour markets, where variations in the cost of living and amenities drive the attractiveness of jobs. For example, in areas with shortages of nurses in public hospitals, private hospitals may be able to pay more to attract nurses, but the public sector may not be able to do this. Nursing shortages in the public sector then persist. The

dominance of unions or employers, coupled with a lack of competition, further restricts the market’s responsiveness to reduce shortages. Yet, pay remains a largely forgotten policy lever in the numerous health workforce strategies that exist, despite its significant influence on recruitment and retention.

These frictions slow down the ability of local labour markets to adapt to changes in demand and supply, making workforce shortages more persistent, difficult to resolve, and perpetuating practice variations.

Addressing these issues requires a combination of long-term and short-term policy strategies. In the long term, increasing the supply of



healthcare workers is crucial. However, lessons from the medical graduate expansion in the 2000s suggest that this needs to be accompanied by contemporaneous changes to training and career pathways to direct health professionals into area of high need, train more generalists, and have flexibility with the scope of practice. Improving the efficiency of the existing workforce is also vital. This includes encouraging full utilisation of available staff, including scope of practice, increasing the number of hours worked where appropriate, and optimising the skill mix to ensure that tasks match the right level of expertise. By redesigning care pathways, healthcare systems can better use their existing staff.

Immigration also plays an essential role in supplementing the domestic workforce, especially in areas experiencing acute shortages. The self-sufficiency promised in past medical workforce policy has, and will not, be achieved, so embedding reliance on health workers from overseas should be the norm. Greater flexibility in pay and working conditions can help attract and retain staff, particularly in underserved regions. Additionally, providing better information about job opportunities and career pathways can empower workers to make more informed decisions, enhancing the overall efficiency of the labour market.

There is heavy regulation of the health workforce in terms of pay, conditions, and scope of practice of health professionals, and this is essential for ensuring patient safety and maintaining professional standards. However, excessive regulation (e.g. around the scope of practice) can entrench workforce shortages and harm the patients we are trying to protect. Have we got this trade-off right? Greater labour market flexibility can help alleviate these issues.

In conclusion, addressing health workforce shortages requires a nuanced understanding of local labour markets, a willingness to embrace flexibility to meet local labour market conditions, and a commitment to using data and evidence to guide policy and evaluate its impact. Both long-term and short-term strategies are needed, but they must be grounded in the realities of how healthcare. For healthcare workers, this means advocating for smarter workforce planning, supporting innovative but flexible care models, and recognising the critical role that pay, conditions, and local context play in sustaining a motivated and responsive health workforce. ■

Allied health exercise groups

Applying a value-based health care lens to evaluation

i Introduction

The delivery of group exercise programs by health services with the intention of maintaining and/or improving the physical health of older Australians is a well-established service. There is, however, a scarcity of literature related to applying a value-based health care lens when evaluating group programs in a community-health setting.

Value-based health care (VBHC) evaluation focuses on measuring and improving the value of care provided, which is defined as the health outcomes achieved for the cost incurred. It emphasises client-centred care, measurable outcomes, and the cost of achieving these outcomes.

A recent evaluation of cohealth's allied health groups aimed to apply a VBHC lens to its data analysis. cohealth is a not-for-profit community health organisation that provides primary care, allied health, mental health and social care services in Melbourne's CBD, inner-north and inner-west, and the east coast of Tasmania.

+ Valuation of allied health groups

In 2024, cohealth delivered 13 different allied health group programs focused on strength and conditioning, balance and falls risks, addressing mobility challenges, and pain management. The groups are delivered by a multidisciplinary team of Physiotherapists, Exercise Physiologists, Psychologists and Allied Health Assistants.

Clients are supported through assessment, goal-directed care planning and clinical outcome measurement to identify what outcomes are most important to the client and what group(s) they would find most beneficial.

Across all groups, over 800 group sessions were delivered to over 600 community members from Melbourne's inner-north and inner-west. Most clients presented with more than one health concern, with muscle, bone and joint conditions such as Osteoarthritis being the most common.

Focus on the Stronger Living group

cohealth's most attended group is 'Stronger Living' – a 12-week clinical exercise group that uses individualised strengthening programs to help clients meet their goals. This group is targeted towards older adults, with a focus on improving individual balance and strength in a social environment. It is delivered by a Physiotherapist or Exercise Physiologist together with an Allied Health Assistant across six locations in Melbourne's inner north and west including Collingwood, Fitzroy, Footscray, Niddrie, Kensington and Braybrook.

The following sections focus on the key findings for the Stronger Living group as an example of Value-based health care.

What we found

In 2024, 285 clients attended the Stronger Living group with most group members attending on average 11 out of their 12 sessions. The age of most group attendees was 66, and 84% spoke English as their first language.

Overwhelmingly, clients showed statistically and clinically significant improvements in both balance and strength, demonstrated by improvements in validated outcome measures such as the Sit to Stand test and Single leg balance tests. In addition to clinical outcome measurement, we also tracked whether clients achieved their self-identified goals. Of the clients who had goals recorded, 88% either fully or partially reached their group related goal.

These results confirm that when older Australians are actively involved in setting and working toward their own goals, outcomes improve. It also demonstrates the high levels of engagement by ageing community members in group settings, thus indicating that there are likely secondary benefits related to social connection and engagement in physical activity.

Value for money

When comparing group programs with individual consultations, we found that group programs are approximately 4.7 times more cost effective (78.7% less expensive) than one-on-one appointments. This is based on costings related to individual and group models of care using the disciplines of Physiotherapy and Exercise Physiology.

Based on these findings, group programs are significantly more cost effective and resource efficient, particularly when considering the scheduling limitations and lower scalability of individual sessions.

Conclusion

The evaluation of cohealth's group exercise programs, particularly the Stronger Living group, demonstrates that group-based care models deliver excellent value for money—achieving positive client directed outcomes at a fraction of the cost of individual sessions. This reinforces the importance of scalable, sustainable solutions within health systems facing increasing demand and constrained resources.

As health services continue to adapt to the evolving needs of an ageing population, embedding a VBHC lens into the design and evaluation of group programs offers a practical pathway to improve both the quality and efficiency of care, as well as engagement in preventative models such as these group programs. Building on these findings, cohealth strives to entrench a VBHC lens to all future program design and delivery, including monitoring and evaluation frameworks. 

How financial advice can help ease retirement worries

How seeking advice with HESTA can help you achieve your retirement goals.

We work our whole lives in anticipation of the ultimate goal: retirement. For many of us, that means not setting the alarm, living life on our own terms and finally having the time to do what we really want to do.

But what if you think you can't afford to retire? Or what if you are worried you will run out of money in retirement? These types of concerns are not unusual.

A [report by National Seniors Australia](#) found 59% of women and 47% of men are worried about outliving their savings in retirement*.

Women worry more not so much because they expect to live longer than men, but because of their roles throughout life. Many are mothers, carers and, more often than not, the people doing the lion's share of running the household.

Reducing worry

The National Seniors Australia report found that quality financial advice was a possible antidote to retirement anxiety. 35% of respondents who received financial advice that met their needs indicated they do not worry about retirement. Another 15% said they previously worried but no longer do.

HESTA's Jen Harding, General Manager — Advice Development and Growth says help is always available for our members.

“We appreciate that for our members, there's often not been much time to think about the future or to set financial goals. Life's busy!”

“That's where our online member-only tool [Future Planner](#) is a great first step. It helps you work out how much money you might need in retirement, see how much money you're currently projected to have in retirement based on what you have now, and explore options to grow your super.”

Ready to start planning your future?

Log in to your online account now to get started. [Discover Future Planner](#)

For those closer to retirement, Jen says HESTA's [Retirement Hub](#) is a central spot to plan for the next chapter.

“Our super experts can guide you through the financial options available to you, including whether a HESTA Retirement Income Stream is right for you, and checking your Centrelink entitlements,” says Jen.

“We offer members a range of different advice options, from phone and online, to information sessions, to one-on-one appointments with a super adviser.”



How does your next chapter read?

Our Retirement Hub can help

Take a look

A unique perspective

When giving one-on-one advice, HESTA super advisers are acutely aware of the hurdles members can face in achieving a comfortable retirement. Developing trust as well as understanding members' values are key elements of the conversation.

Jen recalls meeting a couple who were very anxious about their appointment.

"They weren't sure what to expect, were unsure about sharing some of their financial decision making and whether their funds were enough to last them in retirement," Jen says.

In reality, they were very realistic with their lifestyle expectations and were easily living within their means.

"After the meeting they mentioned that the experience was far less daunting than they imagined. They felt listened to, validated and more confident in taking the next step.

"At HESTA, our super advisers know that when it comes to retirement, planning is key. By taking

the time to engage with your super and access advice, you're less likely to worry about your finances at retirement.

"The real value in advice, in having control of your money, is having options available to you. This, combined with the peace of mind you get from an expert in their field, just can't be described in monetary terms."

*Retirement Income Worry: who worries and why? National Seniors Australia, January 2020. [Read the report.](#)

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CAROLINE RADOWSKI
Executive Manager
– Mental Health and
Wellbeing,
Brisbane North PHN



North Brisbane Safe Space Network

A proven, peer-led model delivering value-based mental health care and saving lives in North Brisbane and Moreton Bay.

As commissioners of health services, our responsibility is clear: invest in models of care that deliver high-quality outcomes, are cost-effective, and respond meaningfully to the needs of our communities. In North Brisbane and Moreton Bay, the Safe Spaces program is a proven model of evidence-based service that exemplifies the core principles of value-based health care.

Brisbane North PHN currently commissions four Safe Spaces in suburbs with high levels of need and distress at Bardon, Strathpine, Redcliffe, and Caboolture. These sites operate outside traditional business hours, offering people a safe and welcoming alternative to emergency departments (EDs) during times of emotional crisis.

Crucially, Safe Spaces are peer-led, trauma-informed, and accessible to all regardless of age, diagnosis, or referral status. They represent a shift from clinical-first models, focusing instead on early intervention, recovery, and human connection. The evidence of Safe Spaces' impact is clear.

Filling a system gap and reducing pressure on EDs

Traditional health systems struggle to support individuals experiencing psychological distress outside of normal operating hours. EDs, while always available, are not designed to respond to non-physical crises. As a result, people in distress often receive care that is inappropriate for their needs, while frontline hospital staff already under pressure must respond without the right tools or environment.

Safe Spaces offer an essential alternative. They provide immediate, non-clinical support that de-escalates distress and reduces the risk of harm. Since their establishment, they have supported the avoidance of 1,600 ED presentations equating to more than \$16.3 million in hospital-related cost savings between April 2022 and September 2024. This is not theoretical value; it is real, measurable return on investment in prevention and early intervention.



“One of the most unique strengths of Safe Spaces is the workforce. Staffed by individuals with lived experience, the peer model creates trust, empathy, and a sense of shared understanding that clinical services can sometimes lack.”

A complimentary model to the clinical system

The recent establishment of Medicare Mental Health Centres (MMHCs) has strengthened the service landscape, providing more options for individuals with moderate to severe mental health concerns. However, as commissioners, it is important to note that MMHCs do not replace the role Safe Spaces play. While MMHCs bring clinical care to the forefront, they operate during standard hours and are designed to treat people with diagnosis, ongoing conditions.

Safe Spaces complement this system by offering peer-led emotional support during after-hours periods, helping individuals manage immediate distress before it escalates to clinical levels. While there are some shared elements such as referral pathways and wraparound support, the core function and operating model of Safe Spaces are distinct. This complementary relationship strengthens the broader mental health ecosystem and offers consumers more flexible pathways to care.

Centring peer workforces and recovery-oriented practice

One of the most unique strengths of Safe Spaces is the workforce. Staffed by individuals with lived experience, the peer model creates trust, empathy, and a sense of shared understanding that clinical services can sometimes lack. This human connection is often what makes the difference for guests who feel isolated or misunderstood in their struggles.

The service environment is also purposefully non-clinical, calming, inclusive, and designed to de-escalate rather than diagnose. Guests are offered sensory tools, emotional safety plans, and the opportunity to participate in gentle group conversations or private reflection. In short, they are given space to breathe, regulate, and reconnect.

Feedback from service users has been overwhelmingly positive. In addition to the financial savings, 86 per cent of guests report reduced distress after their visit, and 74 per cent said the experience improved their ability to manage future stress. These are outcomes that speak to both quality of care and longer-term resilience central goals of value-based commissioning.

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“With sustainable funding, Brisbane North PHN can continue to strengthen and evolve Safe Spaces — an innovative, recovery-oriented model of distress care that is demonstrably saving lives.”

Strengthening What Works: The Case for Continued Investment

With sustainable funding, Brisbane North PHN can continue to strengthen and evolve Safe Spaces — an innovative, recovery-oriented model of distress care that is demonstrably saving lives. To assess its effectiveness and guide future planning, Brisbane North PHN commissioned an independent external evaluation over three years. This evaluation established a strong evidence base, confirming that Safe Spaces deliver meaningful outcomes for people experiencing emotional distress. The evidence is clear: Safe Spaces work.

The ongoing challenge is not proving their impact but ensuring their sustainability and continued innovation. Brisbane North PHN is working to secure long-term funding so that Safe Spaces can coexist with emerging services, including the new Medicare Mental Health Centres (MMHCs), and continue to play a vital role in a modern, person-centred mental health system.

Looking Ahead: The Need for Strategic, Long-Term Investment

Each year, Safe Spaces prevent an estimated 895 emergency department presentations and generate a net financial benefit of \$5.4 million after operating costs. But beyond the numbers, Safe Spaces offer something less easily measured: dignity, choice, and hope for people in emotional crisis.

As the system evolves to incorporate services like MMHCs, it's critical to protect the diversity of care models that underpin a responsive and effective mental health system. This includes recognising the distinct and essential role peer-led services play in suicide prevention, early intervention, and emotional support.

Our commissioning decisions today will define the mental health landscape of tomorrow. Investing in the long-term sustainability of Safe Spaces is not simply about maintaining a successful service it's about safeguarding lives, strengthening the health system, and delivering care that reflects the values we all aspire to accessible, person-centred, and driven by outcomes that matter. 



Health professional support a key response to family, domestic and sexual violence

For the first time, primary health care professionals will receive free, tailored, ACT-specific training to recognise and respond to early signs of family, domestic, sexual violence and child sexual abuse (FDSV).

FDSV, including child sexual abuse are serious public health issues that can cause significant physical, emotional, psychological and financial harm. It is estimated that a full-time General Practitioner (GP) is likely to see up to 5 women per week who have experienced some form of intimate partner abuse in the last 12 months. People who have experienced child sexual abuse are 2.4 times more likely to have 6 or more visits to a GP in the last 12 months.

Primary health care professionals, such as GPs, are often the first point of health professional contact for victim-survivors of FDSV, due to the physical injuries and/or mental health problems resulting from abuse and violence. GPs have

an important role to play in prevention, early identification and responding to disclosures appropriately.

a) Family Safety Pilot Program

Capital Health Network (CHN), ACT's Primary Health Network (PHN), through funding from the Australian Government has established the FDSV Training and Link Worker Support Pilot Program in the ACT. This initiative forms part of Supporting Primary Care Sector Response to FDSV.

CHN's Family Safety Team is expertly advised by a GP who, with her own lived and clinical experience, is in a unique position to provide specific advice and input into the development and delivery of the Pilot activities.

CHN has funded and partnered with specialist local FDSV organisations, Domestic Violence Crisis Service (DVCS) and Canberra Rape Crisis Centre (CRCC), to co-deliver the FDSV Program in the ACT. >

“By piecing together their history, and recognising signs, symptoms and patterns early on, GPs can apply their expertise to respond to FDSV.”

The program aims to support primary health care professionals recognise and respond to early signs of FDSV through:

- a range of free, RACGP-accredited, tailored and trauma-informed training and resources for the ‘whole-of-practice’ (non-clinical and clinical staff, including allied health staff within general practices and Aboriginal Community Controlled Health Services in the ACT).
- Link Workers embedded within DVCS and CRCC, providing a one-stop referral and advice point for practice staff, facilitating coordination of referrals from general practices to relevant support services, improving integration between primary health care and the FDSV sector, and enhancing service navigation for victim-survivors.

b) Incentives for general practices

By participating in CHN’s FDSV Program, general practices will gain:

- a one-off financial incentive of \$5000 to offset staff time associated with undertaking training
- mastery of respectful inquiry strategies and mechanisms to support victim-survivors
- debriefing support from Link Workers
- improved understanding of mandatory reporting requirements and legal responsibilities when supporting patients experiencing FDSV
- improved understanding of FDSV referral pathways.

c) Tips for GPs to recognise and respond to signs of FDSV

Abuse and violence in relationships can be hard to spot, both for the victim-survivor and for the GP. The signs may be subtle at first and gradually increase over time. Eventually the victim-survivor may feel they don’t know what ‘normal’ is meant to feel like, or what a healthy relationship is meant to look like.

By piecing together their history, and recognising signs, symptoms and patterns early on, GPs can apply their expertise to respond to FDSV. It is a good approach to consider the high prevalence of abuse and violence in your patients and in the wider community, and to reflect upon this in all patients presenting with chronic conditions such as migraines, gynaecological problems, mental health issues, pain and addictions. This list is not exhaustive, but these are common examples of clinical signs and symptoms, which upon deeper inquiry can lead to pattern recognition of FDSV.

Disclosures come from feeling safe and valued in the presence of a GP. It may take months or years of 15-minute consultations to gain the trust of a vulnerable person. When trust is gained, asking broad questions with leading statements like ‘we know that people with chronic medical conditions often have had a history of trauma, maybe something has happened in the past, or is happening now, do you think that might also be the case for you?’



If a patient is comfortable enough to disclose, your response as their GP may change the trajectory of their life. An invalidating response not only fosters doubt in the patients' mind, but also nurtures feelings of shame, which may further traumatise them.

The **LIVES** (Listen Inquire Validate Enhance Safety and Support) approach from the **World Health Organization** was designed to structure your

response to disclosures, so that you 'do no harm' whilst giving emotional and practical support to your patients. ^{ha}

If you would like more information about **CHN's Family Safety Pilot**, please contact Dr Suman Shetty: familyafety@chnact.org.au or 02 6287 8080.

You can see some **FDSV Resources** [here](#).

Become an AHHA member

Help make a difference on health policy, share innovative ideas and get support on issues that matter to you – **join the AHHA.**

The Australian Healthcare and Hospitals Association (AHHA) is the ‘voice of public healthcare’. We have been Australia’s independent peak body for public and not-for-profit hospitals and healthcare for over 70 years.

Our vision is a healthy Australia, supported by the best possible healthcare system. AHHA works by bringing perspectives from across the healthcare system together to advocate for effective, accessible, equitable and sustainable healthcare focused on quality outcomes to benefit the whole community.

We build networks, we share ideas, we advocate and we consult. Our advocacy and thought leadership is backed by high quality research, events and courses, consultancy services and our publications.

AHHA is committed to working with all stakeholders from

across the health sector and membership is open to any individual or organisation whose aims or activities are connected with one or more of the following:

- the provision of publicly-funded hospital or healthcare services
- the improvement of healthcare
- healthcare education or research
- the supply of goods and services to publicly-funded hospitals or healthcare services.

Membership benefits include:

- capacity to influence health policy
- a voice on national advisory and reference groups
- an avenue to key stakeholders including governments, bureaucracies, media, like-minded organisations and other thought leaders in the health sector

- access to and participation in research through the Deeble Institute for Health Policy Research
- access to networking opportunities, including quality events
- access to education and training services
- access to affordable and credible consultancy services through JustHealth Consultants
- access to publications and sector updates, including:
 - Australian Health Review
 - The Health Advocate
 - Healthcare in Brief
 - Evidence Briefs and Issues Briefs.

To learn about how we can support your organisation to be a more effective, innovative and sustainable part of the Australian health system, talk to us or visit ahha.asn.au/membership.

More about the AHHA

AHHA Board

The AHHA Board has overall responsibility for governance including the strategic direction and operational efficiency of the organisation.

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AHHA National Council

The AHHA National Council oversees our policy development program. The full list of Council members can be found at: ahha.asn.au/governance

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