

# 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.

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### 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)

The ATN welcomes the review objective to maintain the principles of excellence, and support a broad range of research in basic, clinical medical, public health and health services.

The Ideas Grant scheme has potential to be transformative if grants are awarded mainly on innovation and significance, as opposed to track record. As highlighted in the consultation paper, the conventional model of medical and health grant funding has primarily awarded funding to the 'best' researchers and teams (with established track record). The rebalancing of the Ideas Grants towards away from research excellence may encourage research that is innovative, creative, and perhaps research of the high-risk, high-reward nature. However, we have strong concerns that 5 year limits on grants and capping of grant application numbers will limit collaboration opportunities for many researchers across all 4 research areas.

Collaboration is front and centre in this model with the Team Grants concept, and the People Grants give scope for dedicated support to E/MCRs. The requirement to include early and mid-career researchers in teams is welcome as it helps to address research workforce issues, and allow these researchers different avenues to build track record.

#### 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)

In many respects, Model 1 is reflective of how most research is conducted (i.e. in teams and across disciplines). The broad aim of trying to achieve collaboration via the Team Grants is commendable, however researchers who are not part of existing teams may be disadvantaged, as will researchers who work across many research boundaries in highly interdisciplinary fields (e.g. health economics, biostatistics, data science). The Team Grants model does not acknowledge that

disciplines have specific needs, in particular those working in Health Services Research as methodologists (e.g. biostatisticians, health economists, data scientists) who may work across a large number of diverse projects and add value to different team structures in different ways. Similarly, researchers in fields such as proteomics and genomics have very specialised technical skills whose work tends to be in high demand. These researchers will rarely lead NHRMC grants, but collaborate widely.

The level of additionality this model will achieve should also be considered (i.e. would structuring grants in such a way encourage research/collaboration that would otherwise not happen?)

Furthermore, the caps and restrictions seem unnecessarily complicated, and tracking mechanisms would need to be put in place to keep accountable for grant caps. Thought will need to be given to how many applications the new Team Grants are likely to generate as more researchers who may have previously felt locked out of NHMRC funding (due to not having the necessary track record) may be encouraged to apply.

### **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)

While acknowledging that all models are vulnerable to the peaks and troughs of funding, Model 1 in particular, has the risk of concentrating funding within teams/groups of researchers and creating a reliance on that funding (e.g. for salary support). In practice, large research teams could be left without a significant funding source if they are not successful in receiving extensions or getting another grant. This is further complicated by restrictions on how many grants can be held at any one time.

This could be mitigated by having a safety net which allows team to apply for an extension or additional funding in the penultimate year of the grant (i.e. year 4). If unsuccessful, this would still give researchers one year to secure alternate sources of funding and/or implement contingency and transition plans in terms of staffing.

The capping of one application per round and one grant at any time may also restrict transient collaboration opportunities. e.g. if you are listed on a team grant, does that mean you are not able to partner with another research group on a different team grant if they wanted to pull your expertise in? This would be especially pronounced for researchers who cross boundaries (e.g. in public health researchers, biostatisticians who may be involved across a number of large projects at any one time).

The ability of researchers to move in and out of Team Grants may also be difficult, especially given that researchers would in essence be locked into 5 year funding cycles.

### **Question 1.4:**

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

In and of itself, tighter restrictions on applications made per round and number of grants that can be held at any one time will have a significant effect on the NHMRC grant program. The benefit of caps/restrictions need to be weighed against inhibiting the flexibility within the research process and lifecycle under a Team Grant model. Adjustments should also be made to ensure that there is

targeted investment for research capacity building in areas of need, particularly in less traditional research areas such as allied health, midwifery, nursing and primary care.

There could be consideration of introducing greater flexibility for researchers to be involved in multiple Team Grants under special circumstances, however, this may be difficult to implement in practice and add an additional layer of complexity/administrative burden.

**Question 1.5:**

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

Challenging conventional thought on what constitutes a team is welcome, particularly the suggestion that teams must include E/MCRs. The ATN would appreciate more guidance on how teams of researchers will be assessed relative to one another, given that any team may have multiple CIs, each who would have their track record assessed relative to opportunity (i.e. how would one team composition be assessed compared to another team composition? Is there a baseline?) A clear commitment to gender equity and attention to support through career disruption and relative to opportunity is also needed.

## 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)

Model 2 meets the aims of the Review in terms of providing flexibility and balanced level of support for investigators across different career stages, as well as actively supporting cross-discipline research. The aim of building and supporting national researcher capability is best addressed by Model 2.

Both research excellence and track record are considered in the Investigator Grants, which balances the pure track record focus of the Team Grants.

As per comments made on Model 1, Ideas Grants have merit in encouraging research that is creative and innovative.

**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 advantage of this model in comparison to Model 1 is that it does not preclude investigators from forming teams or seeking out collaborations. Further, there is scope for a single experienced researcher to undertake mentoring and pull in researchers and support from other disciplines without concerns about cap restrictions, as per model 1.

The model also promotes pathways for researchers from a range of career stages (including postdoctoral, transition to independence, and career interruption). Mentoring opportunities for Investigators with less established track records could also be built into the model.

**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)

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**Question 2.4:**

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

The inclusion of a collaborative bonus is welcomed as a way to support translation of research into new products, devices and interventions by commercial pathways and to translate research into health care practice and policy. However, thought should be given in how this is implemented and how 'collaborative gain' is assessed.

The ATN suggests that collaboration should be encouraged between institutions, and where possible, outside of the research sphere, as it would be expected that most researchers are already collaborating across disciplines within their institutions. Applications for the collaborative bonus need to be able to demonstrate additionality that would not be otherwise achieved without the grant, rather than encouraging superficial collaboration.

The model could also be optimised by the addition of Aboriginal and Torres Strait Islander Health Researchers to the funding streams of investigator grants (see also Q.4).

**Question 2.5:**

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

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### 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)

Model 3 is the most streamlined of the three models, and meets the aims of the review to promote both research excellence and research translation (via the two dedicated sub-streams) Significantly, the implementation component of the translation sub-scheme requires a partner co-contribution, which will help to enable and encourage collaboration and partnerships.

On whether the model will actively support research across the spectrum from basic (i.e., biomedical) to clinical, public health and health services research and in diverse disciplines, and

multidisciplinary research remains to be seen, and will largely be determined by the specific guidelines, and implementation matters.

Like all models, there is support for researchers at all career stages with different tracks for standard and new investigators, but the model is less nuanced than model 2.

**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)

One of the benefits of broad reaching project grants is that it provides a flexible base for the research community to determine the type of research they want to undertake. Further, explicit support of both knowledge creation and translation processes, means that a broad range of the research pipeline is supported.

However, a disadvantage of this model is that it may limit the ability to address strategic priorities, although it could be argued that the research community, with support from end-users, and those in hospitals, primary health care and in the community are best placed to identify areas of critical need.

**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)

The New Investigator Stream within this program would replace the existing fellowship structure for Early Career Researchers. However, this proposed funding model has no career structure for research fellows, beyond New Investigators. This may mean a major realignment of how careers in medical research progress and will impact the next generation of researchers in Australia.

**Question 3.4:**

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

In being very simplified, the model loses some of the nuance of support for researchers at different stages of their careers, and researchers with unique needs. While the distinction between the tracks of 'new investigator' for ECRs and 'standard' for established researchers under the Knowledge Creation sub-type is welcomed, Model 3 could adopt the more defined streams of model 2 (i.e. Established, Transition, Postdoctoral, Career Interruption, Cross-discipline, Clinical).

In addition, the ATN suggests that a track for 'Aboriginal and Torres Strait Islander researchers' is established to increase the visibility of this support (see response to Q4 for further detail).

**Question 3.5:**

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

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## General

### Question 4:

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

The ATN strongly supports the aims of the review and the restructure. In conjunction with the Medical Research Future Fund (MRFF), these reforms have the potential to significantly reshape Australia's medical and health research capability, and address sound long-standing issues in the funding and application structure.

As such, further consultation on the specifics of any chosen or hybrid model prior to implementation would be most welcome.

#### *Support for Aboriginal and Torres Strait Islander Health*

While the ATN is pleased that the NHMRC will remain committed to allocating at least 5 per cent of the MREA on Aboriginal and Torres Strait Islander health research, thought might be given into how to make this visible in whatever funding model is chosen.