



Co-design of digital health technologies in Australian First Nations communities

In *The Lancet Digital Health*, Israel Júnior Borges do Nascimento and colleagues¹ analysed current evidence of effects relating to several digital health technology (DHT) solutions, and health-care workers' performance and professional competencies. One of the unintended consequences of telemedicine was that it might increase health-care workers' burden and burnout (relative frequency of mentions in reviews 2.2%, 95% CI 0.3–7.9).¹ Recent findings from remote First Nations primary health-care providers showed that telehealth was associated with increased administrative and clinical workload because of the necessity to attend consultations with providers not on site, who were usually non-general practitioner (GP) medical specialists.² This necessity took local primary health-care clinicians away from their regular clinical work, especially from the management of complex chronic diseases.

In remote Australian First Nations communities—where the burden of disease is high, turnover of staff is extremely elevated, and health services are under-resourced—excessive workload and resultant burnout is widespread.^{3,4} Interventions that inadvertently increase burnout and turnover threaten the quality and safety of all health care for people living in the remote communities. We share early learnings from a digital health implementation project that is currently underway in a remote community in Australia.⁵ This Digital Health Cooperative Research Centre project is unique because it co-designs DHT solutions with both consumers and health-care workers, which is anticipated will minimise unintended consequences while optimising uptake by meeting the prioritised needs of both groups.

Initial engagement included workshops with remote health professionals; meetings and interviews with senior health executives, visiting clinicians, local health-care staff, and managers; and yarning (ie, informal and formal discussions) with First Nations people and community leaders. These discussions identified—from both community and service providers' perspectives—the most important access issues to primary health care that DHTs could address.

One example of a high priority for both consumers and health-care staff was effectively addressing the intermittent access to GPs who were known to the patients and health-care workers and who knew the community well, but only visited the community clinic 1 day each week. Remote primary health-care staff indicated that the added value of having telehealth access to a familiar GP in between face-to-face visits would greatly support provision of primary health-care services, including their ongoing management of chronic diseases, thereby assisting them with managing their workload, rather than being an added burden. For patients, being cared for by a GP who knew them well was important.

The co-design of DHTs, by taking into account consumers and providers' preferences, is a promising approach that is anticipated to improve access to primary health-care services.

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