Dear Mr McKeon

Comments on Consultation Paper Summary, 3 October 2012

The University of Sydney welcomes the release of the draft summary of the outcomes of the review’s public consultations to date, and thanks the Panel for the opportunity for further engagement in the ongoing development of the Review’s recommendations.

Our comments, and those attached from the Sydney Medical School and the Faculty of Dentistry, build on the University’s initial submission of 3 April 2012 and relevant recent inputs to the NSW Health and Medical Research Strategic Review, the Review of Higher Education Base Funding, the NHMRC’s consultations on Advanced Health Research Centres, and Health Workforce Australia’s strategic priority setting processes. We are pleased to see the consultation paper pick up many themes that are consistent with the views and evidence we have provided previously.

The University welcomes the vision, “Better Health Through Research”, and the broad strategic framework and direction developed by the Panel to build stronger connections across, and embed research into all aspects of, the health sector.

The best health research in the world is of limited value unless it can actually be put it into practice for the benefit of the public or patients. Embedding integrated ‘research’ and ‘lifelong learning’ culture at every level of our health system is therefore essential.

Valuing and enabling purposeful collaboration between universities, medical research institutes and clinicians, and strengthen research engagement with allied health, nursing and primary health care will also be fundamental not only to the productivity of the system, but its long term quality and international competitiveness.

Educating future health professionals in ways that ensure they are equipped with the analysis and communication skills required to seek out and interpret the latest research, and apply new knowledge in their clinical practice, will also be critical. Complex problems place an emphasis on collaboration within and beyond individual professions and countries. While disciplinary strength will remain vital, funding and other support systems must facilitate seamless cross-disciplinary and thematic collaborations.
Funding for health education and research, must be viewed as a core part of the overall sustainability of the health system – not an optional extra. Funding must be sufficient to meet reasonable costs. Cross-subsidisation and complexity should be minimised. All major existing and future block and competitive grant funding schemes (state and federal) should be assessed to determine whether they provide incentives that align with the strategy or at are at odds with it. Similarly, the overall approach to the regulation of health and medical research should be based on the principles of regulatory necessity and proportionality.

We strongly support many of the recommendations in the paper, and see opportunities to explore, focus and refine many of the others. We welcome the recognition of the need for substantial growth funding over the next decade, and trust that this ensures that the Review will be used to identify new funding priorities and refocus existing funding, not to find short term budget savings.

If Australia’s population health and the quality of our health care system is to remain comparable with the best available globally, the government will need to prioritise investment in the nation’s health and education system, over and above other competing causes. As we documented in our April submission, the evidence is clear that investment in health and medical research delivers benefits many times over to Australians, at a rates of return better than, or comparable to, other public good investments.

We look forward to working with government (both state & commonwealth), other universities, Medical Research Institutes (MRIs), Local Health Districts (LHDs), primary health care practitioners and others to develop and implement these recommendations.

Yours sincerely

[Signature]

Professor Jill Trewhella
Deputy Vice-Chancellor (Research)

Attachments

A   University of Sydney comments on the Strategic Review of Health and Medical Research in Australia, Consultation Paper Summary, Issues and Proposed Recommendations, Draft for Public Comment, 3 October 2012 (pp.3-12)

B   Sydney Medical School comments (pp.13-15)

C   Sydney Faculty of Dentistry comments (p.16)
The University Of Sydney, Comments On The Strategic Review Of Health And Medical Research In Australia, Consultation Paper Summary, Issues And Proposed Recommendations, Draft For Public Comment, 3 October 2012

This submission represents the University’s position on the recommendations, and builds upon our earlier submissions to the review (3rd April 2012 http://sydney.edu.au/about/government/submissions_2012.shtml#McKeon).

Appended are two submissions developed by health faculties within the University of Sydney, The Sydney Medical School and the Faculty of Dentistry. These faculties are deeply implicated in and impacted by the McKeon recommendations, and their submissions arise in response to specific disciplinary perspectives and roles/positions in the sector.

We draw the Panel’s attention to the Faculty of Medicine’s concerns about the critical importance of any strategy being properly funded and sustainable, with great attention also needed to ensure that implementation is well resourced. As the Faculty states, if the strategy is not funded adequately, or if any new governance structures do not facilitate effective implementation, pursuing reforms of the type proposed at this time may do more harm than good. The University shares these sentiments. While there may be some capacity to refocus and improve efficiencies in some areas, establishing new programs without additional funding would be likely to damage a system that is already overstretched due largely to funding for core direct and indirect costs failing short of true costs.

We also observe that notwithstanding the challenges the government faces in delivering its election commitment to return the budget to surplus by the end of 2012-13, Australia’s GDP and government revenues have grown strongly since it came to power in 2007. The government’s own Treasury budget papers show that since 2007 government spending has exceeded revenue growth, due in part to the government’s response to the GFC and the pursuit of various other funding priorities since then. According to the government’s forecasts, even when it returns the budget to surplus it’s expenditure in 2012-13 will be some $120 billion higher annually than it was in 2007-8. If the health and health care of Australians now and in the future is to remain comparable with the best available globally, the government will need to prioritise investment in the nation’s health and education system, over and above other competing causes. As we documented in our April submission, the evidence is clear that investment in health and medical research delivers benefits many times over to Australians, at a rates of return better than, or comparable to, other public good investments.

Before addressing the recommendations individually, a few broad comments.

A. National leadership is needed
[Recommendations 4, 15, 20-21]
Genuine and effective national leadership will be required to drive the system-wide strategy to enable research to inhabit the system. Leadership must coordinate the development and implementation of the Review recommendations for H&MR; build processes across and between commonwealth and state agencies; assess investments from granting bodies; set research priorities in the national interest; develop evidence-based policy; champion an integrated research and education culture at all levels of the health system; and negotiate to forge links between players.

There is no doubt the as the key national health and medical funding council, the NHMRC will need to play an important role in any future strategy. We remain to be convinced that, however, that it is the appropriate body, even with an expanded mandate, to lead the implementation of the overall strategy. This is because the major impediments to realising the vision do not fall within its powers, or scope, to influence to a large degree. The NHMRC should be tasked with administering the best and most efficient nationally
competitive grant funding scheme possible for the resources available, with responsibility for realising the vision shared between members of a council comprising relevant state and federal government agencies and other representatives. While the NHMRC will need to do important things to realise the vision, so will organisations such as Health Workforce Australia, AHPRA, DoHA, DIISRTE, state hospital systems, universities, medical research organisations and non-university training providers. Shared responsibility, and mutual accountability are two principles that might helpfully underscore the re-design of national governance structures.

B. Funding/Resources should support research excellence
[Recommendations 1-21]
The maintenance of the international standing of Australia’s H&MR system requires supportive scaffolding including a coherent policy framework, appropriate balance of funding investments and adequate funding levels, research excellence and research workforce development. Piecemeal implementation will result in sub-optimal health improvements, and the strategy must be coherent and founded on excellence wherever it exists.

C. Increased co-operation between the Unis, MRI, LHDs, allied health, primary carers is key
[Recommendations 2, 3, 8, 11, 12-15, 20-21]
We applaud the Panel’s recognition of cooperation across the sector as the key to moving forward. This cooperation must be founded on respect for different roles and missions across the health sector, understand the complex inter-dependencies and potential complementarities between the partners, and address inhibitors to and provide incentives for co-operation around H&MR.

Research-intensive universities have responsibility and capacity to lead, be catalysts for, and facilitate the building of relationships and the embedding of research within the health sector.

For example, universities have a critical role in developing “curious” clinicians – both Sydney Medical School and the Faculty of Dentistry are introducing new degrees with significant research components, the Doctor of Medicine (MD) and Doctor of Dental Medicine (DMD) respectively – and providing structured life-long learning. Universities can provide expertise and opportunities to instil and refine allied health and primary care practitioners’ research skills through targeted training, lectures and mentoring. Funding must be able to flow to allied health, primary carers and the community where relatively small investments in innovation are likely to have the greatest health impacts.

Sydney endorses the establishment of a small number of Integrated Health Research Centres (IHRCs), in areas of research excellence, with funding of $10m p/a over 5 years as key drivers of the vision and sites for two-way translation between clinicians and researchers of excellent research into health care and health care problems into research questions. The NHMRC should provide flexibility for the emergence of different types of IHRC based on geography, population groups, morbidity factors and rigorously assess candidates for appropriate governance, genuine engagement with formal partners, community and health consumers, and research excellence.

D. H&MR funding should be an incentive to increased innovation
[Recommendations 1, 3, 9, 11, 12, 20-21]
Increasingly, however, NHMRC funding is punitive due to shortfalls on PSPs and Fellowships, and commonwealth research block grants and state-based schemes taken together fail to adequately cover indirect costs of undertaking commonwealth funded research. These disincentives to innovation must be addressed. In principle, research should be fully funded, and we support the McKeon Panel’s commitment to delivering 60c/$1 indirect costs. McKeon should do more than redistribute funding from existing research funding, it must deliver new and additional funding as an incentive to innovation.
As priorities McKeon must achieve sustainable levels of funding for existing NHMRC programs (e.g., PSPs and Fellowships), secure adequate indirect-costs of undertaking commonwealth research (in ways that treats the different partners equitably) and provide and sustain quality, large-scale enabling infrastructure necessary to support the research endeavour.

D. In focussing on translation, do not overlook pure basic research. [Recommendations 2, 3, 6, 7, 8, 12, 13, 16, 20-21]
We understand the importance to the sustainability of the health care system of rebalancing of H&MR funding to embed H&MR in the health system, maintain research excellence, set national health priorities for investment and enhance commercial and non-commercial pathways.

But this rebalancing needs to occur without damaging the excellent (investigator-driven) biomedical research upon which our international reputation relies and from where translation springs. Australia must continue to generate its share of discoveries and to solve our own health problems; we need our researchers to be attractive, credible and respected partners for the international collaborations that bring us early access to the research conducted outside our borders; and we must have the capacity locally to consider, adopt and adapt the best of international research for the benefit of the Australian population.

E. McKeon recommendations should be funded and achievable [Recommendations 1, 20-21 & see D above]
We support the aspiration that within 8-10 years 3% of the Australian commonwealth and state health budget be invested in defined research activity. However, given the current political and economic climates we are concerned that securing on-going commonwealth funding ($499m cut to research in the MYEFO), and the negotiation of state contributions ($3 billion cut from NSW health over the next four years), may prove challenging particularly against other programs and reforms.

If this proves so, it will jeopardise the phase in during the later years of competitive, block funded and activity based schemes and initiatives, and could undermine the integrity of the overall McKeon strategy. The review will need to consider prioritising initiatives, while ensuring those prioritised join-up to achieve the desired outcomes. States, through LHDs, already invest significantly in H&MR. Agreeing “defined” research investments and setting appropriate KPIs will be critical to achieve buy-in from the states, and it will be important for the commonwealth to work with them to establish agreed processes to identify, assess, track and manage their research investments and determine funding outcomes. The commonwealth may need to adjust the ratio of commonwealth/state funding, of 2/1, to provide incentives to the states in specific programs.
Recommendation.
I. Embed Health in the Health System.
   1. Drive Research Activity in the Health System.
      • Protect and manage existing allocations
      • Use activity based funding to add funding to the system for an additional $1.5bn
      • Longer term; add competitive grants on a 2:1 Federal: State contribution which would be the source for that additional $2-3bn within 8-10 years.

   2. Establish Integrated Health Research Centres
      • 10-20 centres integrating universities, hospital networks, and medical research institutes with significant incremental investment for five years and clear criteria around strategy, governance and focus.

   3. Promote participation by health professionals.
      a. Support 1000 health research professionals with attractive support and career schemes
      b. Streamline accreditation for leading research professionals from overseas

Sydney Response.

Strongly support.
But note challenges to achieving the proposed level of investment, and reduced impact of piecemeal implementation.

Strongly support.
We strongly support the establishment of a small number of Integrated Health Research Centres (IHRCs), in areas of research excellence, with funding of $10m p/a over 5 years. We note the strong interest and support across the sector for this initiative.

Strongly support.
(a) should supplement, not displace, existing ARC/NHMRC fellows, and PSPs/fellowship salaries should be adequate to cover the full costs of the research.
Care needs to be taken to ensure that the initiatives sustain a career-long, joined-up flow through UG, postgraduate training, early and mid career researchers.
(b) Support.
Recommendation.

4. **Realign sector leadership and governance.**
   - Empower and resource the NHMRC to take a leadership role across all HMR in Australia including research impact in the health system, possibly with a new name. Task the NHMRC with tracking and reporting Australian HMR expenditure, workforce, research outputs and research outcomes, working with the Independent Hospital Pricing Authority (IHPA) and Local Hospital Networks (LHNs).

Sydney Response.

We remain to be convinced the NHMRC is the appropriate body to bear this responsibility. Prefer a model based on shared responsibility and mutual accountability between relevant federal and state agencies and other stakeholders. Health and medical research should not be viewed in isolation from the education of future generation of health professionals.

5. **Streamline clinical Trials Processes.**
   - Establish 5–10 national ethics committees to replace local committees, implement a common IT platform for approvals, have the revamped and expanded NHMRC accelerate implementation of Clinical Trials Action Group (CTAG) recommendations, align standard pricing for clinical trials services, build a portal for recruitment and coordination, provide a national clinical trials insurance scheme, and increase funds for non-commercial trials and infrastructure.

Strong support.

NB. It is not clear from the paper whether this rationalisation is focused only on streamlining multi-centred clinical trials, or is intended for all institutional ethics committees.
Recommendation.

II. Set and Support Research Priorities.

6. **Align priority setting processes**
   - Develop and fund 8-10 national health research priorities with 10-15% of the NHMRC MREA.

7. **Support a range of priorities.**
   - Support and provide targeted investment in Indigenous health research, rural and remote research, developing world research and advances in genomics in addition to the national health research priorities.

Theme 3: Maintain research excellence

8. **Train, support and retain the research workforce**
   - Provide active workforce monitoring, higher Australian Postgraduate Awards (APA) stipends, early investigator grants, more flexible track record definitions, research fellowships, career break flexibility and mentoring, with the expanded NHMRC responsible.

Sydney Response.

Support in principle.
See benefits in the establishment of a small number of national health priorities to be funded from 10-15% of MREA.

Please note that:

(i) redistribution of MREA should avoid negative impact on investigator-driven, biomedical research;

(ii) investment should focus on excellence;

(iii) clarification required about how priorities will be set and who will set them; and

(iv) when implementing expert groups should avoid overlaps/redundancy in NHMRC committee structure.

Strong support.

Strong support.
See 3 above. Should supplement, not displace, existing ARC/NHMRC fellows, and PSPs/Fellowship salaries should be adequate to cover the full costs of the research.

Care needs to be taken to ensure that the initiatives sustain a career-long, joined-up flow through UG, postgraduate training, early- and mid-career research.
Recommendation.

9. **Rationalise indirect cost funding for competitive grants**
   - Ensure that all qualified institutions, including MRIs and health care facilities, receive at least 60% indirect cost loading for national competitive grants.

10. **Streamline NHMRC competitive grant processes**
    - Re-engineer the NHMRC granting process to include, but not limited to, streamlining of application processes and assessment criteria, increasing the proportion of five-year grants, simplification of IT platforms, and harmonisation of recording of track records between competitive granting schemes.

11. **Build enabling infrastructure and capabilities**
    - 150-200m p.a. of additional funding for national patient management database, coordination of bio-bank access, and enabling technologies and analytical services.

Theme 4: **Enhance non-commercial pathway to impact**

12. **Enhance public health research**
    - Increase funding for public health research, and facilitate increased collaboration between researchers and State and Territory public health experts.

Sydney Response.

**Strong support.**

*Commonwealth and state should agree to provide entities regardless of who/where they are in the sector, with adequate funding to cover the indirect-cost of undertaking ACGR and McKeon research. Shortfalls on ARC/NHMRC grants and fellowships to be addressed.*

**Strong support.**

*Strongly support recommendation to streamline and align application processes between bodies. Strongly support longer and larger grants, however, flexibility should be retained to support short-term grants for small scale projects leading to applications for larger programs.*

**Strong support.**

*Noting “additional” funding.*
Recommendation.

13. Enhance health system research
   - Build capacity in health services research and health economics, to understand and assist translation, and to evaluate health system innovation.

14. Accelerate health system innovation
   - Accelerate research translation and health system innovation through key performance indicators (KPIs) and recognition of translation as a valuable form of research output, and develop a clinical registry program and translation plans.

15. Inform policy with evidence-based research
   - Inform policy and practice with research evidence, and enhance capability of the expanded NHMRC to procure evidence to support policy makers at the Australian and State and Territory Government level.

Theme 5: Enhance commercial pathway to impact

16. Support research commercialisation
   - Maintain HMR access to Australian Research Council (ARC) linkage grants, replace NHMRC Development Grants with a new Matching Development Block Grant Scheme, and establish a new early-stage development fund (possibly around $250m scale).

Sydney Response.

13. Strong support.

14. Strong support.

15. Strong support.

See 4 above. re NHMRC as national leader.

Recommendation.

17. Enhance the commercialisation environment
   a. Facilitate exchanges between research and industry to help bridge the ‘valleys of death’ i.e. the pre-clinical and early clinical stages of development
   b. Help foster a culture and critical mass of innovation in HMR

Sydney Response.

Support.

Theme 6: Attract Philanthropy

18. Leverage donations.
   • Track HMR philanthropic funds raised and allocate funds (possibly $50m per annum) to match new large philanthropic donations aligned to HMR priorities.

   • Task the Australian Charities and Not-for-profits Commission (ACNC) to encourage aligned smaller charities to collaborate on research funding provision to increase impact.

Sydney Response.

Support.

We recommend Australian philanthropy practices be benchmarked against international practices.

Support.

See 18 above.

Theme 7: Invest and implement

20. Invest for the future
   • Enhance and align HMR investment programs, with extended oversight by the expanded NHMRC. Index competitive research grant budgets (particularly the NHMRC MREA) to increases in health expenditure. Focus initially on realigning and better managing existing investment, then develop new programs over three to five years.

Strong support. See comments above.

• In summary we note it is critical that the national leader establish working relationships between commonwealth and state for the negotiation of investment to enable the phase-in of funded initiatives (competitive, ABF and block) in the later phases of the implementation.
• Difficulties achieving the 3% target due to financial and political issues. But, new funding must be found to provide incentives to better integrate research and health.
Recommendation.

21. Action report recommendations
   - Establish a robust implementation process with a follow up and review by the NHMRC with oversight by an independent panel.

Sydney Response.

Strong support.
See 4 and 15 above re reservations about NHMRC as national leader.
Sydney Medical School applauds the sentiments and many of the recommendations in this draft for public comment. However we view some recommendations with concern, largely because political realities dictate that they may not be implemented or their implementation will differ in subtle respects from the recommendations, such that there could be unintended consequences that hinder rather than assist the development of Health & Medical Research in Australia. In addition, important issues facing our health and medical research community are not canvassed in the draft for comment, and these omissions dampen our enthusiasm.

We are concerned that the draft focuses exclusively on only one aspect, albeit a very important aspect, of Health & Medical Research. While Sydney Medical School supports in principle most of the recommendations of the McKeon review, it does so only if the acceptance of those recommendations is accompanied by the injection of funding that is recommended as necessary in that report. If Government accepted the report “in principle”, but without additional funding (as we believe likely), there is a danger that NHMRC priorities would be distorted to the detriment of basic biomedical research. The unfunded recommendations would then become Government policy to be implemented by NHMRC. This would divert existing NHMRC budget allocation away from the fundamental research that is necessary for there to be anything to “translate”. This concern is exacerbated by the sentence under “Vision” that “Initially, the focus should be on spending current investment more effectively.” Sydney Medical School does not deny that the may be unrealized efficiency gains in the current NHMRC budget, but any such gains are unlikely to offset the cost of the unfunded initiatives.

We are disturbed by the above quotation from the vision statement because it is an inducement for a cash-strapped Government to adopt the Review in its entirety, thus causing NHMRC to focus all or more of its resources on health promotion and research translation. To do so would have long-lasting negative effects on health because there would then be a dearth of basic research to translate into healthcare. It would have a deleterious effect on our international standing in the medical research community where, as the Review points out, Australia currently “punches above its weight”.

Sydney Medical School considers that it would be better not to implement the recommendations at all than to have bad implementation. Below are our comments on each recommendation.

I. Embed Research in the Health System
   1. Drive Research Activity in the Health System. Sydney Medical School supports this recommendation.
   2. Establish Integrated Health Research Centres. Sydney Medical School supports this recommendation provided that there is additional funding or that funding is not diverted from existing NHMRC schemes.
   3. Promote Research Participation by Health Professionals. Support a significant number (e.g. building to around 1,000) of research focused health professionals. Sydney Medical School supports this recommendation provided that there is additional funding. We note that most biomedical research is undertaken by science graduates, and that this will always be so. Greater involvement by clinicians is desirable, but the majority of clinicians will still have clinical practice to maintain and accordingly their commitment to research will be less than full-time. This is not so with science graduates, and Australia’s research productivity will be adversely affected if the career opportunities of medical researchers with a science background are ignored.
   4. Re-align Sector Leadership and Governance. Empower and resource the NHMRC to take a leadership role across all HMR in Australia. In principle, Sydney Medical School supports this recommendation but it has major reservations whether NHMRC is or can become adequate for the task. Many researchers feel that NHMRC has become dysfunctional and dictatorial, and that it is responsive to and serves
its political masters rather than to the needs of the research community. The catastrophe caused in three successive grant rounds by RGMS cannot be underestimated. The salary gap crisis was aggravated by the NHMRC’s reinterpretation of the institutional funding agreements, and together these issues have the potential to cripple health and medical research in Australia. As a result, researchers and their institutions are placed in a paradoxical situation: it is now punitive to be too successful in gaining NHMRC funding because the shortfall between what is needed to undertake research and what is supplied grows with every successful grant application. We emphasize that we are not talking about “unfunded infrastructure costs”: we are talking about the money required to undertake the project. We now have the situation that NHMRC does not fund research. It facilities research, and successful researchers then need to seek separate funding to make a supposedly “funded” grant do-able. These issues are not addressed in the draft for discussion.

5. Streamline Clinical Trial Processes. Sydney Medical School supports this recommendation.

II. SET AND SUPPORT RESEARCH PRIORITIES

6. Align Priority Setting Processes. Develop and fund a set of 8-10 national health research priorities. Sydney Medical School has reservations about what this will achieve other than diverting funds from other more open schemes and providing researchers with an opportunity to enter a less competitive area. It may be a politically attractive recommendation, but, if the criterion is “excellence”, the recommendation is a recipe for lowering the international competitiveness of Australia’s research. We note that currently researchers are required to indicate where applications fit in the National Research Priorities and that the NHMRC has had research priorities in the past. However we suspect that an audit would not reveal any major advances in those areas, and that adoption of this recommendation will just give researchers another opportunity for “gaming the system” in order to get an advantage.

7. Support a Range of Strategic Priorities. Sydney Medical School recognizes the need for a focus on Australia’s areas of disadvantage (and disgrace), particularly indigenous disadvantage and rural isolation, and it is pleasing to see them highlighted by the Review. However this recommendation is superficial and reads like a politically correct recommendation. For example, the problems with indigenous health are not due to a lack of research or funding for research. They are due to a lack of the political will to coordinate disparate research activities and to translate the available research into policy. Throwing more money into indigenous health research is not the solution; adequately funding the translation of existing research would be a better approach, even if more difficult politically.

III. MAINTAIN RESEARCH EXCELLENCE

8. Train, Support and Retain the Research Workforce. Sydney Medical School supports this recommendation in full, but we wish to point out that increasing the current NHMRC PSPs to a realistic level would do much to achieve this goal, and this action is not mentioned in the consultation paper.

9. Rationalise Indirect Cost Funding for Competitive Grants. Sydney Medical School supports this recommendation in full. Institutions exist to undertake research, not to fund it, but increasingly they are required to do both. We emphasize that there are two sources of underfunding: the inadequacy of grant funding for the work expected to be undertaken (discussed above under I.4) and the costs of infrastructure (which is not supplied in the inadequate grants).

10. Streamline NHMRC Competitive Grant Processes. Sydney Medical School feels strongly about this issue, as will be apparent from I.4 above, and it supports the thrust of this recommendation. However it deplores the idea of “charging institutions a fee for processing project grant applications to encourage institution-level triage”. This would create an enormous reviewing workload for each institution, and that load would inevitably fall on high-flying researchers who already devote the December-February period to writing their own grant applications and the June-August period to assessing grants from other institutions on the various NHMRC Committees. An inevitable consequence would be either that the research time of our “best” researchers would be curtailed to the detriment of their research productivity, or researchers would not make themselves available as readily to serve on NHMRC Committees.
11. **Build Enabling Infrastructure and Capabilities.** Sydney Medical School supports this recommendation in full and without reservation.

**IV. Enhance Non-Commercial Pathway to Impact**

12. **Enhance Public Health Research.**
13. **Enhance Health System Research.**
14. **Accelerate Health System Innovation.**
15. **Inform Policy with Evidence-based Research.**

Sydney Medical School considers that these four recommendations should be listed under "I. Embed Research in the Health System" and that they should be priorities of the Integrated Health Research Centres. Separate funding for these recommendations is not necessary. As discussed above, there is a risk that any funding boost would come from diverting funding from existing important schemes, including the NHMRC’s current support for basic biomedical research, without which there will be nothing to translate in the future.

**V. Enhance Commercial Pathway to Impact**

16. **Support Research Commercialisation.**
17. **Enhance Commercialisation Environment.**

Sydney Medical School supports these recommendations, but it does so not because of the direct financial benefits of commercial activity. Most spin-off companies are barely viable and many do not survive. The underappreciated value of commercialization and of the biotech industry lies in that it creates employment, maintains and up-skills the workforce and has flow-on effects enhancing activity in related support industries.

**VI. Attract Philanthropy**

18. **Leverage Donations.**
19. **Encourage Scale in Philanthropy.**

Sydney Medical School supports these recommendations provided that there is additional funding.

**VII. Invest and Implement**

20. **Invest for the Future.**
21. **Action Report Recommendations.**

Sydney Medical School supports these recommendations provided that there is additional funding.
Strategic Review of Health and Medical Research in Australia
Response from Faculty of Dentistry, University of Sydney, to the
draft for Public Comment

The Faculty of Dentistry at The University of Sydney welcomes the report and endorses the
directions proposed by the Working Group.

General comments
- The concepts of commitment by Health Services to research and of integrated Health Research Centres are applauded.
- Career paths in which tenure and risk are commensurate with the duration of research training will essentially underpin the research endeavour.
- Caution is required in assignment of research priorities. The temporal cycle must be compatible with availability of skilled workforce.
- Truly innovative research is not directed but investigator driven.
- As the NHMRC is to be the centrepiece of planned initiatives, NHMRC processes must be truly open and above reproach. Vigour will be maintained only by strict rotation, preferably annual, of grant panel members and assigners.

Specific items
I. EMBED RESEARCH IN THE HEALTH SYSTEM
1. Drive research activity in the health system. This initiative will drive a profound change of culture within the public health system.
2. Establish integrated health research centres. This vertical integration will release the full power of research for national health benefit.
3. Establish research participation by health professionals. This is a key aspect of the new DMD degree at the University of Sydney.

II. SET AND SUPPORT RESEARCH PRIORITIES.
This should not be at the expense of investigator-driven research.

III. MAINTAIN RESEARCH EXCELLENCE.
A more flexible grant term up to 5 years is important. More extensive project grants could be linked to restriction on the number of grants held by individuals.

V. ENHANCE COMMERCIAL PATHWAY TO IMPACT.
This initiative should include project-specific funding to mature research findings rather than offer legal and marketing advice only. Lack of real proof of concept is a major limitation to participation by industry.