

Submission to the Draft

Reducing Health Inequities Mission Medical Research Future Fund (MRFF)

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A note about terminology:

The term '**culturally and linguistically diverse**' with the associated acronym '**CALD**' is widely used in Australia to describe populations other than the Anglo-Celtic majority.

We view '**CALD**' as **limiting and problematic** and note that it does not include consideration of race/ethnicity/religious beliefs which are regarded as impacting significantly on health and other inequalities.

More importantly, the term '**CALD**' is not **readily understood or actively used by communities to identify themselves**. They tend to use and identify with the term 'multicultural' which is why we have preferred to use it.

We note that internationally the term '**global majority**' is increasingly used as an alternative to 'ethnic minority' or 'people of colour', as it challenges Eurocentric minority framing and highlights global representation and systemic inequities. We embrace this shift in language from 'minority' to 'majority', from 'othered' to 'empowered', and encourage others to do so.

1. About World Wellness Group

1.1. Who we are

Established in 2011 as a social enterprise, World Wellness Group Ltd (WWG) is an independent multicultural health and social care organisation working to reduce health inequities. Since 2012 we have been registered as a Health Promotion Charity with the Australian Charities and Not-for-profits Commission (ACNC).

Our work is underpinned by a human rights framework on the basis that health is a human right and the principle of universal access to health care regardless of background, affordability, or visa status. This human right is not always realised in practice. People's access to care and their health outcomes can be affected by the social determinants of health, a complex interplay of social, cultural, political, legal, environmental and economic factors.

These determinants frame our holistic approach to health service delivery and advocacy. A sustained focus on them is essential to address the unfair and unjust conditions that contribute to poor health and mental health, and to ensure that our communities can access care that is safe, equitable and responsive to their needs.

We are committed to working together with our communities. Our *Multicultural Lived Experience Framework* and our substantial multicultural peer workforce are fundamental to the co-design and co-delivery of our services and advocacy.

1.2. What we do

We work in the system to deliver services and simultaneously work on the system at the state or national level to address systemic issues that create and perpetuate entrenched inequities for multicultural population groups. All our work is informed by evidence and research, to which we actively contribute.

Working in the system Key services	Working on the system Key focus areas
• General Practice and Primary Care • Nursing and allied health care • Mental Health & Wellbeing • Psycho-social services • Multicultural Connect Line • Multicultural Carer Support • Domestic and Family Violence Therapy Services • Refugee and Asylum Seeker Health • Health Promotion & Prevention • Wellness and physical activity • Social Care & Navigation • Older Person's wellbeing • Alcohol and other Drugs prevention and support • Gambling harm prevention and support • Peer Support • Peer navigation • Health Justice Legal Support	• Policy influence and systems advocacy and advice based on data and lived experience • Reforming data, evidence and evaluation practices • Education and training • Lived experience engagement and co-design • Elevating multicultural lived experience leadership • Strengthening multicultural workforce pathways • Building strategic partnerships for collective impact • New innovative culture-based service development • Embedding anti-racism in healthcare • Transforming funding models and resource allocation • Research and data

For further detail, see [Our Strategic Framework for Action and Impact 2026-2030](#)

2. Focus of this Submission

Our submission recognises that the Medical Research Future Fund (MRFF) *Reducing Health Inequities Mission* is primarily focussed on research to address inequities in health outcomes by improving access to quality health services by priority populations. The Mission recognises multicultural people as a priority population.

The focus is explicitly on systemic change for priority populations. We do not therefore here address in great detail the long-standing and unethical exclusion (either overt or inadvertent) of multicultural health and mental health from the national research agenda in terms of funding or focus. We do, however, make some observations at 3.5 below.

Our submission is informed by our service delivery and learnings from:

- the lived/living experience of the people who access and deliver our services
- our capacity to engage and consult meaningfully with individuals and communities both locally and nation-wide
- our relationships with other multicultural health and social care services, with Primary Health Networks (PHNs), and overseas organisations such as the UK National Health Service Race and Health Observatory
- our preparation and delivery of nationally significant initiatives such as Mental Health in Multicultural Australia (MHIMA), now the Embrace program of Mental Health Australia, amongst others
- lack of consistent and meaningful national data about multicultural health
- the initial and ongoing impact of COVID-19 on multicultural communities
- our promotion of research to and support of prospective participants

3. Comments and Observations

We welcome and fully support the establishment of the MRFF *Reducing Health Inequities Mission* and its focus on ‘priority populations’.

We offer the following observations:

3.1. Priority Populations

We note that neither the Roadmap (RM) nor the Implementation Plan I(P) provide a clear statement of what the priority populations are, although some can be identified in the body of the text. There is simply a footnote (RM page 1) stating that the Mission “*adopts AMRAB’s definition of “priority populations”*”, relying only on the acronym ‘AMRAB’ and without providing a reference.

We presume that the most recent definition can be found within Australian Medical Research and Innovation Priorities 2024-2026, noting that Australian Medical Research Advisory Board consultation on priorities for 2026-2028 closed on 16 August 2026. We suggest that the RM should identify priority populations more explicitly and include a statement on their intersections.

For example, people from multicultural backgrounds may also identify as LGBTIQ+, people living with disability, people experiencing mental health conditions, people in low socioeconomic circumstances, or those living in regional, rural or remote areas.

3.2. Aims and Funding Principles

We have long advocated for and appreciate the inclusion in the Mission of aims to:

- address systemic issues to reduce inequities
- leverage cross-sectoral partnerships
- understand and address intersectional impacts
- empower people with lived experience
- build a diverse research workforce.

The Funding Principles (RM pages 4-5) also reflect to a large extent our view developed through our experience in a range of research projects, including the importance of:

- paid roles or remuneration for individuals and representative organisations to contribute to research design, methods and outcomes
- dedicated resourcing for co-design beyond advisory roles
- genuine partnerships.

We note that the IP sets out clear applicant requirements for each funding opportunity which clearly reflect the funding principles.

This aligns with our view (consistent with practice in the UK, USA and Canada) that applicants for public research funding should be required to demonstrate

- how the proposal will be inclusive of priority populations and, if not, the reasons for that exclusion
- proposed data collection
- proposed engagement, recruitment and retention strategies
- representation on any advisory groups
- budgetary allocation for the provision of language services when required

The Mission goes considerably further in consciously addressing inequities than many other national strategies on particular health issues and the recently released National Health and Medical Research Strategy.

3.3. Representation

We note that the published membership of the Expert Advisory Panel does not appear to include specific multicultural lived experience or expertise. From our perspective, given the demographics alone, this is disappointing.

In response to a question at the Webinar of 19 September 2026, it was clarified that appointments were made following merit-based assessment of a competitive application process. This would imply that either no multicultural application was received, or if received not considered suitable.

We suggest that the overarching Mission advisory structure could have reflected the focus in the RM and the IP on representation and participation of priority populations in funded projects.

In addition, we suggest that this focus is reflected in any panels or processes set up to assess funding applications. Any lack of representation of multicultural expertise limits confidence that the priorities, barriers and evidence gaps affecting multicultural communities will receive the attention and strategic focus they warrant. It also risks perpetuating the historical underrepresentation and underinvestment in multicultural health equity research.

3.4. Data

Data is essential to inform research priorities and to document, analyse and present research findings.

The RM contains only two references to data:

- Research involving Aboriginal and Torres Strait Islander people must be culturally safe and adhere to contemporary Indigenous **Data** Sovereignty principles (page 4)
- Reducing health inequities relies on increasing the capacity and resources of the sector, including ... **data** systems ... (page 5)

The IP also has only two references:

- “Improving **data** capture within Australia research funding systems to better inform targeted calls for health inequities research” (Enabler, page 14)
- “Genuine involvement of people with lived-experience and/or community partners means that consumer involvement indicators also consider accessibility and inclusion of traditionally under-represented priority populations, as well as the system limitations and power imbalances that challenge **data collection** in these populations” (Monitoring and evaluation, page 15).

The issue of multicultural data is particularly complex and problematic. The issues are comprehensively described in a 2020 Issues Paper from the Federation of Ethnic Communities' Councils of Australia (FECCA) [*If We Don't Count it ... It Doesn't Count.*](#)

There is no current agreed consistent minimum set of relevant indicators. The most common indicators are:

- 'Country of Birth'
As a sole indicator, this is not useful and can lead to misassumptions. For example, 'born in Singapore' can include people of Malaysian, Chinese, Indian and other ethnic groups. It also perpetuates a focus in multicultural research on the overseas born, ignoring second, or third+ generations born in Australia.
- A language indicator.

COVID-19 exposed many of the deficits in multicultural health data collection in relation to infections, deaths and vaccine uptake, and in the interoperability of national and state/territory data systems. In the absence of agreed national indicators, there was significant reliance on complex data integration projects.

In terms of the Mission, we believe that the MRFF should set the data standards and minimum indicators for the relevant priority populations in funded projects, rather than leaving those decisions solely to applicants. This would ensure data consistency and comparability.

There are overseas examples of mandatory diversity data collection and reporting, particularly in health services and research:

- United Kingdom – the 2010 Equality Act and the 2012 Health and Social Care Act
- United States – the 2010 Patient Protection and Affordable Care Act required federally funded health programs to collect data on race, ethnicity and primary language.

There is currently considerable interest in the health sector, and we have participated in a range of related projects.

We are aware that FECCA is hosting a national symposium on multicultural data collection in October 2026 at which we will participate on the panel discussion.

We would be pleased to participate in any further discussion with the Mission or the MRFF more broadly on this issue.

3.5. Funding – the Root Cause of Multicultural Health Inequities

We appreciate the investment of \$150 million over ten years for priority populations. We note that specific annual funding over this period varies in the IP but crudely averages of \$15 million per year. This represents only 1.34 per cent of the [Maximum Annual Distribution Amount](#) for 2026-2027, currently set at \$1,100 million by the Future Fund Board.

An assessment of the percentage of the investment spent on multicultural research is impossible at this stage and will depend on the outcomes of funding applications.

We do note that this allocation appears to perpetuate inequities in public funding for multicultural health research.

The 2021 Census reported that:

- 27.6 per cent of Australians were born overseas
- 48.2 percent (almost half) had at least one parent born overseas
- 29.3 per cent were first generation, 22.2 percent were second generation and 43.55 third+ generations
- 22 percent (5.6 million) people reported using a language other than English at home (an increase from 20.6 percent or 4.8 million people in 2016)
- 3.4 per cent of the population spoke English not well or not at all

It is anticipated that the 2026 Census will show further increases.

Despite the demographics and persistent health disparities, funding inequities continue.

3.5.1. Targeted Research Funding

A May 2026 [La Trobe University Report](#) found that analysis of National Health and Medical Research Council and Medical Research Future Fund awarded funding from 2021–2025 showed that **less than 1 per cent of public medical research funding explicitly targeted CALD communities nationwide.**

This disparity is also reflected in the publication of research papers.

A [2010 review](#) determined that of **4,146** articles published in three major Australian health journals in the period January 1996-August 2008, only **2.2%** had a primary focus on health issues among people from multicultural backgrounds. Professor Helen Skouteris (Monash Warwick Professor in Health and Social Care Improvement) led a repeat of this study to look at the period September 2008-January 2023 and established that in those fifteen years – there had been a sharp decline to **1.1%**. In an astonishing but not unexpected irony, this paper was submitted to but not accepted by several journals and remains unpublished.

3.5.2. General Research

The research sector is rightly guided by a strong commitment to ethics and there are clear national guidelines (such as the NHMRC National Statement on Ethical Conduct in Human Research) and Human Research Ethics Committees (HRECs) review research proposals.

We do, however, question the ethics of frequent:

- use of 'lack of English language proficiency' as an exclusion criterion for participation in research, particularly in clinical trials
- compromising the generalisability of research findings and results of clinical trials if the sample is not representative of the population.

We note that this is often justified as follows:

- poor English language proficiency 'complicates' the consent process
- 'additional expenses' in language services provision
- "They" don't engage, are hard-to-reach and take up too much time.

The NHMRC has recently issued a Summary of Changes to the NHMRC National Statement on Ethical Conduct in Human Research 2025 (effective from early 2026). It has frequently been suggested that the Statement should, given the demonstrated inequities, include a chapter on multicultural populations, similar to Chapter 4.7 Research with Aboriginal and Torres Strait Islander people and communities. This has not occurred and the Revised Statement will therefore continue to be silent on ethics relating to:

- specific research on multicultural individuals and communities
- inclusion in population-based studies to ensure samples are representative of the population as a whole and that, in translation and implementation, the generalisability of findings is not compromised.

4. Conclusion

The Mission represents an important opportunity to address systemic health inequities.

To maximise its impact, multicultural inclusion should be reflected not only in funded projects but also in governance, advisory structures, data collection requirements, funding decisions and research ethics frameworks.

We hope the Mission contributes to a stronger evidence base and greater investment in multicultural health research.