Australian Academy *of* Health and Medical Sciences

Improving alignment and coordination between the Medical Research Future Fund and Medical Research Endowment Account – The Australian Academy of Health and Medical Sciences response to the online survey questions

Q1. What benefits should be achieved through improving the alignment and coordination of the MRFF and MREA? (2100 characters max)

AAHMS has developed a detailed submission informed by input from our Fellows and Associate Members. Our responses to these survey questions are based on that submission. Please refer to our full submission for more detail.

There are considerable benefits to be gained from improving alignment and coordination of the MRFF and MREA. Ultimately, the way to maximise such benefits is to ensure that any new approach is as strategic as possible. Any revised governance model should be developed based on the principle that governance, administration and national strategy are inextricably linked – and should be mutually reinforcing.

Better alignment and coordination of the MRFF and MREA should seek to provide:

- Health and medical research (HMR) investment that delivers the greatest benefit for the community while driving long-term economic growth and productivity.
- A strategic vision that will shape the future of HMR in Australia – one that will have impact beyond the role of any one organisation.
- Strong connection with the health system through mechanisms that enable research and innovation to reach patients and the community.
- Governance, administration and a national HMR strategy that are fit-for-purpose, fill existing gaps and address the fundamental issues facing the sector – we list these in more detail in our full submission.
- A meaningful partnership between the state, territory and federal governments in healthcare in Australia, and in funding for HMR.
- Better principles and structures for balancing the needs of basic science and discovery research with those of strategic investment in capacity and targeted priorities.

These benefits cannot be realised through the models outlined in the consultation paper alone. Better alignment and coordination would be maximised by creating and convening a national HMR strategy committee that develops and oversees the implementation of a national HMR strategy, advises the Minister and is constituted by key stakeholders including those from outside NHMRC and MRFF.

Q2. Which feature/s of the models will deliver these benefits? (2100 characters max)

On balance, from the models presented in the consultation discussion paper, model two is the closest to being the most suitable. However, in implementing any changes, the Government should undertake a considered and staged approach to implementation and should draw on the beneficial aspects of other models, including those not presented in the discussion paper. This could lead to a hybrid model that is best suited to supporting a thriving HMR ecosystem.

Any model must ensure that the MRFF is not seen to be subsumed into the NHMRC and that the different fundamental purposes of the MRFF and MREA remain distinct. This will help deliver an ecosystem that supports a balance of discovery through to translational research.

At the heart of any revised model should be mechanisms that enable close working with all key stakeholders, including those that sit outside of federal government funded HMR, to ensure this model can deliver a strategic vision for HMR. This includes representatives from state and territory governments, peak and expert bodies, industry, health services including clinicians, consumer and community groups, philanthropy, private sector organisations and Aboriginal and Torres Strait Islander health organisations.

The features of the models described in the consultation paper will not be sufficient to deliver this without some additional mechanisms – we believe a national HMR strategy committee would play an important role in whichever model is taken forward, and we expand on this in our full submission. It would exist in addition to the strategic advisory structures supporting the MRFF and MREA.

Australian health and medical research is world-leading. To remain globally competitive and advance both our national and international impact, we need a vision that strategically plays to our strengths, and underpinning structures that can tackle the big challenges. If we can get this right, it could enhance our capacity to leverage internal investment and attract industry to our shores.

Please refer to the full AAHMS submission for further detail.

Q3. 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? (2100 characters max)

The MRFF and MREA have two distinct purposes that guide their investments, both of which are crucial for a successful research and innovation system. AAHMS strongly supports continued separation of these funding pools so that the fundamental purposes of the MRFF and MREA can remain distinct, and all areas of the pipeline can be supported strategically in the short-, medium- and long-term.

Looking at model two, there is a risk that the MRFF could be (or at least seen to be) subsumed into the NHMRC. Whether or not this is the intent, we would caution against a model that creates this perception. We strongly support a revised model that truly integrates MRFF and NHMRC to advance their individual strengths and results in a unified system that is greater than the sum of its parts – with clear messaging to underpin this approach.

A revised model must retain the positive and beneficial aspects of MRFF, MREA and NHMRC culture and ways of working, and allow each to flourish under a new overarching system. NHMRC has historically been a trusted, reliable and transparent source of funding with a solid track record for rewarding excellence in science. The MRFF is a newer fund that has provided a critical opportunity to support priority-driven research, enabling more flexibility to respond to public and health system needs, and allowing the public to have a greater say over how research is translated into health and economic benefits for the community.

Within this system, there has been progress in areas including consumer engagement, timelines for grant approvals, research led by those from non-traditional academic backgrounds, and ways of assessing and undertaking peer review that could inform new ways of working across both funds.

Governance structures should be put in place to safeguard the purpose of both the MRFF and MREA to ensure the system is transparent, accountable, coordinated and strategic – and that funding is delivered based on the most appropriate expert advice to the NHMRC CEO.

Please refer to the full AAHMS submission for further detail.

Q4. Which aspects of the current arrangements could be changed to deliver the most appropriate and effective change, and why? Which feature/s of the models will help deliver this change? (2100 characters max)

An NHMRC as described in model two could be seen as a new agency, in terms of its purpose, goals and mechanisms for distributing funding under a new framework. Should model two be adopted, AAHMS suggests the Government review the existing NHMRC governance structures in detail, beyond that which has been presented in the discussion paper. For instance, the NHMRC Council, as currently constituted, would not have the right mix of expertise and experience to oversee both the MREA and MRFF, as well as other NHMRC functions. It is not clear from the discussion paper what advisory structures would be in place to support the MRFF within the proposed structures.

Any process that aims to change the way HMR funding is delivered should be staged and will take time, however, there are aspects of governance and administration that could be addressed more urgently to effect change that benefits the sector. Some examples of issues for urgent consideration include the following, some of which are noted in the paper:

- Timelines and lack of coordination of the grant schedule between, and in some cases, within, the two funds.
- Different application requirements, form design and post-award arrangements.
- Different grant application and management systems.
- Peer reviewer overload and broader issues with how the peer review system functions.
- Competing or overlapping grant opportunities.

While models one and three have some benefits, AAHMS would not support either of these (as described in the paper) as a final outcome. Although there are merits to model one, it does not appear to have the necessary level of change to adequately address the fundamental issues facing the sector. The proposed model three would require significant legislative change that could hinder the progress that has been made to date. This model risks losing the distinct purposes of the two funds, which as noted above is an important aspect of creating a HMR system that is fit for purpose.

Please refer to the full AAHMS submission for further detail.

Q5. Is there anything you would like to raise that is not otherwise captured by these questions? (2100 characters max)

Improving alignment between the MRFF and MREA is only part of the picture. The benefits of doing this can only be realised if research and innovation can move through the pipeline and ultimately reach patients and the community, which we note is an important goal specified in the discussion paper.

The AAHMS report, *'Research and innovation as core functions of the health system'* argues for urgently developing and implementing plans to further integrate HMR within the health system (www.aahms.org/vision). In developing this report, we spoke to more than 260 individuals including representation from every state and territory, across all career stages and

from all relevant sectors. They told us that a key barrier limiting progress in this area is the fragmentation and disconnect between the many stakeholders working to improve the nation's health, healthcare and research and innovation.

The Government has an opportunity to maximise its investments by establishing the appropriate mechanisms that can enable these stakeholders to work together and become meaningful partners in HMR.

In our response, we propose that the Government should create and convene a national HMR strategy committee that is comprised of members drawn from a wide range of backgrounds, including state and territory governments and the health system. This committee, or a subset of it, could collectively identify, develop and deliver solutions to better embed research and innovation in the health system – working with relevant partners. Its role might include developing better clinician researcher pathways, promoting an active health-academia-industry interface and advancing consumer involvement in research.

Neither NHMRC nor the MRFF can achieve this on their own through funding – as we have seen in the past – and the proposed model two structure does not present sufficient opportunities to meaningfully connect with the health system. A national HMR strategy committee could be explicitly tasked with filling this gap.

Please refer to the full AAHMS submission for further detail.