Australian Government

Consultation summary report: Improving alignment and coordination between the Medical Research Future Fund and NHMRC's Medical Research Endowment Account

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Executive summary

The purpose of this national consultation was to seek stakeholder views on options to improve alignment and coordination between the Australian Government's two major sources of health and medical research funding, the Medical Research Future Fund (MRFF) and the National Health and Medical Research Council's (NHMRC's) Medical Research Endowment Account (MREA).

Throughout June and July 2023, the national consultation heard views from a broad, diverse and passionate range of stakeholders through roundtable meetings, webinars and written submissions. Stakeholders welcomed the consultation, with many noting that the current arrangements are confusing, pose an undue burden on the health research workforce, and require improvement. For instance, the lack of coordination and strategic oversight between the funds left many unclear about how the whole system fits together, with both gaps and overlaps identified across the research pipeline.

Overall, there was a prevailing view that the two funds should be managed by a single managing agency. There was also a general consensus that governance and advisory arrangements for the two funds would need renewal to facilitate improved alignment and coordination. However, stakeholders advised a staged, incremental approach should be taken to the reforms, with a focus on ensuring the benefits of the two funds are preserved and promoted. However there was no consensus on how the reforms should be staged. Stakeholders value the distinctiveness of the two funds, which are seen as delivering benefits in different ways across the research ecosystem. The MREA is valued for its transparency and focus on investigator-driven research to address a wide range of health needs and to build foundational research capacity. The MRFF is valued for its ability to promote research in areas of unmet need, with the priority-driven fund representing a 'game-changer' for First Nations, rare diseases, rural and remote and health services research stakeholders.

A key message heard was the need for a "seamless but not homogenous" funding model – where the best of both funds is preserved and brought together in closer alignment and coordination. Stakeholders desire a transparent, strategic, cohesive, and fit-for-purpose funding system, including balanced support across the entire research pipeline. Stakeholders also seek a system that creates new avenues for community and consumer engagement, as well as stronger links with other funders and partners, such as industry, philanthropy, and health services.

Regarding the potential models for reform outlined in the discussion paper, stakeholders overall preferred a single body to administer both funds, with some important caveats. For instance, while model 2 was generally preferred to deliver improved coordination while retaining the benefits of two distinct funds, stakeholders raised concerns over the NHMRC's current capability and capacity to fully deliver the distinctive elements (e.g. focus on priority populations and commercialisation) of the MRFF. Likewise, model 3 was seen by many stakeholders to provide the greatest flexibility, adaptiveness, and responsiveness, however risked losing the distinct benefits of both funds and reducing total funding over time. Overall, fit for purpose governance and advisory arrangements were seen as critical for the future delivery of the two funds.

Stakeholders also provided views on how administrative and governance reform should be implemented, with an overall preference for a staged approach that clearly articulates the end goal while allowing early implementation of strategies for addressing key administrative and coordination challenges that do not require formal governance reforms. These stages could be supported with ongoing monitoring and evaluation to assess progress, and for stakeholder views to be incorporated into future design and implementation. Features of international funding models that could be

considered for improving the administration and coordination of the MRFF and MREA were also proposed.

Finally, there was strong support expressed for the development of a national strategy for health and medical research in Australia (national strategy) and some debate about whether the development of the strategy should have preceded this reform process. Many of the ideas provided will be used in the development of a national strategy, which the Minister for Health and Aged Care has committed to delivering.

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Introduction

Purpose of report

The purpose of this report is to provide a summary of feedback received as part of the national consultation to improve alignment and coordination between the MRFF and MREA. The report was developed by the Department of Health and Aged Care (Department) and National Health and Medical Research Council (NHMRC).

Background

A national consultation was undertaken between June and July 2023 to seek stakeholder views on whether, and if so how, to improve the alignment and coordination between the MRFF and the MREA.

The consultation was part of the government's commitment to enhance Australia's reputation as a world leader in high quality, innovative health and medical research and development and to ensure the translation of health and medical research into policy, practice and new technologies that meet the needs of all Australians.

The focus of the consultation was on improving the alignment and coordination of the government's investment in health and medical research. It was also undertaken in the context of an upcoming review of the *MRFF Act 2015* (Cth) and the proposed development of a new national strategy.

Feedback was guided through five questions as well as on three potential models for reform. The models and questions, as well as further context for the consultation, are detailed in the *Discussion Paper: Improving alignment and coordination between the Medical Research Future Fund and NHMRC's Medical Research Endowment Account* (May 2023).

Consultation approach

Activities

The consultation sought stakeholder views through a range of public and targeted consultation activities, including:

- **two Ministerial roundtables**, one led by the Minister for Health and Aged Care, and the other led by the Assistant Minister for Health and Aged Care
- **three Commonwealth roundtables**, led by senior officials from the Department and NHMRC
- **two meetings with government stakeholders**, with state and territory officials and Commonwealth departments and agencies
- **three public webinars**, including one targeted webinar for consumers
- **written submissions**, receiving 177 public written submissions.

Timeline

The national consultation opened on 4 June 2023 and closed on 14 July 2023. Refer to the below table for key consultation activities, milestones and dates.

Table 1: Consultation dates, activities and milestones

Date	Activity/ milestone	Led by
4 June	Consultation opened	Minister Butler and Assistant Minister Kearney
6 June	Webinar 1	Senior officials from the department and NHMRC
8 June	Ministerial roundtable in Adelaide	Minister Butler
9 June	Commonwealth roundtable in Sydney	Senior officials from the department and NHMRC
14 June	Commonwealth roundtable in Perth	Senior officials from the department and NHMRC
19 June	Commonwealth roundtable in Brisbane	Senior officials from the department and NHMRC
26 June	Ministerial roundtable in Melbourne	Assistant Minister Kearney
3 July	Webinar 2	Senior officials from the department and NHMRC
6 July	Webinar 3	Consumers Health Forum and senior officials from the department and NHMRC
11 July	States and territories meeting	Senior officials from the department and NHMRC
13 July	Commonwealth meeting	Senior officials from the department and NHMRC
14 July	Written submissions due; consultation closed	N/a

Stakeholder groups

Diverse stakeholders shared their views on options to improve alignment and coordination between the two funds. These included:

- researchers from across the research pipeline and at every career stage, including:
    - basic science
    - health services
    - commercialisation
    - clinician
    - early- and mid-career
    - researchers with community engagement expertise
- consumers, including consumers with lived experience
- representatives from priority populations, including:
    - First Nations peoples
    - those living and working in regional, rural and remote areas
    - culturally and linguistically diverse communities
    - LGBTQIA+ people
    - older people
    - people with a disability
    - people living with rare diseases
- peak bodies, including:
    - health and medical research
    - scientific and academic
    - industry (small, medium, and large enterprises)
    - consumer advocacy
- state and territory governments
- Commonwealth departments and agencies
- philanthropic organisations
- the public with an interest in health and medical research.

Analysis approach

How feedback was captured

Feedback was captured in a range of formats, including:

- notes from roundtables and meetings
- recordings and Slido questions from webinars, and
- written submissions via the department's Consultation Hub and/or via email.

How feedback was analysed

We conducted a thematic analysis on all written submissions as well as on notes from roundtables and meetings. This involved looking for key words in feedback and identifying patterns.

For feedback received via written submissions, we also undertook some demographic analysis (where appropriate). All demographic information is self-reported and has not been independently validated.

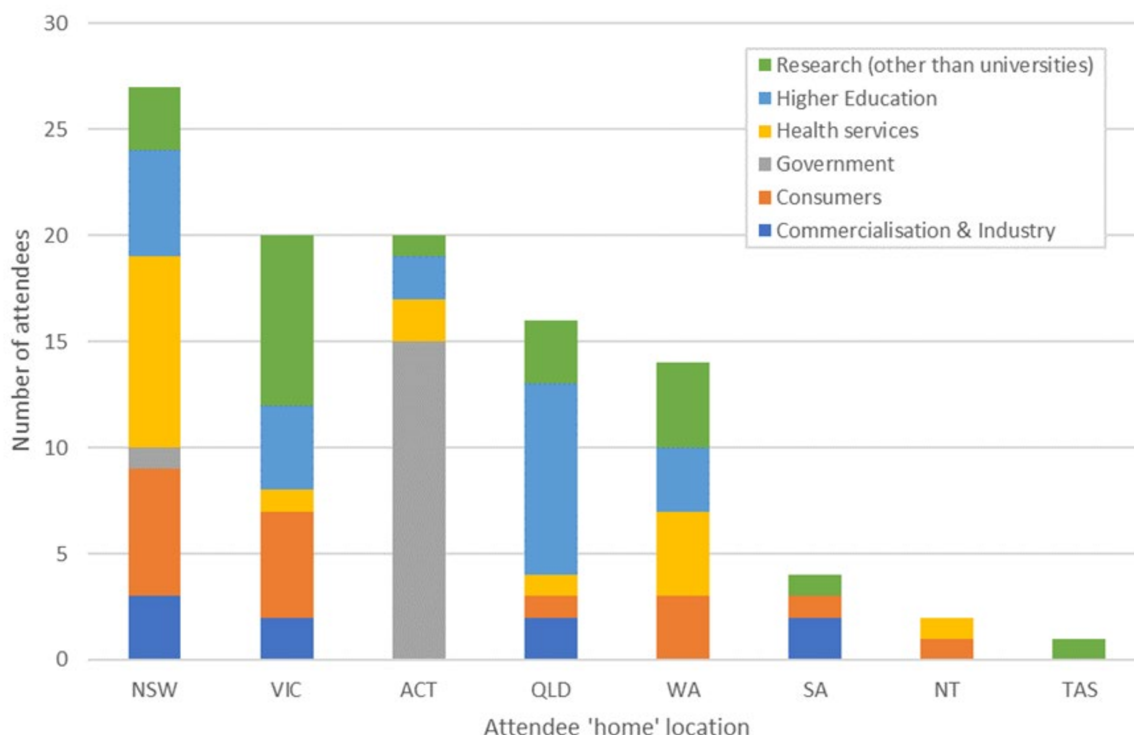
Who we heard from

Webinars

577 live participants for the three webinars.

Roundtables and meetings

104 attendees from diverse stakeholder groups, including from higher education, industry, research, health services, First Nations, consumers, philanthropy, government funders as well as rural, regional and remote communities.

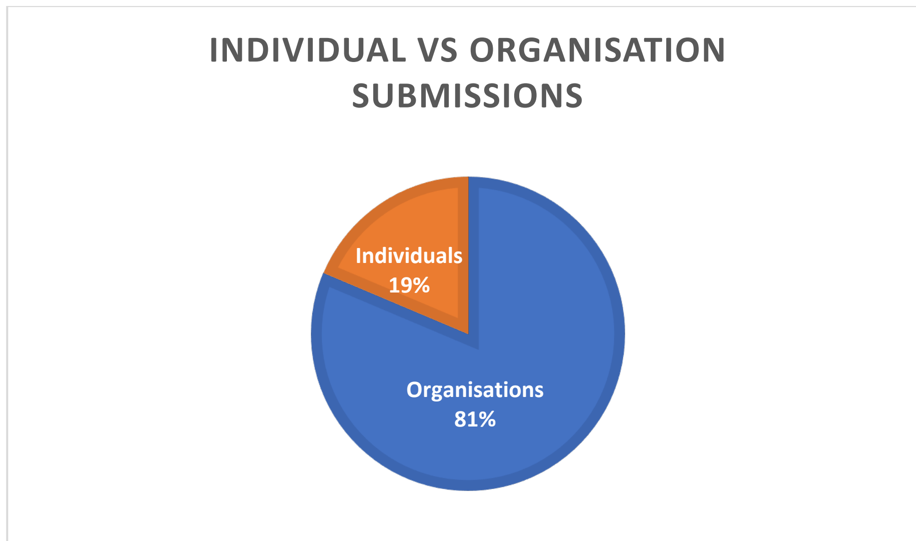


Written submissions

177 written submissions were received via the Consultation Hub and/or email.

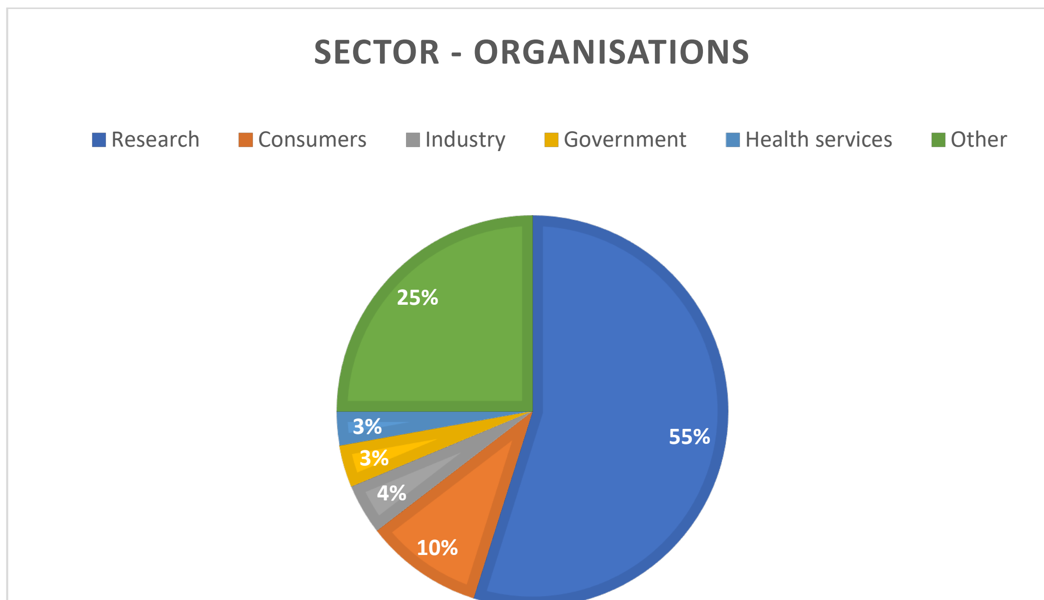
Organisation or individual

Of the 177 written submissions received, 144 (81.3%) were on behalf of an organisation and 33 (18.6%) on behalf of individuals.



Sector representation

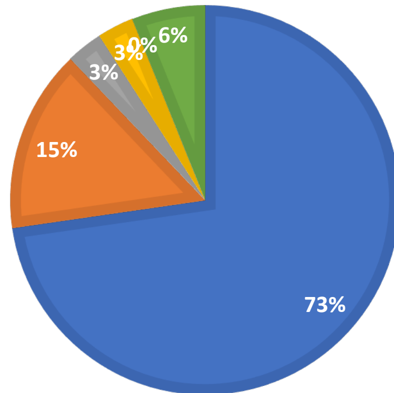
The largest proportion of written submissions from organisations were from the research sector, either higher education or non-university settings (total 79, 54.8%). Other organisations represented consumers (14, 9.7%), industry (6, 4.1%), government (5, 3.4%) and health services (4, 2.7%). Those responding 'other' made up a further 25% (36). These organisations typically represented multiple sectors or peak bodies if not otherwise categorised.



Like organisational respondents, the largest proportion of individual respondents worked in the research sector, either higher education or non-university settings (24, 72.7%). Of the individual respondents who worked in the research sector, three identified themselves as being early to mid-career researchers.

SECTOR - INDIVIDUALS

Research Consumers Government Health services Industry Other

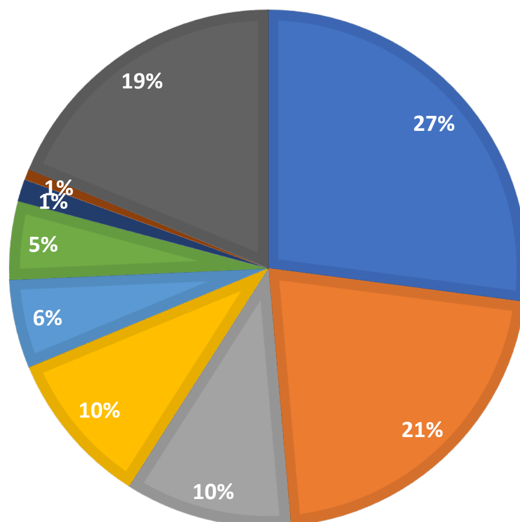


Location

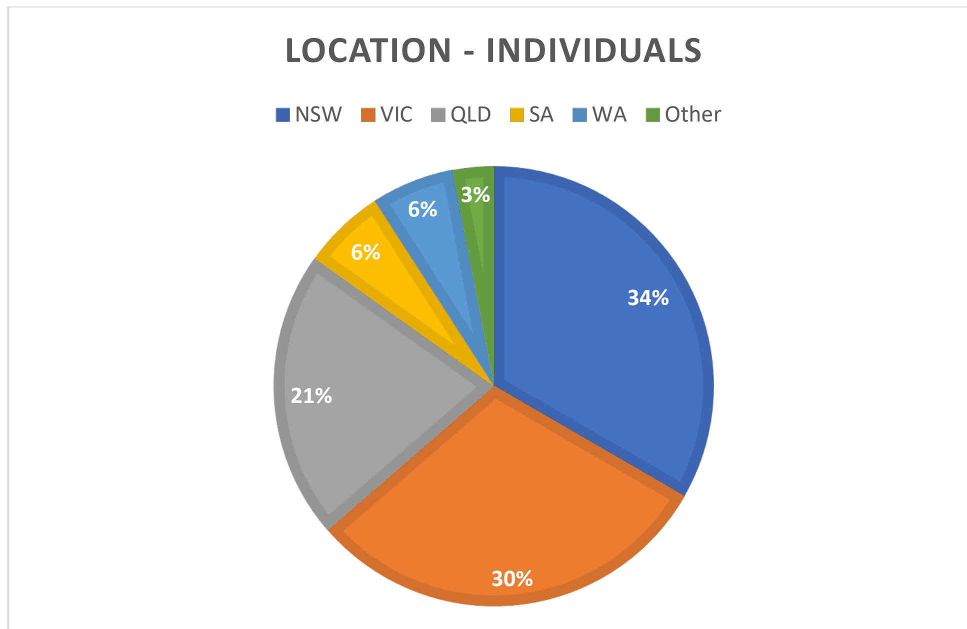
The largest proportion of organisations were located in New South Wales (39, 27%), followed by Victoria (31, 21.5%) and the Australian Capital Territory (15, 10.4%). There were 27 organisations choosing ‘Other’ (18.7%), with most of these clarifying they were nation-wide or Australasian organisations.

LOCATION - ORGANISATIONS

NSW VIC ACT QLD WA SA TAS NT Other

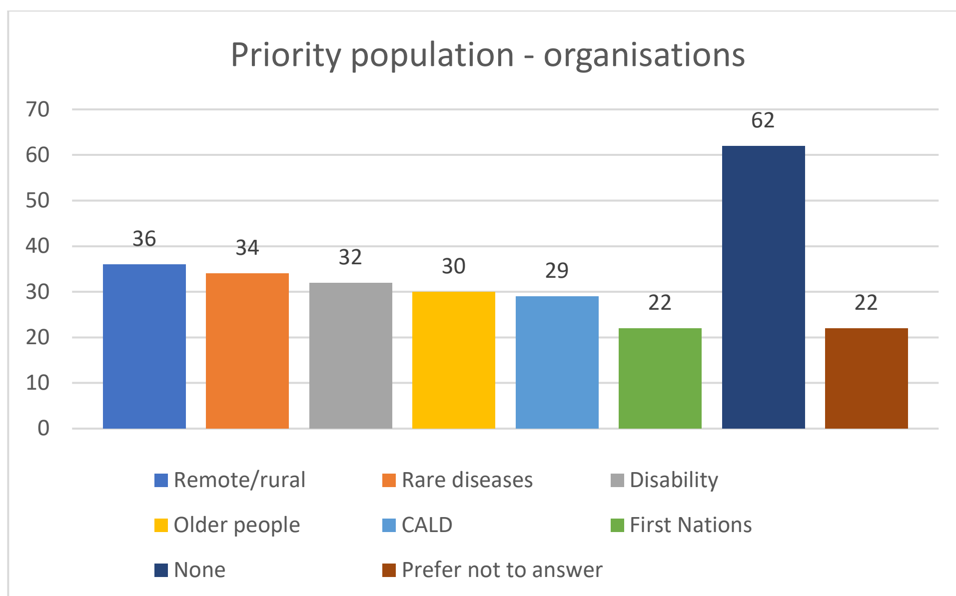


The largest proportion of individuals lived in New South Wales (11, 33.3%), followed by Victoria (10, 30.3%) and Queensland (7, 21.2%).



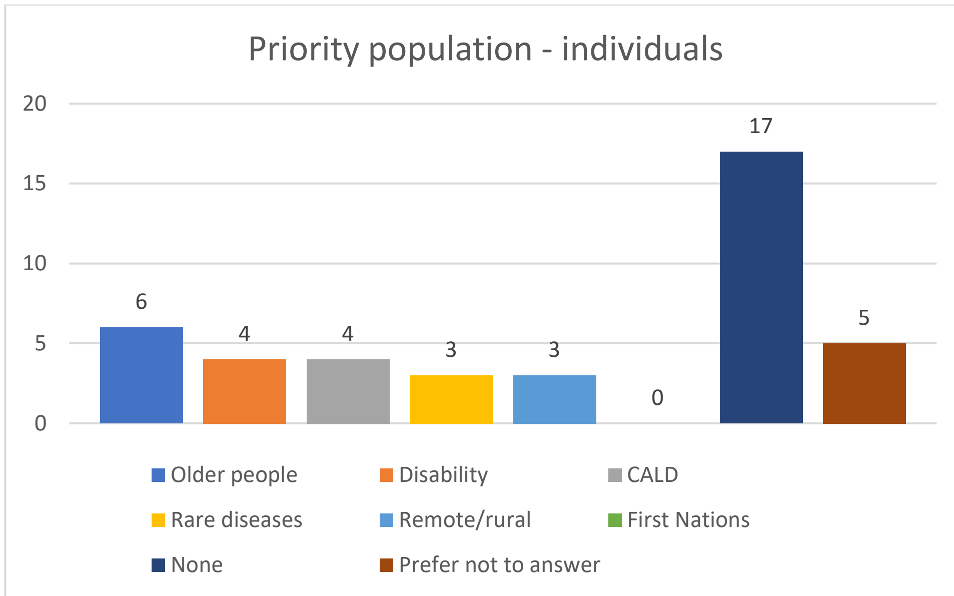
Priority populations

The largest proportion of organisations that represented a priority population identified remote/rural communities (36, 25%), followed by people with rare or currently untreatable diseases/conditions (34, 12.6%) and people with a disability, including people with an intellectual disability (32, 23.6%). Other organisations represented older people (30, 20.8%), people from culturally and linguistically diverse communities (29, 20.1%) and First Nations people (22, 15.2%). There were 62 organisational respondents (43%) that did not self-identify as representing any of the listed priority populations and 22 chose not to answer (15.2%). We note that, of the 60 organisations that responded as representing a priority population, 52 organisations identified that they represented more than one priority population.



Of individual respondents who self-identified as being in a priority population, the highest proportion identified as older people (6, 18.1%) and people with a disability, including intellectual disability (4, 12.1%) followed by people from culturally and linguistically diverse communities (4, 12.1%), people in remote/rural communities (3, 9%) and people with rare or currently untreatable diseases/conditions

(3, 9%). 5 individual respondents identified themselves as representing more than one priority population.



What we heard

Guiding question 1: Benefits to be achieved

We heard from stakeholders that reforms to the MRFF and MREA should deliver a system that will:

- be integrated, transparent, and fit-for purpose – subject to regular evaluation and reviews to ensure it is meeting the needs of all stakeholders with integrity and accountability
- address national health priorities
- encourage and support both investigator-led and priority-driven research
- encourage multidisciplinary research
- provide balanced investment across the R&D pipeline, from pure, basic research through to applied and translational research
- be streamlined and seamless, while recognising the need for tailored governance and administrative processes that optimise different kinds of research
- establish effective coordination and engagement across Commonwealth, state and territory funders including policy makers, to enable more strategic priority setting
- have diversity on assessment panels including researchers, consumers, clinicians, industry and commercialisation representatives, international experts and policymakers, to enable comprehensive review of research proposals
- provide meaningful avenues for consumer engagement at all stages and levels of research
- enable Australia to be globally competitive across the entire health and medical research pipeline
- be mission-driven, supported by a governance framework that fosters an investment approach based on long-term strategic horizons
- deliver greater career security for researchers through the provision of an increased level of funding success, greater grant tenure and improved investment in building capacity within the medical research sector.

Guiding questions 2, 3 & 4: Features of models

The guiding questions also sought feedback on features of the models. Specifically, which features of the models would:

- deliver the benefits stakeholders had identified should be achieved through improving the alignment and coordination of the MRFF and MREA
- ensure current benefits stakeholders identified are retained
- help deliver the change to current elements stakeholders identified to be changed

Model 1 was regarded as being the quickest to implement and pose the lowest risk. However, some stakeholders noted that it may not go far enough to address their identified issues.

Stakeholders noted that a unique strength of model 2 was that it retains the distinct funding focuses of the MRFF and MREA, while delivering greater strategic coordination and alignment compared to model 1. Stakeholders also noted that model 2 would be easier to implement than model 3.

Stakeholders had both positive and cautious responses to the major changes implied in model 3. Stakeholders who regarded model 3 positively noted it would enable the greatest flexibility for funding across the entire research pipeline. In addition, model 3 was through to offer the greatest opportunity for flexibility and opportunity for strategic investment and for responding to emerging challenges.

In contrast, stakeholders concerned about model 3 noted it posed the greatest risk of losing the current system's strengths, including the distinct focuses for the two funds. These respondents often also expressed concerns that merging the two funds could result in reduced total funding over time (ie it might be easier for Government to reduce funding if there is a single $1.5 billion fund) or

preferential funding for one part of the research system over another (eg basic science vs translation/ commercialisation).

For models 2 and 3, stakeholders raised concerns about the NHMRC's capability and capacity to deliver the full breadth of the MRFFs program, particularly commercialisation and the commissioning aspects of research design (eg for health technology assessment, the Missions, or for priority populations). Some stakeholders considered that the NHMRC would require a substantial increase in resourcing and to acquire staff with specific skills and experiences under these models.

For models 2 and 3, respondents further noted that successful implementation would require a change to the culture of the NHMRC to ensure the two funds continue to operate according to their distinct methods, for the purpose of maintaining and promoting the benefits of each (ie 'seamless but not homogenous').

Where feedback could be linked to specific models, features from models 2 and/or 3 were most frequently mentioned with respect to delivering improved coordination and alignment between the two funds.

Guiding question 3: Current elements to be retained

Stakeholders identified elements of current arrangements that they wished to be preserved relating to the MRFF (only), the MREA (only) or to systemic arrangements. These elements are captured in the below table.

Table 2: Current elements to be retained

MRFF	• Priority-driven funding opportunities. • Funding priorities informed by diverse advisory structures that include industry, consumers, collaborative researchers, health services and clinicians. • Support for researchers with non-traditional and diverse backgrounds, with less emphasis on track record. • Research capacity-building in rural and remote areas, particularly through quarantined funding for researchers and organisations located in those areas. • Industry partnerships. • Exclusive funding opportunities for First Nations researchers. • Increased investment into health services research, rare diseases and ethical, legal, social impact of health interventions. • Agility, responsiveness and flexibility.
MREA	• Competitive peer-review processes. • NHMRC's reputation for understanding the research sector's needs. • Gender equity policies. • Predictable patterns and programs of funding. • Well-understood governance structures. • Strong links between the NHMRC CEO and the Minister for Health and Aged Care. • Support for basic research and discovery. • First Nations representation on NHMRC committees. • Provision of feedback to applicants.
Systemic	• Support for both priority-driven and investigator-initiated research. • Review processes and assessment criteria that can be specifically aligned to each grant opportunity.

Guiding question 4: Current arrangements that could be changed

Stakeholders identified elements of current arrangements that they wished to have changed relating to the MRFF (only), the MREA (only) or to systemic arrangements pertaining to both funds. These elements are captured in the below table.

We note that some feedback may reflect historical perceptions of the MRFF, MREA and the broader funding system, rather than current issues.

Table 3: Current arrangements that could be changed.

MRFF	• Opaque priority-setting processes. • Large scope for Ministerial discretion in funding decisions. • Short deadlines.
MREA	• Disconnect between investigator-led research links and health outcomes. • Shift away from panels to individual peer review has led to perceptions of bias and lack of transparency.
Systemic	• Unbalanced funding and infrastructure support across the research pipeline from basic research to translation, commercialisation, public health and health services. • Limited strategic coordination and alignment between funds. • Inadequate avenues for meaningful consumer involvement in priority setting, research, and grant assessment processes. • Barriers for research integration into health services and systems. • Excessive and inefficient administrative processes. • Duplicate and/or overlapping grant opportunities. • Inconsistent use of policies and procedures, e.g. diversity and equity. • Different application systems, processes, and requirements. • Delayed announcement of successful grants. • Perception of inadequate data collection and publication.

Guiding question 5: Additional feedback

National strategy

As outlined in the Discussion Paper, the consultation was undertaken in the context of a proposed new national strategy, including the role of the Australian Government, state and territory governments, industry and philanthropy to support research and innovation and improve health outcomes.

We heard consistent support for the development of a national strategy. Stakeholders noted the workforce challenges in the health and medical research sector and advocated that a workforce strategy should be considered as part of the development of a national strategy.

Many stakeholders argued that the national strategy should be developed prior to any governance and administrative reform. Some argued there should be iteration between the governance reforms and the development of a national strategy – so that the two can inform each other in a cycle aimed to improve both over time.

Approach to change and implementation considerations

We heard from stakeholders that any reforms to the MRFF and MREA should be undertaken in a staged manner to ensure that strengths of the two funds are not inadvertently lost. Stakeholders asked for a clear communication plan (including on timeframes) as well as to be closely engaged

throughout an implementation process. Non-government stakeholders also emphasised a strong need for any changes to the health and medical research system to involve close collaboration with other relevant Commonwealth, state and territory funders (such as the Department of Industry, Science and Resources and the Department of Education, Skills and Employment). Stakeholders also suggested that international models be compared and taken into consideration for possible changes.

Sector analysis

We also undertook quantitative analysis of all written submissions to determine whether a key word or phrase occurred more or less frequently within a group than that word's average frequency across all groups. These key words were then used to validate our thematic analysis to draw out themes unique to each sector, as well themes shared across sectors. We note that researchers made up over half of all respondents to written submissions and as such, their views are strongly represented in the above tables and sector breakdown below. However, we have also highlighted the views of underrepresented stakeholder groups below – while numerically less frequent, these views offer diverse perspectives that are critical for understanding the needs of the entire sector.

Researchers

Researchers – both from higher education and research (other than universities) were most concerned with preserving the current benefits of the MREA, namely robust support for basic research, competitive peer-review processes, the NHMRC's trusted reputation for understanding the research sector's needs, and predictable patterns and programs of funding.

Research stakeholders most wanted to change current arrangements such as excessive and inefficient administrative processes, duplicative and/or overlapping grant opportunities, and different application systems, processes, and requirements.

First Nations researchers noted their inclusion in MREA and MRFF advisory structures and that the gains made in recent years towards their participation in these committees should be preserved in future arrangements.

Researchers were more likely to use key words such as oversight, basic research, robust, fund research, mission, peer review process, overlap and trust.

Industry

Industry stakeholders focused on the risk of losing MRFF benefits and strengths including translation and commercialisation. These stakeholders generally suggested a more conservative level of reform with a greater focus on coordinating the two funds separately to address stakeholder concerns while maintaining the strengths and separate focuses of the two funds.

Several industry stakeholders raised concerns with the proposal for grant opportunities previously administered by Business Grants Hub to transition to the NHMRC using the Sapphire system. We heard this will require close consultation with stakeholders, including industry partners, to ensure the system is fit-for-purpose.

Industry stakeholders also raised the importance of key performance indicators to measure and evaluate outputs of health and medical research against agreed funding goals. They also called for greater representation of industry within MRFF and MREA governance, including on the NHMRC Council.

Industry stakeholders were more likely to use key words such as institution, budget, portal, concept, seamless, size, transfer, leader, and track record.

Consumers

Consumer stakeholders highlighted the need for meaningful consumer involvement across the health and medical research funding system, including in research, peer review and research governance structures. We heard that meaningful consumer engagement cannot be a ‘tick box’ exercise and requires adequate resourcing as well as investment in capacity building and professional development for consumers and researchers.

Consumers also noted that consumers are now included in MRFF and MREA governance arrangements and called for that to continue or be made more senior in future arrangements.

Consumers were more likely to use key words such as partnership, research project, equal, mental, power, rare, unmet, weight and user. We also observed that stakeholders who identified as representing priority populations used many of these same key words as consumers, with the addition of rural, system, impact and lose as unique to this cohort.

Health services

Health services stakeholders highlighted the importance of an integrated, transparent, and fit-for purpose system – subject to regular evaluation and reviews. This would ensure it is meeting the needs of all stakeholders with integrity and accountability and would be equipped to address national health priorities and Australia’s disease burden.

These stakeholders were most concerned with preserving the MRFF’s advisory structures with diverse expertise including industry, consumers, collaborative researchers, health services and clinicians; increased investment into health services research, rare diseases and ethical, legal, social impact of health interventions; and review processes and assessment criteria that can be specifically aligned to each grant opportunity in the current system.

Health services stakeholders most wanted to change current arrangements such as barriers for research integration into health services and systems and lack of support for primary care and prevention research. This included more support for collaborative research, with robust support, flexibility, and career progression for clinician researchers.

Health services stakeholders were more likely to use key words such as alignment, support research, expert, fit, career, rate, target, clinician, and burden.

Government

Government stakeholders were most concerned with preserving the best of both funds, including support for both priority-driven and investigator-led research, and MREA’s established grant assessment program. In addition, government stakeholders were keen to retain the MRFF’s provision for diverse advisory structures, exclusive funding opportunities for First Nations researchers, and increased investment into preventive health research and health services integration.

Government stakeholders most wanted to change current arrangements such as a lack of infrastructure support for the research workforce across the entire pipeline; inadequate avenues for meaningful consumer involvement in priority setting, research, and grant assessment processes; barriers for research integration into health services and systems and inadequate support for prevention research.

Government stakeholders were more likely to use key words such as assessment, meet, bottom, gender, input, build, career, fit and cost.

Shared

There were several key themes that were prevalent across most or all sectors. All stakeholders valued a cohesive, integrated, and fit-for-purpose system, targeted at improving the health of all

Australians. Stakeholders wanted any reform to be carefully implemented and evaluated to ensure the benefits of the current system were not lost.

Stakeholders across sectors wanted health and medical research funding to benefit the community and broader healthcare system, with impact being the focus of funding delivery and evaluation. All stakeholders wanted a funding system that provided robust and well-balanced support and infrastructure for health and medical research across the entire pipeline.

Key words common across all sectors, included Australia, impact, retain, address, burden, focus, risk, career and public.

Next steps

Throughout this consultation, we have heard a consensus among stakeholders for a merged administration of the MRFF and MREA, with both funds managed by the NHMRC. While this view among stakeholders was clear, so was the preference for staged implementation, to ensure the benefits of the two funds are preserved.

In the interim, the NHMRC and the department are working together to address key concerns and issues while we consider options for implementation. This includes working together to better use existing advisory committees (eg MRFF will seek advice from NHMRC committees), developing and implementing policies together, and other efforts that better align the two funds without requiring formal governance reforms.

The government will continue to keep stakeholders informed of the reform process and will provide opportunities for engagement wherever practical.