THE UNIVERSITY OF QUEENSLAND
AUSTRALIA

CREATE CHANGE

Research and Innovation

12 July 2023

The Hon. Mark Butler MP
Minister for Health and Aged Care
The Hon. Ged Kearney MP
Assistant Minister for Health and Aged Care
c/- Department of Health and Aged Care
GPO Box 9848, Canberra, ACT, 2601
HMRconsultations@health.gov.au

Re: Improving alignment and coordination between the Medical Research Future Fund and Medical Research Endowment Account.

Dear Ministers

The University of Queensland (UQ) welcomes the opportunity to contribute to the Department of Health and Aged Care's consultation relating to the potential reform of the governance and administration of the Medical Research Future Fund (MRFF) and the National Health and Medical Research Council's (NHMRC) Medical Research Endowment Account (MREA).

These two funding bodies form a key component of UQ's, and indeed the entire sector's, competitive research funding. UQ continues to perform well in attracting NHMRC funding, with 68 grants funded to a total of $82.9 million in the 2022 grant application round. In addition, over the lifespan of the MRFF, UQ has received $176.8 million in grant funding across 99 projects. UQ research funded by the NHMRC and the MRFF has contributed to life-saving and life-enhancing health and medical outcomes, including the landmark HPV vaccine that has significantly reduced the cervical cancer death rate internationally. It is of critical importance that the nation's investment in health and medical research continues to be able to deliver the greatest benefit to Australian society, while maintaining sustainability and viability in a volatile economic environment. The University's responses to the guiding questions of the Discussion Paper (p.31) are outlined below.

What benefits should be achieved through improving the alignment and coordination of the MRFF and MREA?

We commend the Government's efforts, both toward developing an integrated national health and medical research strategy, and its willingness to canvas options for governance arrangements of both the MRFF and MREA, which will be crucial to supporting this strategy.

The issues associated with the current administrative arrangements have been extensively covered in both the stakeholder feedback section of the consultation paper as well as the ANAO audit of the MRFF, and we will not detail them herein. However, we would observe that improving the alignment and coordination between the MRFF and MREA should lead to several significant benefits, including streamlined administrative processes, both pre- and post-award, as well as reduced administrative burden, thus enabling researchers to focus on core research activities to advance health and medical research outcomes.

From a strategic perspective, improved alignment and coordination of the MRFF and MREA should provide much greater clarity regarding the purpose of both schemes and the way in which they intersect. This should enable a seamless integration of both 'discovery-led' and 'solution-focused' research which can lead to both knowledge impact and translational/end-user impact. This is of key importance with regards to the MRFF, whose research themes – patients, researchers, research missions, and research translation – are central to the Fund's existence. Future rounds of the MRFF must ensure that it achieves its ambitious aims of allowing Australians to benefit from life changing medical discoveries through investment in all stages of research, and by building stronger relationships between researchers, government, industry, and the community.

Improved alignment and coordination must also be aimed at supporting a more stable health and medical research workforce with greater emphasis on career development as well as research excellence and impact. This improved research workforce stability may also help address the 'reproducibility crisis' in medical research which would promote both public confidence and more productive engagement and investment from the MedTech/Pharma and Biotechnology business sectors.

Importantly, an alignment will facilitate greater and sustained investment in health services research and translation, something in which the NHMRC and MRFF have identified as pivotal to ensuring the most immediate and strongest health and economic benefits for Australia. Similarly, it will offer a stable way to increase the translation and commercialisation of health, medical and biomedical technology discoveries. The successful alignment of the two funds may provide a blueprint for meaningful commercialisation goals and actions within the national health and medical research strategy; a historic and current barrier to industry collaboration continues to be the number of differing initiatives extant across jurisdictions and portfolios.

All three models are aimed at taking vital steps towards achieving a well-aligned and coordinated approach. **However, it is UQ's view that Model 2, management of both funds by NHMRC, offers the greatest opportunity to future-proof the health and medical research, translation and commercialisation funding system and to bring about the greatest benefits**. Although Model 2 is assessed as having a moderate implementation complexity, the operational benefits greatly outweigh those that would arise from Model 1, which although considered to be of low implementation complexity, would be highly bureaucratic and potentially ineffective from an operational perspective (and hence may have diminished impact). We suggest that the highly centralised approach used in the U.K. (as described in Model 1) may not be appropriate for the more distributive and devolved Australian health and medical system.

Which feature/s of the models will deliver these benefits?

While Model 1 acknowledges the increased need for alignment, UQ doesn't believe it addresses the existing issues. Under this model, the Health and Medical Research Office retains responsibility for the design and delivery of the MRFF, and while the mechanism for ensuring coordination has not been described in detail we believe that the current bottlenecks, inefficiencies, and inconsistencies between the MRFF and NHMRC grants administration processes would be difficult to address and overcome if Model 1 were to be implemented.

It is clear that Model 3 would be the most complex model to implement, necessitating legislative amendments, coupled with major organisational change. While the effort to enact this approach may be rewarded in the long term, as it implements a single body that effectively oversees national health and medical research priorities, strategy, and funding, the complexity of design of the model, combined with changes to the Acts, and the timeframes involved make it a less viable option in our view

Model 2 has the requisite structure and features that would lead to the benefits as described earlier; it brings the management of both funds under the same organisation, while not necessitating large-scale legislative change. In this model, a single source of advice (NHMRC Council) is provided to the NHMRC CEO rather than potentially confusing array of inputs (as in Model 1). The connection to Strategy, Research Investment, and Consumer & Community Advice is clearly defined through committee structures. This model has the greatest likelihood of resolving the issues raised in previous rounds of stakeholder feedback as it enables the governance arrangements to be redesigned to suit the diverse needs of the health and medical research sector and address government priorities.

It is important to emphasise that adequate levels of funding for health and medical research must be maintained under any model. This concern is particularly relevant for Model 3, which may be more exposed to changes in the federal budget; therefore governance arrangements will need to ensure adequate protection and indexation of MREA/MRFF funding levels.

What elements of the existing arrangements for the MRFF and the MREA work well and should be retained? Which feature/s of the models will help ensure these elements are preserved?

The MRFF has proven to be agile and responsive to emerging needs and priority areas, such as the COVID-19 pandemic, and this ability should be preserved, regardless of the chosen model. The NHMRC plays a vital role in supporting discovery-focused research, and a stronger alignment of the MREA and MRFF would help drive a more effective discovery-to-translation pipeline of health and medical research in Australia. At the moment there are some significant overlaps in MRFF and MREA schemes in relation to the discovery-to-translation pipeline. The recent LGBTQI+ health scheme, for example, was listed first as a NHMRC targeted call, but eventuated in an MRFF grant scheme also. The MRFF scheme for early career researchers is also investigator driven and overlaps with NHMRC Investigator grants. The two separate foci of discovery and priority-driven research should be retained in any future iteration of a combined MRFF/MREA function.

The current structure of the NHMRC grant programs also support career progression of researchers, particularly through the Investigator grant program for individuals and in schemes such as Centres of Research Excellence, which includes a capacity building element for higher degree by research students and early career researchers. This approach might be extended to the MRFF scheme to develop clinical research practitioners via program similar to that managed by the NIHR (UK).

Whichever model is adopted should preserve those current MRFF and NHMRC grant assessment processes that are appropriate for each funding scheme (e.g. detailed risk assessments, review panels for most schemes, representatives of consumers and/or health economics on panels, and a clear focus on priority areas, implementation, and true commercialisation in MRFF).

Which aspects of the current arrangements could be changed to deliver the most appropriate and effective change, and why? Which features/s of the models will help deliver this change?

The ANAO audit of the MRFF and the stakeholder feedback outlined in the consultation paper have already captured many of the issues associated with the current arrangements that necessitate future change.

The NHMRC Sapphire system continues to be dysfunctional and remains a risk regardless of the model selected (as outlined in p.12 of the consultation document). We would recommend that a substantial investment is made in the Australian Research Council (ARC) Research Management System in order to support a unified grant submission platform across the funding councils.

We also note that the Hospital and Health Services do not appear to feed into this structure, and consideration needs to be given as to how end user translation can be a facilitated to support a more holistic health and medical research space.

Fully transparent mechanisms and processes across all schemes should also be prioritised within the chosen model. It is of vital importance that any scheme has appropriate panel oversight in place in order to ensure that outcomes don't display any evidence of bias (gender or discipline, for example).

Is there anything you would like to raise that is not otherwise captured by these questions?

We recommend that the Department of Health and Aged Care align this policy initiative in relation to the MRFF and MREA with the concurrent Universities Accord process, which is considering the national research funding landscape more broadly. In particular, we hope that a whole-of-government approach is taken toward the better alignment of the national research councils, the ARC and NHMRC. A critical issue for this policy agenda must be supporting Universities to fund the full cost of research – including fractional CI salaries (based on FTE commitment), full salary costs for staff employed on grants, as well as indirect costs associated with research, such as infrastructure, equipment, and compliance.

We also recommend the government consider a coordinated research governance arm that includes integrity, regulation, guidelines and compliance, the responsibilities for which are currently split between the ARC and NHMRC.

Substantive and meaningful consideration must also be given to the future resourcing of the NHMRC, to ensure that they are able to effectively manage both the MREA and the MRFF in addition to their other responsibilities. The NHMRC operates at the limit of their capacity with arrangements as they currently stand, so it is of critical importance that there must be substantial uplift in capability across people, systems, governance, and any other resources needed to successfully implement the chosen model. Alignment between the ARC and NHMRC may allow for this capacity uplift in a budget responsible way.

The structure of the advisory committees should be reviewed also, as the NHMRC currently has numerous committees, with only two being required by legislation. AMRAB is effective for setting MRFF strategy, and any new committee arrangements put in place should ensure that the ability of a portion of the funding (currently MRFF) can be utilised to support emerging priorities.

Thank you again for the opportunity to comment on the models and approaches outlined in the Discussion Paper. We would welcome the opportunity for ongoing engagement and consultation with the Government as the process continues over the course of 2023.

The University acknowledges that this process is a vitally important move towards a comprehensive nation-wide, strategic approach to health and medical research, which best supports the entire research pipeline, and which will in-turn will bring about improved health outcomes for the Australian community.

Kind regards,

Professor Alastair McEwan
Pro-Vice-Chancellor (Research)