Response from the Melbourne Academic Centre for Health, a NHMRC-accredited Research Translation Centre, to the consultation on Improving alignment and coordination between the Medical Research Future Fund and NHMRC's Medical Research Endowment Account

Response to guiding questions (p31)-

1) Benefits from greater strategic co-ordination of the MRFF and MREA:

We identify-

a) more efficient delivery of a single national strategy for health and medical research and innovation;

b) greater capacity to identify and respond to health needs across the whole health and medical research (HMR) budget;

c) a timely opportunity to promote the embedding of HMR into the health system through measures such as delivering a clear career development pathway for clinician researchers interested in translation of research into health and healthcare;

d) promotion of beneficial influence from key stakeholders including consumers, healthcare providers and industry;

e) an increase in impact of all publicly-funded HMR by bringing important translational initiatives "under the same roof", including capacity to provide NHMRC-accredited Research Translation Centres with meaningful funding;

f) a greater capacity to identify and respond to the changing needs of the research and translation workforce, particularly that embedded in healthcare;

g) elimination of wasteful duplication of schemes such as investigator grants and clinical trial support, releasing additional funds for research and reducing unnecessary effort amongst researchers applying for funds, researchers acting as peer-reviewers and research funding administrators; and

h) an opportunity to circumvent, by judicious in-house "invisible join" cross-funding between the two funds rather than legislative change, undesirable anomalies arising from section 24 limitations on applicants to schemes funded from the MRFF Health Special Account, such as public health services being ineligible (as state entities) to apply to MRFF schemes such as the Rapid Applied Research Translation initiative whereas private health services *are* eligible (as corporations).

2) Features of the models delivering these benefits;

We think the greatest likelihood of delivering the benefits we cite will arise from careful alignment based on model 2- NHMRC manages both funds with each maintaining its distinctive features.

We do not favour model 1 because it perpetuates a cumbersome and undesirable separation between the governance of the two funds within a single Government Department that appears to have arisen by accident rather than design. Maintaining this separation would make the benefits we expect more difficult to realise and might be regarded as half-hearted tinkering unlikely to reverse the currently steady loss of talent from the HMR profession.

Furthermore, while the "radical re-boot" offered by model 3 has the attraction of form being explicitly designed to drive function, we feel that because of the time and legislative change needed, there is too great a risk of losing the momentum built up by the MRFF in translational research that addresses health need.

In particular, the solution based on model 2 should-

a) maintain flexibility to fund basic, applied, clinical, health services and public health streams across both investigator- and priority-driven initiatives;

b) ensure that industry partnership can be supported from both funding streams;

c) promote alignment with policy and program areas within the Department of Health and Aged Care by ensuring that senior members of the Department sit on NHMRC's strategic decision-making committee(s) to inform priority setting for the allocation of MRFF funds;

d) provide greater clarity regarding which entities within NHMRC will oversee the strategic decision-making process (Council, Research Committee, or other) and how all aspects of research and translation will be encompassed by each decision-making entity; and

e) be supported by ensuring NHMRC is sufficiently staffed with highest quality research funding experts capable of flecibly developing new initiatives, whether these arise from strategic priority-setting from above or investigator-driven ideas from the grassroots.

3) Which elements of MREA and MRFF should be retained?

a) MREA- the full range of NHMRC activities are of value and should be retained, in particular the strong link between the NHMRC CEO and the Minister of Health; the MREA budget should not be eroded and the NHMRC must retain its strong culture of peer review and stengthen still further its advisory committee structure.

b) MRFF- the full range of flexible, priority-driven activities, including the Frontiers program, are of value and should be retained. However, some MRFF programs -such as investigator grants- should be merged with equivalent NHMRC programs to reduce duplication of effort but maintain available total budget. The significant proportional commitment of the MRFF to research addressing health and health system-derived priorities and to translation must be maintained.

4) Which aspects should be changed?

a) We refer above in (1g and 3b) to merging similar programs run by each fund into single competitions with the same total budget; investigator grants and clinical trials are examples. As we favour model 2 it would be up to NHMRC to deliver an "externally invisible join" between the two funds in house. We think this can be done without change in legislation, by judicious draw down from each fund within NHMRC to create composite award portfolios.

b) Further work will be needed, in part driven by the new national HMR strategy, to ensure that model 2 has the optimum governance committee structure.

5) Anything else to raise?

a) It will be essential to safeguard the Aboriginal and Torres Strait Islander focus of both funds;

b) The second phase of the consultation, to develop a national HMR strategy, must also include the development of a strategy to deliver a diverse, inclusive, multiskilled, multidisciplinary and sustainable research workforce.

c) The second phase of consultation should also consider the full costs of research.

d) MACH's Health Service members (we have ten serving ~2.5m Victorians, with a total across these of ~30,000 staff) view the advent of the MRFF as providing them, for the first time, with a realistic chance of accessing competitive, publicly funded HMR, which hitherto they see as having being dominated by the priori and staff of Universities and MRIs. Consequently our Health Service CEOs do not want to "lose the MRFF", and strongly reject model 3.

John Savill
Executive Director, for the
Melbourne Academic Centre for Health (https://machaustralia.org/)
June 2023