

SUBMISSION OF THE GEORGE INSTITUTE FOR GLOBAL HEALTH

Medical Research Future Fund Reducing Health Inequities Mission - National Consultation on the
Roadmap and Implementation Plan

September 2026

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About The George Institute for Global Health

The George Institute for Global Health is a leading independent global medical research institute with major centres in Australia, India and the UK, and an international network of experts and collaborators. Our mission is to improve the health of millions of people worldwide, particularly those experiencing inequity. Through a program of research, advocacy, thought leadership, and disruptive social entrepreneurship, we are driving global impact.

The George Institute for Global Health acknowledges the traditional owners of the lands on which we work, and in particular the Bedegal people, on which our Sydney office is situated. We pay our respects to Elders past, present, and future. We value and respect the ongoing connection of Aboriginal and Torres Strait Islander peoples to Country and seek to work in partnership with communities to deliver better health outcomes.

Overview

The George Institute welcomes the establishment of the MRFF Health Inequities Research Mission and its focus on improving health outcomes for populations and communities experiencing inequity. This submission supports the Mission’s intent while identifying opportunities to strengthen the final Roadmap and Implementation Plan so that it addresses the drivers of inequitable health outcomes in Australia.

The submission argues that health equity cannot be achieved through the health system alone. Greater emphasis is needed on upstream prevention research, cross-sector approaches and the systemic determinants of health. It also recommends that research translation, implementation and evaluation be embedded from the outset of the Mission, rather than treated as separate, later-stage activities. Further, we argue that health systems research is essential for progress towards achieving health equity, and the principle of proportionate universalism should guide the Mission’s aims.

The George Institute recommends that the Mission strengthen its focus on Aboriginal and Torres Strait Islander leadership, self-determination and Indigenous knowledge systems, recognising First Nations peoples as knowledge holders and leaders. Finally, we highlight the need to embed sex and gender as cross-cutting determinants of health across all priority areas, and to recognise women as a priority population because of persistent and systemic health inequities.

Key Messages

- **Health inequities are driven by factors outside health care.** *Priority should be given to prevention research that address systemic and structural drivers of inequities.*
- **Structural barriers reinforce inequities and hinder progress towards equity.** *Identifying, designing, implementing and evaluating health system structures is essential for embedding sustainable action towards health equity.*
- **Equity should be embedded in the Mission's core architecture.** *Priority populations remain important, but equity should be built into governance, funding, implementation and evaluation.*
- **Aboriginal and Torres Strait Islander peoples are knowledge holders and not only a “priority population”.** *Health equity requires shifting power to communities through self-determination.*
- **Sex and gender are fundamental determinants of health and are important drivers of health inequities.** *Sex and gender should be embedded across all priority areas in the Mission and women be included as a priority population.*

I. Health equity will be achieved outside health care

Priority should be given to cross-sector and upstream prevention research

The George Institute welcomes the focus on addressing the social, cultural, economic, structural, political and commercial determinants of health through the Health Inequities Research Mission. However, a stronger emphasis on prevention is needed across the Mission to ensure it achieves its aims. Priority should be given to cross-sector collaborative research that applies systems approaches to address the root causes of health inequities.

Research suggests that up to 80 per cent of health outcomes are influenced by factors outside the health care system.¹ While access to and use of health services are important determinants of health equity in Australia; medical care alone plays a relatively limited role in shaping population health outcomes. Social injustice outweighs genetic factors or health-care access in influencing health outcomes, and so research on health equity must be firmly committed to tackling the systemic causes of social injustice including structural oppression.²

The growing burden of chronic disease in Australia demonstrates the importance of prevention that addresses the upstream determinants of health. One of the leading preventable contributors to chronic disease, disability and premature death in Australia is poor diets. The risks posed by unhealthy diets are clear: they are linked to a range of chronic conditions, including hypertension, cardiovascular disease, diabetes, and obesity.³

Yet when it comes to preventing disease and promoting wellbeing, the playing field is not level, with the most disadvantaged groups affected the most. For example, not everyone can access affordable, healthy food, and the social determinants of health including income level and where we live have a strong role to play influencing health outcomes. Aboriginal and Torres Strait Islander peoples, people on low incomes, those living in rural and remote areas, and those with lower levels of education face the greatest barriers to good health and wellbeing and experience a disproportionate burden of chronic disease. Risk factors for chronic disease, due to unequal social, economic, and environmental conditions, are also more prevalent among so-called disadvantaged groups.⁴ Once these risk factors have progressed to illness, opportunities to achieve equitable health outcomes are already limited.

Health inequities cannot be closed without a stronger focus on prevention. Prevention is central to achieving health equity because it addresses the conditions that give rise to poor health before inequities become entrenched. While the Mission appropriately includes research on Health-in-All Policies, preventive health and health promotion, a stronger emphasis on cross-sector prevention research should be embedded across all priority areas as a fundamental principle.⁵

More research is needed on structural drivers of health equity

Most research on social determinants of health has focused on factors at the individual level, whereas more understanding is needed on upstream structural drivers of social conditions that have the potential to create systemic changes in population health outcomes.⁶

This includes not only addressing downstream behavioural risk factors such as diet, physical activity and smoking, but also investigating the broader systemic drivers of health, including housing, education, food security, income and racism. Consistent with a systems-based approach, prevention should be framed more broadly than clinical early intervention.⁷ The Mission should explicitly emphasise the importance of upstream population-level interventions, including regulatory, fiscal, food-system and urban-planning measures that address the structural determinants of health and reduce inequities before they emerge.

This approach is consistent with the WHO's expanded conceptualisation of social determinants of health that includes not only “the conditions in which people are born, grow, live, work, and age,” but also the “wider forces that shape the conditions of daily life”.⁸

Research should move beyond understanding the problem to implementing solutions

The implementation plan for the Health Inequities Research Mission recognises the importance of research translation, through *Priority area 2.2 Strengthening research translation to ensure emerging health inequities research is accessible, understood and applied by end-users*. However, in its current form, research translation is treated as a distinct activity rather than an essential component of investigative research. Further, while implementation, evaluation and translation are referenced throughout the Roadmap and Implementation plan, research translation appears late in the Mission (2033/34) and receives less than 7% of the Mission’s overall funding.

There is already extensive evidence documenting the causes of health inequities.⁹ The greater challenge in addressing health inequities is not understanding the problem but implementing and scaling effective solutions in different contexts. Future research investment through the MRFF should place greater emphasis on identifying, implementing and scaling effective policy and practice solutions, particularly in partnership with communities most affected by inequity.

While *Priority Area 2.2* appropriately focuses on strengthening research translation, separating translation from the broader research agenda risks reinforcing a linear model in which knowledge is produced first and translated later. In practice, implementation and translation need to be embedded from the outset of research design.¹⁰ Consideration of feasibility, relevance, and community acceptability should occur alongside research development, not after findings are generated, which greatly enhances the chances of research findings being feasible and practical to implement.

This is particularly important given the well-documented challenges associated with translating research evidence into practice. Only a fraction of research innovations are ever implemented, and those that are, take an average of 17 years to be translated into a real-life setting.¹¹

Recent evaluation of The MRFF Cardiovascular Health Mission found that only a third of projects under this mission implemented a suite of translation activities and most research projects did not engage early with practice change partners and clinicians. As part of this evaluation, Review participants thought that increased or longer-term funding would support more transformative research, and this was particularly relevant for enabling effective consumer and community engagement. More community-driven research is needed, with investment focused on research and translation activities that are community-led and designed.

A similar principle should be reflected in the Mission's evaluation approach, which predominantly includes measures relating to healthcare access and service utilisation. These indicators are important, however, on their own they provide only a partial picture of health inequities. The evaluation approach should also include qualitative indicators, including Patient Reported Measures that improve understanding of how and why people interact with health services. For example, the Australian Human Rights Commission's review into health inequities, found that including lived experience and community voices alongside quantitative indicators was crucial in understanding the pervasive and systemic nature of racism and its impacts on health.¹²

II. Achieving health equity requires structural change within health systems

Health systems research is a fundamental component towards embedding sustainable efforts to address health inequities

There is increasing international recognition that to achieve meaningful societal change, scale, and enduring progress towards health equity requires new approaches to the health system that align all areas of the system towards equitable outcomes. Without an increased focus on the structural drivers of health inequity within the system, ¹³the existing process of developing and implementing health policies and reforms will continue to delay action towards equity due to systemic barriers and structures that defer and delegate equity actions and responsibilities.

Health equity is often unaddressed or delayed not because of resistance to the goal itself, but because of structural barriers within the health system. Addressing inequities are repeatedly deferred due to competing priorities in health policy and program design and implementation because responsibilities are diffuse, accountability is weak, resources are constrained and implementation is judged against short-term measures of scale, efficiency and viability. ¹⁴Decisions to defer action shape who benefits, who is visible to the system, what infrastructure is developed and what becomes feasible. There continues to be

limited knowledge on the underpinning systemic structures and mechanisms driving deferral of action and the solutions necessary to overcome this. Health systems research is a critical part of the equity research space to identify the knowledge to address these structural challenges.

The Mission would be strengthened through promoting greater emphasis on equity-centred health systems research that identifies and determines the mechanisms, structures, power balances, contexts and decision-making processes through which inequities are produced, recognised, addressed or allowed to persist and the opportunities to address these. This ensures that not only is research identifying and demonstrating solutions to address critical inequities, but also working towards establishing the structures, accountabilities, and responsibilities that sustain these actions, while also strengthening the capacity to detect and respond to emerging and intersectional inequities. Furthermore, we recommend that MRFF fund equity-oriented evaluations alongside all major health reforms and policies to explicitly identify and address opportunities for optimising reforms and contribute to the broader international evidence.

Equity should be embedded in the design of the Mission, not only reflected through priority populations

The Mission identifies priority populations that experience disproportionate burdens of poor health and barriers to care. However, consideration should also be given to embedding equity within the core architecture of the Mission itself, rather than primarily approaching health inequity through discrete population categories.

Rather than treating equity as an additional consideration, equity should be embedded within governance, funding, implementation and evaluation structures from the outset. This is consistent with public health approaches such as proportionate universalism, which combines universal goals with differentiated investment, support and implementation according to need.¹⁵

This approach complements, rather than replaces, the identification of priority populations by ensuring equity is a core design feature of the Mission.

III. Aboriginal and Torres Strait Islander peoples are knowledge holders and not only a “priority population”

Health equity requires shifting power to communities through self-determination

The George Institute strongly supports the prioritisation of Aboriginal and Torres Strait Islander peoples within the Mission. The final Roadmap and Implementation Plan should further strengthen commitments to First Nations leadership, self-determination and Indigenous knowledge systems across all aspects of

the Mission. Health inequities for Aboriginal and Torres Strait Islander peoples are rooted in historical and contemporary power imbalances including the ongoing impacts of colonisation, discrimination and racism.

As such, the Mission should support approaches that strengthen self-determination and shifting decision making to Aboriginal and Torres Strait Islander organisations and communities. This includes community-controlled governance of research priorities, Indigenous-led design and delivery of health programs, participatory grant models that transfer funding decisions to Aboriginal and Torres Strait Islander organisations and supporting Indigenous data sovereignty approaches that enable communities to control the collection, ownership and use of data about their peoples and communities. The George Institute's Guunu-maana program is an example of what self-determination can look like in a research setting. Guunu-maana's research is driven by community priorities, with Aboriginal and Torres Strait Islander leadership of research governance and decision-making.

The draft Roadmap and Implementation plan requires participants to “empower people with relevant lived-experience” and “be in partnership with relevant health and community services” including Aboriginal Community Controlled Health Organisations. However, while we support Aboriginal and Torres Strait Islander peoples being considered a “priority population” given the extent of health inequities for First Nations peoples and communities, the Mission needs to better recognise First Nations peoples as and knowledge holders and leaders in generating and translating evidence.

Research funded through the Mission should adopt strengths-based approaches that recognise the leadership that already exist within Aboriginal and Torres Strait Islander communities. Historically, research has often framed Aboriginal and Torres Strait Islander peoples through a deficit perspective, focusing primarily on disadvantage and disease burden.¹⁶ While understanding inequities remains important, future investments should also prioritise research that enables community-led priorities. By building on existing strengths and community knowledges, these approaches are more likely to lead to interventions that are relevant, culturally appropriate and sustainable.¹⁷

Self-determination should be a foundational principle, which means moving beyond consultation and participation towards shared authority and decision-making across all stages of research.¹⁸ Community partners and Aboriginal Community Controlled Health Organisations should be fully and appropriately funded through research grants to participate as equal partners throughout the research, translation, implementation. Without changes to decision making structures and resourcing arrangements, efforts to build capability and participation risk reinforcing existing power imbalances rather than addressing them.

Research should move beyond evidence generation to community-led implementation and impact

For many longstanding health inequities affecting Aboriginal and Torres Strait Islander peoples, the challenge is not a lack of evidence regarding what works but the continued failure to adequately resource evidence-informed solutions identified by communities.¹⁹ The Mission should prioritise investment in implementation research and community partnerships that support the adoption, adaptation and sustainability of known solutions. This recognises that community-led approaches are more likely to be culturally appropriate, trusted and effective in improving health outcomes.²⁰

The Mission should incorporate dedicated funding streams and workforce-building requirements that support Aboriginal and Torres Strait Islander researchers at all career stages, particularly early and mid-career researchers. Grant opportunities should also support Aboriginal lead research and invest in the capability of Aboriginal Community Controlled Health Organisations to participate in research, translation and implementation partners. This would help build sustainable research leadership while ensuring evidence generation and translation remain grounded in community priorities.

IV. Sex and gender are fundamental determinants of health and are important drivers of health inequities

Sex and gender should be embedded across all priority areas in the Mission

The George Institute welcomes the Mission's focus on addressing the social, cultural, economic and structural determinants of health inequity. However, the current Roadmap and Implementation Plan do not sufficiently recognise sex and gender as determinants that shape health outcomes, healthcare experiences and access to care across the life course.

Historically health and medical research have been conducted with little regard for sex and gender, based on an assumption that, aside from health conditions that relate to reproductive organs, diseases present similarly in males and females.²¹ We now know that this assumption is wrong. A significant body of evidence demonstrates that many health conditions present differently, disproportionately or exclusively according to a person's sex and gender.²² These differences influence disease risk, symptom presentation, diagnosis, treatment effectiveness, health service utilisation and health outcomes.

The continued neglect of sex and gender in research as a significant public health risk, creating a significant barrier to achieving equitable health outcomes.²³ Failure to adequately account for sex and gender in research contributes to poorer quality evidence and limits the effectiveness of health interventions and policy responses.²⁴

Understanding sex and gender-based health differences is critical to improving health outcomes for all people and should be considered a cross-cutting principle of the MRFF Mission. This is consistent with the requirement to embed sex and gender considerations into all research through the *NHMRC Statement on Sex, Gender, Variations of Sex Characteristics and Sexual Orientation in Health and Medical Research*.

Women should be considered a priority population in the Mission

While sex and gender neutrality in health research and practice limits better health care for all people, it has a notable detrimental impact on women's health outcomes.²⁵

Women continue to face inequitable gaps in arising from sex and gender bias in research, healthcare and policy, resulting in gaps in diagnosis, treatment and health outcomes.²⁶ Recent analysis conducted by the World Bank and McKinsey showed that women experience 25% more years in poor health compared with men, which has significant socioeconomic implications. These inequities are reflected throughout the Australian health system. Women experience delayed diagnoses, under-recognition of symptoms, and poorer healthcare experiences in a range of conditions.²⁷ Women and girls face greater barriers than men and boys in access to health information and services and face gendered bias in the health care system partly based on a lack of awareness and training among health care providers.²⁸ The Centre for Sex and Gender Equity in Health and Medicine, at The George Institute for Global Health, was recently commissioned by the Australian Government to conduct a national audit of sex and gender in medical and health curricula to measure this gap.²⁹

The lack of clinical trial evidence and lack of sex-disaggregated data collection remains a significant driver of health inequities for women.³⁰ Major causes of death and ill health including mental illness, cardiovascular disease, autoimmune conditions and chronic pain, are underresearched, underdiagnosed, and undertreated.^{31 32} Inequities are further compounded for Aboriginal and Torres Strait Islander women, refugee and migrant women, trans and gender-diverse people, poorer women and women living with disability.³³

Recent investment through the NHMRC in women's health is a welcome development, and awareness of these evidence and treatment gaps is improving. However, major gaps remain across all areas of women's health, spanning basic science, clinical trials, clinical guideline development, medical education and training and health policy.³⁴³⁵ Including women as a priority population in the Health Inequities Mission would enable critical research focused on implementation, translation and intersectionality.

V. Conclusion

The George Institute welcomes the Australian Government's commitment to reducing health inequities through the new MRFF Health Inequities Research Mission. The MRFF Missions program is a critical investment in research that improves health outcomes for Australians, and the establishment of a dedicated Health Inequities Mission is an important step towards addressing the underlying drivers of health inequity and closing persistent health gaps across Australia.

This submission has identified key areas that would strengthen the Mission and support its long-term impact. Priority should be given to research that addresses the systemic determinants of health outside the health care system, with prevention embedded across all priority areas. Research translation, implementation and evaluation should also be integrated from the outset, so that evidence is not only generated but implemented in partnership with the communities most affected by inequity. A focus on health systems research is needed to ensure the systemic barriers towards achieving health equity are understood and addressed, and equity needs to be build into the core architecture of the Mission and not only pursued through priority populations.

We believe that the Mission needs a stronger commitment to self-determined approaches. While we strongly support a focus on health inequities faced by Aboriginal and Torres Strait Islander peoples, more focus is needed on the existing leadership and strengths-based solutions that exist in First Nations communities. Achieving health equity requires epistemic justice, and funding for research should centre Indigenous knowledge systems, sovereignty, and lived experience.

Finally, we believe the omission of sex and gender as fundamental determinants of health represents a significant missed opportunity within the Health Inequities Mission. Sex and gender shape health risks, experiences of illness, access to care, treatment, and health outcomes. We recommend that sex and gender be embedded as cross-cutting determinants of health in the Mission and women should be recognised as a priority population given the systemic inequities they experience in the health system.

The George Institute thanks the Australian Government for considering this submission and looks forward to supporting the continued development and implementation of the Mission to improve health equity across Australia.

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