# New Zealand Health Research Strategy - Action One: National Priority Setting

Summary of submissions and consultation

Released December 2019

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# Introduction

This document sets out a summary of the submissions received as part of the 2019 consultation on Action One of the New Zealand Health Research Strategy (NZHRS), to prioritise investments through an inclusive priority setting process. The consultation document[1] sets out the proposed 'prioritisation vehicle' to which the feedback presented in this paper relates.

More context on the NZHRS and Action One specifically is set out in Appendix 1.

## The consultation

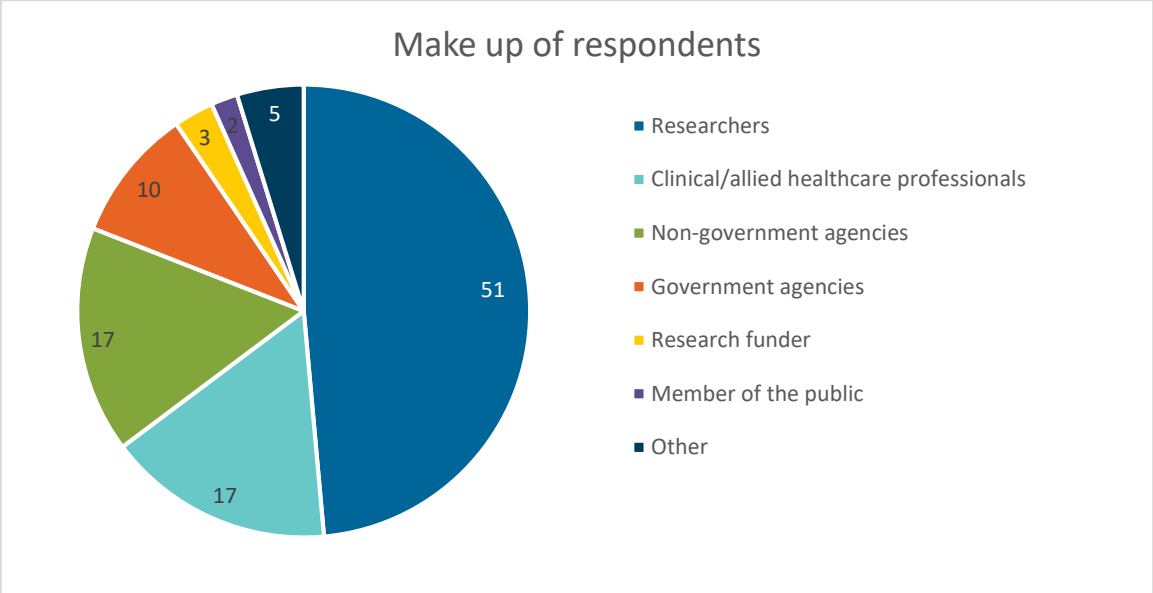
This consultation was a joint initiative between the Ministry of Health, Ministry of Business, Innovation and Employment (MBIE) and the Health Research Council of New Zealand (the HRC).

Feedback was sought between 12 March and 1 April 2019, using two forms:

- an online submission tool (Survey Monkey)
- email submissions ('offline' submissions).

We received 105 responses in total. Of these responses, 73 submissions were made using the online submission tool (Survey Monkey) and 32 'offline' submissions were provided in email format.

The graph below identifies the affiliations of those who made submissions.




The 'other' respondents identified themselves as:

- Commercialisation
- Professional Organisation
- Primary Health Organisation
- Māori Medical Membership Organisation
- National Research Collaboration (a National Science Challenge).

The submissions comprised a mix of organisational (52) and individual (53) submissions.

[1] https://www.hrc.govt.nz/sites/default/files/2019-07/Consultation%20Document%20-%20March%202019_0.pdf

The process to analyse submissions involved coding responses and applying themes. The codes used were tailored to the specific structure of each question and nature of responses. Generally, the coding process considered whether respondents indicated support for the respective proposal or not, and whether their responses included suggestions or not. Suggestions were then allocated a theme, such as whether a structural change, wording change or conceptual change was suggested, or where an endorsement or training need was communicated. The distinction between these themes is set out in Appendix 3.

Email submissions were not coded with the specificity of the online submissions; however, responses were organised into groupings consistent with the code and theme outputs.

Together, this process informed where specific suggested changes had widespread support among submitters or not.

**Notes for presentation of data in this paper:**

Submitters were not required to respond to every consultation question. In the following sections we quantify the number of survey responses received for each question and include all responses relevant to the design and content of the prioritisation vehicle (i.e. not those deemed out of scope).

Generally, feedback provided in the offline submissions was consistent with that provided in the survey submissions, and offline recommendations are included throughout the paper where they add to or differ from the survey feedback. Offline submissions are not quantified in the statements made for each proposed component.

An extension was granted to potential submitters affected by the events in Christchurch in March, which have now been received and incorporated into the analysis.

**A note on terminology**

Consultation sought feedback on 'New Zealand's prioritisation vehicle for health research'. In order to ensure consistency with similar government policy documentation and terminology the title of the final product has been changed to The New Zealand Health Research Prioritisation Framework. Throughout this summary of submissions, the term 'vehicle' has been retained as it reflects the timepoint at which the consultation was undertaken and the feedback that was submitted.

## Snapshot of common themes

> *This version of the prioritisation vehicle is a huge improvement on the previous version, we are very pleased to see comments from our own, and others, previous submissions taken seriously in the revisions.*

Generally, the submissions suggest that the concept of the prioritisation vehicle is endorsed. A number of comments were made by respondents suggesting wording or more substantive structural changes to the components within the vehicle in order to achieve its objectives. The considerations below were common across many submitters and proposals within the consultation:

- language and detail need to be simplified
- misinterpretation of examples as exhaustive
- need for the inclusion of minority communities
- concern for monitoring and governance to make this work in practice

- implementation concerns, particularly around funding application and assessment processes by funders; and the cost for users of the health system
- concern around the separation and hierarchy of research attributes into ‘core’ and ‘guiding’ groups
- concern and some confusion around the duplication between Domains.

## Overarching feedback

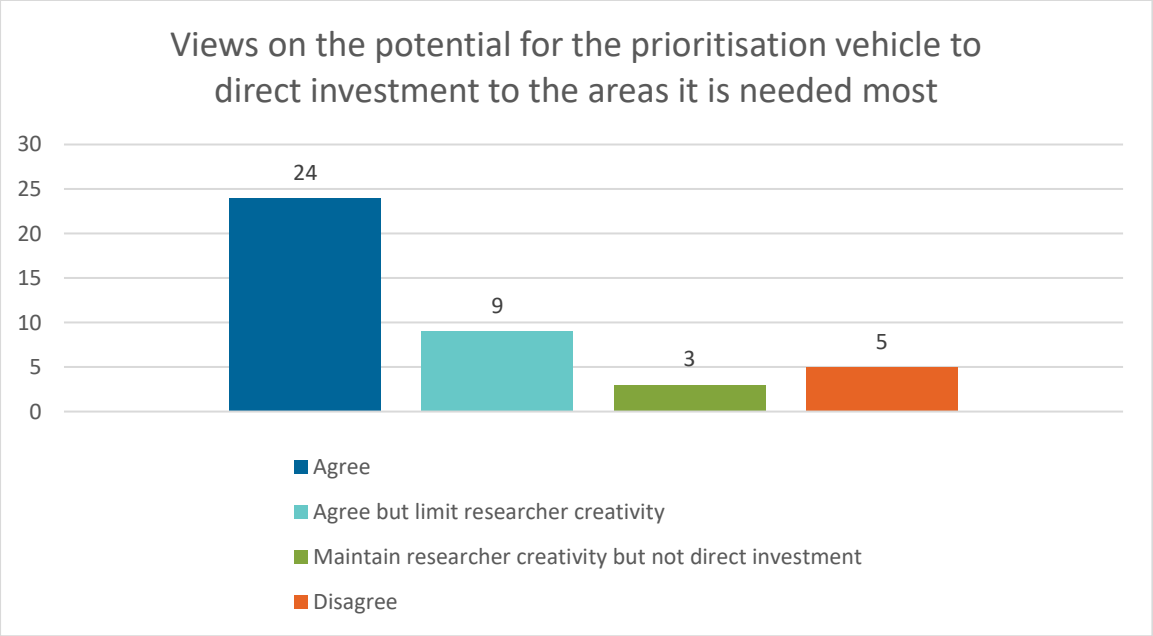
This summary relates to consultation questions 45 to 51.

Consultation questions were positioned to test whether the proposed prioritisation vehicle is designed to achieve its objectives of:

- directing government investment to the areas it is needed most while maintaining researcher creativity
- aligning and coordinating government investment
- creating positive change
- being inclusive and respectful of a diverse range of New Zealand communities
- having a clear purpose and structure for usability.

A majority of survey respondents agreed that the prioritisation vehicle will direct government investment to the areas it is needed most while maintaining researcher creativity.

> *We support the conceptualisation of the health research sector as an ecosystem, whereby all parts of the system are interconnected, interactive and coordinated, and where whānau and communities sit at the heart.*




Key themes arising from these responses included:

- researcher creativity also comes from other sources
- implementation is not clear and could inhibit researcher creativity
- evaluation of implementation and culture shifts is crucial

- an implementation mechanism will be necessary to prioritise research applications to balance investment as intended
- practical implementation could be inhibited by the wordiness and complexity of the document, and the capability and capacity of the workforce.

> *I think it has the best potential yet to be able to do that, and certainly allows for researcher creativity and better accountability to community. It allows for investor investment in areas of most need but possibly also has the risk of those needs being 'hijacked' by the loudest or most entrenched voices if not governed well.*

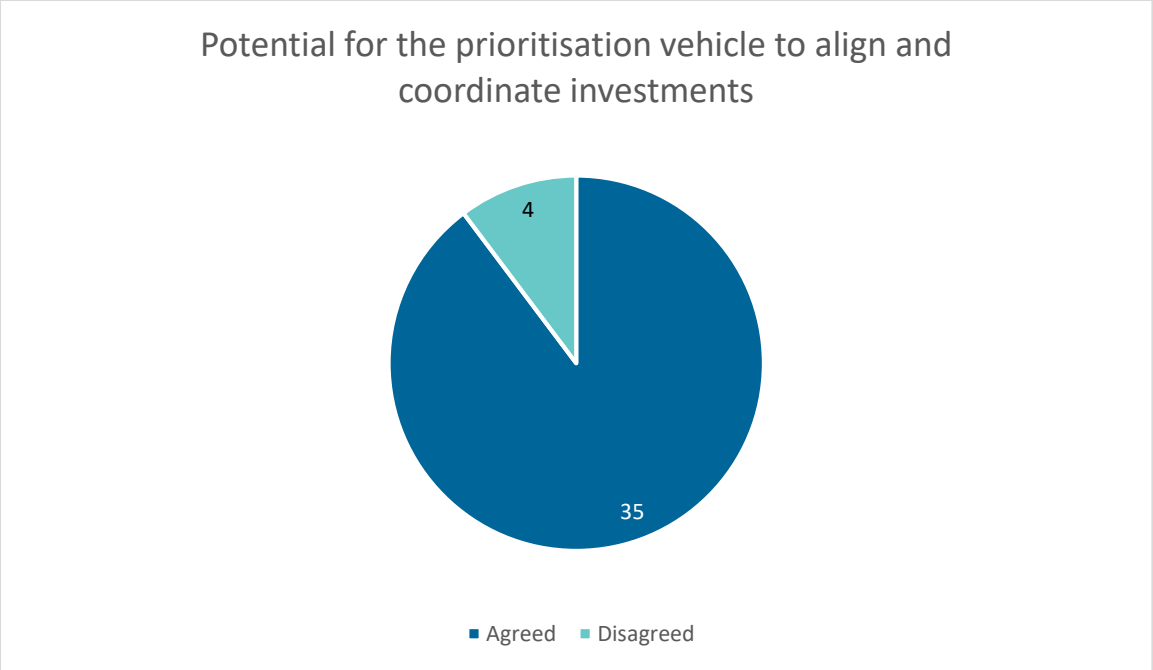
> *Strikes a balance between nudging NZ health research in desirable directions, including addressing health inequalities, and allowing at least most health researchers to see a place for them and their work in the system.*

These themes were shared by offline respondents, who also identified that with no specific measure of success detailed, impact may be interpreted differently between stakeholders.

Some respondents expressed discontent with the proposed concept altogether, seeking health priorities to be determined with community input and co-design. While community input and the concept of co-design are heavily embedded in the prioritisation vehicle and adopted in its development, the approach to prioritising health issues was deemed out of scope based on the outcomes of the last consultation, whereby an approach to identify health (issue) priorities was deemed too narrow.

Survey respondents largely agreed that the prioritisation vehicle has the potential to align and coordinate investments, and identified similar themes regarding the implementation and governance of the vehicle being the key to its success.

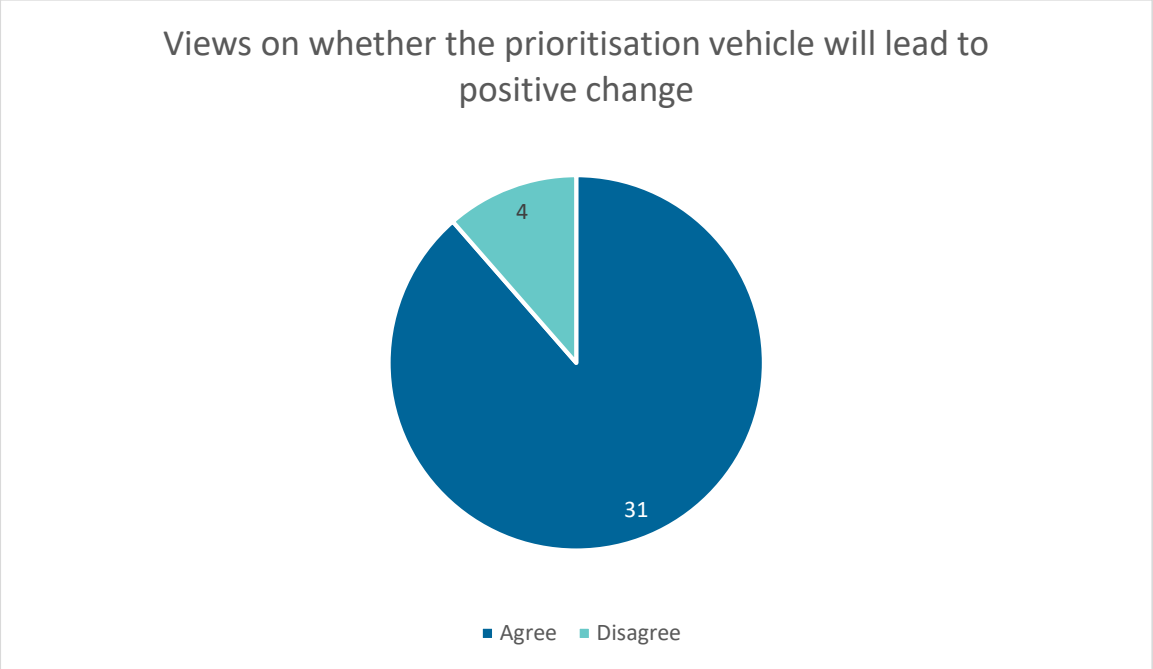
> *This is especially important when the prioritisation vehicle is intended to have a long life; the most important areas for investment will evolve and need to be defined by an ongoing conversation between researchers.*



Offline respondents also identified that high-quality science should be maintained in any framework for prioritising future investment. Only four survey respondents disagreed that it has the potential to align investments, and two of these queried whether evidence supports the assumption that research is strengthened by coordination.

Similar concerns were also expressed by the four respondents who disagreed that the prioritisation vehicle would lead to positive change. While a majority of the survey respondents on this matter agreed, concern for the complexity of the prioritisation vehicle and the need for evaluation throughout implementation were common themes that emerged across these responses.

> *We support the overall concept of the prioritisation vehicle. We think the vehicle will drive for a vibrant health research ecosystem based on defined outcomes and strong collaboration between researchers, the health sector and selected communities. We are pleased that the vehicle recognises that health research would benefit by bringing together research from a diverse range of disciplines.*




A majority also agreed that the prioritisation vehicle is inclusive and respectful of the views and beliefs of a wide range of New Zealand communities.

> *We commend the health research prioritisation vehicle for ensuring coverage of the users, deliverers and regulators of our health system to ensure meaningful impact.*

A key concern raised by those who disagreed is the inclusivity of minority groups here in New Zealand in addition to Māori and Pacific, who are well represented in the document. The general feeling is that all minority groups need to be acknowledged more explicitly.

We received 55 survey responses on the purpose and structure of the prioritisation vehicle, which a majority found to be clear and easy to follow. Several offline respondents commended the vehicle for being accessible for both researchers and lay-people alike. There was a broad endorsement of the diagram on page 3 of the consultation document, as well as the researcher reference guides.

A key theme emerging from those respondents who did not find the purpose and/or structure easy to follow was the complexity of the language being a barrier, with one challenging the concept of the

vehicle altogether. Implementation concerns were also raised, with fears that this could become a tick box exercise. One response found the vehicle lacking in intuition, while another expressed a concern that universities may be better positioned than smaller competitors in positioning their infrastructure to compete for funding based on this vehicle.

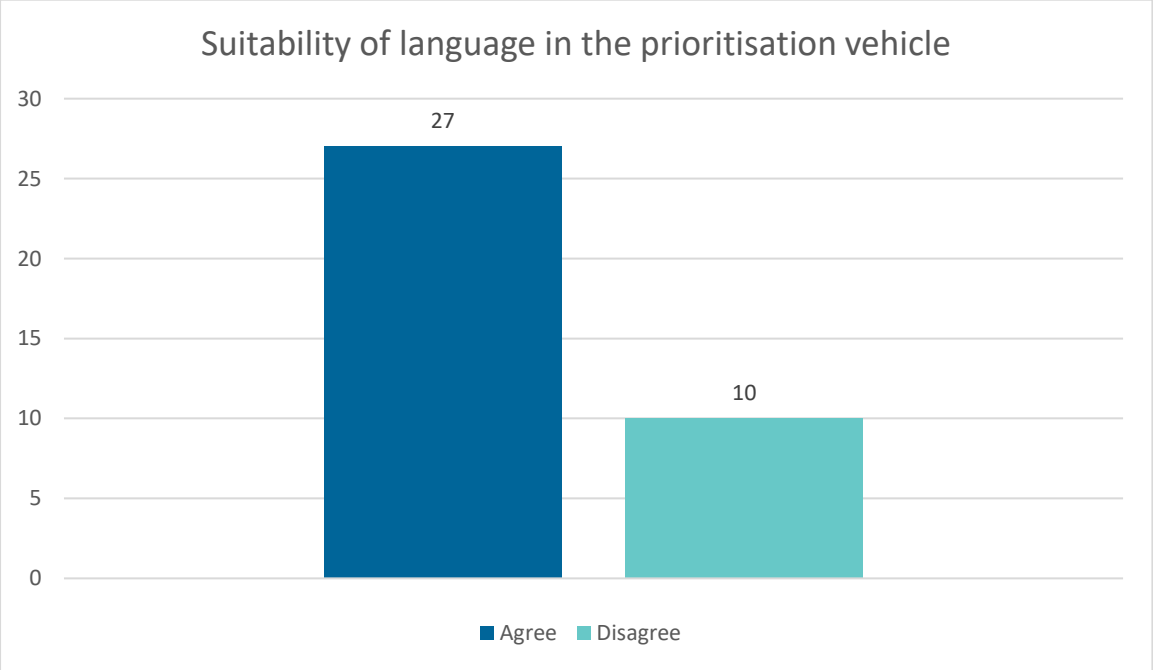
> *Overall, a significant improvement on the first draft. I feel we have a vehicle on wheels, and almost ready to roll.*

### Resulting actions

- The prioritisation approach has been retained and refined based on the specific feedback provided for each component.

## Language

This summary relates to consultation question 52.




The language used throughout the vehicle is intended to be inclusive, culturally aware and easy to understand. A majority of survey respondents reported feeling comfortable with the language used, with three making additional suggestions to use plain language.

> *Well done. I am a layman, and could understand.*

Ten respondents were not comfortable with the language used, citing key issues as the accessibility of language, for example using some terms where there is an assumed understanding, such as 'data sovereignty' and 'self-determination', and where the language used is considered too intellectual. While the language was endorsed as inclusive and holistic by many respondents, others thought that the language in places lacked precision for a prioritisation document.

### Resulting actions

- Refined language throughout to move away from an individualistic worldview and encompass Te Ao Māori worldview throughout.
- Plain English adopted throughout the document, and clarification added where terms encompass a specific meaning, for example distinguishing between ‘innovation’ and ‘discovery’, while highlighting the importance of both.
- Consistent terms used throughout the document for user groups, enabling people to more readily find themselves and their roles within the vehicle.

## Feedback by components

### Domains

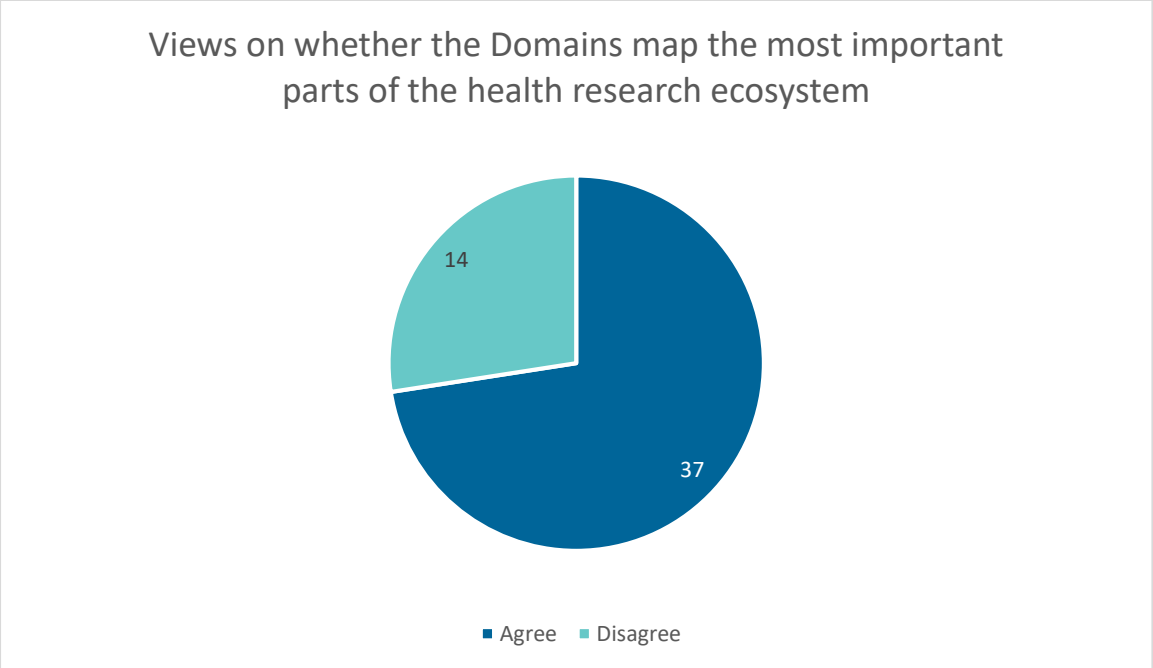
This summary relates to consultation questions 28 to 30.

Consultation questions were positioned to test whether the proposed four Domains, as a vision for health research in New Zealand:

- map the most important parts of the health research ecosystem
- are easily distinguishable from each other.

Other questions regarding purpose, scope and inclusivity were asked specific to each Domain, and are presented in the following sections.

We asked for feedback on whether the proposed Domains collectively map the most important parts of the health research ecosystem.  A majority of survey respondents agreed, identifying training needs and guidelines as necessities for successful implementation, along with some wording suggestions to ensure nuance.

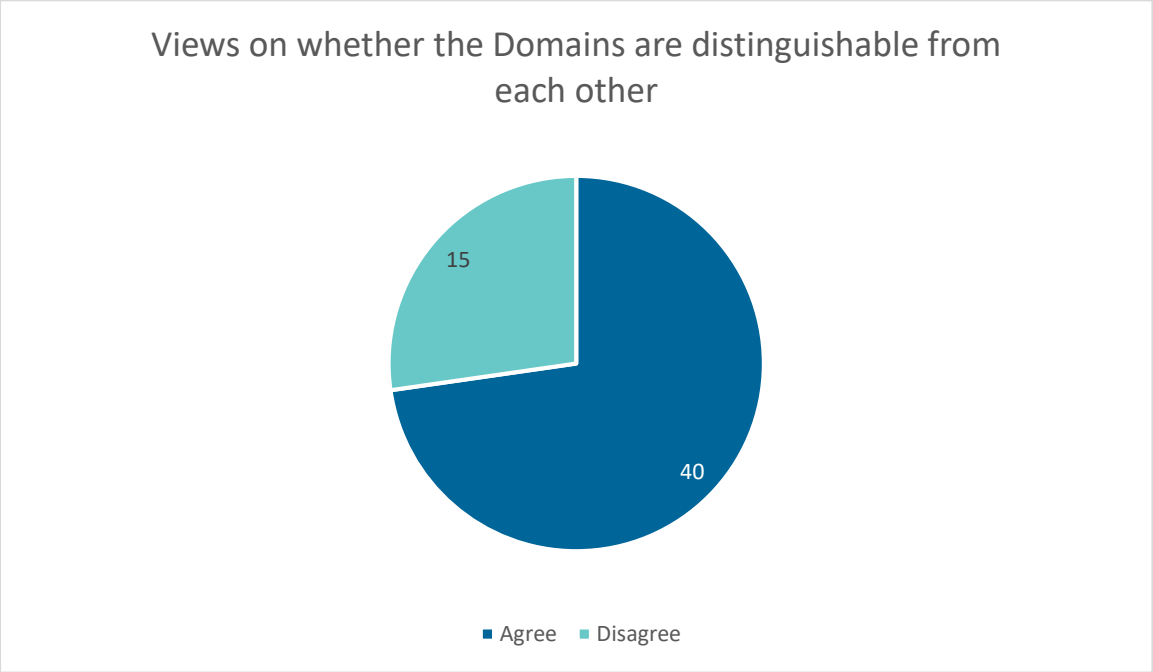


Key issues of the 14 who disagreed include:

- the lack of explicit reference to population groups such as the ageing population and ethnicities other than Māori and Pacific
- implementation practicalities including the distribution by funders when implemented, the need for health systems research to support the infrastructure and system-level change required to support this vision, and the cost implications for health system users
- under-emphasis of international connection and collaboration, and education
- significant cross-over between domains affecting clarity
- uncertainty as to what the domains represent (i.e. aspirational outcomes or research preconditions)
- complexity of language.

A small number of respondents also expressed dissatisfaction with the representation of the biomedical field in the proposed Domains.

These issues were also reflected in offline submissions, where respondents additionally identified specific wording issues with the absence of 'human health' and variations in the term 'innovation', expressing caution not to privilege a specific type of innovation, i.e. commercialisation.




Most survey respondents found the Domains easily distinguishable from each other, emphasising in their comments that the overlap between them is warranted and necessary. The quick reference guide was commended for helping to understand this distinction.

> *We were able to distinguish between the Domains and the "A Quick Reference Guide for Researchers" helped our understanding. We are pleased to see there is potential for Domains to overlap.*
>
> *It is great - a really useful vehicle for capturing diverse, complex, and interrelated components of the health landscape. Illustrating the interconnectedness and need for reduction in siloed thinking and funding really well.*
>
> *It recognises that a whole of system approach is needed ...*

*This is a major step forward for health research in NZ and is far more suited to the needs of the 21st century than the current approaches.*

The overlap between Domains was a contentious point of feedback. Fifteen survey respondents who did not find the Domains easily distinguishable considered the overlap to cause variable interpretation.

*Generally yes, they are substantively distinguishable but their short descriptions confuse the boundaries.*

*The domains seek to create differences between different types of research which are at times unnatural or don't in fact exist.*

Some offline respondents endorse the fluidity between Domains, which illustrates some progression since the last consultation where feedback suggested a siloed approach. A trade off from having greater fluidity between domains, however, is increased complexity for end-users.

Respondents also expressed concern about how the Domains will map to funding opportunities in practice, in that it would not be suitable for funding opportunities to be limited by Domains. In particular, three offline respondents expressed concern that a disproportionate share of funding would need to flow into Domain 1. This indicates some misinterpretation, which suggests an opportunity to clarify the purpose of each component within the vehicle.

## Domain 1: Our people flourish in their whānau, communities and social contexts

This summary relates to consultation questions 8 to 12.

We requested feedback on the purpose, scope and inclusivity of Domain 1.

Respondents generally agreed that Domain 1 provides a broad and holistic view of how health research can facilitate individuals to flourish. There was strong support for contextual knowledge generation for all communities, considering the broader macrosocial influences of health and wellbeing, along with specific social determinants of health and equity for priority populations.

While the purpose of Domain 1 was generally considered clear and supported (with 39 of 46 respondents agreeing clarity of purpose), some issues were expressed around the scope of this Domain (21 agreed with the Domain scope and 22 disagreed). A key point of contention between respondents was whether the breadth of scope is suitable, with some suggesting it is too broad and others too narrow. In a similar trend, there were mixed responses regarding the framing of an 'ecosystem', with some respondents favouring the flexibility allowed for in the model, and others feeling there was too much potential for varied interpretation.

Two respondents suggested that the scope is relatively insular, limited to the local or regional context rather than the broader international research environment, for which New Zealand is highly dependent on to produce high-quality health research.

The explicit focus on equity was raised as a strength of Domain 1 by multiple respondents, particularly the need for research to be led by communities of interest and priority populations.

*We fully support the statement that research led by Māori and other communities facing major health disparities, discrimination and exclusion is fundamental to achieving health equity.*

*We agree an important contributor to achieving these aims will be research led by communities of interest; for this to happen, research capacity building among Māori, Pacific and disabled people is essential.*

The need to build capacity was an implementation issue raised by many, with concerns around a lack of capacity and resourcing among priority populations to contribute and a fear that senior researchers become overburdened. There would need to be significant resourcing to improve researcher capability for community consultation.

While the Domain provides a rich account of who research ought to be generated for, feedback suggests there is a lack of focus on the broader policy and economic drivers of health and wellbeing in these groups, and the need for research into these determinants. Some disagreed, raising concerns about being crowded out of the limited funding ring-fenced for health research.

Several respondents identified a lack of reference to the important role of basic or discovery science in improving the health of all people, generating new leads and growing the knowledge stock. As the largest recipient of health research funding, these respondents suggested that there should be explicit reference to the biomedical sciences.

Most survey respondents identified Domain 1 as a key area of the health research ecosystem (32 out of 42). Along with the support of a broad and inclusive approach to outlining the determinants of individual flourishing, the emphasis on 'high-risk, high-reward' science was also applauded. Multiple respondents were however concerned with the interchangeable use of 'discovery' and 'innovation', specifically that research does not need to change practice to be of value.

Respondents suggested that commercialisation should be framed as a goal of research rather than an intended outcome, as in many cases highly valuable research cannot be commercialised or that the process of commercialisation can prohibit important discovery and innovation. There were also concerns regarding the language surrounding commercialisation being too aspirational given New Zealand's limited workforce capacity, geographic remoteness and infrastructure shortfalls.

The survey respondents found the Domain to be generally representative of the diverse communities in New Zealand. Of those who disagreed, primary issues included a lack of specific reference to certain populations, including a growing migrant community, the elderly, the LGBTQI community, those of lower socioeconomic status and those suffering from mental illness. Respondents broadly felt there should also be more explicit reference to the cumulative impacts of advantage or disadvantage on wellbeing, in particular the health impacts of discrimination, and discrimination based on health status.

Many responders praised the inclusivity of the Domain, however suggested that prescriptive identifiers should be avoided to empower self-identification.

*Disagree with Development Group's decision to adopt the UN convention 'SOGIESC' as a homogeneous term for all sex and gender diverse communities. Māori sex and gender diverse communities have a right to self-identify and position themselves by the terms they prefer or consider culturally appropriate, e.g. takatāpui*

It was also noted that certain individuals prefer not to be identified or researched and the need for ethics to be responsive to such instances, and for this to be explicitly embedded into Domain 1.

Certain respondents voiced that although Domain 1 highlights the diversity of communities, it lacks emphasis on how a changing population results in new and emergent health challenges.

## Domain 2: We enhance a people-centred health system within our strong and diverse communities

This summary relates to consultation questions 13 to 17.

A majority of survey respondents (25) thought the purpose and scope of Domain 2 were clear, while a further 14 found the purpose clear however the scope unclear. Three people felt that neither the purpose nor the scope were clear, suggesting incorporation of human clinical research earlier, and to extend the translation scope beyond 'discoveries' given that prior findings can cumulatively create discoveries and therefore form part of translation.

Consistent with feedback on other components of the prioritisation vehicle, the overlap between Domains was queried along with a number of implementation practicalities, particularly around the potential for funding to be limited to Domains. A number of other comments were made regarding the design of this Domain. In summary, suggestions included:

- extending the scope of this Domain to include systems science, and research evaluating the appropriateness of interventions for diverse communities
- lifting the importance of meaningful relationships within this Domain to include engagement in healthcare delivery and research
- expanding the definition of translation beyond technology and the immediate time period
- acknowledging roles outside of researchers, i.e. the broader health workforce
- recognising prevention and intervention as a key component of a people-centred health system
- considering the implication of 'enhance' in the title where we may be focusing on introducing rather than improving something
- considering quality assurance
- providing more detail about certain terms, for example explaining economic validation and who cost effectiveness will benefit
- considering the financial implications for all users including funders, researchers and users of the health system
- simplifying the language used
- considering training needs for implementation, in particular, for assessing committees.

Offline respondents also added that research into overcoming barriers to translation is essential, as is emphasising the importance of international connection and collaboration, particularly to leverage capacity development.

Suggestions to include certain research topics were deemed out of scope on the basis of the previous consultation outcomes.

> *I believe the headline description of purpose could more precisely reflect the actual purpose of domain 2, which (in being about the collection of services and practices which make up our system of healthcare delivery) I think is clearly distinct from the other domains. I'd submit that "people-centred" and "diverse communities" and "social context" and "healthy environment" are all critical characteristics or values which are intrinsic across all 4 domains, but in my view it clouds the valid distinctions and relationships between domains when these characteristics are applied to define each category.*

A majority of survey respondents felt that Domain 2 represents a key area of the health research ecosystem, with conflicting comments about the level of detail on health services research included, and one suggestion to move towards aspects of care and delivery. Six disagreed, instead identifying that many areas of health research are compiled in one Domain, which along with the duplication between Domains may be problematic. Some important interconnections were identified as missing, particularly between international consortiums for small patient populations, and nursing and allied health research, resulting in some feeling that this is still disease-centred rather than people-centred.

> *It is the person, not the disease, that has to be taken care of.*

Twenty-five survey respondents thought Domain 2 was adequately representative of diverse communities, while 11 did not, stating in similar feedback as received for Domain 1, that minority groups required explicit inclusion.

Overall, there is support for this Domain based on what it is intended to do, subject to clarity in the wording and detail associated.

## Domain 3: We meet the challenges of our changing world and promote a healthy environment

This summary relates to consultation questions 18 to 22.

We received 32 survey responses on the purpose, scope and inclusivity of Domain 3. Of these, a clear majority (27) found the purpose to be clear, however there were again mixed responses on clarity of the scope.

Feedback suggested that the scope of the Domain is too broad in that it would enable research only partially connected to health research to potentially be funded, for example town planning. An offline respondent found the scope too environmentally focused, losing the connection to health. In contrast, this point was endorsed by other offline respondents, with one requesting it be extended to more explicitly include the nature of food supply, physical activity and urban environment.

> *It is good to see an emphasis on poverty and healthy homes along with other Kiwi issues, these are health related research issues of importance.*

Five survey respondents found neither the purpose or the scope to be clear, with similar issues around the breadth requiring refinement, and the use of examples being interpreted as exhaustive given the breadth of scope.

> *Providing examples for this domain is problematic - Since almost all health issues could be described as future threats this is not enough of a discriminating factor to encompass a specific set of topics in health research.*

This view was also shared by respondents when commenting on this Domain being representative of a key area of health research. While 22 survey respondents felt that Domain 3 is representative and only five did not, respondents commented that this Domain attempts to combine too many disparate areas into one.

A number of wording amendments were suggested to clarify and position the scope:

- encouragement to think about global health and determinants including disease aetiology
- considering the need to respond to current as well as future challenges

- greater emphasis on climate change
- consideration of digital and built environments
- making environmental and occupational health more visible.

Some specific disease and research opportunities were also mentioned and deemed out of scope of the proposed Domain. One respondent felt this Domain belongs in the natural sciences sector where there are other avenues of funding.

> *Inclusion of this domain, and the focus on environmental issues, is entirely consistent with Māori models of health and Māori worldviews which are expansive and locate Māori within our wider natural environment. Therefore, Māori health is inextricably linked to the health and wellbeing of our ecosystems. We are pleased to see acknowledgement of the distinctive Māori approaches to environmental issues and the high value of indigenous knowledge in this field of research.*

A close majority agreed that this Domain is inclusive of diverse communities in New Zealand. Similar comments around the need to explicitly extend the scope to include all minority communities apply here, as well as looking at digital and built environments to support these groups. Despite general support, some concern was raised about the language used for Pacific and Asian communities, and a request was made to acknowledge knowledge sharing between Māori health initiatives and global indigenous efforts.

## Domain 4: We have effective and accountable government services and systems for wellbeing and health research

This summary relates to consultation questions 23 to 27.

We received 39 submissions on the proposed Domain 4. Of these, 18 found both the purpose and scope to be clear, with mention made on the need for a monitoring plan. A further 10 found the purpose clear however raised concerns with the scope. These concerns largely relate to the crossover with other Domains and the relationship to the Attributes.

> *The scope of Domain 4 in my view should encompass the impact on funding models, and also the related impact of our choice of performance metrics, as central components of the health infrastructure.*

Duplication with other Domains and particular wording and language suggestions were raised by respondents who found neither the purpose nor scope to be clear:

- some terms are ambiguous and undefined, such as ‘data sovereignty’
- big data could simply be referred to as data given its importance as infrastructure
- ethics should be built into all research and reflected here.

Attention was drawn by these respondents to the perceived barriers of this Domain working in practice, such as financial implications, racism, sexism and cultural safety. Generally, it was felt that the scope didn’t match the purpose.

The majority of survey respondents found Domain 4 to represent a key area of the health research ecosystem, with queries raised about accountability and fostering the future workforce, focusing on both practitioners and researchers. Five respondents did not think that Domain 4 represents a key area, referring to repetition across Domains, and broader application of infrastructure as key requirements, such as big data, knowledge transfer and ethics.

Most respondents felt the Domain is adequately representative of diverse communities in New Zealand. A key concern raised by those who did not agree was the lack of inclusion for minority groups other than Māori and Pacific, with one comment identifying the individualistic approach taken rather than the family approach. Other suggestions included:

- measuring the impact of our spend, particularly at Ministry of Health and District Health Board (DHB) level to ensure the development of evidence-based policy, decision-making, monitoring and evaluation
- recognising the importance of digital health technologies, such as records
- clarification of roles, including researchers, research funders, DHBs.

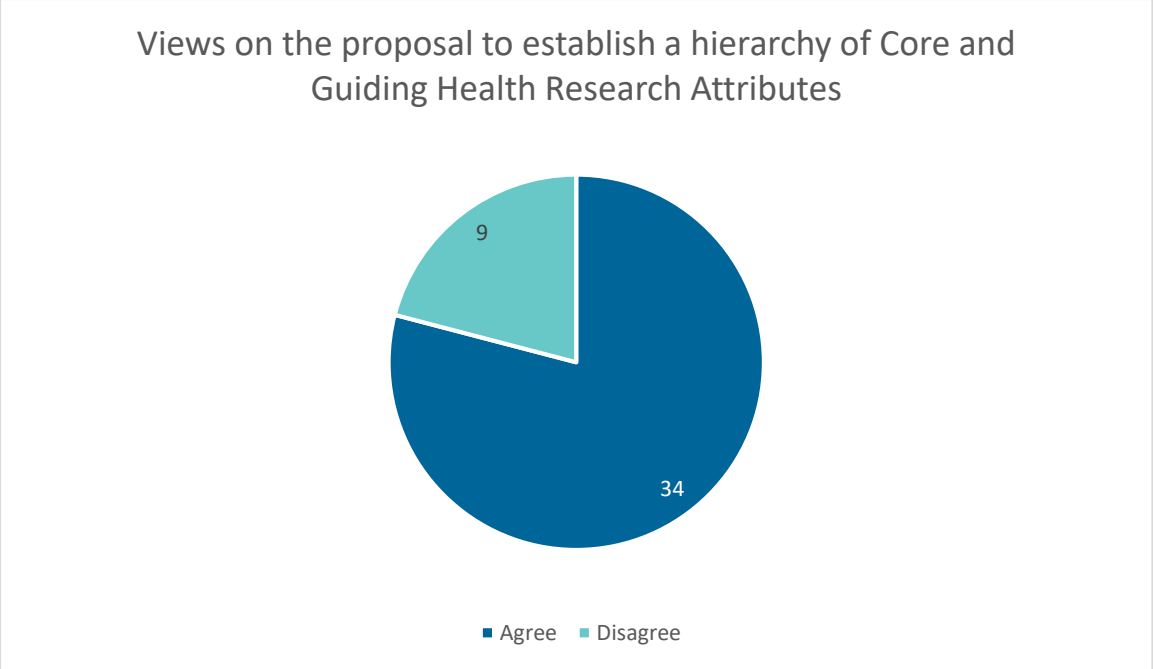
### Resulting actions

- The Domains have been redesigned to provide a simpler, consistent and high-level structure. This includes amending the titles to more direct, plain English Domain names. Much of the text has been removed from the description of the individual Domains, and high-level Research Aims and Infrastructure Aims have been created instead.
- Wording has been amended for greater inclusion of minority communities, adopting an equity lens rather than listing priority populations. The importance of patient and community-engagement in health research is emphasised.
- Social determinants of health are acknowledged, including a life-course approach and a 'One-health' approach encompassing the intersection of health with the environment.
- A section on how the Domains should be used, specific for funders, research providers, researchers and research teams, and communities, has been added to the introductory text.
- The Quick Reference Guide originally positioned in the Appendix has been removed, as the Domains and the role of each user group with respect to the Domains has been made clearer, enabling these groups more agency in determining applicable Aims.

## Attributes

This summary relates to consultation questions 39 to 42.

We sought feedback on the proposal to introduce a hierarchy of Core and Guiding Health Research Attributes, the distinction between them, and the likelihood of the attributes facilitating a balance of investment across funders.




A majority expressed agreement with the proposal to establish a hierarchy of Core and Guiding Health Research Attributes. Despite the numbers, general comments suggest that there is not widespread support for the two sets of attributes being mutually exclusive in a hierarchy. If a hierarchy is pursued, comments suggest further clarity about the distinction is required.

> *I think that all research should consider (and make clear) it's relevance to these attributes, but having a hierarchy that research must fit into will limit advances and new ways of thinking.*

This sentiment is consistent with the specific feedback received on each set of attributes, set out below.

Twenty-seven survey respondents felt it was clear how the Core and Guiding Attributes would be used.

> *I read the core guiding health research attributes as underpinning all investment decisions, whereas certain guiding health research attributes may be more relevant to some investment processes versus others.*

Twelve survey respondents did not find this distinction clear, with one suggesting a scoring system be used, and several suggesting depictions in diagram form would be easier to understand.

Transparency was identified as critical in any resulting decision-making process using these attributes, which was also identified by the 15 who disagreed that the attributes would enable funders to tailor their investment processes to achieve a balance of investment, along with other implementation concerns including what mechanisms will be in place to execute and monitor this.

> *This has not necessarily worked elsewhere. Who says that funders know the right balance of investment across the health research system? Also this could well be manipulated by politics, certain groups with their own agenda's etc.*

On the contrary, 25 survey respondents felt the attributes would enable funders to tailor their investment processes to achieve a balance of investment. Generally further clarification was sought on what the attributes mean for different users, for example researchers and research funders.

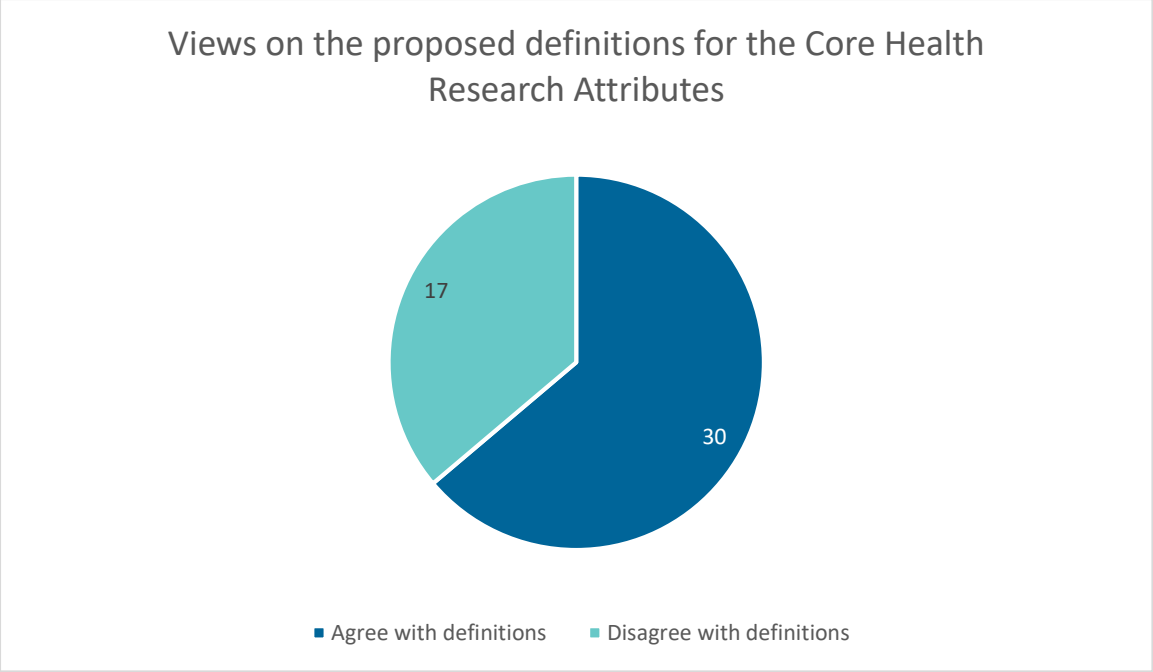
> *I think it will allow investors to tailor their processes to achieve balance across the research system, but good governance will be required to ensure that that actually happens over time.*

## Core Health Research Attributes

This summary relates to consultation questions 31 to 34.

A majority of survey respondents (38) supported the Core Attributes as being the most appropriate attributes to be classified as Core. Misinterpretation was evident with some respondents identifying Guiding Attributes in response to this question despite expressing agreement.

Of the 16 that disagreed, most identified a different combination of the proposed Core and Guiding Attributes, with wellness and prevention, capacity and capability, community partnership and engagement and national and international connection and contribution being the most prominent Guiding Attributes selected here. While some alternative attributes were suggested, there was no resounding support across respondents for these (i.e. they were one-off). In the context of the general feedback, this response suggests support for combining the attributes and removing the hierarchy.




There was good support for the definitions as proposed with some minor wording changes suggested. The seventeen who disagreed with the definitions made a number of wording suggestions and expressed concerns about the implications of these attributes in practice. In summary:

- a definition of equity is necessary to set an ambitious bar while acknowledging that not all research will make significant contributions towards minimising this in the short-term (rather it is dependent on use of findings, not necessarily discoveries, by next-users of

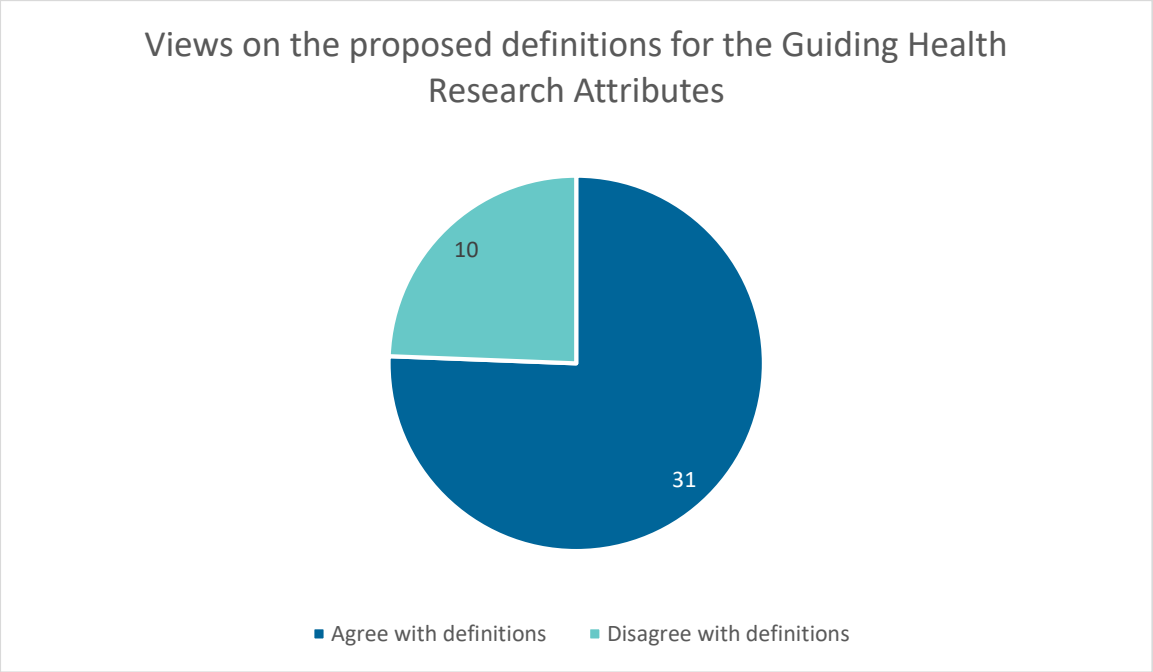
knowledge); there was also concern that the requirement to have a 'mitigation plan' is too prescriptive or negative

- the implications of a 'Why in NZ?' attribute may limit our international prospects, suggesting instead that is built into the other attributes rather than separated, or amended to reflect our contribution as an active and responsive participant in global health
- implications were raised for 'Impact', particularly regarding the mechanisms in place to support open publishing so that this is not a barrier to creating impact
- ensuring that the foundation of excellence is applied in practice by assessors or reviewers using sound and fair processes to support a range of research methodologies.

## Guiding Health Research Attributes

This summary relates to consultation questions 35 to 38.

A majority of survey respondents agreed with the proposed guiding attributes (noting that some of these respondents identified the same Attributes as they did for the question regarding Core Attributes). Several respondents suggested additional or alternative attributes around value and health management.




Survey respondents largely agreed with the proposed definitions, making some corrections and suggestions to make the definitions even more inclusive. Ten disagreed with the proposed definitions, with most suggesting extensions to the definitions, for example around capacity and capability and wellbeing and prevention. A specific note was made to use wording that reflects that communities in the context of health research can be one person or patient.

Common themes around implementation practicalities and simplification of wording were applicable to this proposal too, and offline respondents raised issues with the term 'extended peer review' as having the potential to interfere in a fair and equitable review process.

Generally, the feedback suggests support for the attributes and their definitions, however, again the need for a hierarchy was queried in that it may complicate use of the attributes in practice, limit advances and new ways of thinking, or risk politicisation preventing an effective tool.

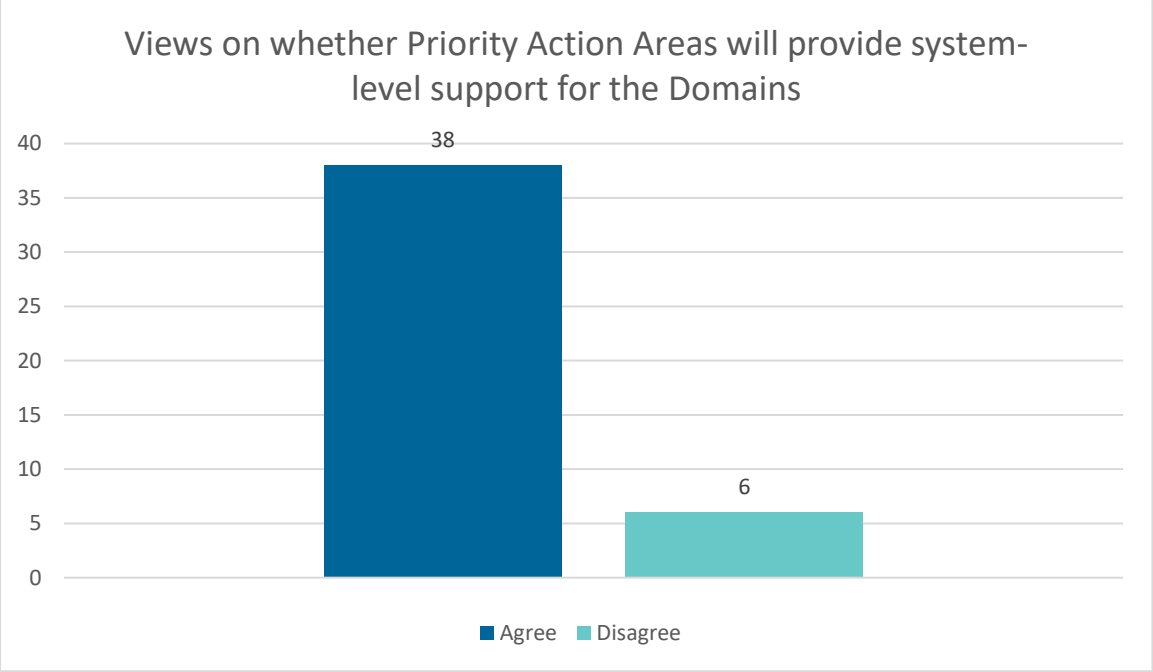
### Resulting actions

- The five Core Health Research Attributes have been retained and renamed as Health Research Attributes, with all the Guiding Health Research Attributes subsumed within these (no longer explicitly called out as separate attributes).
- A clear definition of each Health Research Attribute has been provided, also setting out the expected role of funders, researcher providers, researchers and researcher teams, and communities to aid implementation.

## Priority Action Areas

**This summary relates to consultation questions 43 to 44.**

A majority of survey respondents agreed that the proposed Priority Action Areas will provide adequate system-level support for the Domains.




Most respondents endorsed the proposed Priority Action Areas.

> *They are congruent with how I read the proposal, and resonate with the areas I would expect to see addressed.*

Consistent with feedback on the other vehicle components, implementation and governance concerns were also raised which may need to be addressed in the design of the vehicle, including:

- the breadth of the Priority Action Areas makes them impractical to implement, for example infrastructure having the potential to mean many things in this context
- terms such as 'self-determination' and 'strengthening engagement' may have the effect of forced interaction or the potential to raise false hope
- the need to review funding mechanisms across funders in order to realise the intent of the model in balancing investment
- ensuring a focus on capability as the vehicle is implemented, including the consideration of resourcing more explicitly within the vehicle prior to implementation, and the addition of education as a Priority Action Area distinct from the 'Growing Capability' action

- the importance of supporting data infrastructure, i.e. building and maintaining high quality datasets and retaining data for future advances
- supporting guidance will be important for usability.

Offline respondents also identified some of these concerns.

> *Significant work needs to be done to develop resource capacity within public health systems if DHBs are to be expected to actively participate in delivering research.*

Caution was also expressed around the potential for political priorities to override the balance intended by the model in practice.

Some comments regarding Priority Action Areas indicated a misinterpretation of who these apply to, suggesting further clarity or guidance is required around what each component of the system means for different users within the sector.

### Resulting actions

The Priority Action Areas have been removed from the final Prioritisation Framework. It was determined that this component of the vehicle was no longer required in the context of other changes resulting from the consultation, in particular the incorporation of Infrastructure Aims within the Domains, and clarification of roles for key user groups with respect to each component of the framework.

## Considerations for Implementation and Governance

We received many implementation concerns and suggestions from respondents in their feedback across every component of the prioritisation vehicle.

> *Urge that all government funding agencies work diligently to ensure that the 4 Domains and 5 Core Health Research Attributes (CHRA) in particular are firmly embedded in individual agency Investment Plans as well as in both the funder-specific and collective strategic approaches to program design and infrastructure and capability investment mandated by the Priority Action Areas.*

Respondents identified a need to ensure effective monitoring and governance is set up, i.e. the powers and structure are in place to see the potential of the prioritisation vehicle realised. Governance practicalities include the balance of funding distribution across funders and addressing the need for health systems research to support the infrastructure and system-level change required to support this vision. Some also identified the cost for users of the health system resulting from implementation of the prioritisation vehicle as a potential barrier requiring assessment.

Feedback suggests that further clarification is also needed on what the prioritisation vehicle means for different sector participants. Analysis of submissions indicates some misinterpretation as to what it means in practice for each group, particularly for researchers engaging in assessment processes. Making these roles more explicit within the vehicle may mitigate concerns around funding restrictions and application and assessment process details more specifically.

Translation of research findings was also identified as being a crucial gap to close to ensure the impact of this proposed coordination is realised.

### Resulting actions

Recommendations from submitters regarding implementation and stewardship of the final Prioritisation Framework have been noted and will be useful to inform future guidance. These recommendations have also been communicated to the Steering Group to consider at a Strategy- and system-wide level.

# Appendix 1: Background to the New Zealand Health Research Strategy

In June 2017, the New Zealand Health Research Strategy 2017-2027 (NZHRS) was published. For the first time, the Government is bringing together the science, health, research and innovation sectors to create a cohesive, collaborative and well-connected health research system, to maximise the impact of health research in New Zealand.

The Strategy is a partnership between the Health Research Council of New Zealand (the HRC), the Ministry of Health, and the Ministry of Business, Innovation and Employment (MBIE), who are working to implement a set of co-ordinated and complementary actions that will enhance the funding, conduct and uptake of health research.

The 10 actions that make up the NZHRS are:


## Overview of the prioritisation process

### Development Group

The priority-setting process has been overseen by an independent Development Group, which was formed for the purpose of Action 1 of the NZHRS.

Thirteen members of the Development Group were appointed in 2018 for their mana, knowledge, expertise in health services or research, different world views and experience, and their ability to think strategically for the benefit of all New Zealanders.

The members were:

- Professor Michael Baker
- Emeritus Professor Richard Bedford (Co-Chair)
- Professor Vicky Cameron
- Dr Kyle Eggleton

- Dr James Hutchinson
- Professor Margaret Hyland
- Ms Rose Kahaki (Co-Chair)
- Mr Philip Patston
- Professor John Potter
- Professor Stephen Robertson
- Professor Linda Tuhiwai Smith
- Dr Dale Bramley
- Fepulea'i Margie Apa.

### Evidence appraisal

An extensive review of international literature on setting priorities for health research investment was conducted to inform the prioritisation process. Advice was also sought from overseas experts who had contributed to similar processes. All of the information gathered underlined the importance of setting health research priorities in conjunction with infrastructure priorities.

### Sector consultation

Two prior national consultations were undertaken in addition to the consultation presented in this summary, with feedback from all three consultations shaping the final framework. The consultation page[2] on the HRC website provides a detailed account of:

- the process undertaken
- the results and analyses of consultation feedback
- statements on key decisions made, which have been published to ensure transparency throughout the process.

[2] https://www.hrc.govt.nz/what-we-do/setting-national-research-priorities

## Appendix 2: Consultation Questions

The questions below are an exact copy of those that appeared in the online submission tool and the consultation document. The consultation document is available for additional context here[3] and sets out the proposed components of the prioritisation vehicle consulted upon.

**Contact details**

1. Please enter your name
2. Please enter your email address or alternative contact details
3. Please enter your organisation
4. Is this submission being made on behalf of this organisation?
   - Yes
   - No

   If you answered no, please confirm whether this submission is being made on behalf of another organisation or as an individual.
5. Which interest group to you best represent?
   - Researcher
   - Clinician/allied healthcare professional
   - Non-government agency
   - Government agency
   - Member of the public
   - Research funder
   - Other (please specify)
6. If you do not want your submission published, please let us know below.
   - You may publish this submission
   - Do not publish this submission
7. Please indicate whether you object to the release of any part of your submission under the Official Information Act.
   - I do not object
   - I object (please specify which part of your submission and the grounds that apply)

**Suitability of Domain 1**

8. Do you have feedback on Domain 1? *Note that answering yes displays additional questions about Domain 1.*
   - Yes
   - No
9. Are the purpose and scope of Domain 1 clear?
   - The purpose and scope of Domain 1 are clear
   - The purpose of Domain 1 is clear, but the scope is not clear
   - The purpose of Domain 1 is not clear, but the scope if clear
   - Neither the purpose or scope of Domain 1 are clear
   - I don't know/I don't have a view
   - If you do not think the purpose and/or scope of Domain 1 is clear, please indicate what would make this clearer.
10. Is Domain 1 representative of a key area of the health research ecosystem?
    - Yes

[3] https://www.hrc.govt.nz/sites/default/files/2019-07/Consultation%20Document%20-%20March%202019_0.pdf

No
I don't know/I don't have a view
If you answered no, please explain why.

11. Do you agree that Domain 1 is adequately representative of diverse communities in New Zealand?
    Strongly agree
    Agree
    Neither agree nor disagree
    Disagree
    Strongly disagree
    I don't know/I don't have a view
    If you disagree or strongly disagree, please indicate which communities you think are not adequately represented.
12. Do you have any other comments on Domain 1?

**Suitability of Domain 2**

13. Do you have feedback on Domain 2? *Note that answering yes displays additional questions about Domain 1.*
    Yes
    No
14. Are the purpose and scope of Domain 2 clear?
    The purpose and scope of Domain 2 are clear
    The purpose of Domain 2 is clear, but the scope is not clear
    The purpose of Domain 2 is not clear, but the scope if clear
    Neither the purpose or scope of Domain 2 are clear
    I don't know/I don't have a view
    If you do not think the purpose and/or scope of Domain 2 is clear, please indicate what would make this clearer.
15. Is Domain 2 representative of a key area of the health research ecosystem?
    Yes
    No
    I don't know/I don't have a view
    If you answered no, please explain why.
16. Do you agree that Domain 2 is adequately representative of diverse communities in New Zealand?
    Strongly agree
    Agree
    Neither agree nor disagree
    Disagree
    Strongly disagree
    I don't know/I don't have a view
    If you disagree or strongly disagree, please indicate which communities you think are not adequately represented.
17. Do you have any other comments on Domain 2?

**Suitability of Domain 3**

18. Do you have feedback on Domain 3? *Note that answering yes displays additional questions about Domain 3.*

Yes
No

19. Are the purpose and scope of Domain 3 clear?
    The purpose and scope of Domain 3 are clear
    The purpose of Domain 3 is clear, but the scope is not clear
    The purpose of Domain 3 is not clear, but the scope if clear
    Neither the purpose or scope of Domain 3 are clear
    I don't know/I don't have a view
    If you do not think the purpose and/or scope of Domain 3 is clear, please indicate what would make this clearer.
20. Is Domain 3 representative of a key area of the health research ecosystem?
    Yes
    No
    I don't know/I don't have a view
    If you answered no, please explain why.
21. Do you agree that Domain 3 is adequately representative of diverse communities in New Zealand?
    Strongly agree
    Agree
    Neither agree nor disagree
    Disagree
    Strongly disagree
    I don't know/I don't have a view
    If you disagree or strongly disagree, please indicate which communities you think are not adequately represented.
22. Do you have any other comments on Domain 3?

**Suitability of Domain 4**

23. Do you have feedback on Domain 4? *Note that answering yes displays additional questions about Domain 4.*
    Yes
    No
24. Are the purpose and scope of Domain 4 clear?
    The purpose and scope of Domain 4 are clear
    The purpose of Domain 4 is clear, but the scope is not clear
    The purpose of Domain 4 is not clear, but the scope if clear
    Neither the purpose or scope of Domain 4 are clear
    I don't know/I don't have a view
    If you do not think the purpose and/or scope of Domain 4 is clear, please indicate what would make this clearer.
25. Is Domain 4 representative of a key area of the health research ecosystem?
    Yes
    No
    I don't know/I don't have a view
    If you answered no, please explain why.
26. Do you agree that Domain 4 is adequately representative of diverse communities in New Zealand?
    Strongly agree

Agree
Neither agree nor disagree
Disagree
Strongly disagree
I don't know/I don't have a view
If you disagree or strongly disagree, please indicate which communities you think are not adequately represented.

27. Do you have any other comments on Domain 4?

**Feedback on the proposed Domains**

28. Do you think that the proposed Domains map the most important parts of the health research ecosystem in New Zealand for the next decade?
    Yes
    No
    I don't know/I don't have a view
    If you answered no, what lacks emphasis or is missing at the system level?
29. Are the proposed Domains easily distinguishable from one another?
    Yes
    No
    I don't know/I don't have a view
    If you answered no, please indicate what would make the distinction between Domains clearer.
30. Do you have any other feedback on the overall proposal to introduce Domains?

**Suitability of Core Health Research Attributes**

31. Do you think the five proposed Core Health Research Attributes are the most appropriate attributes to be classified as core?
    Yes
    No
    I don't know/I don't have a view
32. If you answered no, which attributes do you believe should be classified as Core Health Research Attributes?
    Why in New Zealand?
    Mana Tāngata
    Equity
    Excellence
    Impact
    Community partnership and engagement
    Innovation and discovery
    Wellbeing and prevention
    Building on gains
    National and international connection and contribution
    Capacity and capability
    Other (please specify)
33. Do you agree with the proposed definitions of the Core Health Research Attributes?
    Yes
    No
    I don't know/I don't have a view

If you answered no, what do you suggest? *Please make it clear which attribute you are providing feedback for.*

34. Do you have any other feedback on the Core Health Research Attributes?

**Suitability of Guiding Health Research Attributes**

35. Do you think the six proposed Guiding Health Research Attributes are the most appropriate attributes to be classified as guiding?
    Yes
    No
    I don't know/I don't have a view
36. If you answered no, which attributes do you believe should be classified as Guiding Health Research Attributes?
    Community partnership and engagement
    Innovation and discovery
    Wellbeing and prevention
    Building on gains
    National and international connection and contribution
    Capacity and capability
    Why in New Zealand?
    Mana Tāngata
    Equity
    Excellence
    Impact
    Other (please specify)
37. Do you agree with the proposed definitions of the Guiding Health Research Attributes?
    Yes
    No
    I don't know/I don't have a view
    If you answered no, what do you suggest? *Please make it clear which attribute you are providing feedback for.*
38. Do you have any other feedback on the Guiding Health Research Attributes?

**Suitability of Health Research Attributes**

39. Do you agree with the proposal to establish a hierarchy of Core and Guiding Health Research Attributes?
    Strongly agree
    Agree
    Neither agree nor disagree
    Disagree
    Strongly disagree
    I don't know/I don't have a view
    If you disagree or strongly disagree, please indicate why.
40. On a scale of 1 (not at all clear) to 5 (extremely clear), is it clear how the Core and Guiding Health Research Attributes will be used differently?
    5 (extremely clear)
    4
    3
    2

1 (not at all clear)
I don't know/I don't have a view
If you answered 1-3, please indicate what would make the difference between Core and Guiding Health Research Attributes clearer.

41. Do you think that using Core and Guiding Health Research Attributes will enable funders to tailor their investment processes to achieve a balance of investment across the health system?
    Yes
    No
    I don't know/I don't have a view
    If you answered no, please indicate why.
42. Do you have any other comments on the Core and Guiding Health Research Attributes?

**Suitability of Priority Action Areas for funders**

43. Do you agree that the proposed Priority Action Areas will provide adequate system-level support for the Domains?
    Strongly agree
    Agree
    Neither agree nor disagree
    Disagree
    Strongly disagree
    I don't know/I don't have a view
    If you disagree or strongly disagree, please indicate why and identify any system-level priority action areas for funders that you think are missing.
44. Do you have any other comments on the proposed Priority Action Areas?

**Suitability of the prioritisation vehicle concept and structure**

45. On a scale of 1 (not at all clear) to 5 (extremely clear), how clear is the purpose of the prioritisation vehicle?
    5 (extremely clea)
    4
    3
    2
    1 (not at all clear)
    I don't know/I don't have a view
    If you answered 1-3, please indicate what would make the prioritisation vehicle easier to understand.
46. Do you agree that the prioritisation vehicle, if successfully implemented, will provide an overarching system by which health research funders can align and coordinate their investments?
    Strongly agree
    Agree
    Neither agree nor disagree
    Disagree
    Strongly disagree
    I don't know/I don't have a view
    If you disagree or strongly disagree, please indicate why.

47. Do you think that the prioritisation vehicle will direct government investment to the areas it is needed most while maintaining researcher creativity?
    - The prioritisation vehicle **will** direct government investment to the areas it is needed most **and** maintain researcher creativity
    - The prioritisation vehicle **will** direct government investment to the areas it is needed most but it **will not** maintain researcher creativity
    - The prioritisation vehicle **will not** direct government investment to the areas it is needed most **nor** maintain researcher creativity
    - The prioritisation vehicle **will not** direct government investment to the areas it is needed most but it **will** maintain researcher creativity
    - I don't know/I don't have a view
    - If you do not think that the prioritisation vehicle will direct government investment to the areas it is needed most and/or you do not think it will maintain researcher creativity, please indicate why.
48. Do you agree that the proposed prioritisation vehicle will lead to positive change?
    - Strongly agree
    - Agree
    - Neither agree nor disagree
    - Disagree
    - Strongly disagree
    - I don't know/I don't have a view
    - If you disagree or strongly disagree, please indicate why.
49. Do you agree that the prioritisation vehicle is inclusive and respectful of the views and beliefs of a wide range of New Zealand communities?
    - Strongly agree
    - Agree
    - Neither agree nor disagree
    - Disagree
    - Strongly disagree
    - I don't know/I don't have a view
    - If you disagree or strongly disagree, please indicate which communities you feel are left out.
50. On a scale of 1 (not at all clear) to 5 (extremely clear), how clear and easy to follow is the structure of the prioritisation vehicle?
    - 5 (extremely clear)
    - 4
    - 3
    - 2
    - 1 (not at all clear)
    - I don't know/I don't have a view
    - If you answered 1-3, please explain what is not clear and any structural changes you suggest to improve the clarity.
51. Do you have any other comments on the overall concept and structure of the prioritisation vehicle?

**Suitability of language**

52. Are you comfortable with the way that issues of language have been dealt with in the prioritisation vehicle?

Yes
No
I don’t know/I don’t have a view
If no, which terms cause you concern, and what alternatives to the language used would you like to suggest, and why?

## Appendix 3: Themes applied to submissions analysis

| | |
|---|---|
| Themes | Themes are not required where no submission point has been made. For submissions where no comment is made in addition to the submission point (i.e. the survey answer), apply the 'not applicable' theme. For submission points/codes with additional comments i.e. Codes with 'and makes suggestions' are applied, apply the theme that best corresponds with the comment. Where multiple themes apply to a submission comment, add a new line for every theme. |
| Out of scope of proposals | Apply this theme to comments made that are not within scope of what is being proposed in the discussion document, for example prioritisation of specific health issues (as this has been consulted on previously and the position arrived at using prior feedback). |
| Implementation consideration/suggestion | Apply this theme to comments that make practical suggestions for successful implementation of the prioritisation vehicle, e.g. oversight mechanisms to ensure coordination and balance. |
| Education/training need | Apply this theme to comments that identify training needs or specific support needs of stakeholders to ensure successful implementation. |
| Structural changes suggested | Apply this theme to comments made around the positioning or make up of the components forming the prioritisation vehicle (where more than a simple wording change). |
| Concept changes suggested | Apply this theme to comments made around using a different approach to the prioritisation vehicle altogether or changing a key element of the vehicle in a way that shifts the meaning (Note: only include comments that are in scope). |
| Wording changes suggested | Apply this theme to comments making wording suggestions, i.e. additions, clarifications, definitions etc. |
| Repetition | Apply this theme to any comments that have been repeated by the same submitter (ensuring that the comment is captured in the most appropriate worksheet). |
| Endorsement | Apply this theme to any comments that endorse the proposal subject. |
| Not applicable | Apply this theme for every submission point/code where no additional suggestion is made. |