

Structural Review of the NHMRC Grant Program: IRU submission

All members of the Innovative Research Universities (IRU) undertake research assessed as being above or well above world standard in health and medical research, with a strong emphasis on effective improvement in health outcomes.

IRU universities have a particular commitment to conduct translational research to deliver lasting benefits to the communities in which we work. We are based in outer metropolitan areas of the State capitals and in Australia's regional areas, areas with concentrations of populations with lower level health outcomes. Embedded in these regions, through our research, we continuously contribute towards critical health outcomes.

The review of the structure of NHMRC grants is important for ensuring that the NHMRC continues to underwrite Australia's excellent record in health and medical research, supporting that research to address the current and future challenges in health and medical outcomes for Australians and across the world.

The IRU members have addressed the detail of the review's proposed three models for future grants in their submissions, arguing that none is suitable as presented to position the NHMRC well for the future.

The IRU submission provides greater context for the members' submissions and draws out the key messages through:

1. the context for the review;
2. a focus on best possible health and medical outcomes for all Australians;
3. improving Indigenous health outcomes as a national priority;
4. a suitable future model for funding programs; and
5. major issues with the proposed models.

1. The review's context

As outlined in the Consultation Paper, there has been a fourfold increase in MREA funding since 2001, which in real terms equates to something like a threefold increase. This increase in funding, in supporting continued growth in the value of health and medical research in Australia and buttressing our world position, has created even greater growth in demand for funding from the new researchers joining the system. This now means very few applications are succeeding.

The level of investment through the NHRMC is currently not set to increase requiring consideration of how best to target the available funds and distribute them to best effect.

Government has also identified the need for greater emphasis on making use of the research outcomes, ensuring translation into practice and commercial outcomes where relevant. This has led to the creation of the Medical Research Future Fund (MRFF) and the Biomedical Translation Fund (BTF) but also set a challenge to ensure that the base research activity is effectively linked to the subsequent use and exploitation.

2. A focus on optimal research leading to the best possible health and medical outcomes for all Australians

The NHMRC currently supports a large number of distinct programs as outlined in the Review's discussion paper. In focusing on the structure of the programs for the future, the outcome to be achieved must remain to support optimal research leading to the best possible health and medical outcomes for all Australians and to the world. It is essential that the NHMRC ensure that funding targets new and emerging issues and is not too conservative in reinvesting in existing research issues. Health and medical researcher pathways are important to achieving these outcomes but must remain subordinate to it.

3. A priority for indigenous health research

Indigenous health research should remain a top priority for MREA funding. IRU strongly supports the proposal in the Consultation paper for

“at least five per cent of the annual MREA allocation to Aboriginal and Torres Strait Islander health research” as well as “capacity building for Aboriginal and Torres Strait Islander researchers.”

With 20% of national indigenous enrolments, IRU universities strive to be a university of choice for Aboriginal and Torres Strait Islander students and researchers, with our member universities uniquely placed to work with Australia's Indigenous communities. Capacity for this research, and effective support for its translation is still narrowly available, with the Menzies School of Health Research at Charles Darwin University a major resource.

This means that the broad solutions to the general challenges of containing applications to streamline approvals considered below may not be suitable for this priority area. A particular risk would flow from capping on the number of grants held per researcher. The researcher base needs to be much better established providing the necessary breadth of applicants before such rules would be suitable.

The Review should explore whether Indigenous health research may be an area where a focus on research centre grants or other specific program may be needed to achieve the best outcomes.

4. Building the most suitable model

A decision to restructure Australia's long-standing health and medical research grants system is a major step. IRU members agree that some streamlining of the programs and mechanisms to reduce the level of unsuccessful applications and their associated resource consumption should be the aim, consistent with the fundamental aims of the MREA.

IRU members have looked thoroughly at the options proposed by the NHMRC. The individual submissions of IRU member universities provide a more detailed assessment of the three models proposed outlining the respective advantages and disadvantages of each model. While opening up interesting options, our conclusion is that none of the three alternate models proposed in the Consultation Paper is a viable, workable alternative.

Further work is needed to build a better model. In its submission, Griffith University has outlined an alternative 'Model 4' that focusses at the major outcomes required from the MREA. IRU endorses the Griffith rationale for how to better structure the grant programs and supports the Review considering the approach which Griffith proposes.

5. Cross-cutting issues with the proposed models

a. Capping of grants

IRU supports the approach of restricting the number of applications and grants held by Chief Investigators (CIs), subject to this not being suitable yet for Indigenous health research.

Such limits should, at least in theory, address NHMRC's key concern of reducing the overall number of applications. At the same time, such restrictions might have the unintended outcome of discouraging collaboration, especially cross-institutional collaboration as well as multi-disciplinarity.

One alternative adjustment CDU proposes would be to examine ways to encourage institutions to submit quality applications without placing limits on the number of grants that can be held. Institutions that consistently submit over a prescribed number of applications with a very low success rate could be asked to not exceed the number or to submit a lower number of applications the following year.

b. Enabling disciplines

All of the models proposed pose problems for researchers in enabling research areas and disciplines such as epidemiologists, biostatisticians, health economists as well as some clinical researchers. Such researchers have broad portfolios of research where, in addition to their specific area of research, they make crucial contributions to other research projects. The number of such researchers in Australia is already very limited and capping will probably make it increasingly difficult for them to collaborate widely. In addition, without their input, the feasibility and quality of research of other research projects will be compromised. This is particularly important for institutions which currently do not have an associated medical school.

c. Ensuring national capacity building

The Team Grants foreseen in Model 1 are likely to favour larger and long-established institutions which have the capacity to support a larger number of full time researchers. This is not only a challenge for smaller institutions which are steadily building their health and medical profile but a broader challenge to Australia's national capacity building exercise.

The majority of Australia's established institutions and research infrastructure is located in the inner suburbs of Australia's major cities. This model risks further entrenching research in metropolitan centres to the detriment of regional and remote locations, where crucial research focused on improving health outcomes for Australia's most disadvantaged populations is taking place.

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