

# Structural Review of NHMRC's Grant Program

## Public consultation

### Template for written submissions

*The NHMRC will consider submissions that address the consultation questions and use the template provided. The consultation questions are listed below for each of the three models canvassed in the discussion paper, with a general question at the end of this template. You may answer as many of the questions as you wish. The questions can also be found on page 22 of the consultation paper.*

<b>Name:</b>	Professor Caroline Finch
<b>Organisation name:</b> <i>[if submitting on behalf of an organisation]</i>	On behalf of the DVCR/PVC Research Group of the Regional Universities Network (RUN) comprising: Central Queensland University Federation University Australia Southern Cross University University of New England University of Southern Queensland University of the Sunshine Coast ( <a href="http://www.run.edu.au">www.run.edu.au</a> )
<b>Email address:</b>	<a href="mailto:c.finch@federation.edu.au">c.finch@federation.edu.au</a>

#### Alternative model 1

*Refer to information about alternative model 1 in the consultation paper and respond to the consultation questions below.*

##### Question 1.1:

How effectively would the model optimise NHMRC's public investment in health and medical research by meeting the aims of this Review, including the major objectives of NHMRC's grant program found on page 12 of the consultation paper? (500 words max)

- Model 1 emphasizes the importance of collaboration, and it will be important that cross-institutional collaboration, in particular, is highly supported.

##### Question 1.2:

What advantages and disadvantages of this model do you see for you or your organisation if the model was introduced? (For example, what impact would it have on a researcher at your stage of experience? Would it support research in your research area?) (500 words max)

- Having separate People Grants for ECRs is an excellent idea, particularly if it comes with a research funding package. However, it would be better to directly link these People Grants to an Ideas or Teams Grant, to ensure that ECRs are not working in isolation and fully benefit from mentorship and collaboration with more experienced researchers.
- Scholarships would be better being a subset of the Team/Ideas/People grants, to ensure the recipients are integrated into a team focussed on a program of research work.

##### Question 1.3:

Can you identify negative consequences for Australia's health and medical research system if the model was introduced and how might these be mitigated? (500 words max)

- If funding can be used to support CI salaries, a concern would be that Universities might then decide not to fund research staff and expect that all researchers would be self-funded through

the NHMRC. Thus, the direct funding available for research may be consumed by indirect costs. Such circumstances would need to be explicitly disallowed.

- The focus of Model 1 suits discovery (“Ideas”) rather than translation/implementation of research. A specific research program regarding Translation (such as in Model 3) should cover the full spectrum of health and medical research, from cutting-edge discovery to real-world implementation and evaluation and should be incorporated into this or any model.
- The Team grants may favour teams from single institutions or universities with large staff numbers – they could discourage collaborations with researchers from other institutions, thereby disadvantaging researchers at regional universities. There are excellent NHMRC-funded researchers at regional universities, but who do not work in large centres with many other NHMRC-funded researchers. It is also possible that such grants will be considered by panels as being more viable if they are centrally located within major cities or at major institutions.
- This model fails to recognise the integral contribution of key disciplinary expertise provided across several projects, as this model would restrict the number of grants people with these essential skills can contribute. This particularly applies to Health Economists, Biostatisticians and Bioinformaticians who are in low supply and generally contribute to multiple projects. Limits on grant numbers will have a negative impact on the involvement of those in such disciplines being on CI teams.

#### Question 1.4:

Could the model be adjusted to optimise its impact? If so, how? (500 words max)

- For specialised research institutes that regularly apply for and receive grants, rather than making them go through the grants treadmill every year, would it be feasible ask the eligible research institutes to pitch for a comprehensive, large scale funding program every 5 years (on the basis of past performance)? Let the institute decide how best to manage the funding and research programs across that institute in combination with their other programs. Renewal would be on a 5-year cycle, but every year a research progress/outcomes report would be required. There would need to be parameters around that program that would include number of ECRs employed, etc.
- The remaining funding could go into an ideas pool and a translation pool that these centres could participate in, but would not receive additional funding out of the ideas grant.
- *In order to address the issues of specialty skills involvement, two approaches could be considered:*
  - *Create special exemption criteria for those who will be multi-CI roles because of their skills-based expertise*
  - *Consider having 3 categories of investigators: CIs, AIs and Skills-Based Is; with no limit on the latter for people who can be clearly identified as Health Economists, Biostatisticians and Bioinformaticians*

#### Question 1.5:

Do you have other comments about the model? (500 words max)

- The RUN Network welcomes the increased priority for research fellowships aimed at Early Career Researchers as a means of kick starting health and medical research careers. But there is still a need for ongoing career progression for such fellows past their first fellowship and also support for high performing senior research fellows. For the latter, especially for those at the PRF or SPRF level, research activities are likely to be programmatic in nature, covering different projects. It may be hard to continue to get adequate project funding to justify this program of work with a fellowship linked to a project model.

## Alternative model 2

Refer to information about alternative model 2 in the consultation paper and respond to the consultation questions below.

### Question 2.1:

How effectively would the model optimise NHMRC's public investment in health and medical research by meeting the aims of this Review, including the major objectives of NHMRC's grant program found on page 12 of the consultation paper? (500 words max)

- The RUN network believes that the collaborative bonus would be a boost to increased collaboration in health and medical research across Australia, including outside of the metropolitan cities.

### Question 2.2:

What advantages and disadvantages of this model do you see for you or your organisation if the model was introduced? (For example, what impact would it have on a researcher at your stage of experience? Would it support research in your research area?) (500 words max)

- The model drives individual investigator success at the price of teams, and essentially replicates the current model with a cap in place. Collaborative gain would be difficult to measure and to implement if there is a cap on the number of applications.
- This model provides a unique opportunity to develop strong programs of research, in particular using RUN's research strengths and regional outreach and translation as part of collaborative networks. We support the moves to increased collaboration.

### Question 2.3:

Can you identify negative consequences for Australia's health and medical research system if the model was introduced and how might these be mitigated? (500 words max)

- Using track-record and broad research outlines will drive conservatism in that those who apply may create risk averse and innovation averse applications.
- Linking Investigator and Ideas grants may actually be highly bureaucratic and not save any resourcing in terms of administration.
- This model puts emphasis on discovery and could negatively impact on research into preventive medicine/population health applications.

### Question 2.4:

Could the model be adjusted to optimise its impact? If so, how? (500 words max)

- If this model was to move forward then perhaps the Investigator model would work best in a way that would reward high flyers in Australian health and medical research – perhaps through a scheme similar to the ARC Laureate Schemes?
- Other than Fellowships there are no schemes to promote and reward outstanding research success for the individual (and their team) and to also fully fund a program of work.
- The Ideas component should be a greater portion of the funding to encourage innovation and discourage small incremental advances in knowledge.

**Question 2.5:**

Do you have other comments about the model? (500 words max)

- The collaboration bonus is a good idea, but what constitutes collaboration will need careful and clear defining. For people working in population health/preventive health/health promotion research there would need to be recognition that some of the key collaborative partners may be from outside the traditional health system (e.g. workplace or sporting clubs involved in the direct implementation of health and safety initiatives).
- Could an NHMRC Linkage scheme (akin to the ARC Linkage Scheme) be considered to encourage direct research into translation and implementation?

**Alternative model 3**

Refer to information about alternative model 3 in the consultation paper and respond to the consultation questions below.

**Question 3.1:**

How effectively would the model optimise NHMRC's public investment in health and medical research by meeting the aims of this Review, including the major objectives of NHMRC's grant program found on page 12 of the consultation paper? (500 words max)

- This model would be the most effective for research aimed at primary prevention of illness and injury and for implementation/translation of evidence into practice.

**Question 3.2:**

What advantages and disadvantages of this model do you see for you or your organisation if the model was introduced? (For example, what impact would it have on a researcher at your stage of experience? Would it support research in your research area?) (500 words max)

- Model 3 would be the most functional. It would allow large packages of funding to be given to outstanding research institutes/teams across a range of research projects to encourage a cohesive, productive program of research rather than just a piecemeal approach to research.
- Within the RUN Network, much of our health and medical research involves translational approaches and implementation of programs directly influencing preventive health and health service delivery. This model would allow public good/public health research to be funded.
- However, for this model to be successful it will be important that the Implementation component should allow in-kind contributions by partner organisations, as seeking funding from community groups on implementation studies may be a hindrance to collaborative activities.
- Model 3 would be good for preventive health, population health and health services research. However, to fully reach its potential, it will be important that recognition and weighting is given to non-traditional health partners. For example, NHMRC-funded (and other) research conducted within RUN universities is heavily embedded in its communities and relevant industry groups (such as schools, sporting clubs and local councils). This ensures that its research is more readily up taken by these groups.

**Question 3.3:**

Can you identify negative consequences for Australia's health and medical research system if the model was introduced and how might these be mitigated? (500 words max)

- Model 3 will only work if there is recognition of a broad definition of translation that includes the very important role of population health approaches. Currently, the translation area, even within the NHMRC, is driven largely by biomedical research translated into pharmaceutical (and other) products or IP, or clinical guidelines within health services. In the public health

area, it is more common to talk about implementation and dissemination research. It is crucial that the NHMRC recognises that research employing health promotion principles, health policy influence and behaviour change programs are just as important forms of “translational medicine”.

- To be effective, translation (including implementation and dissemination) research requires a greater diversity of team members than would be normal for usual focussed project grants. When the desired outcomes are relevant to, and intended to be adopted by, regional communities, there would be value in requiring (or having bonus points for) regional university engagement.
- Model 3 seems to remove Fellowships all together, which makes it much less optimal than others.

**Question 3.4:**

Could the model be adjusted to optimise its impact? If so, how? (500 words max)

- No single model seems optimal. Could aspects of Model 3, be combined with one of the others?

**Question 3.5:**

Do you have other comments about the model? (500 words max)

**General**

**Question 4:**

Do you have comments on the other issues discussed in this paper? (500 words max)

- The RUN universities welcome this review by the NHMRC and looks forward to the latter reviews that will focus on review and other processes.
- The RUN universities agree with further capping of the number of grants individuals can hold. We also strongly agree with the capping of the number of submissions in a single from two perspectives:
  - limiting the number of applications researchers can submit will improve Australian health and medical research to focus on ideas and translation rather than diversification of research and “more of the same” research
  - caps on numbers of submissions will significantly reduce reviewer/assessment burden.
- Rather than having just one closing date per year, the reduction in assessor burden and capping of applications could make having have multiple closing dates much more feasible. This could be particularly suitable for projects that involve partners and collaborators from outside of the traditional medical research institutes, as they often work to different financial timetables.
- There is some concern about fellowships being contingent on concurrent project funding in the same funding round and the effect this will have on research careers and the conduct of important research. Regional universities have been successful in attracting research fellows without project funding, particularly in population health areas. Such fellowships have conferred high research esteem that has been instrumental in attracting research funding from non-NHMRC sources. The point here is that the NHMRC does not, nor should it, fund all

health and medical research conducted by regional universities - in fact, overall it funds little of this in population health areas. Funding in the form of fellowships can, and has been used, to leverage funding from many other sources. Restricting all fellows to have NHMRC project funding, will remove this leverage potential. It would be good for the NHMRC to recognise it can play an important leverage role in increasing overall health and medical research efforts Australia-wide

- RUN believes that in light of the large number of Australians who live in regional and rural Australia, and the particular health issues and disparities of those communities, it is important that health and medical research continues to be conducted specifically in these regions. The models presented allow for large scale programs of work that can deliver on this need. However, this will require capacity development and support of local workforces at regional universities. Population health and health service delivery research, in particular, targeted at regional and rural communities, needs to be conducted locally within those communities and RUN Universities are well placed to do so.
- Could consideration be given towards there being a category of engagement/team composition whereby more assessment points are awarded to teams involving researchers from regional universities as CIs to encourage/support important health and medical research in these areas?
- Track record assessment must expand to more directly assess direct engagement with end-users of the research (translation/implementation/evaluation). Regional universities have a strong history of conducting research that more directly engages with relevant industry partners and end-users of its research.
- Could consideration be given towards specifically enhancing support to preventive medicine research (including the contributions from sport and exercise science, health promotion and others health sciences) that will have a long term impact on the level of national health?