Chapter 2

Key Issues

2.1 The establishment of the Medical Research Future Fund (MRFF) will provide a dedicated vehicle for investment in medical research. The committee heard:

> As a capital protected fund it will ensure that medical research funding is available on an ongoing basis. The fund will support the sustainability of the health system into the future. It will enable research that may lead to the discovery of new medicines and technologies used for prevention, treatment and cure.[1]

2.2 The MRFF will almost double medical research spending; it will be transformative by focusing on health outcomes, not just interesting research, and will strengthen Australia's position as a major player in the international field of medical research.

2.3 As noted in Chapter 1, amendments to the MRFF Bill seek to clarify and enhance the decision making and accountability mechanisms to be used in the disbursement of funds from the MRFF. The amendments provide for:

- establishment of an independent expert Australian Medical Research Advisory Board (Advisory Board) to develop the Australian Medical research and Innovation Strategy (Strategy) and the Australian Medical Research and Innovation Priorities (Priorities);
- creation of a requirement to have a Strategy;
- creation of a requirement to have Priorities;
- a requirement that decision-making mechanisms for the disbursement of funds from the MRFF must take account of the Strategy and the Priorities which determines the focus of medical research and innovation every two years; and
- clarification of the involvement of the National Health and Medical Research Council (NHMRC) in the effective disbursement of funding from the MRFF.

2.4 Submitters to the inquiry welcomed the Australian Government's commitment to medical research through the MRFF and were generally supportive of the intent of the Bills.[2] The Medical Research Future Fund Action Group (MRFF AG) described the MRFF as providing 'an extraordinary opportunity to improve the future health and wellbeing of all Australians and to support economic growth in the key areas of medical devices and pharmaceuticals while contributing to a safer, more effective and efficient health system'.[3] The committee heard that the MRFF had the capacity to

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1 Mr Mark Cormack, Deputy Secretary, Strategic Policy and Innovate Group, Department of Health, *Proof Committee Hansard*, p. 32.

2 See for example: Australian Medical Association, *Submission 50*, p. 1.

3 MRFF AG, *Submission 10*, p. 3.

bridge the gap between world-class research and the development of an innovation economy.[4]

2.5 Submitters noted that a number of concerns identified with the Bills have been resolved by the amendments passed by the House of Representatives on 22 June 2015.5 These amendments improve the integrity, transparency and accountability to the Parliament and clarify how the funds will be governed. However, submitters made further suggestions to enhance aspects of the Bills, including:

- the composition and operation of the Advisory Board and the establishment of the Strategy and the Priorities;
- the relationship between the NHMRC and the proposed MRFF;
- existing definitions of 'medical research' and 'medical innovation' in the Bills;
- the importance of commercialisation and translation being prioritised in the allocation of funds from the proposed MRFF; and
- the process for awarding funds, grants and any other investments from the proposed MRFF.

The proposed Medical Research Future Fund Advisory Board

2.6 Submitters welcomed the government amendments establishing the Advisory Board and offered suggestions regarding its composition and operation. The committee notes that the Bill as amended provides for an Advisory Board of up to eight members, including the CEO of the NHMRC, and that collectively the membership of the Advisory Board must possess an appropriate balance of experience or knowledge in the fields of: medical research; policy relating to health systems; management of health services; medical innovation; financing and investment; and commercialisation of research and innovation.[6]

2.7 The committee heard that the current membership requirements should be further amended to ensure broad representation from key medical organisations on the Advisory Board.[7] For example, the Australian Academy of Science noted:

> A broad and representative membership of Advisory Board including key stakeholders such as the Australian Chief Scientist, professional medical associations, relevant scientific organisations…and relevant consumer and

4 Professor Sharma Arun, Chair, Deputy Vice-Chancellor's Research Committee, Universities Australia, *Proof Committee Hansard*, p. 32.

5 *House of Representatives Votes and Proceedings*, No. 127—22 June 2015, p. 1425.

6 Supplementary Explanatory Memorandum, p. 10.

7 See for example: Cancer Voices Australia, *Submission 1*, p. 2; Deakin University, *Submission 2*, p. 2; Philanthropy Australia, *Submission 6*, p. 3; MRFF AG, *Submission 10*, p. 4; Research Australia, *Submission 11*, p. 2; Federation University Australia, *Submission 15*, p. 2; Multiple Sclerosis Research Australia, *Submission 19*, p. 2; University of Sydney, *Submission 31*, p. 2; Orygen, *Submission 34*, pp 2–3; Alzheimer's Australia, *Submission 28*, pp 2–3; University of Western Sydney, *Submission 40*, pp 2–3 and Australian Council of Trade Unions, *Submission 45*, p. 4.

> patient advocacy groups would also help to ensure alignment of MRFF priorities with Australia's broader national research priorities, and with the priorities of the Australian people as represented by health consumer and professional organisations.[8]

2.8 Some submitters recommended amending the membership requirements to include representation from sectors such as research translation[9] and clinical trials[10] to ensure the MRFF can effectively deliver greater value and returns to the Australian people through the translation of medical research into health and economic benefits.[11] Additional recommendations focused on providing avenues for the Advisory Board to consult with independent expert advice as required.[12]

2.9 Some submitters expressed support for a consumer voice on the advisory board. Speaking at the committee's public hearing, Mr Michael Wilson, Chief Operating Officer and Managing Director of JDRF Australia, said

> I would support that quite strongly, selected such that the ultimate beneficiaries of research, patients, are represented in an appropriate manner; and that the description of the success of the fund be couched in patient related terms—in health outcome terms…[13]

2.10 The Department of Health told the committee that the inclusion of the Advisory Board in the MRFF Bill:

> [C]larif[ies] and enhance[s] the decision making and accountability mechanisms to be used in the disbursement of funds from the MRFF…[14]

2.11 The committee notes that there is scope to broaden the criteria for board members in the legislation so that the Advisory Board membership includes expertise in health consumer issues. As proposed by the MRFF Action Group, this could be achieved through an addition to the existing selection criteria rather than by adding an ex officio position.

Determining the Strategy and the Priorities

2.12 As outlined in Chapter 1, the Advisory Board, will be responsible for the establishment and review of the Priorities and the Strategy for the MRFF. Submitters observed that the Priorities and the Strategy will guide the funding disbursements of the MRFF, and:

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8 Australian Academy of Science, *Submission 4*, pp 2–3.

9 Council of Academic Public Health Institutions Australia, *Submission 36*, p. 2.

10 Professor John Zalcberg OAM, Australian Clinical Trials, *Proof Committee Hansard*, pp 9–11.

11 See: ACTU, *Submission 45*, p. 4 and Supplementary Explanatory Memorandum, Medical Research Future Fund (Consequential Amendments) Bill 2015, p. 2.

12 See: Univeristy of Notre Dame, *Submission 38*, p. 3; Group of Eight, *Submission 13*, p. 2 and Professor Alan Pettigrew, *Submission 18*, p. 2.

13 Mr Michael Wilson, CEO, JDRF Australia, *Proof Committee Hansard*, p. 2.

14 Mr Mark Cormack, Department of Health, *Proof Committee Hansard*, p. 53.

> [S]hould deliver a rigorous and transparent mechanism for identifying national health and medical research priorities as well as a strategy for their delivery (and reporting) through a competitive funding process.[15]

2.13 Many submissions were supportive of the proposed role of the Advisory Board in determining the Strategy and the Priorities. In its submission, Orygen—National Centre for Excellence in Youth Mental Health (NCEYMH) strongly agreed with the criteria that the Advisory Board must apply when establishing the Priorities and the Strategy:

> We also believe that the four criteria that the Advisory Board must take into account in setting priorities (burden of disease, numbers of potential beneficiaries, value for money, complementarity with other research and innovation funding) are broadly appropriate. [16]

2.14 The Australian Clinical Trials Alliance further substantiated this view at the committee's public hearing, explaining:

> [T]he legislation as currently written provides the best balance of flexibility to generate better health outcomes for Australians…In terms of priorities, the combination of burden of disease and research tractability – that the particular question is capable of being answered – is an important consideration and one that an appropriately constituted advisory board is well positioned to make judgements about.[17]

2.15 Mr Cormack of the Department of Health told the committee that the Strategy and the Priorities would work together to ensure that there is a refreshing of priorities and a responsiveness to emerging issues:

> The role of the priority-setting process is, in many ways, to get down to the specifics. The strategy gives you the general framework within which the fund will operate for the five-year period, and the act requires publication of that strategy. The priorities will get down to individual priorities.[18]

Committee view

2.16 The committee concurs with these positions and notes that the current requirements for the Health Minister to be satisfied that the Advisory Board collectively possesses experience and/or knowledge in the fields of medical research, policy relating to health systems, management of health services, medical innovation, financing and investment and commercialisation will allow for broad representation from Australia's medical sector on the Advisory Board.[19] Such representation will ensure that the Advisory Board has the flexibility to successfully establish Priorities and a Strategy that will allow for 'well-targeted investments' from the MRFF,

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15 University of Tasmania, *Submission 42*, p. [2].

16 Orygen, *Submission 34*, p. [3].

17 Professor Steve Webb, Australian Clinical Trials Alliance, *Proof Committee Hansard*, p. 12.

18 Mr Mark Cormack, Department of Health, *Proof Committee Hansard*, p. 54.

19 Medical Research Future Fund Bill 2015, part 2A division 4 section 32G, p. 32.

underpinned by a strong business case and consideration of how such investment will 'translate into improvements in the health, life expectancy and quality of life for all Australians'.[20]

2.17 The committee further notes that, in light of the submissions noting the value of patient and consumer input, there is scope for consultation with and consideration of consumer needs in the development of the Strategy and Priorities for the MRFF.

Relationship between the National Health Medical Research Council and the Medical Research Future Fund

2.18 The committee heard that the Bills provide for the MRFF to leverage the existing expertise and administrative systems of the NHMRC to assist in the disbursement of MRFF funding.[21]

2.19 Many submitters expressed support for this initiative, with the Australian Academy of Science stating:

> It would be in Australia's advantage to utilise the expertise and processes that are already in place through agencies such as the NHMRC to make sure maximum benefits are gained from future investments in medical research and innovation.[22]

2.20 The Children's Cancer Institute supported this view, suggesting that the establishment of the MRFF as a distinct body from the NHMRC is critical:

> Funding bodies such as the NHMRC cannot adequately support the innovation system in its full complexity beyond the invention phase, which, combined with a lack of industry investment, has resulted in a dramatic gap in the volume of Intellectual Property generated in the medical research field and the capacity for its commercialisation and translation in Australia.[23]

Further:

> [T]he MRFF and the NHMRC should have different purposes for existence. The NHMRC should remain an incredible engine for the proliferation and support of scientific knowledge within Australia at the more basic and developmental end of the spectrum. The MRFF must be rooted in a desire to change the health of people very close to the projects that it is supporting.[24]

2.21 Many of the arguments for maintaining separation between the NHMRC and the MRFF centred around allowing the MRFF to retain the flexibility to provide

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20 Supplementary Explanatory Memorandum, Medical Research Future Fund Bill 2015, p. 2.

21 Whole of government submission, *Submission 27*, pp 7–8; *Supplementary Explanatory Memorandum*, p. 3.

22 Australian Academy of Science, *Submission 4*, p. 4.

23 Children's Cancer Institute, *Submission 17*, p. 1.

24 Mr Michael Wilson, CEO, Juvenile Diabetes Research Foundation Australia, *Proof Committee Hansard*, p. 4.

funding for projects that are currently beyond the capability of the NHMRC to grant due to legislative constraints:

> [T]he NHMRC, because of its act, is unable to fund this type of clinical infrastructure through the medical endowment fund. We see that this provides a broader opportunity to allow this type of research, which is so pivotal to patient welfare, to occur.[25]

2.22 It has further been suggested that maintaining a complementary relationship between the NHMRC and the MRFF will lead to significant economic benefits for the Australian community, with the University of Sydney suggesting that '…together, the NHMRC and the MRFF could provide a return of $3.39 for every $1 invested'.[26]

2.23 The committee notes some submitters who expressed concern that the MRFF may duplicate the existing structures within the NHMRC.[27] To this end, some suggested that the NHMRC would be the most effective body to administer the MRFF:

> [U]tilising all the systems and the peer review…in terms of maximising everything in place and avoiding extra cost to set up a whole new administrative system is the goal of having it [the MRFF] under the umbrella of the NHMRC.[28]

2.24 Mr Cormack from the Department of Health drew the committee's attention to the Explanatory Memorandum which provides the following summary of the government's expectation that the MRFF would leverage rather that duplicate the work of the NHMRC:

> The Government is committed to boosting health and medical research. This must not just do more of the same, but demonstrate greater value and returns to the Australian people. The MRFF will give particular impetus to the translation of medical research into health and economic benefits. The MRFF will complement the Medical Research Endowment Account operated by the National Health and Medical Research Council (NHMRC), and leverage the existing capabilities of the NHMRC, including peer review, grants management, and the provision of expert advice.[29]

Committee view

2.25 The committee notes that the majority of submitters support the current structure of 'synergy', but separation between the MRFF and the NHMRC.[30] The

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25 Professor John Zalcberg OAM, Australian Clinical Trials Alliance, *Proof Committee Hansard*, p. 12.

26 University of Sydney, *Submission 31*, p. 2.

27 See: Deakin University, *Submission 2*, p. 2; QIMR Berghofer Medical Research Institute, *Submission 16*, p. 1 and University of NSW, *Submission 14*, p. 2.

28 Dr Phoebe Phillips, Australian Society for Medical Research, *Proof Committee Hansard*, p. 19.

29 *Explanatory Memorandum*, p. 2.

30 Mr Michael Wilson, Juvenile Diabetes Research Foundation Australia, *Proof Committee Hansard*, p. 12.

committee believes that the MRFF represents a unique opportunity for the translation and commercialisation of medical research, and that by ensuring complementarity between the NHMRC and the MRFF, the MRFF will have the capacity to:

> …complement the excellence within the existing NHMRC programs, but initiate changes that are consistent with the McKeon review to build national health, priority-focused institutional support and translational initiatives…it will create a more complete program of activities than at present, which will achieve greater impact and efficiency within the health sector.[31]

2.26 The committee also notes that the MRFF will hold the legislative power to award medical research and innovation grants to organisations beyond the current scope of the NHMRC; particularly towards the States and Territories in addition to government research organisations such as CSIRO.[32]

2.27 Given that the MRFF is a transformative initiative that will provide significant funding and support innovative work to bridge the gap between pure research and application of research results in the field, it is important that there should be focussed leadership vested in a new organisation. The skills and mission of the new organisation should reflect the role of the MRFF in playing a strategic role that complements the narrower mandates of existing Australian Government research organisations. The committee further notes that section 62 of the Bill includes a requirement for a review of the Act in 2023. The committee recognises that this review could include consideration of future efficiencies of governance arrangements.

Definition of 'medical research' and 'medical innovation'

2.28 A number of submissions noted that amendments should be made to the current definitions of 'medical research' and 'medical innovation'.[33]

Medical Research

2.29 The Bill defines 'medical research' as 'research into health'.[34] Evidence to the committee was divided on whether this definition was appropriate with some submitters supportive of retaining the definition and others advocating the application of a more detailed definition.

2.30 In its submission to the committee, the Group of Eight (GoE) urged the committee to reconsider its current definition of 'medical research' as it would 'limit

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31 Mr Ian Smith, Medical Research Future Fund Action Group, *Proof Committee Hansard*, p. 45. The Strategic Review of Health and Medical Research (McKeon Review) was established by the Australian Government in late 2011. This review reported to the Government in February 2013 and recommended a 10 year strategic health and medical research plan for the nation.

32 Professor Douglas Hilton, Medical Research Future Fund Action Group, *Proof Committee Hansard*, p. 52.

33 Australian Health Economics Society, *Submission* 5, p. 2; Innovative Research Universities, *Submission 29*, p. 2.

34 Medical Research Future Fund Bill 2015, section 5, p. 6.

research funded through the MRFF to medicine or health fields'. In turn, this would likely 'hinder Australia's capacity to produce truly outstanding advances in health and medicine'.[35] GoE suggested stated that research funding should be expanded and made available to include other disciplines that are involved in medical research such as information technology, physics, engineering, mathematics and chemistry.[36] Despite these concerns, the GoE noted that:

> [T]he legislation does make it clear that the MRFF will be able to support activities that go beyond research and in particular it will assist those activities that underlie the implementation and use of research findings, including those which require commercialisation.[37]

2.31 In contrast, the University of New South Wales (UNSW) noted that funding from the MRFF 'should be restricted to basic medical research, applied medical research or translational medical research'. UNSW argued that funding should not be made available to build infrastructure or develop commercial medicines. The committee is not convinced that 'Australian universities, medical research institutes and hospitals' should be the only recipients of MRFF funding.[38]

2.32 Mr Nathan Smyth of the Department of Finance noted the importance of retaining a broad definition of 'medical research':

> In terms of the definition of 'medical research', I think we have a very expanded approach to that, rather than a restrictive, narrow approach, and we see that as being incredibly beneficial for research purposes, innovation purposes and commercialisation purposes. The building of an enormous amount of research infrastructure will lead to significant opportunities for career path progression for university graduates and the like to build the knowledge base of the medical research community in Australia. The medical research action group talked about a broad definition around that in relation to people who are involved in computer programming, in mathematical concepts, in other sciences and in medical research, which all contribute to, I suppose, the definition that we would see as being medical research across the country. There are broad applications and benefits across the economy for the application of this fund.[39]

2.33 The committee concurs noting that the retention of a broad definition of 'medical research' as currently reflected in the Bills will allow the MRFF to adopt an appropriately multidisciplinary approach to funding medical research.

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35 Group of Eight Australia, *Submission 13*, p. [3].

36 Group of Eight Australia, *Submission 13*, p. [3].

37 Group of Eight Australia, *Submission 13*, p. [3]. See also: The University of Melbourne, *Submission 26*, pp 3–4.

38 University of New South Wales, *Submission 14*, p. 1.

39 Mr Nathan Smyth, First Assistant Secretary, Governance and Public Management, Department of Finance, *Proof Committee Hansard*, p. 59.

Medical Innovation

2.34 The definition of 'medical innovation' was raised as an issue requiring further attention throughout the inquiry.

2.35 The Bill currently defines 'medical innovation' as:

> The application and commercialisation of medical research, and the translation of medical research into new or improved medical treatments, for the purpose of improving the health and wellbeing of individuals.[40]

2.36 In its submission to the committee, MRFF AG highlighted their concern that 'the reference to 'treatments' alone is potentially too narrow, as treatment does not ordinarily include diagnosis or prevention. As such, it could exclude, for example, the development of diagnostic devices or vaccines'.[41] MRFF AG suggested re-defining 'medical innovation' in the Bill to mean:

> [T]he application, commercialisation and translation of medical research into new or better ways to improve the health and wellbeing of individuals and the community.[42]

2.37 Submitters also suggested that it is not clear whether the current definition of 'medical innovation' would permit atypical treatments such as biotechnological and other medical devices that may not originate in the medical community—such as those developed in the physics, chemistry and engineering disciplines—to be supported by the proposed MRFF.[43]

2.38 Mr Cormack of the Department of Health pointed to the Strategy and the Priorities as the vehicles that will guide the 'decision making mechanisms for the disbursement of funds from the MRFF':[44]

> It is the general framework in which the investment will take place. It will certainly be required to take into account advice from the NHMRC and its determination of priorities, under its own requirements, under the act. It will also be required to take into account other Commonwealth government science priorities. We have seen some of those put forward recently.[45]

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40 Medical Research Future Fund Bill 2015, section 5, p. 6.

41 MRFF AG, *Submission 10*, p. 3.

42 MRFF AG, *Submission 10*, p. 3. This alternative definition is supported by Research Australia, *Submission* 11, p. [1] and Multiple Sclerosis Research Australia, *Submission 19*, p. [2].

43 Australian Academy of Technological Sciences and Engineering, *Submission 8*, p. 2; University of Notre Dame, *Submission 38*, p. 2.

44 Mr Mark Cormack, Deputy Secretary, Strategic Policy and Innovation Group, Department of Health, *Proof Committee Hansard*, p. 53.

45 Mr Mark Cormack, Deputy Secretary, Strategic Policy and Innovation Group, Department of Health, *Proof Committee Hansard*, p. 54.

Committee view

2.39 The committee considers that the definition of 'medical innovation' is flexible, but acknowledges the concerns about the 'narrow' definition from submissions. While the responsibility for determining the overarching funding disbursement strategies and priorities for the MRFF appropriately rests with the Advisory Board, the committee notes that a broadening of the definition of 'medical innovation' may be appropriate to clarify the purpose of the fund.

Commercialisation and translation

2.40 A key focus of this Bill is to ensure that research activities funded through the MRFF lead to practical improvements in health for all Australians through commercialisation and translation. This is described in the Explanatory Memorandum to the Bill which states that the Finance Minister may direct funding to:

> [T]he COAG Reform Fund for making payments to the States and Territories for expenditure on medical research and medical innovation—including application and commercialisation activity that translates discoveries to new treatments and practice.[46]

2.41 Some submitters disagreed with this particular focus in the Bill arguing that commercialisation should not be a driving factor in medical research. In evidence to the committee, Mr Michael Wilson of Juvenile Diabetes Research Foundation Australia emphasised that on occasion commercial objectives do not always align with public health outcomes:

> You have commercial decisions being made with regard to profit, but, in the end, the ultimate beneficiary must be the patient, and that is not an incentive that is always present in decisions made at earlier stages in that. There are market failures in those incentives. There are examples where the public interest would suggest that a particular drug or therapy or device should be progressed but the commercial interest perhaps does not recognise the same benefit because the benefit will accrue to the public purse, not to the commercial purse, and hence something may not progress because of a lack of foresight or lack of an ability to bring that potential benefit to bear at an earlier stage in the system. So the misalignment of incentives in the system is a challenge for good research to progress.[47]

2.42 The University of New South Wales agreed noting:

> There must be a focus on providing the right environment and infrastructure to capture and capitalise on new developments with commercial potential but commercialisation should not be a driver for determining medical research priorities.[48]

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46 Explanatory Memorandum, Medical Research Future Fund Bill 2015, p. 4.

47 Mr Michael Wilson, Chief Operating Officer and Managing Director, Juvenile Diabetes Research Foundation Australia, *Proof Committee Hansard*, p. 1.

48 University of New South Wales, *Submission 14*, p. 2.

2.43 However, the majority of submitters highlighted the need to ensure medical research projects are developed and awarded in consideration of marketable end products and for those who stand to benefit most from a practical application of the research—the Australian health consumer.[49]

2.44 In its submission, Deakin University agreed with the importance of commercialisation and translation of medical research noting that:

> Commercialization of research findings will clearly be a priority for the MRFF. Despite a very strong research track record, Australia has not performed well in translating research findings into commercial returns. The MRFF provides an opportunity to develop strong incentives for universities and industry partners to work together to improve commercial outcomes. It will be important to recognize the high failure rate of start-up companies and build this into funding policies.[50]

2.45 Mr Cormack of the Department of Health noted that 'the legislation is now quite explicit—more explicit in terms of leveraging the capacities of the NHMRC, but also not exclusively the NHMRC'.[51] The MRFF is intended to bridge a gap in the current system, to bring valuable scientific discoveries closer to the point of application in the field for the benefit of relevant health consumers.

2.46 Professor Kelso of the National Health and Medical Research Council (NHMRC) highlighted that the NHMRC already has a number of mechanisms that the MRFF could seek to emulate. For example, she spoke about the use of specialist panels that are able to review funded research:

> [I]f it was research that was specifically associated with early commercial research, and we do have one scheme in that area. If it was an area of work which was for later stage commercial research than that which we currently support then we would be well capable of establishing appropriate peer review committees with that relevant expertise—so using our fundamental processes of peer review but with specialist panels according to the goals of the scheme.[52]

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49 Deakin University, *Submission 2*; p. 1; Bionics Institute, *Submission 3*, p. 1; *Submission 8*, p. 2; Medicines Australia, *Submission 9*, p. 4; MRFF AG, *Submission 10*, p. 6; Knowledge Translation, *Submission 12*, pp 1–3; Biotech and Related Industries Leadership Group, *Submission 20*, pp 1–4; La Trobe University, *Submission 30*, p. 1; Universities Australia, *Submission 32*, pp 3–4; CSL, *Submission 35*, pp 20–23; University of Western Sydney, *Submission 40*, p. 2; The University of Wollongong, *Submission 41*, p. 3.

50 Deakin University, *Submission 2*, p. 1. See also: Universities Australia, *Submission 32*, p. 3. This submission states that 'research translation is essential and should be guided by national health priorities, noting that translation of research into clinical practice and preventative health strategies in Australia lags well behind research discoveries'.

51 Mr Mark Cormack, Deputy Secretary, Strategic Policy and Innovation Group, Department of Health, *Proof Committee Hansard*, p. 56.

52 Professor Anne Kelso, Chief Executive Officer, National Health and Medical Research Council, *Proof Committee Hansard*, pp 55–56.

Committee view

2.47 The committee is satisfied that the AMIRS and AMIRP will ensure a balanced approach that allows for the funding of both novel and commercial projects. The committee is also satisfied that the funding and management of medical research and innovation within the MRFF will be conducted in an appropriate manner by using the expertise of the NHMRC and a range of other Commonwealth research bodies.

Awarding of funds, grants and other investments from the proposed Medical Research Future Fund

2.48 Some submissions to the inquiry expressed concern that the process for determining the awarding of grants, funds and investments to organisations, states and territories, universities or corporations from the MRFF has not been adequately discussed in the Bills. To this end, some submitters recommended that competitive processes and expert review mechanisms be put in place to evaluate proposed expenditure from the MRFF.[53]

2.49 In allocating funds for medical research and innovation, many submitters also stressed the importance of investments continuing to support research infrastructure, the maintenance of databases and any other indirect costs of medical research.[54] In its submission, the Australian Academy of Science outlined a best practice approach to funding research from the MRFF:

> The Academy firmly believes that the best approach to allocation of MRFF funding within identified Priorities is to use a competitive process and expert review mechanism to ensure funding is targeted towards the very highest quality research. It would be to Australia's advantage to utilise the expertise and processes that are already in place through agencies such as the NHMRC to make sure maximum benefits are gained from future investments in medical research and innovation.
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> The precise mechanisms might differ according to the priority areas to be targeted by the fund, and the level at which funding is being allocated. For example the peer review approach utilised by the NHMRC would be most appropriate for investigator led research, and it would be advantageous to take advantage of the NHMRC's expertise in this regard. Whereas broader research support, such as for the development of research infrastructure, might best be competitively awarded using mechanisms similar to the

53 Cancer Voices Australia, *Submission 1*, p. 2; Deakin University, *Submission 2*, p. 2; Australian Health Economics Society, *Submission 5*, p. 4; MRFF AG, *Submission 10*, pp 4–5; Federation University Australia, *Submission 15*, p. 3; University of Melbourne, *Submission 26*, pp. 2–3; Innovative Research Universities, *Submission 29*, p. 2; Orygen—The National Centre of Excellence in Youth Mental Health, *Submission 34*, p. 3.

54 Deakin University, *Submission 2*, p. 2; Australian Health Economics Society, *Submission 5*, p. 3; Australia Melanoma Consumer Alliance, *Submission 23*, p. 1; La Trobe University, *Submission 30*, p. 1.

> university block-grant arrangements, or the ARC ERA [Excellence in Research Australia], or other indicators of excellence.[55]

2.50 Mr Cormack confirmed that the MRFF would utilise this approach by describing how the MRFF will largely disburse funds through established research grant application pathways:

> [A]nd this is where a large proportion of the funding will no doubt flow, is the MRFF health special account, which enables a flow through directly to the NHMRC—directly in some cases to research institutes and directly to corporations. So in that pathway, the decision made each year at the program level to disburse funds through the budget process would flow directly, in that instance, to the NHMRC. The NHMRC is able then to utilise its peer review capabilities and grant management capabilities to disburse that.
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> I guess the other flow is through other corporate Commonwealth entities such as the CSIRO [Commonwealth Scientific and Industrial Research Organisation] and the ARC [Australian Research Council]. Again, they all do different things. They all do them well, and I think it is certainly likely that, for example, the CSIRO, with its particular advantages, may be a most appropriate program level decision in a given year for investments from the MRFF account, as indeed it may be for the NHMRC. I think the act is pretty explicit in how these things could flow. Each of those vehicles give flexibility to government while at the same time leveraging the very substantial capabilities of those organisations and, indeed, the state governments in their current research endeavours.[56]

2.51 A number of witnesses observed that researcher peer review will not be appropriate in all circumstances, for instance in some cases where there is greenfield research, complex multidisciplinary breakthroughs, or where commercialisation or enabling infrastructure are the focus rather than pure scientific research. Dr Tamika Heiden the Principal of Knowledge Translation Australia observed:

> The problem that we have at the moment is that we probably do not have the expertise to peer review on the types of activities that I am talking about. … you will ask for funding specific to activities that are just for translation and not necessarily for the research-finding of knowledge-which is on top of that. … I would really like to see us open that up to talk about both commercial innovation and also social innovation that actually effects change to health delivery and health services-a much broader spectrum of things, rather than just a new drug or a new piece of equipment. So I would just be mindful of that in the innovation area.[57]

2.52 Mr Krystian Seibert, the Policy and Research Manager of Philanthropy Australia, said:

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55 Australian Academy of Science, *Submission 4*, p. 4.

56 Mr Mark Cormack, Deputy Secretary, Strategic Policy and Innovation Group, Department of Health, *Proof Committee Hansard*, p. 56.

57 *Proof Committee Hansard*, pp 40-41.

> I will make one point at the beginning: not all funding for medical research will be of a nature that is amenable to peer review. I am looking at one example, which is one of the biggest contributions that philanthropy made, together with Commonwealth and state governments, to medical research: the construction of the Queensland Institute of Medical Research building.[58]

2.53 The MRFF Action Group made the point that pressures can arise where rapid decisions and responses can be required, leaving no time for a competitive process. As examples they referred to Influenza outbreaks, including the 'Swine flu', where the response of the NHMRC was criticised for being 'way too slow'. While they proposed that competitive processes and merit assessments should be the default approach for awarding funds, they thought that rather than imposing a rigid rule mandating this in all cases, there should instead be an accountability mechanism for reporting the exceptions where funding is not awarded competitively or using expert review.

Committee view

2.54 The committee is satisfied that the Bill provides clear mechanisms on the disbursement of funds from the MRFF. As stated in the Explanatory Memorandum:

> The MRFF will complement the Medical Research Endowment Account operated by the National Health and Medical Research Council (NHMRC), and leverage the existing capabilities of the NHMRC, including peer review, grants management, and the provision of expert advice.[59]

2.55 To add to the level of transparency and accountability, the committee recognises advantages in reporting back to the parliament on the processes through which funds are awarded, in particular the use of expert advice and competitive processes. Where appropriate this reporting could aggregate information at the program level, while exceptions to a merit or competition principle should be reported at the level of the relevant grant or payment.

Committee view

2.56 The committee acknowledges the many submissions that have reflected positively on this Bill to establish the MRFF. The committee also acknowledges much of the constructive feedback that has led to the amendments made to this Bill by the government.

2.57 The formation of a broad and representative Advisory Board will ensure that the priorities and strategies of the MRFF reflect the current and emerging health needs of the Australian public. In reflecting these broad needs, the priorities and strategies will in turn fund projects that harness the spectrum of research disciplines that encompass modern medical research.

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58 *Proof Committee Hansard*, p. 40.

59 Explanatory Memorandum, Medical Research Future Fund Bill 2015, p. 2. See also: Mr Mark Cormack, Deputy Secretary, Strategic Policy and Innovation Group, Department of Health, *Proof Committee Hansard*, p. 56.

2.58 The committee is satisfied that the MRFF and bodies such as the NHMRC hold different but complementary purposes. The MRFF will establish and review the strategic direction of medical research and will also be the primary funder of medical research. However, the committee notes that in delivering against this remit, the MRFF will draw on established and proven grant processes and project management expertise.

2.59 The committee is confident that this model whereby the MRFF holds and disburses research funding according to a series of flexible and transparent priorities and strategies will lead to improved health outcomes for all Australians.

Recommendation 1

2.60 The committee recommends that the Bills be passed.

Senator Zed Seselja

Chair