RESEARCH AUSTRALIA

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Our Voice
Your Innovation

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Dear Natasha,

Response to the consultation on the MRFF Australian Medical Research and Innovation Priorities and the MRFF Act Review

Thank you for the opportunity to provide a response to the draft MRFF Australian Medical Research and Innovation Priorities and the MRFF Act Review and for the opportunity to participate in the Roundtable Discussion held on 6 September.

Research Australia is the peak body for the Australian health and medical research and innovation sector. Our membership is drawn from the whole pipeline of health and medical research and innovation, from universities and medical research institutes to charities and patient groups, and health care providers and companies commercialising new health technologies. We wanted to take the opportunity to respond to the consultation with a letter, rather than individual responses to each priority as our feedback is at a higher level that cuts across majority of priorities.

There are many positive enhancements that have been included in the draft priorities for 2022-24. Our main concern is the lack of cohesion that links all the priorities to drive transformation across the entire health and medical research and innovation ecosystem. Specifically, whilst we agree with the importance of dedicated priorities for *consumer-driven research, Aboriginal and Torres Strait Islander health, priority populations, and artificial intelligence and digital health*, we recommend these priorities also be considered as cross-cutting enablers across all priorities. Applying these enablers across all priorities will strengthen cohesion ensuring the MRFF continues to transform health and medical research and innovation to improve lives, build the economy and contribute to health system sustainability.

Priorities should be responsive to the National Health and Medical Research Strategy and MRFF and MREA alignment

Whilst we consider all priorities critical, an overarching strategic vision remains absent from the current priorities. We believe the National Health and Medical Research Strategy has the potential to fill this gap. Amidst a complex funding landscape, spanning at least five federal portfolios, states and territories, philanthropy, and private enterprise, structural inefficiencies and inconsistency impede progress. Discrete priorities without a unified direction and coordination risks duplication and waste, hindering advancement despite Australia's significant investments in healthcare. The MRFF, with the suggested priorities, has the potential to support this complex funding landscape and research priorities, however, without the National Health and Medical Research Strategy, the MRFF will run the risk of continuing to implement piecemeal activities.

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Further to this, the National Health and Medical Research Council (NHMRC) and the MRFF must not operate in isolation; rather, they should be integrated into the broader funding landscape and focused on turning research outputs into practical outcomes through enhanced coordination, including with bodies such as the Australian Centre for Disease Control, which is currently being established, and will utilise research findings in interventions for the prevention and control of disease. Our response to the consultation on Improving alignment and coordination between the Medical Research Future Fund and NHMRC's Medical Research Endowment Account provides further information and recommendations.

In addition, the priorities should be responsive to the Research and Development (R&D) Strategic Examination.

Alignment with other national strategies and priorities

The priorities would be strengthened through increased alignment with other national strategies and priorities. We note Priority 11 highlights the need for *Research into the health impacts of climate change should contribute to the policy objectives of the National Health and Climate Strategy.* Other priorities would also benefit from specifically identifying relevant national strategies and priorities to which they are aligned. For example, the new National Science Statement and new National Science Priorities, released in August 2024 provides an opportunity to position the health, disability and aged care sectors as an 'industry' that is vital to Australia's future success and prosperity. One of the five priorities is specifically *Supporting healthy and thriving communities.* An example of potential alignment between the MRFF with the Science Priorities include the focus on encouraging people to undertake STEM careers, however there is little on supporting the existing research workforce; the MRFF could contribute to this critical gap, through its workforce priorities, and in general across the priorities.

Workforce environments and workforce across the ecosystem

Additional focus in the priorities on creating and maintaining environments that enable health and medical researcher capacity and capability should be strengthened. For example, the draft Good Institutional Practice Guide (the Guide), released by NHMRC identifies the importance of workplace environments 'to promote open, honest, supportive and respectful institutional cultures conducive to the conduct of high-quality research'. Our response to the Guide provides further information. In addition, the workforce priority needs to be designed in a way to ensure it can immediately be responsive to the findings and recommendations of the impending workforce survey and audit.

Specifically, further prioritising of workforce models to enhance the allied health workforce and clinician researchers could be strengthened. We note the inclusion of clinician researchers in the priorities, however, building on both our response to the Draft Outline of the National Allied Health Workforce Strategy and our '*Clinician Researchers: Research activating the health system*', prioritising clinician researchers across the entire health and medical research and innovation ecosystem will strengthen a research active health system. Clinician researchers are health practitioners including medical, nursing and midwifery, allied health or other health professions, active in research. Effectively, clinician researchers hold two roles – being clinicians or health care practitioners and conducting research. By being truly embedded in Australia's health system, clinician researchers play an important bridging role between the research world and the health system, delivering better care and health outcomes for Australians.

Given the 'dual role' of clinician researchers, the decline in the clinician researcher workforce is a problem affecting both the traditional research side of the health and medical research pipeline – universities and medical research institutes – and the health system end of the pipeline – local health districts, primary health networks and public and private hospitals. The onerous application process and low success rates of some MRFF schemes (and existing NHMRC schemes) present a significant disincentive for clinician researchers who are already typically working long hours in our healthcare system. The MRFF has an opportunity to contribute to strengthening the clinician researcher workforce across the health and medical research and innovation research ecosystem.

Promoting genuine partnerships through consumer-led research

As noted earlier, it is critical to have a dedicated priority for consumer-led research to enable the system to be responsive to enable consumers, community and those with lived experience to be integrated into all aspects of research. However, consumer-led research should be an underpinning enabler across all priorities.

A move from engagement to genuine partnership with lived experience is a cornerstone of improvement in all aspects of the health system, including research. Implementing best practice in lived experience research ensures that the voices of those with lived and living experience are not only heard but also respected, valued and amplified in the research process. Lived experience researchers are not research participants but rather those who use their personal knowledge and expertise to inform the strategic direction, governance, design and delivery of research.

They are most prominent in mental health research, as well increasing in other human services sectors such as in the disability sector, in addressing research questions related to the delivery of care and service design. They have research expertise and may have formal qualifications, particularly in social sciences, but not necessarily a higher degree research qualification.

Those working in lived experience research roles consistently report challenges in being recognised within the research community. While their work is often referenced and utilised in policy, grey literature, service design and intangible knowledge sharing, there is little recognition or support of lived experience researchers in traditional funding or publishing methods. Often lived experience researchers are not able to be identified as a chief or principal investigator and may not even be acknowledged as a formal author or contributor to their work. There needs to be a recognition that expert lived experience researchers may not have a traditional research career pathway.

Within the current research system, a lack of formal recognition or publication of work makes finding future funding, permanent roles and research partners more difficult. It also significantly impacts the ability for research to engage with lived experience experts at the conceptualisation, design and planning stages, missing the opportunity for true co-design and resulting in often tokenistic engagement with lived experience.

As with all priorities, it is critical to align this priority with other policy agendas, frameworks and statements, such as the Statement on Consumer and Community Involvement in Health and Medical Research. Further information is provided in Research Australia's 2024 submission to this review.

Aboriginal and Torres Strait Islander Health and Priority Populations

As noted earlier, it is essential to have priorities dedicated to both Aboriginal and Torres Strait Islander Health and Priority Populations. However, both priorities should be an underpinning enabler across all priorities. Such as approach will continue to identify attitudinal, behavioural and systemic opportunities and barriers to a more response health and medical research and innovation ecosystem as well as address institutional discrimination and bias. For example, the strengths and expertise of elements in the Indigenous research methodologies and Indigenous data sovereignty agendas could be applied to non-Indigenous consumer-driven research. Or the need for all health and medical researcher capacity and capabilities to include culturally safety (for First Nations people and other culturally and linguistically diverse communities) and inclusion (of people with disability) to enable a workforce that is more reflective of Australia's diverse population.

We do wish to highlight a number of concerns with the current priorities in relation to the specific highlighting of people with intellectual disability. We encourage the inclusion of all people with disability. We also recommend that any mention of gender equity be expanded to include all priority populations and equity groups, as well as specific mention be made of those who may experience multiple discrimination through intersectionality, such as the participation of a First Nations woman with disability in consumer-led or lived experience research, or as a more traditional researcher.

Artificial Intelligence and Digital Health

As noted earlier, it is critical to have a dedicated priority for Artificial Intelligence (AI) and Digital Health to continue to be responsive to the opportunities both AI and Digital Health can offer the entire health and medical research and innovation ecosystem. In addition, research into better understanding the evolving risks and opportunities of the current and potential uses of AI across these domains is also critical, such as the use of synthetic data, inherent biases and community perceptions. However, AI and Digital Health as a method or tool, should be an underpinning enabler across all priorities.

Further information is provided in Research Australia's response to the consultation by the Department of Industry, Science and Resources on Safe and Responsible AI in Australia.

In response to how often MRFF Strategies and Priorities should be refreshed, to allow rapid response to emerging priorities while maintaining sufficient time for mobilisation of research efforts, our recommendation is for either the option Priorities: 3 years, Strategy 6 years; or an alternative schedule of Priorities: 4 years, Strategy: 8 years. We believe the rapid changing nature of a number of the priorities, such as AI and digital health, as well as global health security would not benefit if we were to implement the schedule of Priorities: 5 years, Strategy 10 years.

Specifically in response to supporting a change to the Act to enable states and territories to apply directly for MRFF funding, Research Australia acknowledges the critical role jurisdictions play in health and medical research and innovation. Enabling more flexibility of funding to enable jurisdictional bodies such as hospitals and local area health networks would strengthen health and medical research and innovation, and contribute to a research active health system. However, strong risk mitigation strategies to prevent funding being absorbed by the jurisdictions will be needed.

Thank you again for the opportunity to comment on the draft Priorities. We look forward to continuing to work closely with AMRAB and the Health and Medical Research Office to ensure that we collaboratively continue to transform health and medical research and innovation to improve lives, build the economy and contribute to health system sustainability.

Yours sincerely,

Nadia Levin
Chief Executive Officer
Research Australia