AUSTRALIAN CENTRE FOR HEALTH ACCESS RDN
Australian Centre for Health Access — A social enterprise of RDN

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RDN response to the MRFF Australian Medical Research and Innovation Strategy 2026-2031 and Priorities 2026-2028

RDN's Australian Centre for Health Access (ACHA) welcomes the opportunity to respond to the draft Medical Research Future Fund (MRFF) Australian Medical Research and Innovation Strategy 2026-2031 and Australian Medical Research and Innovation Priorities 2026-2028.

About ACHA

ACHA is a social enterprise of RDN – the Charity for Health Access, focusing on applied research, innovation and practical health access solutions. ACHA supports RDN to share successful evidence-based approaches beyond NSW and Australia - to improve health access for rural, remote and other under-resourced communities.

The context for the draft MRFF Strategy and Priorities

ACHA supports a more focused set of priorities linked to the Strategic Objectives and to clearer delineation between the National Health and Medical Research Council (NHMRC) and the Medical Research Future Fund (MRFF), with the MRFF focused on translation and implementation. ACHA supports the proposed vision, shared enablers and focus on health equity, Aboriginal and Torres Strait Islander community-based, governed and directed research; and determinants of health, digital health and workforce capability. Across the proposed priorities, investment should consider whether research, technologies and models of care can be delivered and accessed across primary and social care, community, and rural and remote settings. This includes local research participation and training, community-based governance, Indigenous data sovereignty, digital access and bias, service capacity and implementation.

Changes that would enhance the Strategy and its Impact

1. Health access for rural, remote and under-resourced communities should be visible in how the strategy is delivered, not just assumed

Rural and remote communities are recognised within the MRFF Priority Populations, but the strategy should more clearly address whether research can be delivered in the settings it is intended to benefit. Workforce availability, service capacity, distance, transport, affordability, infrastructure and digital connectivity can affect implementation. Research investment should include primary and social care, community-based services, Aboriginal Community Controlled Health Organisations and rural and remote services, rather than be concentrated around metropolitan and academic settings.

2. Broad terms need clear, measurable definitions before they can guide grant decisions

Terms such as workforce capability, system capability, co-design, embedded research and translation need clearer definitions so applicants can show what they will do and how success will be assessed. Applications should identify the intended change, who will use the research, how communities are

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involved, and how uptake and sustainability will be assessed. Training or participation alone should not be treated as evidence of increased capability.

3. Integrated digital health systems should support service integration, not substitute for it

Digital integration should strengthen coordination across general practice, community services, Aboriginal Community Controlled Health Organisations, allied health, specialist services and hospitals. In rural and remote communities, implementation should account for connectivity, affordability, workforce, technical support and local service capacity. Success should be assessed through access, coordination, continuity of care and health outcomes, not technology use alone.

4. A climate-resilient health system should be defined by continuity of access to care

Health system resilience should include whether people can continue to access essential services during and after environmental disruption. Rural and remote research should consider workforce, transport, communication, referral pathways, medicines and supplies, infrastructure and digital connectivity, with local communities and health services involved in identifying relevant risks and responses.

5. Geographic location and access to health services should be named as a determinant of health

Geographic location and access to health services should be recognised as determinants of health. In rural and remote communities, distance, transport, workforce and service availability, infrastructure and digital connectivity can interact with socioeconomic conditions. The priority should also recognise Aboriginal and Torres Strait Islander concepts of health, including family, community, culture, Country, and social and emotional wellbeing.

6. Embedding research in the health system, and building a sustainable research workforce, need to reach rural, remote and other under-resourced settings

Embedding research should mean more than locating a researcher within a service. Funded projects should show how local services, health professionals and communities shape priorities, design, implementation and use of findings, and whether local services are best to generate and use research after funding ends. Research opportunities, protected time, mentoring, infrastructure and training should extend to rural and remote services, primary care, community health and Aboriginal Community Controlled Health Organisations.

7. Priority populations should have a defined role in relevant research

Priority populations should have a defined role in relevant research, including priority setting, co-design, decision making, implementation and evaluation. The approach should also recognise that people may experience several overlapping barriers to health access.

Summary

ACHA supports the overall direction of the draft Strategy and Priorities. This feedback focuses on how these commitments will be carried through into future MRFF grant opportunities across different geographic and service settings.

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ACHA recommendations:

ACHA recommends that health equity, translation, implementation and the Shared Enablers apply across primary care, community health, rural and remote services and other under-resourced settings. Grant opportunities should clearly define capability, translation, embedded research and community involvement, and specify how these will be assessed. Geographic location and access to health services should be recognised as determinants of health, and health system resilience should include continuity of access to essential care.

Research investment should support local participation and research training, meaningful roles for priority populations, and coordination across health services. Artificial intelligence research should consider bias, digital access and testing across diverse settings. Research involving Aboriginal and Torres Strait Islander peoples, communities or data should specify community governance, decision making and Indigenous data sovereignty arrangements. Rural proofing should be used, where relevant, to identify unintended consequences for rural and remote communities.

Prepared on behalf of the Australian Centre for Health Access (ACHA)

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