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Advancing health and medical research and innovation across Regional, Rural, Remote and Very Remote Communities in Australia

Policy Discussion Paper

November 2025

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Acknowledgements

Research Australia is the national peak body for health and medical research and innovation. We use our unique convening power to position health and medical research as a driver of a healthy population and contributor to a healthy economy. This report was delivered during a time of key national reforms, and we acknowledge the importance of this report in contributing to the reforms, and being responsive to an evolving landscape.

Research Australia acknowledges the many very remote, remote, rural and regional Countries across Australia and their Traditional Custodians. We pay our respects to Aboriginal and Torres Strait Islander Elders, past and present and acknowledge the vital role Aboriginal and Torres Strait Islander peoples and their cultures play in contributing to the health of their Country, their communities, as well as to Australia - as the first scientists, healers and story tellers of this land. We acknowledge the importance of Connection to Country for health and wellbeing.

Cite: Research Australia Policy Discussion Paper: Advancing health and medical research and innovation across regional, rural, remote and very remote communities in Australia Policy Discussion Paper 2025.

The drafting of this report was completed by Dr Talia Avrahamzon and Max Chester. Contributing staff members included Nadia Levin and Hayden Nichols. The development of the report was guided by a steering committee, with contributions from Associate Professor Martina Sanderson-Smith, Professor Marianne Wallis AM, Associate Professor Melissa Nott, Professor Coralie English, Ms Shirley Savey, Professor Anna Ugalde, Professor Tim Carey, Professor Victoria Traynor, Professor Kathryn Burdon. Guiding feedback was also supplied by the Rural Health Research Institute, Australian Health Research Alliance Rural Sub Committee, Equitable Cancer Outcomes across Rural and Remote Australia, University of Wollongong and VCCC Alliance. We greatly acknowledge all contributions and guidance.





Executive Summary

This policy discussion paper provides an overview of the current regional, rural, remote and very remote (RRRvR) health and medical research policy, funding and systems landscape. It identifies key priority areas for enhancing the importance of dedicated RRRvR research. An original version of this paper was developed to guide discussions at Research Australia's University Roundtable, held at Charles Sturt University, in July 2025[1]. The final version incorporates the feedback received at the Roundtable and further input from Research Australia's members.

A steering committee comprised of Research Australia's regional university members guided the original development of this paper. We acknowledge their contributions and guidance throughout the process. We also acknowledge all universities, research entities, health service systems, industry and consumer-based organisations committed to partnering with, strengthening and empowering RRRvR communities through health and medical research and innovation.

1. The Research Australia University Roundtable (the Roundtable), is a committee of Research Australia, providing a forum for discussion of matters of relevance to the University members of Research Australia which directly inform Research Australia's policy and advocacy platforms. The July Roundtable, held at Charles Sturt University, in Orange NSW, focussed on elevating the national discussion on health and medical research and innovation in regional, rural, remote and very remote (RRRvR) communities. Link to communique.

Recommendations

Priority Areas	Recommendations
Priority 1: Addressing funding inequities and funding sustainability through systems change	• Develop and implement a systems-wide approach to increasing applications and funding allocations to RRRvR health and medical research across funding policy, governance and decision making processes; • Create dedicated streams for RRRvR research within existing funding bodies; • Equitable funding should reflect the differing infrastructure, workforce limitations, and logistical challenges faced by RRRvR communities; • Prioritise longer-term strategic investment and grant funding (including the potential of block funding to health services) that supports community engagement and builds research infrastructure and capacity in RRRvR communities; • Increase representation for RRRvR research communities in policy development and funding assessment panels; • Consider further the application requirements of MM2-7 and ensure local communities are prioritised, including around eligibility, evaluation criteria, and inclusivity in the application process; • Increase monitoring and evaluation of funding distribution and impact; • In developing broader funding solutions for health and medical research and innovation including public-private partnerships, philanthropy, and regional innovation funds, ensure a focus on RRRvR; • Undertake a formal economic feasibility study to provide evidence for the real cost and long-term value of funding research in RRRvR areas.

Priority Areas	Recommendations

Priority 2: Acknowledging diversity and addressing equity and intersectional discrimination	• Ensure the diversity of RRRvR is embedded across funding allocations;
	• Embed an institutional / systems wide approach to ensure equity and address systemic intersectional discrimination through the development of an institutional tool, that can be both a monitoring and evaluating framework as well as aligned to an individual and organisational capability development program;
	• Ensure alignment between cultural and social determinants of health into the core research agenda, with dedicated programs linking health research to rural economic, environmental, and social policy to address inequities and build disaster resilience in RRRvR communities;
	• Amendment to the online processes in Sapphire for inclusion of community Co-Investigators;
	• Ensure assessment criteria recognise diverse research methodologies valuable in RRRvR contexts and include community impact and practice change as valid research outcomes alongside traditional publications;
	• Address digital access barriers to enable RRRvR community representatives to participate in MRFF applications;
	• Recognition of the different pathways into research and different research models (not the typical pipeline into research) – assessment of researchers should not be dependent on publications or citations by other researchers. New recognition models need to include prioritising the track record of RRRvR research into local and national policy and practice;
	• In recognising the role of Aboriginal Community Controlled Organisations and Health Organisations and a First Nations' led health and medical research and innovation focus:
	  • Establish dedicated research roles within ACCHSs by funding permanent research coordination and support positions to manage approvals, funding applications, and reporting;
	  • Broaden the research workforce by building research capacity across the full ACCHS workforce, including Aboriginal Health Workers, Liaison Officers, Allied Health professionals, and Aboriginal Health Practitioners;
	  • Create shared research–health service positions to embed dual roles that combine research and service delivery to improve workforce attraction, retention, and knowledge translation in RRRvR communities;
	  • Provide dedicated research infrastructure funding and include budgets in research grants for staff time, data extraction, administrative tasks, and use of facilities, vehicles, and accommodation;
	  • Fund meaningful community engagement and co-design and allocate specific resources for ongoing community involvement, co-design, and knowledge translation to ensure equitable and culturally grounded research partnerships.

Priority Areas	Recommendations
Priority 3: Strengthening research capacity	• Expand the definition in the Research Infrastructure Roadmap to include community engagement, not just industry engagement; • Ensure infrastructure included as part of research grants are implemented in the regions – not absorbed into the central university campus; • Strengthen local research and digital infrastructure to enable researchers to build capacity in local health services and communities and align with national and jurisdiction based digital health strategies, AI ethics frameworks, and the Australian Data Strategy; • Digital health and AI should be elevated as a core research priority and recognised as a key enabler of health equity; • Enhance data interoperability and timely access to RRRvR locally relevant datasets; • Establish dedicated national rural health translation centres or funding streams for implementation research, in close partnership with health services. These centres should act as regional hubs for implementation science, ensuring that research findings are rapidly translated into practice, adapted to local contexts, and scaled across RRRvR communities to deliver measurable health system impact. • Align the MRFF and NHMRC RRRvR focus to the National Research Infrastructure Roadmap to ensure national research infrastructure capabilities are designed by and for RRRvR communities; • Identify systemic ways for research approval processes to include capacity building in local communities as part of the research applications; • Develop standardised outcome measurement frameworks that can be applied across multiple health conditions while remaining sensitive to RRRvR contexts, moving beyond disease-specific metrics to include community-defined wellbeing indicators; • Establish strong and diverse methodological approaches suited to the reality of rural and remote settings and build capacity in reviewers and ethics committees to understand such methodological approaches; • Create cross-health condition data linkage protocols to examine health interactions and comorbidities specific to RRRvR populations, supporting more holistic health system insights.

Priority Areas	Recommendations
Priority 4: Workforce	• As part of the National Health and Medical Research Strategy Workforce Plan, develop a specific focus on the RRRvR research workforce strategy; • Develop / identify / implement models to increase RRRvR EMCRs and clinician researcher workforce including Career pathways for EMCRs, mentorship networks across metropolitan and RRRvR universities and incentives for clinician-researchers to remain in rural areas; • Develop / implement systematically planned, and resourced place based / region-wide research training models for health service workforce; • Implement integrated health condition research clusters that allow researchers to study multiple related conditions simultaneously, maximising workforce and resource efficiency in RRRvR areas; • Develop condition-neutral capacity-building frameworks to strengthen local research skills that are transferable across multiple health domains, reducing siloed expertise; • MRFF and NHMRC grants to establish long (>5 y), fixed-term Chair of Rural Research positions based in RRRvR locations, that are site rather than project specific; • MRFF and NHMRC grants to establish long (>5 y), fixed-term Chair of Rural Nursing Research positions; • Provide targeted funding and institutional support to enable nurse practitioners and clinical nurse specialists to lead and participate in applied, practice-based research and not be required to relocate to non-RRRvR areas; • Expand opportunities for doctoral and postgraduate study that allow nurses to remain in clinical practice while undertaking research, including scholarships, supervision networks, and institutional support to make research careers more accessible to RRRvR nurses; • Embed research components into undergraduate and postgraduate nursing curricula, with a focus on RRRvR health challenges; • Harness nurses' strong community connections and understanding of social determinants of health to design and implement participatory, community-driven research; • Provide competitive research funding specifically for nurse-led studies addressing RRRvR health priorities; • Australian Department of Health, Disability and Aged Care to provide for additional Rural Health Medical Training (RHMT) funds specifically for RRRvR led research.

Priority Areas	Recommendations
Priority 5: Genuine partnerships with RRRvR communities	• Develop a statement or set of principles to embed genuine partnerships in funding policy, assessment, governance systems and reporting frameworks; • Apply Indigenous research governance frameworks and collective impact models to propose principles for shared decision-making, data ownership, and long-term capacity building; • Less bureaucracy for MRFF and NHMRC reporting and more flexibility in being able to adapt the research and change budget items.
Priority 6: National coordination	• The National Health and Medical Research Strategy should elevate and embed RRRvR as a priority and be reflected in governance and accountability frameworks; • The ongoing collation and dissemination of MRFF and MREA RRRvR research funding data should be introduced as a priority; • Establish cross-institutional research ethics pathways to streamline approval processes for studies addressing multiple health conditions, reducing duplication and accelerating research translation; • Create a bipartisan national framework, with a dedicated focus on RRRvR, to guide long-term investment and coordination in Australia's health and medical data infrastructure; • Establish bilateral research agreements and participate in international rural health research networks with countries facing similar challenges (e.g., Canada, New Zealand, Nordic nations) to share data, models, and innovations.

Background – Regional, Rural, Remote and Very Remote Australia

Regional, rural, remote and very remote (RRRvR) Australian communities are vital to Australia's prosperity, culture, and identity, offering unique strengths that underpin the country's economic and social fabric. RRRvR communities are often characterised by strong social cohesion, tight-knit networks, and a deep connection to the land, fostering a sense of belonging and resilience[2]. The strengths and wellbeing benefits associated with living in these communities include higher levels of life satisfaction and overall wellbeing compared to their counterparts in major cities[3]. RRRvR Australia represent an under-utilised national asset, with significant potential for innovation, community-driven development, and a renewed focus on sustainable growth. Health and medical research and innovation plays a vital role in contributing to and elevating this potential.

2. Butterworth I, Duggan T, Greene R, McConnell M, Smith JA, Tegan S, Williams C, Lalchandani N, Stearn A. (2024). The importance of 'place' and its influence on rural and remote health and well-being in Australia. Aust J Rural Health. 2024 Aug;32(4):840-846.

3. National Rural Health Alliance. (2021). Mental Health in Rural and Remote Australia. https://www.ruralhealth.org.au/wp-content/uploads/2024/05/nrha-mental-health-factsheet-july2021.pdf Accessed 25 June 2025.

Approximately 7 million people – or 28% of the population in Australia – live in RRRvR communities[4], which encompass many diverse locations and communities. RRRvR communities are facing an unprecedented period of change arising from factors including an ageing population and workforce, a decline in skilled and essential workers, concerns about the sustainability of small regional towns and communities, the rise of remote work, the transition to a net zero economy, an increased risk of natural disasters and the impact of climate change[5].

4. Australian Institute of Health and Welfare. (2022). Rural and remote health. https://www.aihw.gov.au/getmedia/5100f01d-8db2-4380-ad24-8b78c492e290/rural-and-remote-health_archived-version-2022-07-07.pdf Accessed 25 June 2025.

5. Commonwealth of Australia. (2024). Review of Regional Migration Settings Discussion Paper – June 2024, p.3.

Despite the strengths of RRRvR areas, Australians living in these communities face unique challenges. Multiple analyses across a broad spectrum of policy areas have highlighted a breadth of inequities between RRRvR and non-RRRvR regions. In terms of health outcomes, this includes access to healthcare, maldistribution of the health workforce, as well as the social determinants of health (such as education, employment, housing) all impacting on the ongoing health and wellbeing of regional communities[6]. They also highlight a link between funding inequities, health outcomes and missed opportunities for innovation in RRRvR areas.

6. Monash University. (2023). The Driving Force Behind Improving Rural-Based Healthcare Research. Monash Lens https://lens.monash.edu/@medicine-health/2023/09/18/1386086/the-drivers-force-behind-improving-rural-based-healthcare-research Accessed 25 June 2025.

How do we leverage the strengths of 'regional, rural, remote and very remote communities' and 'health and medical research and innovation' and address these health inequities?

Regional, rural, rural and very remote (RRRvR) – a definition

Throughout this paper we use the term regional, rural, remote and very remote (RRRvR). We note the application of the Modified Monash Model (MMM) in identifying these regions, and how the MMM is an official framework used to identify and classify areas by remoteness and population size, guiding the distribution of the health workforce and services across Australia. It is also applied by research funders, including the Medical Research Futures Fund (MRFF) and the National Health and Medical Research Council (NHMRC).

The MRFF funds projects relevant to rural, regional, and remote health based on geographic classifications using the MMM, specifically MM 2 (regional centres) through MM 7 (very remote communities). The NHMRC defines 'rural health research' as research where activity descriptions or keywords include 'rural', 'remote', 'regional', 'country', or 'isolated'.

While the MMM provides a useful framework for resource allocation and workforce planning, we acknowledge that it does not capture the cultural, social, and contextual dimensions that shape community identity, resilience, and health priorities.

For the purpose of this paper, our use of the term RRRvR recognises both the MMM definition as well as diversity and the unique histories, values, lived experiences, and community assets that distinguish RRRvR regions and influence health and research outcomes.

Unique Positioning of RRRvR Research

The strengths of RRRvR research lies not in replicating metropolitan models, but in offering alternative, community-grounded approaches to health and medical research. Non RRRvR standards, or metropolitan standards, have become default benchmarks when considering health, education and other statistics and the reasoning for doing so is increasingly unclear[7]. This underpinning philosophy needs to be applied to health and medical research and innovation, so that we can collectively elevate the unique role of RRRvR research communities in helping to improve health outcomes locally instead of drawing comparisons with metropolitan settings. These communities have the agility, willingness and collaborative capabilities, and with appropriate investment and recognition, they will be both the beneficiaries of research and the leaders in creating solutions that serve all Australians.

7. T. A. Carey. (2025). Why Settle for Equity? Australian Journal of Rural Health 33, no. 2.

Further to this, health and medical research and innovation infrastructure, such as universities, research institutes, and health systems contribute to local communities through developing localised solutions – contributing to both a healthier community and a healthier local economy.

Case Study: Southern Cross University's Response to the 2022 Lismore and Northern Rivers Floods

Southern Cross University (SCU) played a critical role in emergency response and recovery during the catastrophic Lismore and Northern Rivers floods of 2022, leading efforts which were multi-faceted and deeply integrated into the community's needs.

SCU's Lismore campus became a lifeline – sheltering evacuees, hosting schools and essential services, and serving as a coordination hub for relief and recovery efforts. At the same time, SCU leveraged its academic capacity to address the health impacts of the disaster, from immediate medical care and mental health services to long-term research on community wellbeing and trauma treatment.

These combined efforts have solidified SCU's role as both a safe haven in times of crisis and a driver of recovery and resilience for the region. The lessons learned in 2022 are being translated into research and initiatives that will help ensure the Northern Rivers community is better prepared for future challenges. SCU's experience in the floods has, in many ways, exemplified its core values and its commitment to its community.

More information on SCU's response can be found here.

However, we need a national system that ensures and enables health and medical research and innovation to be led and undertaken in RRRvR communities. RRRvR research activities are not without distinct challenges, yet the unique connection to community allows for the co-design of projects that are better tailored to community needs and more likely to result in meaningful impact. Health and medical research and innovation that is led by local institutions, place-based, locally designed, and responsive to community needs leverage the existing leadership, connections and understanding of the communities being served. This, in turn, ensures research reflects lived experience and cultural contexts, builds on the localised social and cultural determinants of health, and addresses the specific systemic challenges (such as regional workforce development) faced in RRRvR settings.

RRRvR Policy Landscape – International, national and local

RRRvR policy sits within an already complex policy landscape of health and medical research and innovation. This diagram reflects some of the international, national and localised policy frameworks that inform, intersect and impact on RRRvR health and medical research and innovation (note these examples in the following table are not exhaustive).

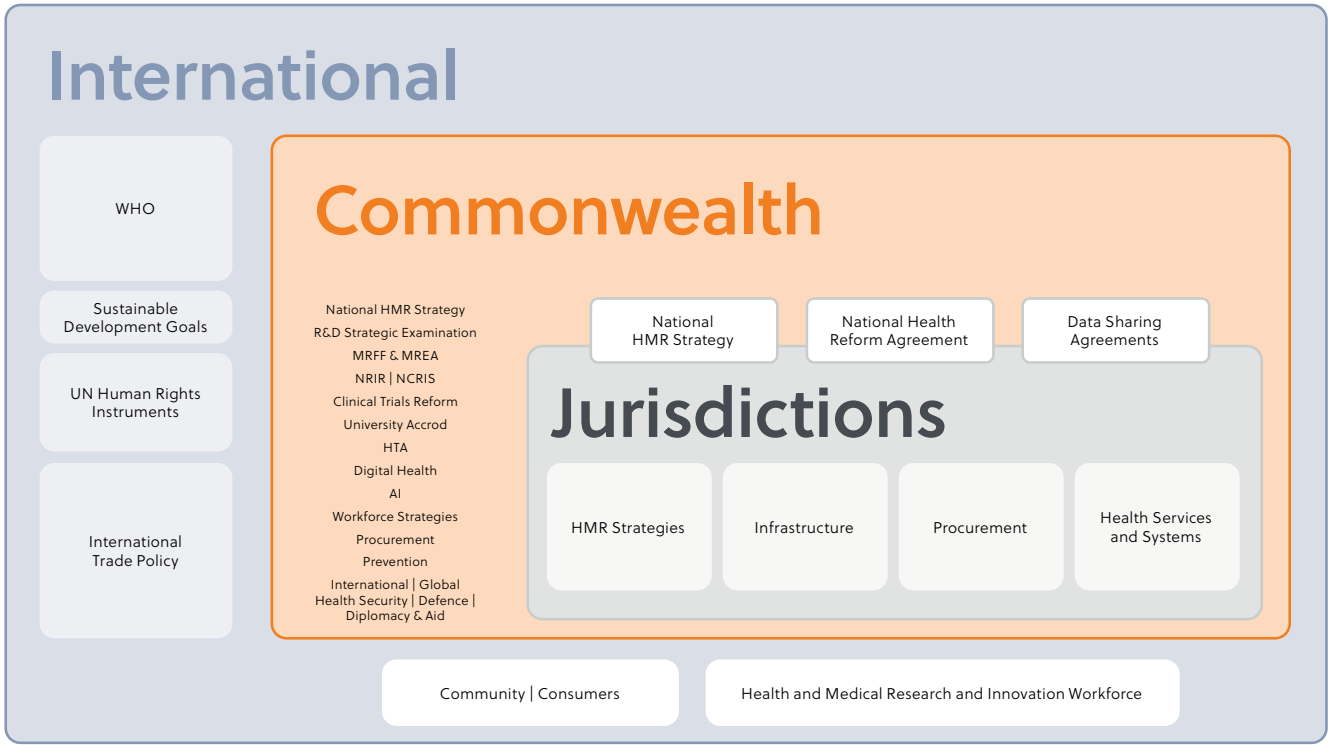


Table 1: Policy landscape of health and medical research and innovation, Research Australia

In relation to RRRvR specifically, whilst the following focuses on mental health, its example demonstrates the need and application of a line of sight from the International through to the local. The International Declaration on Rural Mental Health Research[8] offers a global framework of 10 guiding principles aligning closely with the sector's call for equity, community-led research, and structural reform. These principles, such as valuing lived experience, ensuring cultural safety, and embedding rural leadership, should be explicitly referenced in policy and funding streams to strengthen Australia's alignment with international best practice. Similarly, local frameworks, such as the Orange Declaration on rural and remote mental health[9] could be considered as a foundational document that articulates the unique challenges and strengths of rural and remote mental health systems for this region. Its emphasis on place-based, community-embedded approaches continues to resonate from the International Declaration. This should be reaffirmed in national strategies.

Furthermore, there are additional policy frameworks and agreements that support the realisation of obligations of government to the rights of particular populations, for example, Aboriginal and Torres Strait Islander peoples and disabled people. Not only are these guided by the UN Declaration of the Rights of Indigenous Peoples[10] and Convention of Rights of Persons with Disability[11], both of which Australia is a signatory, but also at a national and local level, informed by the National Agreement on Closing the Gap[12] and Australia's Disability Strategy[13] respectively. These are critical given the health disparities between Aboriginal and Torres Strait Islander people, and non-Indigenous populations; and between people living with disabilities and those who are not; and for some, are further impacted by intersectional experiences.

Despite increasing recognition of the disparities in health outcomes between RRRvR and non-RRRvR Australians, the national policy frameworks that contribute to elevating RRRvR remain fragmented. RRRvR health strategies fail to mention research; and research strategies fail to elevate RRRvR. At the time of beginning the literature review for this paper, the National Health and Medical Research Strategy Issues

8. Roberts, R., Munoz, S.-A., Thorpe, K., Dalton, H., Deacon, L., Meredith, D., Gussy, M., Bain, S. F., Swann, C., Lindstrom, M., Blanch, J., Beautrais, A., Silverblatt, H., Salvador-Carulla, L., Colgan, F., Heinz, T. D., Perkins, D., Russell, S., & Grattidge, L. (2024). International declaration on rural mental health research: 10 guiding principles and standards. Australian Journal of Rural Health, 32(4), 611-616.

9. Perkins, D., Farmer, J., Salvador-Carulla, L., Dalton, H., & Luscombe, G. (2019). The Orange Declaration on rural and remote mental health. Australian Journal of Rural Health, 27(5), 374-379.

10. United Nations. (2007). United Nations declaration on the rights of indigenous peoples. United Nations. https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html Accessed 14 August 2025.

11. United Nations. (2007). Convention on the Rights of Persons with Disabilities (CRPD). United Nations. https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf Accessed 14 August 2025.

12. Closing The Gap. (2020). National Agreement on Closing The Gap. Closing The Gap. https://www.closingthegap.gov.au/national-agreement/national-agreement-closing-the-gap Accessed 14 August 2025.

13. Department of Health, Disability and Ageing. (2021). Australia's Disability Strategy 2021–2031. Australian Government. https://www.disabilitygateway.gov.au/sites/default/files/documents/2025-01/5831-dss3513-ads-strategy-2021.pdf Accessed 14 August 2025.



Paper released in April 2025 did not mention a focus on RRRvR health and medical research. We acknowledge that the current draft released in August does have a focus on RRR. Similarly, whilst the 2020 National Strategy Framework for Rural and Remote Health promotes a national approach to policy, planning, design and delivery of health services, it does not elevate the importance of research.

RRRvR Funding Landscape

The NHMRC (through the Medical Research Endowment Account (MREA)) and MRFF remain the main funding bodies for research investment in RRRvR communities. Both the MRFF and the NHMRC express a commitment to funding research to bolster health and wellbeing in the regions. For example, the Australian Medical Research and Innovation Strategy 2021–2026, underpinning the MRFF states that:

Research funded through the MRFF will address existing areas of unmet health need, to address underinvestment and support capacity development with a focus on achieving equity in health outcomes, particularly for Aboriginal and Torres Strait Islander people and other priority populations[14].

14. Department of Health, Disability and Ageing. (2021). Australian Medical Research and Innovation Strategy 2021-2026. Australian Government. https://www.health.gov.au/sites/default/files/documents/2021/11/australian-medical-research-and-innovation-strategy-2021-2026.pdf Accessed 25 July 2025.

The MRFF categorises Australian's living in RRRvR areas as a 'priority population' in its 2024-2026 Priorities. An RRR focus has been embedded in several MRFF grant opportunities by promoting research that is:

- Conducted in an RRRvR location based on a MMM classification of MM 3 or above
- Conducted by a lead or administering organisation that is located in an RRRvR area based on a classification of MM 2 or above
- Conducted by a lead Chief Investigator and investigator team that are predominantly located in an RRRvR area
- Focused on priority populations such as Aboriginal and Torres Strait Islander communities and RRRvR communities

However, despite the requirement to consider the Priorities when making decisions on MRFF disbursements, it is difficult to determine how this is occurring due to the lack of transparent processes and available data specific to RRRvR research. In a retrospective study of publicly available data on NHMRC funded research projects aimed to specifically deliver health benefits to those living in rural or remote communities, Barclay et al. found an increase from 1% in 2000 to 2.4% in 2014[15]. This study, and the question it posed "does the investment match the need?" remains highly relevant, highlighting the ongoing chronic underinvestment in RRRvR health research despite clear evidence of need.

15. Barclay, L., Phillips, A., & Lyle, D. (2018). Rural and remote health research: Does the investment match the need? Aust J Rural Health, 26(2), 74-79.

A more recent 2022 MRFF Report on funding for rural, regional and remote health research[16], which provided analysis between 2017 to 2022, continues to demonstrate limitations to the available data, but also the ongoing disproportionate investment. Since its inception in 2015 until 30 April 2023, the MRFF has invested $297.4 million in 70 grants that focused on RRRvR health research or on research being conducted in RRRvR areas; and $86.5 million in 42 grants that were awarded to organisations located in RRRvR areas. Whilst the paper does not offer a comparative figure of all MRFF grants for the same period, between 2015 through to 30 June 2021, 670 grants with a total project value of $1.8 billion had been awarded through 142 grant opportunities under MRFF[17]. This again, demonstrates the disproportionate funding streaming towards RRRvR health and medical research and innovation. We do recognise the significant increase in the last few years by the MRFF to redress the historical funding disparities.

16. Department of Health and Aged Care (Australia). (2023). Medical Research Future Fund Report on funding for rural, regional and remote health research. Australian Government. https://www.health.gov.au/sites/default/files/2023-07/medical-research-future-fund-report-on-funding-for-rural-regional-and-remote-health-research.pdf

17. Australian National Audit Office (2021). Department of Health's Management of Financial Assistance under the Medical Research Future Fund. Australian Government. https://www.anao.gov.au/sites/default/files/Auditor-General_Report_2021-22_3.pdf

The MRFF Report also highlighted the disproportionate number of applications received from lead or administering organisations located in RRRvR areas classified as MM 2 and above, where a total of 130 applications reflecting only 3.7% of all applications compared to those in metropolitan areas (3346 applications or reflecting 96.3% of all applications with data available).

We note a number of the recommendations included in the MRFF Report have been identified as recommendations in this policy discussion paper. We encourage the ongoing collation and dissemination of MRFF and NHMRC data and analysis, and to increase investment in the monitoring and evaluation of the grants. The cost of not collating the data, and the inaction in not urgently addressing the disparity, risks further underinvestment which will only compound and exacerbate health inequities for RRRvR communities.

Where does RRRvR research happen?

RRRvR health and medical research and innovation occurs across different institutions. There are 12 universities with main operations based in RRRvR settings. There is also a significant number of metropolitan universities which have a presence in the regions. For example, university Departments of Rural Health (UDRH) and Rural Clinical Schools (RCS) are hubs for rural research, often linked to an urban campus for research support. UDRHs and RCSs foster a collaborative network of rural and urban researchers. Almost all universities, however, undertake forms of research in and with RRRvR communities.

Based on publicly available NHMRC funding data between 2022 and now (post-covid), the following provides further information about which institutions are receiving funding (noting that there is no available data specifically for RRRvR research per se).

Funding Summary Table

Institution Group	Total Funding (Million AUD)
Group of Eight Universities	$1,276.34 million
All other Universities	$614.63 million
All other institutions	$409.52 million
Regional Universities Network	$2.87 million

In summary, the Group of Eight Universities received the highest share of NHMRC funding, accounting for over $1.27 billion, reflecting their dominant role in Australia's research landscape. The Regional Universities Network received only $2.87 million, indicating a stark disparity in funding allocation. All other Universities and institutions received moderate funding, but still significantly less than the Group of Eight. The concentration of funding in the Group of Eight suggests a strong preference for established research infrastructure and capacity.

The policy implications of this demonstrate inequity in research funding, where there is a clear need to rebalance funding to support regional and emerging institutions, which are vital for inclusive national development. A potential approach is to have targeted investment introducing dedicated funding streams for regional universities which could foster innovation and address local health challenges. As noted previously, there is also a need for ongoing monitoring and evaluation of the distribution of funding to help ensure fair access and strategic growth across all institution types. Furthermore, capacity building to support infrastructure and talent development in underfunded institutions may yield long-term national benefits.

In addition to university-led research, there are a range of research institutes, organisations and local government agencies who deliver research activity in RRRvR communities. Local health services play a critical role in driving and sustaining research and should be better reflected throughout health and medical research and innovation policy. This includes recognising health services as both settings for and active contributors to research.

Every institution has a role to play in improving health outcomes through focussing on equitable research that prioritises RRRvR, however we need to recognise the different strengths, roles, and responsibilities different institutions should play.

Investing in RRRvR

Bolstering health and medical research and innovation capacity in RRRvR communities can have a profound and positive impact on local populations – for health outcomes, health care services, and the local economy. It enables the development of locally relevant solutions to health challenges, improves access to evidence-based care, and strengthens the local health workforce through training and career opportunities. Enhanced research capacity creates community engagement, empowers local voices in shaping health priorities, and supports culturally responsive and safe, place-based innovations. It also contributes to economic development and service improvement by embedding research within local systems, ultimately leading to better health outcomes and more resilient, self-determined communities.

RRRvR research institutions, including universities, have built strong reputations for leading health innovation in the communities within which they are located. This distributed network supports the development of a skilled regional research workforce and provides opportunities for training, career pathways, and the retention of researchers within RRRvR areas. Their work often combines clinical insight with social and environmental perspectives, recognising the intersection of health with broader determinants such as geography, culture, and access.

Case Study: Strengthening the primary care sector to support self-care of older people during disasters

The University of Wollongong (UOW) has a strong connection and sense of responsibility to its community and region from the Illawarra to the South Coast. In response to the multiple crises of 2020, the Global Challenges program developed an additional special initiative to encourage researchers to focus on disaster and crisis resilience in synergy with its underlying challenge areas. The funding secured through the Global Challenges Seed Funding initiative supported a team of UOW researchers to undertake a mixed method scoping study to explore the self-care of older people affected by disaster.

Findings showed that bushfires and the COVID-19 pandemic negatively affected older peoples physical and mental health with the bushfires having more significant impacts. The most affected older people were those with lower self-rated health and levels of resilience as well as fewer sources of support and social connection. The importance of building adaptive capacity within communities to mitigate the impacts of disasters was highlighted. Understanding older people's experiences of self-care during disasters is critical for developing interventions that are better targeted to their needs. Primary care as the frontline of health care delivery has a crucial role in contributing to interventions that support older people to stay healthy and socially connected not only during times of natural disaster but in the difficult days that follow.

It is hoped that these findings will inform the development of practice-based interventions and policy about ways to support the self-care of older people during a disaster. These studies provide a foundation for further regionally based research investigating the adverse impacts of disasters on the physical and mental health of older Australians and the critical importance of maintaining social connections.

Priorities

The following priorities were identified as critical in order to address chronic underinvestment in RRRvR health and medical research and innovation despite clear evidence of need. They are listed in priority order[18]:

18. These priorities.

Priority 1: Addressing funding inequities and funding sustainability through systems change

Priority 2: Acknowledging diversity and addressing equity and intersectional discrimination

Priority 3: Strengthening research capacity

Priority 4: Workforce

Priority 5: Genuine partnerships with RRRvR communities

Priority 6: National coordination

Priority 1: Addressing funding inequities and funding sustainability through systems change

In order to address funding inequities, a systems-wide approach needs to be incorporated into government research funding processes to increase a focus on RRRvR research. Increasing transparency of applying the MRFF priorities through governance structures; representation through workforce and capability development (ensuring those in decision making roles are representative of RRRvR and all understand the strengths and challenges of RRRvR); and in monitoring and evaluation of funding and impact should be addressed.

RRRvR representation in funding review panels may be increased to ensure appropriate expertise is represented. Likewise, building capacity across all review panels to understand the strengths, needs, priorities and challenges of RRRvR communities and research should also be strengthened. Embedding assessment processes to ensure genuine partnerships with local communities as part of research applications, not only based on the applicant's location in MM2-MM7, should be further developed, however, there is a need to ensure that applicants move beyond a tick box approach, and/or don't cause an unintended increased burden on local communities. This will ensure RRRvR communities are elevated to being a key stakeholder in both the application and assessment process. Some of the risks in not addressing this leads to restricted co-design and limited translation of findings into practice.

In addition, the creation of dedicated funding streams that support research in MM2-MM7 zones within existing NHMRC and MRFF structures also has the scope to expand and concentrate investment. Long-term strategic investment that contributes to building research capacity and infrastructure in RRRvR communities instead of short-term project funding should be strengthened. However, it is critical to note that health and medical research and innovation is funded through a range of sources, including public-private partnerships, philanthropy, and regional innovation funds. Strategies to diversify investment and accelerate rural health research and innovation should be explored through all of these funding streams.

Priority 1: Recommendations

- Develop and implement a systems-wide approach to increasing applications and funding allocations to RRRvR health and medical research across funding policy, governance and decision making processes;
- Create dedicated streams for RRRvR research within existing funding bodies;
- Equitable funding should reflect the differing infrastructure, workforce limitations, and logistical challenges faced by RRRvR communities;
- Prioritise longer-term strategic investment and grant funding (including the potential of block funding to health services) that supports community engagement and builds research infrastructure and capacity in RRRvR communities;
- Increase representation for RRRvR research communities in policy development and funding assessment panels;
- Consider further the application requirements of MM2-7 and ensure local communities are prioritised, including around eligibility, evaluation criteria, and inclusivity in the application process;
- Increase monitoring and evaluation of funding distribution and impact;
- In developing broader funding solutions for health and medical research and innovation including public-private partnerships, philanthropy, and regional innovation funds, ensure a focus on RRRvR;
- Undertake a formal economic feasibility study to provide evidence for the real cost and long-term value of funding research in RRRvR areas.

Priority 2: Acknowledging diversity and addressing equity and intersectional discrimination

RRRvR research settings across Australia are marked by significant diversity in geography, population, culture, research and health system capacity. These contexts range from densely populated regional centres with university infrastructure to sparsely populated remote and very remote communities with limited access to services and research support. Each setting presents distinct social, cultural, and environmental characteristics, including differences in health priorities, workforce availability, digital connectivity, and community expectations. Acknowledging this breadth of diversity is essential to designing and delivering research that is respectful, relevant, and responsive to the unique strengths and needs of each community. Utilising and investing in local research infrastructure is a central component in ensuring this is achieved across Australia.

One approach to recognising the diversity, is through integrating cultural determinants of health (such as cultural factors – such as connection to Country for First Nations people – that contribute to one's health and wellbeing) and social determinants of health (such as housing, education, transport, food security, and climate change) into the core research agenda, with dedicated programs linking health research to rural economic, environmental, and social policy to address inequities and build disaster resilience in RRRvR communities.

Aboriginal and Torres Strait Islander peoples, rights and research

Regardless of whether research is undertaken in RRRvR or non-RRRvR settings, the importance of ethical, culturally safe, responsive and locally informed research approaches, including working with Aboriginal and Torres Strait Islander community-controlled organisations, should be embedded across all research activities. As noted previously, the international and national policy landscape of both the UNDRIP (including recent Sessions of the UN Permanent Forum on Indigenous Issues (UNPFII) focussing on Indigenous determinants of health and Closing the Gap National Agreement), offer frameworks for ensuring genuine partnerships and self-determination, including in research activities.

During the Twenty-third Session of the United Nations Permanent Forum on Indigenous Issues (UNPFII), 2024, "Improving the health and wellness of Indigenous Peoples globally: operationalization of Indigenous determinants of health" was tabled. Key themes highlighted the centrality of self-determination, cultural identity, traditional knowledge, and connection to land as fundamental determinants of Indigenous health. The Forum recognised that persistent inequities was rooted in colonisation, dispossession, discrimination, and lack of culturally relevant services – continuing to drive poorer health outcomes for Indigenous Peoples globally. The session called for urgent, systemic change: centring Indigenous leadership, respecting Indigenous data sovereignty, empowering communities, and integrating Indigenous concepts of well-being into local and global health policy. The operationalisation of these determinants is critical for addressing health gaps, creating culturally safe health systems, and fulfilling international commitments to Indigenous rights, equity, and sustainable development.

Specifically in relation to health and medical research and innovation, the NHMRC and the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) sets out Ethical Guidelines[19] and Research Ethics Framework[20], respectively, with clear principles and responsibilities for undertaking research with Aboriginal and Torres Strait Islander communities, that should underpin RRRvR research.

19. See https://www.nhmrc.gov.au/research-policy/ethics/ethical-guidelines-research-aboriginal-and-torres-strait-islander-peoples

20. See https://aiatsis.gov.au/research/ethical-research/research-ethics-framework

These approaches are important across the research landscape to diminish forms of ingrained cultural insensitivity, including in areas such as governance practices for grant applications. As part of current research governance, applicants require a partner organisation letter of support by senior officers at grant application stage. It has been highlighted that many local organisations, including Indigenous community-controlled organisations, have infrequent Board meetings which, coupled with the short timelines of a targeted call or a MRFF scheme, does not allow the thorough scrutiny and deliberation that communities are entitled to exercise, especially considering historical experiences where research has not always delivered reciprocal benefit. Moreover, frequent changes to the required format or wording of support letters prevent the re-use of previously endorsed documents, imposing additional administrative burden on small local organisations, including Indigenous organisations. Addressing these structural barriers is essential to ensuring equitable participation and respectful engagement in health and medical research.

At a local level, Aboriginal Community Controlled Health Services and Organisations (ACCHS/Os) play a central role in delivering holistic, culturally safe healthcare in rural, regional, remote, and very remote communities, and their approach to health is fundamentally different from that of general GP-based primary care. Embedding research within ACCHSs therefore requires a tailored, community-driven model that reflects their unique structure and priorities. A key consideration is workforce capacity – establishing dedicated research positions to manage,



Cultural Advisors Nolene Dungun and Ada Parry with Aboriginal Health Practitioner Gregoriana Parker in Wadeye, NT. Image supplied by the Kids Research Institute Australia from their Optimising Rotavirus Vaccine in Aboriginal Children (ORVAC) Study, a collaborative research initiative in communities across the Northern Territory which aims to reduce the global burden of diarrhoeal disease in young children.

coordinate, and support research activities, including project approvals, funding applications, and reporting processes. Building research expertise across ACCHSs must extend beyond clinicians to include the full spectrum of the health and wellbeing workforce – Aboriginal Health Workers, Aboriginal Liaison or Community Support Officers, Allied Health professionals, and Aboriginal Health Practitioners. These roles bring essential cultural, community, and relational knowledge that strengthens both research relevance and impact. Developing sustainable and shared research-health service positions within ACCHSs can also enhance workforce attraction and retention in RRRvR areas, while ensuring that research and knowledge translation directly contribute to improved practice, policy, and health outcomes.

Equally important is the need for appropriate research infrastructure and funding mechanisms that recognise the additional responsibilities and resource demands placed on ACCHSs when participating in or leading research. Research funding should include dedicated budgets to support staff time for data extraction, administrative tasks, and the provision of physical resources such as office space, vehicles, and accommodation. In many remote locations, researchers rely on ACCHSs for these logistical supports, underscoring the need for fair remuneration. Moreover, sustainable research partnerships require ongoing investment in community engagement, co-design, and knowledge translation, ensuring equity and reciprocity throughout the research process. Embedding these structural and financial supports into research frameworks will enable ACCHSs to fully exercise their leadership in shaping and implementing health research that reflects Aboriginal priorities, values, and aspirations.

Addressing systemic intersectional discrimination

Addressing systemic intersectional discrimination in RRRvR health and medical research and innovation is critical as individuals can experience overlapping forms of systemic discrimination to accessing healthcare and achieving improved health outcomes. Discrimination based on gender, ethnicity/race, disability, sexuality, socioeconomic status, and geographic location interact in unique ways to amplify health inequities. The concept of spatial justice outlined in "Rural and remote health care: the case for spatial justice" provides a critical lens for understanding how geographic inequities intersect with other forms of disadvantage[21]. The argument that RRRvR communities face structural barriers that require not just more funding, but different kinds of evidence and engagement, supports the call for qualitative, community-informed research approaches. This is particularly relevant for regions where traditional metrics and sample sizes fail to capture lived realities.

21. Hayes, K., Coxon, K., & Bye, R. A. (2025). Rural and remote health care: the case for spatial justice. Rural Remote Health, 25(1), 8580.

Addressing systemic intersectional discrimination needs to be addressed at multiple levels, including attitudinal and behavioural changes, supported by systemic and institutional monitoring and evaluation, and capacity building approaches to support changes to address bias and deficit discourses. This needs to be underpinned across all aspects of institutions and systems, including leadership and values (beyond mission statements); governance, systems, policies and procedures; workforce – capabilities and capacity; and service offers (e.g. whether that be funders; research institutes; health service systems; research infrastructure such as ethics committees).

For example, despite the focus on both First Nations and RRRvR as MRFF priority populations, the research system and processes can inadvertently 'exclude' and discriminate against RRRvR communities, including First Nations co-investigators who are critical to co-design projects.

"The application process is really difficult for people outside of Urban areas with little IT and other support – we have had to not include some Chief and Associate Investigators because it has proven impossible to work out the challenges of just getting them registered and through the Sapphire process – the complicated authentication process has proven impossible! This is particularly so for Aboriginal researchers in remote areas – who are often the most important members of the team." Dr Christine Jefferies-Stokes – Paediatrician, researcher, Goldfields region of WA

In this example, the risk of not improving the application process will impact on the involvement of community co-investigators who are critical for project design, implementation and translation. The systemic digital access barriers prevents equitable research participation, and need to be urgently addressed. Expanding this, if we do not take a whole of systems reform approach to embedding a focus on RRRvR as well as a broader intersectional lens across the health and medical research system, an ongoing disconnect between the good intent of research policy value statements that include priority populations, and addressing research and health equity for RRRvR communities could widen.

Priority 2: Recommendations

- Ensure the diversity of RRRvR is embedded across funding allocations;
- Embed an institutional / systems wide approach to ensure equity and address systemic intersectional discrimination through the development of an institutional tool, that can be both a monitoring and evaluating framework as well as aligned to an individual and organisational capability development program;
- Ensure alignment between cultural and social determinants of health into the core research agenda, with dedicated programs linking health research to rural economic, environmental, and social policy to address inequities and build disaster resilience in RRRvR communities;
- Amendment to the online processes in Sapphire for inclusion of community Co-Investigators;
- Ensure assessment criteria recognise diverse research methodologies valuable in RRRvR contexts and include community impact and practice change as valid research outcomes alongside traditional publications;
- Address digital access barriers to enable RRRvR community representatives to participate in MRFF applications;

- Recognition of the different pathways into research and different research models (not the typical pipeline into research) – assessment of researchers should not be dependent on publications or citations by other researchers. New recognition models need to include prioritising the track record of RRRvR research into local and national policy and practice;
- In recognising the role of Aboriginal Community Controlled Organisations and Health Organisations and a First Nations' led health and medical research and innovation focus:
  - Establish dedicated research roles within ACCHSs by funding permanent research coordination and support positions to manage approvals, funding applications, and reporting;
  - Broaden the research workforce by building research capacity across the full ACCHS workforce, including Aboriginal Health Workers, Liaison Officers, Allied Health professionals, and Aboriginal Health Practitioners;
  - Create shared research–health service positions to embed dual roles that combine research and service delivery to improve workforce attraction, retention, and knowledge translation in RRRvR communities;
  - Provide dedicated research infrastructure funding and include budgets in research grants for staff time, data extraction, administrative tasks, and use of facilities, vehicles, and accommodation;
  - Fund meaningful community engagement and co-design and allocate specific resources for ongoing community involvement, co-design, and knowledge translation to ensure equitable and culturally grounded research partnerships.

Priority 3: Strengthening research capacity

Health and medical researchers in RRRvR communities face key infrastructure challenges, including poorer digital connectivity, inadequate data systems, limited access to research facilities, and shortages of trained personnel. In addition, geographic isolation and high travel costs further complicate fieldwork and collaboration. Many innovations in rural and remote communities have been driven by dedicated individuals but later lapse as they lack the appropriate facilities or ongoing support to maintain them[22]. In part, these issues are a symptom of sustained underinvestment by the NHMRC, MRFF, and other funding bodies in non-metropolitan research infrastructure as well as the opportunity to align the National Research Infrastructure Roadmap to emerging RRRvR priorities. The opportunity cost in not addressing RRRvR research infrastructure needs includes delayed translation of research findings into practice in RRRvR locations. The following provides some examples of increasing this capacity.

22. Department of Health, Disability and Ageing. (2020). National strategic framework for rural and remote health. Australian Government. https://www.health.gov.au/sites/default/files/documents/2020/10/national-strategic-framework-for-rural-and-remote-health.pdf Accessed 25 June 2025.

Digital Health Infrastructure

Addressing these infrastructure barriers and investing in new technologies, including digital health and AI is essential to building a strong, locally embedded health and medical research and innovation ecosystem in RRRvR communities. Strengthening local research and digital infrastructure has the scope to build significant capacity in local health services by enabling more efficient data sharing, access to clinical trials, and the implementation of evidence-based practices tailored to local needs. Furthermore, improved digital connectivity supports innovations such as AI, telehealth and remote research participation. These efforts enhance service delivery and create sustainable research ecosystems that directly benefit health outcomes.

Digital health and AI should be elevated as a core research priority, with investment in AI-enabled decision support, tele-trial networks, and digital health literacy programs to address RRRvR-specific challenges such as workforce shortages, telehealth access, and data connectivity, positioning digital transformation as a key enabler of health equity.

Data infrastructure

Building research capacity in RRRvR communities also requires the strengthening of data infrastructure. Not only is it critical to strengthen local research and digital infrastructure to build capacity, but there is also an essential need for systems that enable streamlined, secure, and efficient collection, linkage, and sharing of data across RRRvR areas. Enhanced data interoperability and timely access to locally relevant datasets are critical for informing research, driving evidence-based decision-making, and supporting collaboration across regions.

Other approaches to improving data infrastructure includes developing standardised outcome measurement frameworks that can be consistently applied across multiple health conditions while remaining sensitive to the unique social, cultural, and geographic contexts of RRRvR settings. Such frameworks could move beyond narrow, disease-specific metrics to incorporate community-defined indicators of wellbeing, ensuring that local priorities and perspectives shape how health outcomes are understood and measured. Strengthening data infrastructure also requires diverse and contextually appropriate methodological approaches that reflect the realities of rural and remote research environments. Building the capacity of research grant reviewers and ethics committees to recognise and support these methodologies is critical to enabling high-quality, locally grounded research. Finally, establishing cross-condition data linkage protocols will allow for the examination of health interactions and comorbidities specific to RRRvR populations, generating more holistic insights into health systems and outcomes. Together, these actions will create a more robust, inclusive, and responsive data ecosystem that empowers RRRvR communities to lead and sustain their own research agendas.

Case Study: CQ University AI-enhanced interventions to support mental health in communities disproportionately affected by climate-related disasters

CQ University has explored the integration of artificial intelligence (AI), particularly large language models (LLLMs), in addressing the mental health impacts of climate change, with a focus on supporting RRRvR communities. These areas are often disproportionately affected by climate-related disasters and face significant barriers to accessing timely and adequate mental health support.

The research proposes the co-design of AI-enhanced platforms, such as the ***Virtual Psychologist*** chatbot, to enable early detection and personalised support for climate-related psychological distress. By leveraging AI-driven innovations, including real-time natural language processing, the article examines how digital mental health tools can bridge service gaps in underserved areas.

While such technologies show promise, challenges remain in ensuring culturally sensitive and emotionally intelligent responses, safeguarding user data, and tailoring interventions to diverse regional populations.

Collaborations

Another approach to increasing capacity is to promote cross-collaboration across the health and medical research and innovation ecosystem and between universities, researchers and organisations to further strengthen research networks in RRRvR communities. Ensuring that the research collaborations are supported by principles of genuine partnerships can ensure different collaborators contribute to leveraging the different strengths across the ecosystem and increase research capacity building, throughout the research lifecycle, at the local level. However, collaboration, including with communities, should be strengthened across the policy, funding and research systems. For example, the current disparate funding streams and limited visibility of investment at the local level prevent communities from being part of co-creation and co-designing integrated service systems[23].

23. Woolcock. Gregg. Groth (2025) Policy alignment for place-based solutions for better health outcomes in rural and remote communities. Deeble Institute for Health Policy Research. Perspectives Brief 34. Australian Healthcare and Hospitals Association.

Another important aspect of research capacity is in its application to evidence-based policy and translation. Mechanisms to support research translation, including a focus on health services research, implementation science, knowledge translation hubs, or other models for scaling successful local pilots nationally is critical. For example, consideration for establishing dedicated national rural health translation centres or funding streams for implementation research, in close partnership with health services could be

explored. These centres should act as regional hubs for implementation science, ensuring that research findings are rapidly translated into practice, adapted to local contexts, and scaled across RRRvR communities to deliver measurable health system impact.

Additionally, while the 2021 National Research Infrastructure Roadmap[24] is bench to bedside focussed – Section 6.3, Research Translation, considers only infrastructure to support 'industry' engagement for product delivery. However, research translation in RRRvR also requires 'community' engagement to build research capacity. We acknowledge that the next iteration of the Roadmap is currently under development, providing a real opportunity to expand the definitions for infrastructure to include support for community engagement activities to build research capacity in the community.

24. Department of Education. (2021). 2021 National Research Infrastructure Roadmap. Australian Government. https://www.education.gov.au/national-research-infrastructure/resources/2021-national-research-infrastructure-roadmap Accessed 14 August 2025.

Case Study: Impact Tas: A partnership project which is improving access to evidence-based osteoarthritis care across the State of Tasmania.

With strong executive buy-in, cash investment from partner organisations and in-kind support from the Tasmanian Health Service, the University of Tasmania has successfully implemented a new model of care for osteoarthritis in the public health system. Good Life with osteoArthritis from Denmark (GLA:D®) is an evidence-based exercise and education program that has proven effectiveness in 10 countries, including Australia. In collaboration with the Department of Health and Primary Health Tasmania, the team has established a referral pathway to GLA:D® via an eReferral process, which has resulted in beneficial change to health practice and increased health system efficiency. The project has improved access to exercise and physiotherapy in the State. It has upskilled regional allied health professionals in best-practice osteoarthritis management, resulting in improved quality of care and improved patient outcomes.

Priority 3: Recommendations

- Expand the definition in the Research Infrastructure Roadmap to include community engagement, not just industry engagement;
- Ensure infrastructure included as part of research grants are implemented in the regions – not absorbed into the central university campus;
- Strengthen local research and digital infrastructure to enable researchers to build capacity in local health services and communities and align with national and jurisdiction based digital health strategies, AI ethics frameworks, and the Australian Data Strategy;
- Digital health and AI should be elevated as a core research priority and recognised as a key enabler of health equity;
- Enhance data interoperability and timely access to RRRvR locally relevant datasets;
- Establish dedicated national rural health translation centres or funding streams for implementation research, in close partnership with health services. These centres should act as regional hubs for implementation science, ensuring that research findings are rapidly translated into practice, adapted to local contexts, and scaled across RRRvR communities to deliver measurable health system impact.
- Align the MRFF and NHMRC RRRvR focus to the National Research Infrastructure Roadmap to ensure national research infrastructure capabilities are designed by and for RRRvR communities;
- Identify systemic ways for research approval processes to include capacity building in local communities as part of the research applications;
- Develop standardised outcome measurement frameworks that can be applied across multiple health conditions while remaining sensitive to RRRvR contexts, moving beyond disease-specific metrics to include community-defined wellbeing indicators;
- Establish strong and diverse methodological approaches suited to the reality of rural and remote settings and build capacity in reviewers and ethics committees to understand such methodological approaches;
- Create cross-health condition data linkage protocols to examine health interactions and comorbidities specific to RRRvR populations, supporting more holistic health system insights.

Priority 4: Workforce

The disparities in health workforce recruitment and retention between RRRvR and non-RRRvR communities are well documented. Compared to the overall population where 27% live in RRRvR areas (26% of all employed individuals work in RRRvR locations), only 13% of the HMR workforce live in regional or remote areas[25]. Specifically for the health and medical research and innovation workforce, the 2024 Australian Health and Medical Research Workforce Audit highlighted researchers in regional areas often raised the difficulty of accessing the same opportunities available to researchers in metropolitan locations, citing training and funding as difficult to access[26].

25. Department of Health, Disability and Ageing. (2024). The Australian Health and Medical Research Workforce Audit. Australian Government. https://www.health.gov.au/sites/default/files/2024-11/the-australian-health-and-medical-research-workforce-audit.pdf Accessed 25 June 2025.

26. Ibid.

Case Study: James Cook University (JCU) Cohort Doctoral Studies Program (CDSP)

Upskilling RRRvR health professionals to undertake research whilst living and working in a RRRvR community is a model that has been successfully implemented by the James Cook University (JCU) Cohort Doctoral Studies Program (CDSP).

This innovative program supports working health professionals to complete a research degree, with a strong focus on publishing research and research translation. Just some of the many examples of research translation into practice as part of the scheme include:

- Research leading to the development of a national culturally-sensitive smoking cessation program for pregnant Aboriginal and Torres Strait Islander women;
- Research influencing NSW Health tuberculosis policies for inclusivity of Aboriginal Australians;
- Research examining at-home infusion pump drug delivery in the tropics which resulted in alterations to practice;

Research engagement of health professionals who live and work in RRRvR communities has many benefits beyond the educational gains of the individual. These health professionals not only understand the health needs of their communities, they also have important links in the community and are likely to remain in the community.

Harnessing solutions that arise in rural and regional areas for local problems builds regional capacity, and often has implications for health care more broadly, and avoids one size fits all solutions.

Nearly 30% of Australians live in regional, rural, remote or very remote (RRRvR) communities – critical to the nation's prosperity, culture, and identity, offering unique strengths shaping Australia's economic and social fabric. Charles Sturt University Orange Campus pictured.



Dedicated holistic, whole of pipeline RRRvR workforce models should be supported, and if needed developed. The models should include focussing on Early to Mid-Career Researchers (EMCRs) and clinician researchers, as well as research intensive and leadership positions that focus on the creation of rural hubs. Such leadership positions should be viewed as critical infrastructure for progressing RRRvR research and not linked to individual projects (only).

Recognising pathways beyond traditional researcher pathways, as well as considering the importance of creating a research-active whole of RRRvR health system through strengthening the research capacity of the existing health services workforce is critical in research translation, implementing evidence-based practice, and working towards health equity. In doing so, research training should be supported by a systematically planned, implemented, and resourced place based / region-wide research training models[27]. The lack of a holistic, workforce pipeline approach increases the risk of RRRvR clinicians not engaging or retaining in research activities and a lack of attraction and retention of EMCRs, and other researchers in RRRvR locations.

27. Quilliam et al. Design and implementation characteristics of research training for rural health professionals: a qualitative descriptive studyBMC Medical Education (2023) 23:200

Further to this, in RRRvR communities, "clinicians" could be expanded to include other healthcare workers such as Aboriginal Health Practitioners, Health Workers, Community Support Officers, Allied Health professionals, and others who play vital roles in RRRvR care delivery and research. Clinicians often cannot have their time 'bought out' to conduct research due to severe workforce shortages. Models that rely on clinician time must be re-thought in the context of RRRvR health systems.

Another challenge is the transient workforce patterns in RRRvR areas which in turn require investment in systems and environments that support research continuity beyond individual staff. This includes supporting small, flexible, community-led projects that build local capacity.

Taking a sector lens, nurses play a vital and often under-recognised role in strengthening the health and medical research ecosystem across RRRvR communities. As the largest health workforce in these areas and frequently the primary point of care, nurses are uniquely positioned to lead and inform research that reflects the realities of rural healthcare delivery. Yet, current research priorities often overlook nursing research leadership, leaving limited pathways for nurses to shape policy and innovation. Furthermore, recognising that nurse practitioners and clinical nurse specialists frequently function as de facto primary healthcare providers in RRRvR contexts underscores the need for dedicated research support and professional development. Creating pathways for nurses to pursue doctoral studies while remaining in clinical practice, such as those modelled by James Cook University (JCU), would further integrate research into everyday care. Additionally, embedding nursing education and research within rural clinical training is essential – through student research projects addressing community health priorities, integration of research methods into clinical placements, and mentorship programs that pair students with local healthcare teams for practice-based research. Finally, nursing's deep

community connections and understanding of the social determinants of health make it an invaluable conduit for participatory and contextually grounded research. Strengthening nursing research leadership and infrastructure would not only elevate its role but also enhance the quality, relevance, and sustainability of health research in RRRvR Australia.

Priority 4: Recommendations

- As part of the National Health and Medical Research Strategy Workforce Plan, develop a specific focus on the RRRvR research workforce strategy;
- Develop / identify / implement models to increase RRRvR EMCRs and clinician researcher workforce including Career pathways for EMCRs, mentorship networks across metropolitan and RRRvR universities and incentives for clinician-researchers to remain in rural areas;
- Develop / implement systematically planned, and resourced place based / region-wide research training models for health service workforce;
- Implement integrated health condition research clusters that allow researchers to study multiple related conditions simultaneously, maximising workforce and resource efficiency in RRRvR areas;
- Develop condition-neutral capacity-building frameworks to strengthen local research skills that are transferable across multiple health domains, reducing siloed expertise;
- MRFF and NHMRC grants to establish long (>5 y), fixed-term Chair of Rural Research positions based in RRRvR locations, that are site rather than project specific;
- MRFF and NHMRC grants to establish long (>5 y), fixed-term Chair of Rural Nursing Research positions;
- Provide targeted funding and institutional support to enable nurse practitioners and clinical nurse specialists to lead and participate in applied, practice-based research and not be required to relocate to non-RRRvR areas;
- Expand opportunities for doctoral and postgraduate study that allow nurses to remain in clinical practice while undertaking research, including scholarships, supervision networks, and institutional support to make research careers more accessible to RRRvR nurses;
- Embed research components into undergraduate and postgraduate nursing curricula, with a focus on RRRvR health challenges;
- Harness nurses' strong community connections and understanding of social determinants of health to design and implement participatory, community-driven research;
- Provide competitive research funding specifically for nurse-led studies addressing RRRvR health priorities;
- Australian Department of Health, Disability and Aged Care to provide for additional Rural Health Medical Training (RHMT) funds specifically for RRRvR led research.

Priority 5: Genuine partnerships with RRRvR communities

As noted previously, RRRvR health and medical research and innovation is undertaken by many research institutions. Sometimes, but not always, these institutions are located within the communities they are researching. However, centring partnerships with the local community should be elevated and embedded in the policy, funding, and research system. Further, intergovernmental and cross-sector collaboration remains inconsistent. Whilst there may be some ad hoc efforts within some communities, such as collective impact initiatives, there is no overarching national framework being used by Government to operationalise bringing national policy makers together with local stakeholders around a shared purpose of improving health and wellbeing at a local community or population level[28].

28. Woolcock. Gregg. Groth (2025) Policy alignment for place-based solutions for better health outcomes in rural and remote communities. Deeble Institute for Health Policy Research. Perspectives Brief 34. Australian Healthcare and Hospitals Association

There are many existing frameworks and statements that could be adapted to ensure this occurs. For example, the Closing the Gap National Agreement[29] Priority Reform 1 sets out clear examples of genuine partnership and governance models that could inform the development of a statement and principles of genuine partnerships with RRRvR communities. Taking this approach also promotes reciprocity and capacity building – and ensures that self-determination underpins this partnership. Partnership governance models are required to prevent tokenistic and also overly bureaucratic approaches. This may require strong linkage with other recommendations for systems reform, including focussing on workforce and as an example, enabling community health nurses and Aboriginal and Torres Strait Islander health workers to be elevated to essential partners in co-design processes.

29. Closing The Gap. (2020). National Agreement on Closing The Gap. Closing The Gap. https://www.closingthegap.gov.au/national-agreement/national-agreement-closing-the-gap Accessed 14 August 2025.

Statements such as the NHMRC Statement on Consumer and Community Involvement in Health and Medical Research[30] or the NHMRC Statement on Sex, Gender, Variations of Sex Characteristics and Sexual Orientation in Health and Medical Research[31] could inform the development of a RRRvR statement. In addition, broader research movements that centre particular communities of interest, such as work emerging from the National Disability Research Partnership or the Indigenous Data Sovereignty movement could be adapted for a similar approach to ensuring genuine partnerships are prioritised in funding policy, assessment, governance systems and reporting frameworks (as noted previously).

30. NHMRC. (2016). Statement on Consumer and Community Involvement in Health and Medical Research. NHMRC. https://www.nhmrc.gov.au/about-us/publications/statement-consumer-and-community-involvement-health-and-medical-research Accessed 14 August 2025.

31. NHMRC. (2024). Statement on Sex, Gender, Variations of Sex Characteristics and Sexual Orientation in Health and Medical Research. NHMRC. https://www.nhmrc.gov.au/research-policy/gender-equity/statement-sex-and-gender-health-and-medical-research Accessed 14 August 2025.

In developing such a statement , we could explore –

What do different partners bring to the partnership to ensure local RRRvR's research capabilities are strengthened?

As noted previously, the funding system also needs to be responsive to genuine partnerships. For example, due to the inherent unpredictability of co-design projects, budget variations are commonly required to adapt to community recommendations. The process for variations is cumbersome and time consuming and delays to approval can hinder project progress. The risk of not addressing this bureaucratic process can lead to delays in project delivery. For example, "It's been 3 months since we submitted an amendment and we haven't heard back about it" (Associate Professor Julia Marley, CIA $3.2M MRFF co-design project).

Priority 5: Recommendations

- Develop a statement or set of principles to embed genuine partnerships in funding policy, assessment, governance systems and reporting frameworks;
- Apply Indigenous research governance frameworks and collective impact models to propose principles for shared decision-making, data ownership, and long-term capacity building;
- Less bureaucracy for MRFF and NHMRC reporting and more flexibility in being able to adapt the research and change budget items.

Priority 6: National coordination

The National Health and Medical Research Strategy, currently in development, offers a unique opportunity to set RRRvR health and medical research and innovation as a national policy direction, direct funding, and increase monitoring and evaluation in RRRvR health and medical research and innovation.

A significant aspect of national coordination is the collation and dissemination of data. It is well established that an abundance of data is collated and there is a range of data assets, such as Australian Bureau of Statistics Person Level Integrated Data Asset[32] and Australian Health and Welfare Health Data Hub[33], as well as National Research Infrastructure including Australian Research Data Commons and Population Health Research Network. However, the lack of national leadership and a long-term strategy to optimise Australia's health and medical data, limited discoverability due to fragmentation, barriers to timely data access, the need for strategic consolidation under national stewardship, under-developed person-centred data infrastructure, and undefined long-term investment continuity, all risk data value realisation for RRRvR and beyond[34]. In order to address this fragmentation and impacts, there is a critical need for a bipartisan national framework involving government, industry, and the broader health and medical research community. Such a framework should guide long-term investment and coordination in Australia's health and medical data infrastructure, enabling world-leading data-driven research, improvement, and innovation.

32. See https://www.abs.gov.au/about/data-services/data-integration/integrated-data/person-level-integrated-data-asset-plida

33. See https://www.aihw.gov.au/reports-data/nhdh

34. See https://researchaustralia.org/wp-content/uploads/2025/07/Communique-Long-term-Strategic-Guidance-of-Australias-Digital-Health-and-Health-Data-Infrastructure-Final.pdf

Nationally coordinated data infrastructure capabilities, with dedicated focus on RRRvR underpins realising many of the priorities detailed in this paper, including research capacity and genuine partnerships. For example, the fundamental need to ensure the collation and sharing of health outcomes data with researchers and local communities is essential to enable the assessment and monitoring of improvements in relation to community priorities at the individual level and to understand population need[35]. Data sharing agreements, such as demonstrated in the National Agreement of Closing the Gap Priority Reform 4 – Shared access to data and information at a regional level, is an example of ensuring data is disseminated at a local level in order to make localised decisions, and could be embedded in the development of the Genuine Partnership Statement / set of principles or standards set out in the recommendations of Priority 5.

35. Woolcock. Gregg. Groth (2025) Policy alignment for place-based solutions for better health outcomes in rural and remote communities. Deeble Institute for Health Policy Research. Perspectives Brief 34. Australian Healthcare and Hospitals Association

Priority 6: Recommendations

- The National Health and Medical Research Strategy should elevate and embed RRRvR as a priority and be reflected in governance and accountability frameworks;
- The ongoing collation and dissemination of MRFF and MREA RRRvR research funding data should be introduced as a priority;
- Establish cross-institutional research ethics pathways to streamline approval processes for studies addressing multiple health conditions, reducing duplication and accelerating research translation;
- Create a bipartisan national framework, with a dedicated focus on RRRvR, to guide long-term investment and coordination in Australia's health and medical data infrastructure;
- Establish bilateral research agreements and participate in international rural health research networks with countries facing similar challenges (e.g., Canada, New Zealand, Nordic nations) to share data, models, and innovations.

Conclusion

RRRvR research communities in Australia have a unique capacity to lead effective place-based health and medical research to bridge current gaps in health outcomes and elevate the strengths and priorities of the communities. They have the agility, willingness and collaborative capabilities, and with appropriate investment and recognition, these communities will be both the beneficiaries of research and the leaders in creating solutions that serve all Australians. A coordinated national policy and funding framework – elevated and embedded through a range of governance systems, is urgently needed to harness the strengths of RRRvR research bodies and address long-standing inequities. Building on the demonstrated capabilities of RRRvR institutions and ensuring sustainable investment in research infrastructure and the workforce will be essential in addressing equity and centring the aspirations, priorities and needs of RRRvR communities.



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