



EVALUATION OF THE MEDICAL RESEARCH SUPPORT PROGRAM

FINAL REPORT OF THE PROCESS, OUTCOME AND ECONOMIC EVALUATION

27 February 2026

Acknowledgements

We acknowledge and thank all stakeholders who participated in interviews for this evaluation. They gave generously of their time and shared valuable insights that informed this report.

We acknowledge the contribution of experts from the Office for Health and Medical Research Office in the NSW Ministry of Health to this evaluation plan: Kate McGregor, Ainsley Martlew, Jason Boyd.

We are grateful to the members of the Evaluation Advisory Group for their expert guidance and thoughtful feedback: Jason Boyd (Chair), Dr Jaclyn Aldenhoven, Ignatius Li, Ainsley Martlew and Professor Andrew Milat.

MHC Consortium

The MH Consulting Group (MHC) consortium members are Professor Mary Haines, Melanie Kelly (Insight Economics), Greg Masters (Nexus Management Consulting), Ryan Romero, Cyra Patel, Cindy Peng, Benedict Chin (Insight Economics) and Rhys Tucker (Insight Economics), Professor Steve Hanney, Professor David Currow.

MHC is a boutique consultancy, established in 2015, specialising in research strategy and program reviews. We bridge research, policy, and practice, working across all areas of public policy. Our clients span sectors including health, research, education, human services, and transport. Learn more at www.mhcgroupp.com.au.



Insight Economics is a boutique economics and public policy consultancy bringing together deep public sector expertise and advanced analytical capabilities to help governments and businesses tackle important public policy challenges and realise strategic opportunities. We are experts in complex economic modelling, data analytics and the evidence requirements for new investment and policy approvals. Learn more at: www.insighteconomics.com.au



Nexus is a boutique Sydney-based management consulting firm that specialises in the government, university and not-for-profit sectors. It helps organisations change for the better through services in strategic planning, program evaluation and management review. Learn more at www.nexusmc.com.

Disclaimer:

*MH Consulting Group Pty Ltd (MHC) has prepared this report for the benefit of the Office for Health and Medical Research, Ministry of Health (the **Client**). The report should not be used or relied upon for any purpose other than as an expression of the conclusions and recommendations of MHC to the Client as to the matters within the scope of the report. MHC and associates expressly disclaim any liability to any person other than the Client who relies or purports to rely on the report for any other purpose.*

MHC has prepared the report with care and diligence. The conclusions and recommendations given by MHC in the report are given in good faith and in the reasonable belief that they are correct and not misleading. The report has been prepared by MHC based on information provided by the Client and by other persons. MHC has relied on that information and has not independently verified or audited that information.

Table of Contents

1. Executive Summary.....	19
1.1 Evaluation purpose and questions	19
1.2 How the evaluation was conducted	20
1.3 Key findings and evaluative judgement	20
1.4 Recommendations.....	22
SECTION 1 – BACKGROUND AND METHODS	23
2. Background and purpose of evaluation.....	23
2.1 Overview of the Medical Research Support Program (MRSP)	23
2.2 Program logic and theory of change	25
2.3 Evaluation purpose and scope	30
3. Methodology.....	33
3.1 Evaluation design	33
3.2 Evaluation methods.....	34
3.3 Data collection.....	37
3.4 Data analysis	42
3.5 Limitations	46
SECTION 2 – EVALUATION FINDINGS	48
How to read the evaluation findings	48
4. Process evaluation findings	49
4.1 KEQ1: How effective and efficient are the Program’s administration and delivery processes?	49
Key findings and evaluative judgement	50
4.1.1 Program design	51

4.1.2 The Program's application process.....	58
4.1.3 Grant awards processes	62
4.1.4 Governance and administration	64
4.2 KEQ2: How effective are the Program's reporting, data collection, and impact metrics, and where are there gaps or opportunities for improvement?	66
Key findings and evaluative judgement	66
4.2.1 The suitability, usefulness and use of the Program's metrics	67
5. Outcome evaluation findings.....	73
5.1 KEQ3: To what extent has the Program achieved its intended objectives and delivered meaningful outcomes?	73
Key findings and evaluative judgement	75
5.1.1 Evidence for MRI-level outcomes.....	77
5.1.2 Evidence for system-level outcomes	121
6. Economic evaluation findings	132
6.1 KEQ4: What are the costs and benefits of the Program, and does it represent value for the NSW HMR ecosystem and the people of NSW?	132
Key findings and evaluative judgement	133
6.1.1 Trend analysis: The role of the MRSP relative to other funding sources for NSW MRIs	135
6.1.2 Economic impact modelling: key data, assumptions and scenarios	139
6.1.3 Estimated total costs of the MRSP including administrative costs	144
6.1.4 Direct economic impacts of the MRSP on MRIs	145
6.1.5 Economic impact of the MRSP on NSW medical research ecosystem.....	151
6.1.6 Economic impact of the MRSP on patients and carers in NSW and beyond	158
6.1.7 Qualitative analysis: Social, cultural, environmental and other workforce impacts	164

6.1.8 Putting it all together: The impact of the MRSP for NSW	166
SECTION 3 – Evaluative judgement and recommendations.....	169
7. Evaluation synthesis	169
7.1 Testing the program logic: evaluative judgement of the program logic pathway.....	169
7.2 Assessment of attribution and additionality.....	176
8. Conclusions and recommendations	178
8.1 Conclusions.....	178
8.2 Future looking – NSW Health Research and Innovation Strategy	180
8.3 Recommendations.....	182
9. Appendices.....	184
Appendix 1. Grant processes for the MRSP	184
Appendix 2. Framework and methods for the economic evaluation	187
Appendix 3. MRSP-funded MRIs	200
Appendix 4a. Director-level survey instrument	201
Appendix 4b. Grant administrator-level survey instrument.....	217
Appendix 5. Case studies.....	228
Appendix 6. Additional graphs	239
Appendix 7. Summary of outcomes used in the economic evaluation, as reported by MRI	241
Appendix 8. Sensitivity and break-even analysis summary	243

List of Figures

Figure 1. Current-state program logic: linking the program objectives to the MRSP indirect research funding.....	28
Figure 2. MRSP evaluation and review – How they interrelate	31
Figure 3. Stakeholder groups interviewed for the MRSP evaluation	38
Figure 4. Economic, health, social, cultural and environmental impacts considered in this economic evaluation	44
Figure 5. Objectives of the MRSP	51
Figure 6. Eligibility criteria and requirements for MRSP funding	52
Figure 7. MRI perspectives on aspects of the eligibility criteria	54
Figure 8. Funding allocation model of the MRSP	55
Figure 9. Allowable and ineligible MRSP expenses	56
Figure 10. Perceptions on MRSP expenses.....	57
Figure 11. Flowchart illustrating process of assessing MRIs’ eligibility for MRSP funding	58
Figure 12. MRI perspectives on the application process.....	59
Figure 13. MRI perspectives on communications with OHMR.....	63
Figure 14. MRI grant administration staff views on clarity, appropriateness and proportionality of MRSP reporting.....	68
Figure 15. Proportion of MRIs identifying at least one ‘challenging to report’ metric	68
Figure 16. Annual reporting time	71
Figure 17. MRI-level outcomes.....	77
Figure 18. MRI perceptions of the incremental benefits of the MRSP on research infrastructure at their MRI	78
Figure 19. MRI perceptions of the impact of ceasing the MRSP on research infrastructure at their MRI.....	79
Figure 20. Total MRSP expenditure for all MRIs by expense type	84

Figure 21. MRI perceptions of the incremental benefits of the MRSP on their MRI's financial stability and viability	85
Figure 22. MRI perceptions of the impact of ceasing the MRSP on their MRI's financial stability and viability.....	85
Figure 23. Total infrastructure and research expenses relative to MRSP funding for all MRIs	87
Figure 24. Proportion of MRI expenses relative to MRSP funding for all MRIs	87
Figure 25a. Total income for all MRIs by income type	88
Figure 25b. Total income for all MRIs by income streams	89
Figure 26. Average grant success rates for all reporting MRIs	91
Figure 27. Mean MRI income (total, research and MRSP) by MRI tier funding level	92
Figure 28. Proportion of average MRI income by income type and tier	93
Figure 29. Total MRSP expenditure for all MRIs by activity type	94
Figure 30. MRI perceptions of the incremental benefits of the MRSP on the workforce capacity and capability at their MRI	95
Figure 31. MRI perceptions of the impact of ceasing the MRSP on their workforce capacity and capability.....	96
Figure 32. Total number of full-time equivalent staff (FTEs) by type of staff for all MRIs	98
Figure 33. Total number of full-time equivalent staff (FTEs) for research staff at all MRIs	99
Figure 34. MRI perceptions of the incremental benefits of the MRSP on research outputs at their MRI.....	102
Figure 35. MRI perceptions of the impact of ceasing the MRSP on their research outputs.....	103
Figure 36. Mean and median annual numbers of publications across the 13 currently-funded MRIs, 1996–2024	111
Figure 37. Mean and median numbers of publications based on data provided directly by MRIs, by year, 2012–2024	112
Figure 38. Total MRI income from research streams for MRIs	114
Figure 39. MRI perceptions of the incremental benefits of the MRSP on research collaborations at their MRI	115

Figure 40. MRI perceptions of the impact of ceasing the MRSP on research collaborations at their MRI.....	115
Figure 41. Proportion of MRIs who collaborate with other organisations, by type of collaborator ...	116
Figure 42. Nature of MRI collaborations: Proportion of MRIs who engage in types of collaborations with other organisations.....	117
Figure 43. System-level outcomes.....	121
Figure 44. MRI perceptions of the incremental benefits of the MRSP on the health and medical research ecosystem	122
Figure 45. MRI perceptions of the impact of ceasing the MRSP on the health and medical research ecosystem	123
Figure 46. Income sources among Australian independent MRIs, 2023.....	135
Figure 47. Direct and indirect costs of research among Australian independent MRIs, 2023	135
Figure 48. Government funding for indirect costs received by NSW MRIs by source (2010-2024)	137
Figure 49. MRI perceptions of the incremental benefits of the MRSP on their MRI's financial stability and viability.....	137
Figure 50. Direct MRI benefits and costs of the MRSP (\$2025, '000s).....	149
Figure 51. Citation analysis: MRSP-supported MRIs compared to all NHMRC-funded research	153
Figure 52. MRI jobs created through MRSP support (FTE).....	154
Figure 53. Direct and indirect ecosystem benefits (\$2025, '000s, NPV _{5%})	156
Figure 54. Costs of adverse events and long-term diabetes complications with decreasing HbA1c - Lifetime costs potentially avoided through early diabetes diagnosis	161
Figure 55a. Hypothesised current-state program logic: linking the program objectives to the MRSP indirect research funding.....	173
Figure 55b. Actual Current-state program logic: linking the program objectives to the MRSP indirect research funding	175
Figure 56. The contribution of the MRSP to MRI and system wide outcomes	177

List of Tables

Table 1. Key evaluation questions for the evaluation	32
Table 2. Key definitions for this evaluation	34
Table 3. Median times for key outcome notifications for the MRSP application	61
Table 4. MRIs' perceptions of which outcomes the MRSP had the greatest impact on at the MRI level.....	77
Table 5. Exemplars of the MRSP's contribution to research infrastructure.....	80
Table 6. Exemplars of research excellence tied to infrastructure underpinned by MRSP funding	104
Table 7. Key data on scholarly research outputs across the 13 currently funded MRIs in 2024 (extracted from SciVal)	112
Table 8. Exemplars of MRIs' collaborations with other organisations	118
Table 9. MRIs' perceptions of where the MRSP had the greatest impact on the NSW health and medical research ecosystem.....	124
Table 10. Examples of translation of excellence in research to health policy and practice	129
Table 11. Additionality of MRSP funding – reported by MRIs.....	141
Table 12. The MRSP cost calculations (\$'000s)	144
Table 13. Uplift in grant and other revenue funding (\$2025, '000s, NPV5%)	146
Table 14. Revenue from MRSP-enabled infrastructure (\$2025, '000s, NPV5%)	147
Table 15. Revenue from commercialisation (\$2025, '000s, NPV5%)	147
Table 16. Benefits from avoided turnover (\$2025, '000s, NPV5%)	148
Table 17. Direct benefits to MRIs only (partial analysis) (\$2025, '000s, NPV _{5%})	150
Table 18. Benefits from running clinical trials (\$2025, '000s, NPV _{5%})	155
Table 19. Benefits from knowledge spillovers (\$2025, '000s, NPV _{5%}).....	156
Table 20. MRI ecosystem benefits (\$2025, '000s, NPV _{5%}).....	157
Table 21. Summary of impacts by MRSP funding round	167

Table 22. Alignment of the MRSP with NSW Health Research and Innovation Strategy strategic outcome areas	180
Table 23. Strategic recommendations to inform the MRSP Review	182

List of Breakout Boxes

Breakout box 1. Suggestions for improving the application process	60
Breakout box 2. Challenging to report metrics per the MRIs.....	69
Breakout box 3. Enhancements to metrics suggested by MRIs	70
Breakout box 4. Suggestions for improving the reporting process.....	72
Breakout box 5. Example of the MRSP's impact on ability to attract world-class researchers to NSW MRIs leading to increased opportunities for capacity growth	99
Breakout box 6. An example of the impact of losing MRSP funding on workforce capacity	101
Breakout box 7. Example of MRSP's contribution towards innovation	107
Breakout box 8. Example of the MRSP's contribution towards investing in infrastructure to support research programs	114
Breakout box 9. Sector-wide collaboration through the Collaborative Research Infrastructure Enablement Pilot.....	119

List of Case Studies

Case study 1. Innovations in robotics: IIAMR's Centre for Robotics & Health Technology	82
Case study 2. Strengthening research governance and facilities to attract clinical trials	83
Case study 3. Leveraging the MRSP to improve financial stability.....	90
Case study 4. Investing in scientific skills and capability to further research and innovation: Establishment of the NSW Organoid Innovation Centre (CMRI).....	100
Case study 5. Fostering research excellence through the Victor Chang Innovation Centre's Stem Cell Production, and Cell Function and Screening Facilities.....	106
Case study 6. MRSP-funded infrastructure that supports research innovation for real-world impact	108
Case study 7. A genome sequencing platform for Indigenous Australians	109
Case study 8. Infrastructure that enables clinical trials: an onsite pharmacy.....	113
Case study 9. Increasing collaboration via the Cardio-Oncology Alliance.....	119
Case study 10. Facilitating collaboration through the Westmead Research Hub	126
Case study 11. PrecisionGo™: a national precision medicine pipeline.....	127
Case study 12. The impact of MRSP funding on commercialisation activities.....	130
Case study 13. Infrastructure investments that leverage national and international grant funding to advance the development of tuberculosis and COVID-19 vaccines.....	228
Case study 14. The MRSP contributes operational infrastructure that stabilises workforce and builds research capacity	229
Case study 15. For contribution towards clinical research: Attracting research talent and excellence with world-class facilities: the HMRI neuroimaging centre	230
Case study 16. For contribution towards health services research: Driving improvements in clinical care: The Australia New Zealand Hip Fracture Registry	231
Case study 17. For contribution towards public health research: Reducing intentional self-harm	232
Case study 18. Strengthening pandemic preparedness for vaccine-preventable infectious diseases	233
Case study 19. Integrating oral health research into policy and practice	234

Case study 20. A novel low dose, fixed dose combination for the treatment of hypertension	236
Case study 21. Translating health service innovations into practice: the case of Medibus	237
Case study 22. Increasing productivity with workplace mental health programs	238

Abbreviations

Abbreviation	Term
AAMRI	Association of Australian Medical Research Institutes
AIHW	Australian Institute of Health and Welfare
ARC	Australian Research Council
BCR	Benefit-Cost Ratio
CBA	Cost Benefit Analysis
CMRI	Children's Medical Research Institute
CPI	Consumer Price Index
CRC	Cooperative Research Centre
FDA	US Food and Drug Administration
FTE	Full Time Equivalent
GCP	Good Clinical Practice
GSP	Gross State Product
HERDC	Higher Education Research Data Collection
HMRI	Hunter Medical Research Institute
HMR	Health and Medical Research
HRI	Heart Research Institute
IRIISS	Independent Research Institute Infrastructure Support Scheme
IP	Intellectual property
KEQ	Key Evaluation Question
OLS	Ordinary Least Squares (regression)
MRI	Medical Research Institute
MRFF	Medical Research Future Fund
MRSP	Medical Research Support Program
NeuRA	Neuroscience Research Australia
NHMRC	National Health and Medical Research Council
NPV	Net Present Value
OHMR	Office for Health and Medical Research
PC3	Physical Containment Level 3
QALY	Quality Adjusted Life Years

Abbreviation	Term
RBG	Research Block Grants
RSP	Research Support Program
RTP	Research Training Program
R&D	Research and Development
TGA	Therapeutic Goods Administration
VCCRI	Victor Chang Cardiac Research Institute
WIMR	Westmead Institute for Medical Research
WHO	World Health Organization

Glossary

Term	Definition
Attribution	Refers to the extent to which observed outcomes can be directly linked to MRSP funding, i.e. the line linking MRSP funding with particular outcomes or impacts. Direct attribution is where there is a clear observable line between MRSP funding and an outcome (e.g. The MRSP funded a specific workforce position or equipment). Indirect attribution is where the outcome is a flow-on effect of an MRSP-funded activity that occurred alongside activities resulting from other funding sources (e.g. MRSP-funded business operations that enabled research activities to occur).
Additionality	Refers to the extent to which MRSP funding enabled activities or outcomes that would not have occurred, or would have occurred to a lesser extent or later, in the absence of the Program, recognising that outcomes arise from interacting inputs within a complex research system, i.e. how much impact is due to the MRSP. Additionality aims to both quantitatively and qualitatively determine how much impact is due to the MRSP as opposed to other sources of funding, activities and contextual factors.
Commercialisation	The process of transforming new ideas, research and scientific breakthroughs (i.e. MRI's intellectual property) into market-ready products or services, which generate a benefit to the MRI, whether monetary or otherwise. ¹ Commercialisation is one pathway for research translation, defined below.
Contribution	Refers to the extent to which the MRSP has led to or influenced outcomes occurring. This evaluation assesses both attribution and additionality to draw conclusions on the extent to which the MRSP contributed towards a specific outcome.
Costs of research	• Direct costs of research: Encompasses all costs related directly to specific research activities or projects. They include researcher salaries, materials and supplies, equipment, publication costs, and conference and travel expenses tied directly to research projects. • Indirect costs of research: Encompasses all costs that support the research ecosystem (and MRIs in the context of this report) that are not tied directly to a research project, but are necessary to provide a supportive environment where research and its translation can occur. They include facilities and maintenance, utilities, finance and administration, data management, IT and security, regulation and compliance, business development and research support, as well as salaries for individuals hired in relevant roles. • Full costs of research: Encompasses all costs that support research activity, including both the direct and indirect costs of research, i.e. full costs = direct costs + indirect costs.

¹ Definition adapted from the NSW Government Health and Medical Research [Commercialisation Framework](#).

Term	Definition
Medical research institute (MRI)	A discrete institution that is an independent legal entity, whose primary purpose is to conduct health and medical research. To be recognised as an MRI, the institution must have an established track record of conducting research and attracting research funding through competitive mechanisms. They must also have their own governance structure and infrastructure to conduct their work. In the context of this report, MRIs refer to MRSP-funded MRIs.
NSW health and medical research (HMR) ecosystem	A complex interconnected system comprising actors involved in research and health and research infrastructure that work together to advance research in the field of health and medicine.² This complex system comprises: • Actors including researchers, clinicians, institutions, universities, funders, industry and patients • Infrastructure including physical infrastructure (such as buildings, clinics, hospitals, laboratories and office spaces), technological assets (such as data repositories and archives, technical capabilities and services (such as statistics and commercialisation), and operational infrastructure (such as administration) • Research conducted across the pipeline, including basic science and discovery research, clinical medicine and science research, health services research and public health research Translation of research findings into improved health outcomes, treatments and policies, e.g. through the availability of new medicines and devices, and changes to policies, practice and clinical guidance.
Research excellence	Refers to the highest-quality research which will contribute new knowledge, complexity of thinking, new thinking, breakthroughs in understanding difficult concepts and transcendence of boundaries.³ This includes research that: • Meaningfully and substantially advances knowledge in a specific field • Leads to new discoveries and innovations • Demonstrates leadership in their field nationally and internationally
Research infrastructure	Comprises the facilities, equipment, resources and services that support leading-edge research and innovation.⁴ It encompasses: • Physical assets and spaces, such as laboratories, equipment, buildings, clinics and office spaces • Technological assets, such as datasets and data archives

² Based on the [National Health and Medical Research Strategy 2026 – 2036](#)

³ Definition extracted from Australia's Chief Scientist's definitions [Trust in Science: Clarifying the distinctions between research integrity, research quality, excellence, and impact](#)

⁴ Based on the [2021 National Research Infrastructure Roadmap](#)

Term	Definition
	Technical capabilities, such data sciences, statistics, health economics, clinical trials, laboratory technicians, commercialisation and research grants development Operational infrastructure, such as administration and the running costs to operate research spaces
Research quality	Refers to the process of conducting research, which requires the best research design, the right methods, measurements, data analysis, reporting and supervision standards. Research quality relates to the rigour of the research undertaken. Quality research is rigorous, transparent and in principle reproducible. ⁵ Research quality also refers to the quality of research outputs, with high quality research referring to methodologically robust, impactful research.
Research translation	The process of moving research findings into practical applications in real world settings so that they are accessible and usable by practitioners, policymakers and the public to improve health outcomes. Research translation can include: - Disseminating new clinical interventions and health guidelines - Developing and commercialising new drugs and medical devices (a detailed definition of commercialisation is provided above) - Changing health policies, programs and services.⁶
Stakeholders	In the context of this report, “stakeholders” encompasses organisations with a strong interest in the MRSP. We sought the views of three stakeholder groups for this evaluation: MRIs that have received MRSP funding, administrators and advisors to the Program, and organisations affiliated with MRSP-funded MRIs. They are described further on page 34. In this report, the term “stakeholders” refers to all three stakeholder groups included in this evaluation.

⁵ Definition extracted from Australia’s Chief Scientist’s definitions [Trust in Science: Clarifying the distinctions between research integrity, research quality, excellence, and impact](#)

⁶ Adapted from the NHMRC definition of research translation <https://www.nhmrc.gov.au/research-policy/research-translation-and-impact>

1. Executive Summary

Summary at a glance

Program: The Medical Research Support Program (MRSP) is the NSW Government’s flagship funding program for independent Medical Research Institutes (MRIs), providing approximately \$40 million per annum in recurrent funding to support indirect research costs and core research infrastructure.

Overall finding: The evaluation finds that the MRSP represents value for money for NSW. The Program provides essential, stabilising investment that sustains NSW’s independent MRIs and underpins research infrastructure, workforce capability and research excellence that would not otherwise occur. Benefits are largely realised at an individual MRI level, with more limited evidence of system-level efficiencies, collaboration or collective infrastructure outcomes. While it is clear that MRIs contribute towards achieving broader health system and state-wide impacts, attributing discrete outcomes directly to the MRSP is not possible as they occur in a complex ecosystem with several inputs.

Key evidence: Over 2012–2025, the MRSP delivered an estimated \$1.2 billion in net economic benefits (\$2025 dollars), with a benefit–cost ratio of 2.6, even before downstream health benefits are considered. For each 1% increase in MRSP funding, there was a 0.73% uplift in total NHMRC and MRFF funding to NSW.

Future considerations: The evaluation found consistent evidence of support across the sector for refreshing the Program’s objectives, design and reporting framework. A targeted refresh would strengthen strategic clarity, improve alignment with contemporary research and health system priorities, and ensure ongoing fitness for purpose in the context of the NSW Health Research and Innovation Strategy 2025–2030 and the wider NSW Innovation agenda.

1.1 Evaluation purpose and questions

The evaluation examines the operation of the MRSP from the 2012–2016 funding round through to the current 2024–2028 funding round, to understand what has been working well, what could be improved, and how the MRSP can remain sustainable into the future. The evaluation was structured around four key evaluation questions (KEQs), covering the process, outcome, and economic components:

Evaluation component	Key evaluation questions (KEQs)
Process evaluation	KEQ1 - How effective and efficient are the Program’s administration and delivery processes? <i>(Linked OHMR Domains: Sustainability, Capability Building)</i>
	KEQ2 - How effective are the Program’s reporting, data collection, and impact metrics, and where are there gaps or opportunities for improvement? <i>(Linked OHMR Domains: Sustainability, Capability Building, Policy and Practice)</i>

Outcome evaluation	KEQ3 - To what extent has the Program achieved its intended objectives and delivered meaningful outcomes? <i>(Linked OHMR Domains: Knowledge Advancement, Capability Building, Policy and Practice, Health and Community Impact, Economic Benefit, Sustainability)</i>
Economic evaluation	KEQ4 - What are the costs and benefits of the Program, and does it represent value for the NSW HMR ecosystem and the people of NSW? <i>(Linked OHMR Domains: Economic Benefit, Sustainability, Health and Community Impact)</i>

1.2 How the evaluation was conducted⁷

Research infrastructure funding plays a foundational role within a complex research ecosystem. For this reason, the evaluation used a contribution-focused approach to reflect non-linear pathways to outcomes and address challenges in attribution and additionality.

The evaluation drew on existing program and administrative data, supplemented by targeted primary data collection to address evidence gaps. Data sources included:

- Program and administrative documentation
- Desktop analysis of OHMR administrative data
- Interviews with MRSP administrators and advisors, MRIs and organisations affiliated with MRSP-funded MRIs
- Surveys of current MRSP-funded MRIs
- Case studies
- Targeted data requests
- Publicly available data on research activity and research funding data from other schemes

Quantitative and qualitative data were analysed separately and then synthesised across multiple sources to strengthen robustness and triangulation. Evaluative judgement was made on the whole-of-program outcomes at the MRI, system and state-wide levels.

1.3 Key findings and evaluative judgement

The evaluation found that the MRSP operates as a high-value enabling investment, supporting MRI viability, research infrastructure and workforce capability, and enabling research activity that would not otherwise occur. The Program delivered an estimated \$1.2 billion in net economic benefits over 2012–2025, with a benefit–cost ratio of 2.6, demonstrating clear value for money despite the indirect and non-attributable nature of many downstream health system outcomes.

⁷ Evaluation methods were designed in accordance with NSW Treasury evaluation and cost-benefit analysis guidelines.

Key findings for each of the key evaluation questions (KEQs)

KEQ1 - How effective and efficient are the Program's administration and delivery processes?

The MRSP's administration and delivery processes are partially effective. The Program plays a distinct and valued role in supporting MRI viability through flexible infrastructure and indirect cost funding, but its objectives and design have not fully kept pace with contemporary research and health system priorities. The flexibility of MRSP expenditure is a core strength of the Program, but creates challenges for ensuring accountability and compliance. Administration costs were between 0.4% and 0.7% of the annual total of MRSP funding, which is substantially less than a guide of 5–10% to administer funding grants. Administration is lean and efficient, with very low overheads relative to funding, though further efficiencies are possible through greater focus on strategic oversight rather than manual eligibility processes.

KEQ2 - How effective are the Program's reporting, data collection, and impact metrics, and where are there gaps or opportunities for improvement?

The MRSP's reporting and data arrangements are partially effective, meeting accountability and transparency requirements but providing limited insight into outcomes, impact and system benefit. While the available data supported an assessment of compliance with the intended purpose of the funds, for this evaluation it had very limited utility in assessing the extent to which the Program objectives are being met or contributing to broader goals for the NSW health system. There is a misalignment between reporting requirements and the Program's stated objectives.

KEQ3 - To what extent has the Program achieved its intended objectives and delivered meaningful outcomes?

The MRSP has **partially achieved** its objectives. There is strong evidence that the Program supports MRI financial viability by partially filling the gaps in covering the indirect costs of research, which are difficult to cover from most other sources of income. This has enabled MRIs at an individual level to build and sustain research infrastructure, operational capacity and workforce capability, which has leveraged additional funding for research and enabled both a greater volume and excellence in research. However, these benefits have largely occurred at an individual MRI level. While individual MRI successes have collectively enabled a thriving health and medical research ecosystem in NSW, the Program has not achieved the objective of building collective infrastructure assets and capacity and associated efficiencies at a system level. Its contribution to collaboration remains variable and context dependent. While MRIs demonstrate meaningful impacts on policy, clinical practice and health outcomes, the MRSP's contributing role is enabling rather than causal, with broader health system outcomes unable to be directly or discretely attributed to the MRSP.

KEQ4 - What are the costs and benefits of the Program, and does it represent value for the NSW HMR ecosystem and the people of NSW?

The MRSP represents value for money for the NSW health and medical research ecosystem and the people of NSW. Over 2012–2025, the Program delivered an estimated \$1.2 billion in net economic benefits (\$2025 dollars) with a benefit–cost ratio of 2.6, even before downstream health benefits are considered. The Program's impact on an uplift in research funding was the largest economic impact reported (65% of the net benefits realised), followed by the impact of additional clinical trial activity (15% of the net benefit effect), avoided turnover (10%) and revenues from uplift in commercialisation (9%). The strongly net positive impact of the MRSP on research outcomes estimated in the bottom-up economic analysis was also consistent with the top-down trend analysis of research funding which

showed that the MRSP has had a significant positive association with research activity in NSW. Each 1% increase in MRSP funding was associated with a 0.73% uplift in total NHMRC and MRFF funding to NSW. Beyond economic impacts, some important social, cultural and environmental benefits were also reported, but these tended to be limited and sporadic across the MRIs, with the primary effects being the uplift in high impact research.

1.4 Recommendations

Drawing on the evaluation findings and the professional judgement of the evaluation team, the recommendations below are provided as guidance to support NSW Health:

1. Clarifying and strengthening the Program's overarching purpose and objectives
Recommendation 1.1 – Establish a clearer overarching purpose for the MRSP
Recommendation 1.2 – Refresh the programs objectives and program logic to align with the overarching purpose
2. Developing and implementing a more contemporary outcomes and reporting framework
Recommendation 2.1 – Develop an outcomes framework linked to the updated objectives and the statewide HMR outcomes indicators that align with the refreshed program logic.
Recommendation 2.2 – Consider mechanisms for sector learning, transparency and feedback
3. Modernising and simplifying the design settings and funding model
Recommendation 3.1 – Test options for clarifying and updating eligibility criteria
Recommendation 3.2 – Explore alternative approaches to the current tiered allocation model
Recommendation 3.3 – Consider opportunities to maintain flexibility while strengthening transparency on allowable expenses
4. Improving the transparency, administration, governance and processes
Recommendation 4.1 – Assess whether strengthened governance arrangements would improve strategic oversight
Recommendation 4.2 – Examine options to improve communication and engagement with MRIs
Recommendation 4.3 – Explore modernisation of administrative systems and data management

SECTION 1 – BACKGROUND AND METHODS

2. Background and purpose of evaluation

2.1 Overview of the Medical Research Support Program (MRSP)

Background

The [MRSP](#) is the NSW Government's flagship funding program for independent MRIs, representing the largest single investment in health and medical research (HMR) by the NSW Government. Originally known as the NSW Infrastructure Grants Program, it was introduced in 1996 to support eligible medical research institutes (MRIs) with the indirect costs of research. The MRSP has been administered by OHMR since 2011.

Government sources provide the majority of competitive grant income funds received by MRIs in Australia.⁸ However most competitive research grants, including those provided by the National Health and Medical Research Council (NHMRC) and the Medical Research Future Fund (MRFF), only provide funding for the 'direct' costs of research. The MRSP was introduced to help bridge this funding gap by contributing to the full cost of conducting quality research, thereby ensuring a sustainable and robust NSW HMR ecosystem.

Program purpose and objectives

The MRSP provides research infrastructure support funding to eligible independent MRIs to support the indirect costs of research. It aims to develop statewide capacity to deliver world class HMR through the provision of this funding.

As outlined in the most recent application guidelines⁹, the 3 objectives of the MRSP are:

1. Excellence – support excellence in health and medical research through the delivery of high-quality outputs
2. Critical mass – promote critical mass in health and medical research as part of the effective use of resources
3. Sustainability – monitor and help ensure the financial sustainability of participating institutes.

These objectives have remained constant over the period covered by this evaluation (2012–current).

⁸ 2024 AAMRI Report

https://aamri.org.au/wp-content/uploads/2024/12/AAMRI_Public_Report_2024_FINAL_WEB.pdf

⁹ Medical Research Support Program application guidelines and program details 2024–2028

<https://www.nsw.gov.au/sites/default/files/noindex/2024-06/mrsp-2024–2028-application-guidelines.pdf>

Funding mechanism

For eligible MRIs, the MRSP operates on a tiered funding model and does not fund research projects directly or capital works (see Appendix 1 for an overview of the MRSP grant processes). It is also not intended to fund infrastructure activities where statewide assets (such as biobanks) already exist (see section 2.2 for further details on where MRSP funds cannot be directed).

Funding is awarded across four-year terms. Each term is divided into 2 funding periods:

- Period 1 (Years 1–2): Allocations are determined at the start of the term.
- Period 2 (Years 3–4): Allocations are determined following a mid-term review.

MRIs are grouped into funding tiers based on the average annual income they have received from eligible nationally competitive HMR grants¹⁰ over the preceding 3 years. However, not all funded grants from these sources are eligible for inclusion in the three-year assessment period, as a grant is only considered eligible if:

- Funds are provided on a nationally competitive basis
- Funds are awarded for HMR
- The scheme is advertised nationally and available to all Australian research institutions
- The scheme has a well-defined mechanism for competition and selection by a qualified panel.

This average annual eligible income is used to determine whether an MRI meets the \$3 million threshold for Program funding eligibility (see Appendix 1 – Eligibility criteria) and to assign the MRIs to a funding tier.

MRIs in higher tiers receive a higher rate of support, expressed as a funding rate per NHMRC grant dollar. Historically, support has ranged from 30 to 45 cents per NHMRC dollar, depending on the tier. Funding allocations themselves are calculated based on eligible NHMRC grant income only. This is limited to NHMRC grants that meet the same eligibility criteria as above.

The total funding pool is fixed per annum and has remained relatively stable across Program terms, with \$37.3 million per year in the 2012–2016 period and \$44.5 million per year allocated during both the 2016–2020 and 2020–2024 periods. For the 2024–2028 term, the Program provides up to \$40 million per year.

Applicant MRIs must disclose if they receive or expect to receive other NSW Government infrastructure funding during the term. MRSP allocations may be adjusted accordingly, particularly where recipients are also funded under:

- [The Prevention Research Support Program](#)
- [Cancer Institute NSW infrastructure programs](#)
- Other NSW Government infrastructure schemes.

Additional infrastructure contributions from non-NSW sources, such as universities or Commonwealth programs, are acknowledged but do not affect MRSP allocations.

¹⁰ Grants awarded by NHMRC, MRFF, Australian Research Council, and Cancer Australia

2.2 Program logic and theory of change

This section presents the theory of change and program logic for the MRSP. The theory of change provides a summary narrative explaining how and why the initiative's activities are expected to achieve its objectives, based on evidence, logic, and stated assumptions.

The program logic, shown in Figure 1, schematically sets out the MRSP's objectives and inputs (blue boxes) and the grey boxes illustrate MRI activities, outputs, intermediate (less than 5-7 years) and longer term (greater than 5-7 years) outcomes. It established the basis for the evaluation and informed the evaluation questions.

Theory of change

Need for the MRSP

MRIs rely upon additional funding to undertake research as most¹¹ competitive research grants, including those provided by the NHMRC and the MRFF, only provide funding for the 'direct' costs of research. The MRSP was introduced as a means of helping to bridge this funding gap by contributing to the full cost of conducting quality research, thereby ensuring a sustainable and robust NSW HMR ecosystem. Non-government sources of funding are also used by MRIs to provide for research infrastructure and include philanthropy, commercial income, fee-for-service research and student fees.

Funded activities

According to application guidelines and funding agreements with the MRIs, funds are required to be directed towards the recipient's costs of operating and carrying out the functions of a research institution to achieve the MRSP's objectives. Specifically, the grant is intended to assist with costs incurred by the recipient in its conduct of HMR funded by other sources, and that are not covered by the funding agreements for those projects. OHMR has advised that these institutional costs may include administration, commercialisation, data storage, data security, IT infrastructure, HR, business development costs, specialised equipment etc.

Funds can **NOT** be directed, according to the MRSP application guidelines, and clause 5 of the 2024-2028 funding agreement, towards:

- Research projects
- Capital works (as opposed to capital equipment)
- An activity where statewide assess already exists (e.g., biobanking)
- Make a loan, advance, donation, commission, gift of similar benefit for any purpose
- Make repayments of existing loans, investments or debts
- Provide security for any purpose
- Pay Fringe Benefits Tax

¹¹ Some competitive non-government grants do cover the full costs of research, but they are in the minority and make a very small contribution to overall national research investment.

- Pay fees or expenses, including sitting fees, to any board member, non executive director or non-executive committee members of the Grantee (other than reasonable travel expenses for the purposes of attending the business of the board)
- Pay legal fees or settle any claim, order or judgment against the Grantee, staff or board members
- Make termination of employment or redundancy payments.

Assumptions

Assumptions underlying the theory of change include:

- The MRSP funding addresses a recognised, major barrier to independent MRI competitiveness and financial sustainability due to the lack of funding for the full costs of research in many large grant programs
- The MRSP funding will enable MRIs to attract more research grants and deliver additional high-quality research outputs than would be possible in its absence
- The HMR sector contribute significantly to both public health improvements and broader economic development
- The MRSP funding will be administered transparently by the NSW Government and managed responsibly by MRIs and used for eligible, high-value purposes aligned with the MRSP objectives and guidelines.

Development of the program logic

Between 2019 and 2022, OHMR developed an initial program logic for the MRSP designed to be adaptable over time. This initial program logic was subsequently used as a basis for sector engagement.

For the current evaluation, MHC built on this earlier initial 2022 program logic. The updated program logic presented in Figure 1 has been developed by MHC in the following ways:

- **Linked the Program's objectives to outcomes** – The program logic set out the intended outcomes aligned to the 3 objectives of the MRSP, reflecting the purpose of the evaluation.
- **Addresses the 'additionality/contribution' challenge** – A key methodological issue for the evaluation was to isolate the contribution of MRSP funding from other sources of support. That is, identifying the added value of MRSP funding to MRI outputs and outcomes. This was addressed through analytical methods (see section 3.1) and tested using a program logic model with a dotted line that distinguishes MRSP-specific inputs and objectives (left side, blue boxes) from MRI-wide activities and impacts (right side, grey boxes).
- **Aligned with OHMR's recent evaluation program logics** – The structure, domains and level of detail are consistent with other OHMR evaluations to support internal coherence across the evaluation of OHMR programs¹².

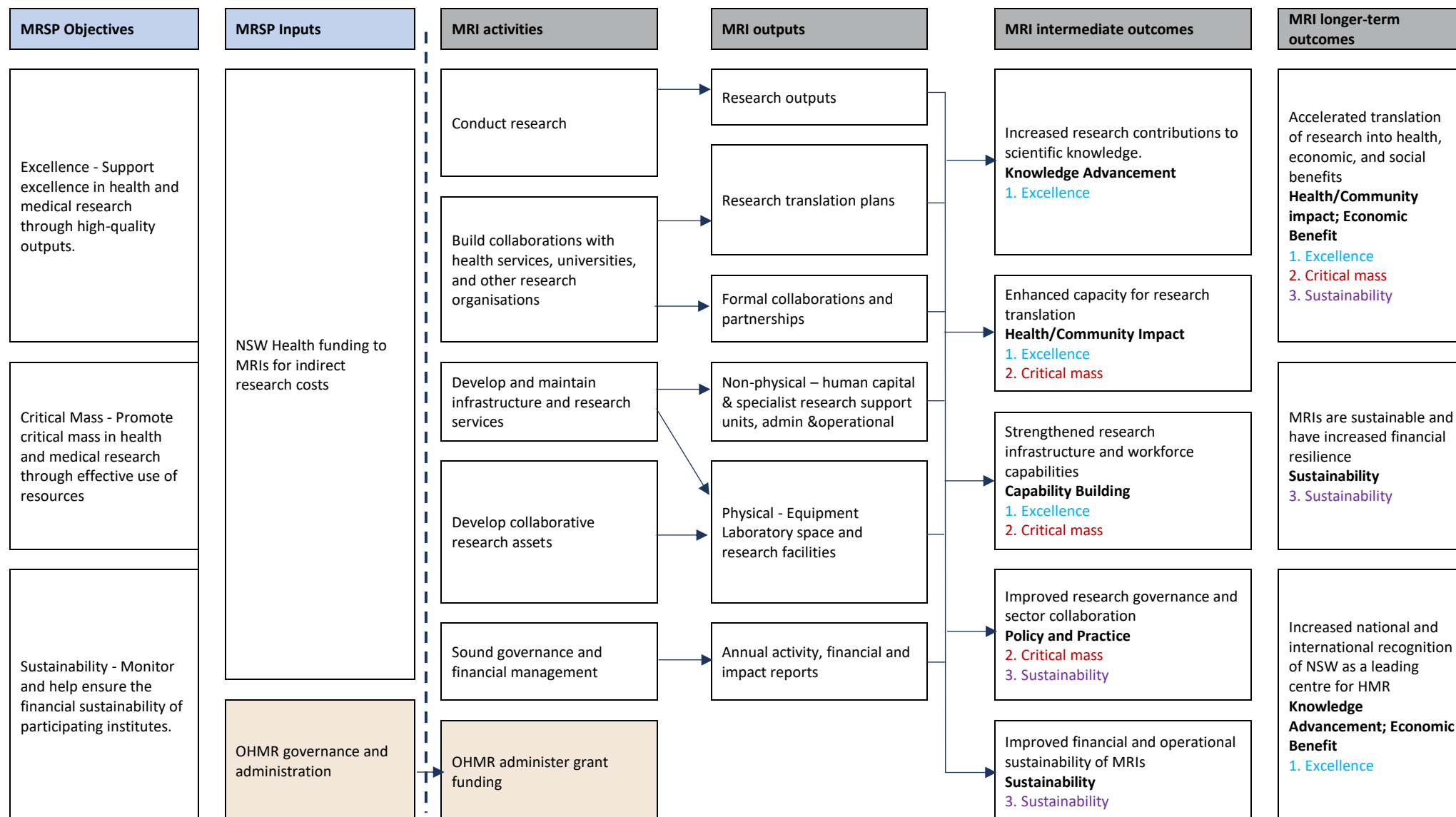
¹² OHMR [Cardiovascular Research Capacity Program Interim Evaluation](#) and the [Commercialisation Training Program Evaluation](#)

- **Compliant with NSW Treasury evaluation requirements (TPG22-22)** – The logic model¹³ includes inputs, outputs, outcomes and benefits for NSW.
- **Aligned with the OHMR outcomes framework** – The intended outcomes of the MRSP are grouped according to OHMR’s 6 domains of research benefit¹⁴:
 - Knowledge advancement
 - Capability building
 - Policy and practice
 - Health and Community impact
 - Economic benefit
 - Sustainability.

¹³ <https://www.treasury.nsw.gov.au/sites/default/files/2023-07/202306-evaluation-workbook-1-foundations-of-evaluation.pdf>

¹⁴ https://medicalresearch.nsw.gov.au/__data/assets/pdf_file/0006/1016079/OHMR-Reporting-and-Evaluation-of-Health-and-Medical-Research.pdf

Figure 1. Current-state program logic: linking the program objectives to the MRSP indirect research funding



Notes:

- Each interim and long-term outcome is mapped to one or more of OHMR's 6 domains of benefit.
- Interim outcomes are defined as within 5-7 years and longer-term outcomes are greater than 5-7 years.
- Peach box is OHMR grant administration
- Outcomes are colour coded by the MRSP objective
 - 1. Excellence** - Support excellence in health and medical research through high-quality outputs
 - 2. Critical Mass** - Promote critical mass in health and medical research through effective use of resources
 - 3. Sustainability** - Monitor and help ensure the financial sustainability of participating institutes

2.3 Evaluation purpose and scope

The drivers for this evaluation

This evaluation was required by NSW Treasury and is part of good public stewardship.

- This evaluation was required by NSW Treasury (TPG22-22, TPG23-08)^{15 16} and is part of good public stewardship. The MRSP evaluation supports the NSW Government's strategic priorities, the need for transparency, and the continuous improvement of health research funding mechanisms.
- There was a need for a rigorous independent evaluation to assess the contribution of funding given to MRIs to improve public health outcomes and the NSW economy.

Evaluation objectives

The evaluation objective was to examine the operation of the Program from the 2012–2016 funding round through to the current 2024–2028 funding round, to examine progress to date towards the Program's objectives.

The purpose of the process, outcome and economic evaluations was to assess the:

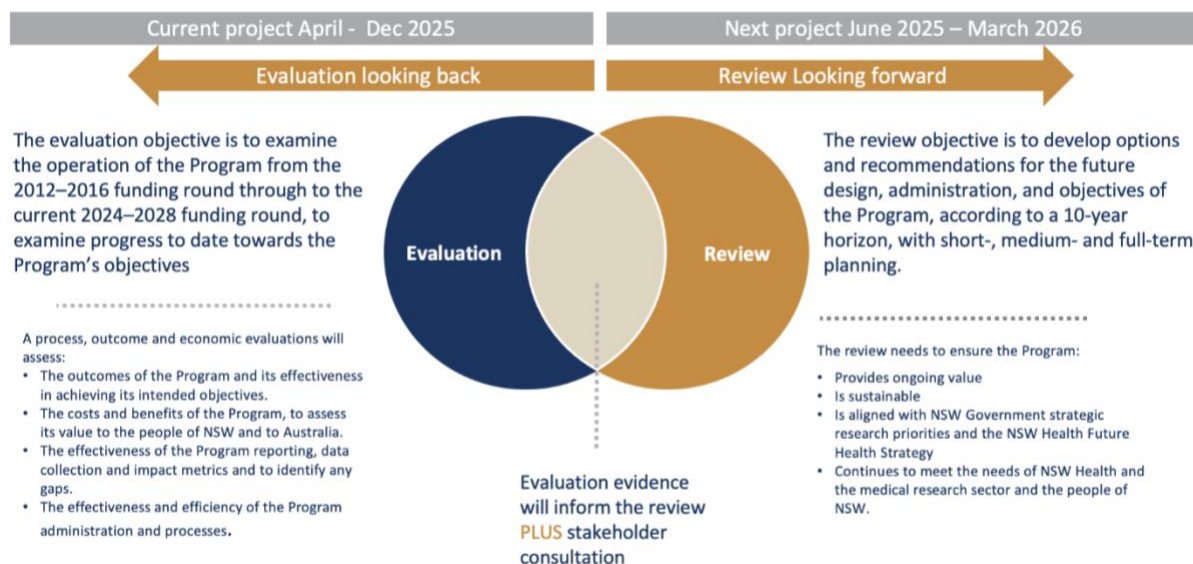
- Effectiveness and efficiency of the Program administration and processes
- Effectiveness of the Program reporting, data collection and impact metrics and to identify any gaps
- Outcomes of the Program and its effectiveness in achieving its intended objectives
- Health, economic, social, cultural and environmental costs and benefits of the Program, to assess its value to the people of NSW.

The evaluation takes a retrospective view, assessing the operation and outcomes of the Program from 2012 to 2025. The findings of this evaluation will inform the MRSP Review, a distinct forward-looking process to shape strategic options and recommendations for the future design, administration and objectives of the MRSP. The relationship between these two bodies of work is shown in Figure 2.

¹⁵ <https://www.treasury.nsw.gov.au/sites/default/files/2023-02/evaluation-tpg22-22.pdf>

¹⁶ https://www.treasury.nsw.gov.au/sites/default/files/2023-04/tpg23-08_nsw-government-guide-to-cost-benefit-analysis_202304.pdf

Figure 2. MRSP evaluation and review – How they interrelate



Scope

- **Within scope:**
 - **Scope of the evaluation:** The MRSP’s performance and impact were assessed at a whole-of-program level
 - **Timeframe and funding rounds:** The evaluation covered funding rounds from 2012–2016 through to the current 2024–2028 round.
- **Out of scope:**
 - Assessment of the performance of individual grants or institutions funded through the MRSP.
 - An assessment of the value of MRIs and their strategic importance in NSW
 - A formal financial audit, performance audit, or forensic audit, including comprehensive verification of institutional records held by MRIs.
 - Requirements specific to the subsequent Review of the MRSP. While the Review will draw on evaluation evidence and stakeholder consultation, it has a separate purpose: to develop options and recommendations for the MRSP future design, administration, and objectives over a 10-year horizon (with short-, medium- and long-term planning). The Review will consider how the Program can:
 - Provide ongoing value
 - Remain sustainable
 - Align with NSW Government strategic research priorities, the NSW Health Research and Innovation Strategy, and the NSW Health Future Health Strategy

- Continue to meet the needs of NSW Health, the medical research sector, and the people of NSW.

Key evaluation questions

The evaluation was structured around 4 key evaluation questions (KEQs), covering the process, outcome, and economic components. Each KEQ was aligned to one or more domains of the OHMR Outcomes Framework (the Outcomes Framework), ensuring the evaluation reflected the MRSP's intended strategic contributions.

Table 1. Key evaluation questions for the evaluation

Evaluation component	Key evaluation questions (KEQs)
Process evaluation	KEQ1 - How effective and efficient are the Program's administration and delivery processes? <i>(Linked OHMR Domains: Sustainability, Capability Building)</i>
	KEQ2 - How effective are the Program's reporting, data collection, and impact metrics, and where are there gaps or opportunities for improvement? <i>(Linked OHMR Domains: Sustainability, Capability Building, Policy and Practice)</i>
Outcome evaluation	KEQ3 - To what extent has the Program achieved its intended objectives and delivered meaningful outcomes? <i>(Linked OHMR Domains: Knowledge Advancement, Capability Building, Policy and Practice, Health and Community Impact, Economic Benefit, Sustainability)</i>
Economic evaluation	KEQ4 - What are the costs and benefits of the Program, and does it represent value for the NSW HMR ecosystem and the people of NSW? <i>(Linked OHMR Domains: Economic Benefit, Sustainability, Health and Community Impact)</i>

3. Methodology

3.1 Evaluation design

The MRSP evaluation was designed as a whole-of-program evaluation covering the period from the 2012–2016 funding round through to the current 2024–2028 funding round. It examined the MRSP’s performance and contribution at a program-level, rather than assessing the performance of individual funded institutions or specific MRI initiatives.

A mixed-methods design was applied, integrating qualitative and quantitative evidence to answer the evaluation questions and support robust judgement. The design comprised 3 complementary components:

- **Process evaluation** – examined how the Program has been designed and delivered over time, including the effectiveness and efficiency of administration, governance, application and assessment processes, and reporting and data arrangements (KEQs 1 and 2).
- **Outcome evaluation** – examined the extent to which the Program has achieved its intended objectives and contributed to intermediate and longer-term outcomes (KEQ 3), recognising the non-linear pathways from infrastructure funding to research and health impacts.
- **Economic evaluation** – examined program costs and benefits and the Program’s value to the NSW health and medical research ecosystem and the people of NSW (KEQ 4).

The evaluation design was informed by relevant NSW Government requirements and guidance, and anchored in the MRSP program logic and OHMR outcomes framework to ensure the evaluation questions, lines of inquiry, and assessment focus reflected the MRSP’s objectives and intended pathways of impact.

Given the nature of research infrastructure funding and the complexity of the broader research ecosystem, the design explicitly accounted for attribution and additionality challenges. Rather than relying on experimental designs or simple before-and-after comparisons, the evaluation adopted a contribution-focused approach that considered the plausibility of the MRSP’s role alongside other influences, supported through synthesis across multiple lines of evidence.

Impacts were examined at multiple levels to reflect the expected flow of benefits through the system:

- **MRI-level** – effects on participating institutes, including capability, capacity, collaboration and sustainability.
- **System-level** – broader effects across the NSW health and medical research ecosystem, including precinct-based and cross-institutional impacts.
- **State-wide level** – contributions to broader outcomes for NSW, including health system and population-level outcomes.

The design prioritised proportionality and feasibility, with an emphasis on using existing information where available and targeting primary data collection to fill key gaps and support interpretation. The approach also emphasised evidence triangulation to strengthen credibility and reduce reliance on any single data source. Limitations relating to data availability, consistency, and time lags between investment and impact are addressed in Section 3.5.

3.2 Evaluation methods

Methodological approach and policy alignment

The evaluation methods were implemented in accordance with the NSW Treasury Policy and Guidelines: Evaluation (TPG22-22, February 2023) and the NSW Government Guide to Cost-Benefit Analysis (TPG23-08, February 2023). These requirements were complemented by the MRSP Program Logic and the OHMR Outcomes Framework to ensure alignment with established benchmarks and good practice in program evaluation.

The approach supported robust judgement while remaining proportionate to the scale and maturity of the MRSP. Evidence was analysed at a whole-of-program level and synthesised across multiple sources to strengthen validity and reduce reliance on any single dataset.

Addressing attribution and additionality

A central methodological challenge for the evaluation was assessing the additionality of the MRSP - that is, the extent to which observed outcomes could reasonably be attributed to MRSP funding, over and above what would have occurred in its absence. As an infrastructure funding scheme, the inputs of this Program are distal to the desired effects, making it challenging to ascertain and quantify the direct effect of the MRSP on outcomes especially at the system and state levels. This challenge also reflects the complex NSW research ecosystem, where outcomes are influenced by multiple funding sources, long timeframes, institutional strategies, and changing contexts and priorities.

Rather than focusing solely on observed change which is affected by multiple factors, the evaluation examined how and to what extent MRSP funding contributed to those changes. This included identifying outcomes, activities, or capabilities that were uniquely enabled by MRSP funding or were materially strengthened or expedited by the predictability and scale of the MRSP.

Table 2 outlines the key definitions of contribution, attribution and additionality for this evaluation.

Table 2. Key definitions for this evaluation

Term	Definition
Contribution	Refers to the extent to which the MRSP has led to or influenced outcomes occurring. This evaluation assesses both attribution and additionality to draw conclusions on the extent to which the MRSP contributed towards a specific outcome.
Attribution	Refers to the extent to which observed outcomes can be directly linked to MRSP funding, i.e. the line linking MRSP funding with particular outcomes or impacts. • Direct attribution is where there is a clear observable line between MRSP funding and an outcome (e.g. the MRSP funded a specific workforce position or equipment). • Indirect attribution is where the outcome is a flow-on effect of an MRSP-funded activity that occurred alongside activities resulting from other funding sources (e.g. the MRSP funded business operations that enabled research activities to occur).

Term	Definition
Additionality	Refers to the extent to which MRSP funding enabled activities or outcomes that would not have occurred, or would have occurred to a lesser extent or later, in the absence of the Program, recognising that outcomes arise from interacting inputs within a complex research system, i.e. how much impact is due to the MRSP. Additionality aims to both quantitatively and qualitatively determine how much impact is due to the MRSP as opposed to other sources of funding, activities and contextual factors.

To strengthen attribution and test the plausibility of the MRSP's contribution, the evaluation applied a combination of approaches, including:

- MRI surveys and stakeholder interviews to distinguish MRSP-specific impacts from general institutional activity
- Elicitation of self-reported counterfactuals from MRIs and other stakeholders regarding what would likely have occurred in the absence of MRSP funding
- Desktop analysis of funding, performance, and trend data across the sector, including reference to available benchmarks
- Triangulation of administrative, qualitative, and quantitative data sources
- Application of contribution analysis to test and refine the program logic and assess the Program's role in producing intended outcomes.

This approach recognises that pathways from infrastructure funding to research and health impact are non-linear and context-dependent, and integrates this understanding across the evaluation.

Process evaluation methods

The process evaluation addressed KEQs 1 and 2, focusing on the effectiveness and efficiency of the Program's administration, delivery, reporting, and data collection arrangements.

The process evaluation was informed by a structured assessment framework derived from the NSW Government Grants Administration Guide, encompassing principles related to program planning and design, proportionality, outcomes focus, value for money, governance, probity, and transparency.

Assessment was undertaken across the program life cycle and across all funding rounds within scope, including:

- Program design
- Application and assessment processes
- Awarding of grants
- Program reporting and data collection
- Program governance and administration.

Evidence was synthesised to identify strengths, limitations, and opportunities for improvement in the Program's design and delivery, rather than to assess the performance of individual grants or institutions.

Outcome evaluation methods

The outcome evaluation addressed KEQ3, examining the extent to which the MRSP has achieved its intended objectives and contributed to intermediate and longer-term outcomes outlined in the program logic.

The outcome evaluation assessed evidence at both the MRI and system levels, with a focus on contribution rather than attribution of outcomes solely to the MRSP. Lines of inquiry were structured around the MRSP's 3 objectives, including the contribution towards:

- Excellence in research (MRSP Objective 1)
- Excellence in health (MRSP Objective 1)
- Strengthened research infrastructure (MRSP Objective 2)
- Growth in workforce and research capacity (MRSP Objective 2)
- Facilitating research collaborations (MRSP Objective 2)
- Financial stability and resilience of MRIs (MRSP Objective 3)
- Impact across the health and medical research ecosystem.

Findings were informed through triangulation and synthesis of multiple evidence sources, with explicit consideration of plausible counterfactual scenarios.

Economic evaluation methods

The economic evaluation addressed KEQ 4 by assessing the costs and benefits of the MRSP over the 2012–2025 horizon and its overall value for money to the people of NSW and to Australia (through improvements in healthcare) through time. This required the assessment of the 'additional' or incremental economic, health, environmental, social, and cultural costs and benefits of the MRSP for NSW relative to a hypothetical counterfactual (or 'base case') where the MRSP did not exist.

The economic impact evaluation was developed in alignment with NSW Treasury guidelines for cost benefit analysis (TPG23-08). A summary of the approach and methods for the economic evaluation is provided here, with greater detail on the framework and methods provided in Appendix 2.

The following steps were undertaken to complete the economic evaluation:

- Literature and data review
- Data request and data acquisition to close information gaps
- Stakeholder consultations and case study development
- Trend analysis of NHMRC funding in NSW as a result of MRSP funding
- Economic impact modelling
- Quantitative impact analysis of social, cultural and environmental impacts.

3.3 Data collection

This evaluation drew on multiple sources of evidence to support the process, outcome, and economic components of the evaluation at a whole-of-program level. Data collection methods were selected to align with the evaluation questions and the program logic, and to balance rigour with feasibility.

The evaluation primarily relied on existing data sources, supplemented by targeted primary data collection where evidence gaps were identified or where additional context was required to support interpretation. Quantitative and qualitative data were combined across methods to support triangulation and interpretation. Methods were guided by a structured evidence plan, including an internal evidence matrix developed during evaluation design, to support appropriate coverage across the evaluation questions.

Existing program and administrative data

Program documentation and administrative datasets were reviewed to assess program design, funding allocations, reporting requirements, and implementation over time. These data informed analysis across all evaluation questions, particularly trends across funding rounds and alignment with program objectives.

The administrative and program data reviewed included, but was not limited to:

- MRI data
 - Funding agreements
 - Funding applications
 - Annual progress reports
 - Annual financial reports
 - The following data were extracted from annual progress and financial reports:
 - Sources of revenue
 - Sources of expenditure
 - MRSP-specific expenditure
 - Workforce
- Program documents
 - Application forms
 - Program application guidelines
 - Previous reviews
 - Review panel meeting minutes.

Analysis of this data occurred between May 2025 and November 2025.

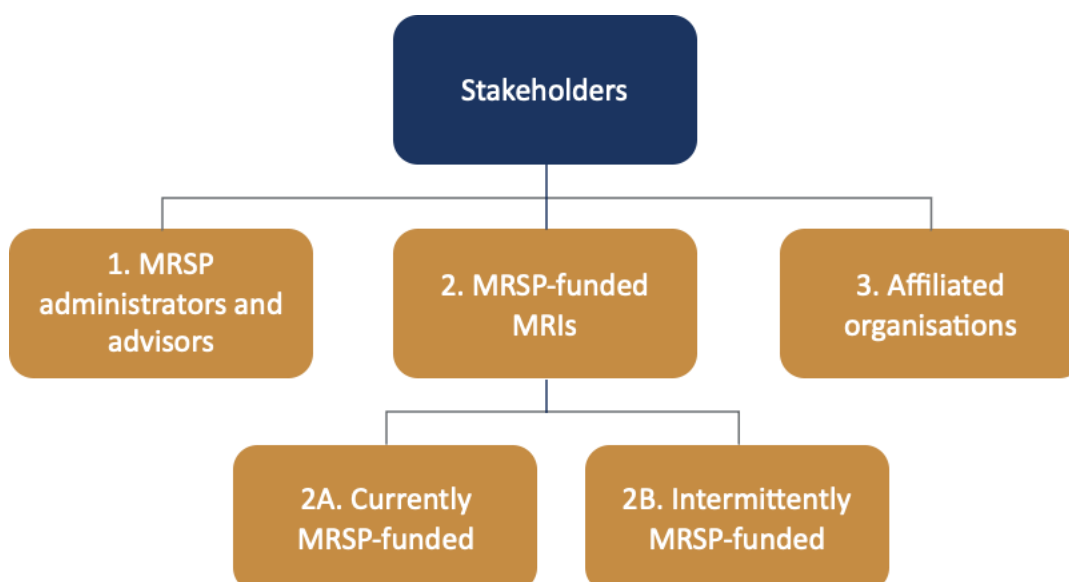
Interviews

Semi-structured interviews were conducted with three groups of stakeholders (see Figure 3) relevant to the MRSP:

- MRSP administrators and advisors
- MRIs who have received MRSP funding, specifically those who are currently receiving funding and those who have received funding intermittently
- Organisations affiliated with MRSP-funded MRIs.

Appendix 3 lists the MRIs that have received MRSP funding over the evaluation period.

Figure 3. Stakeholder groups interviewed for the MRSP evaluation



Interviews with MRSP administrators and advisors

Semi-structured interviews were conducted with MRSP administrators and advisors to understand program objectives, implementation history, governance arrangements, and perceived strengths and challenges in program design and delivery. These interviews provided contextual insight to support interpretation of findings across the process and outcome evaluations.

In total, 7 people were interviewed across six consultations (1 group and 5 individual (n=6) consultations).

Interviews were conducted between August 2025 and September 2025.

Interviews with current MRSP-funded MRIs

Interviews with representatives from currently funded MRIs explored the Program's contribution to research capability, outcomes achieved, reporting burden, and the role of MRSP funding within broader institutional funding portfolios. Interviews were designed to capture both strategic and operational perspectives.

In total, 65 stakeholders were consulted across 13 group interviews with each MRI. Interview participants included roles such as MRI Directors, Chief Operating Officers, Chief Financial Officers, research leaders, and business or grants managers. Interviews were conducted between August 2025 and September 2025.

Interviews with MRIs with intermittent MRSP funding

Interviews were conducted with MRIs that had received MRSP funding intermittently to understand factors influencing funding continuity, perceived impacts during funded and non-funded periods, and the Program's role relative to other funding sources. These interviews supported consideration of plausible counterfactual scenarios.

In total, 1 stakeholder interview was conducted. This interview occurred in August 2025. One current MRSP-funded MRI that intermittently lost MRSP funding also contributed to findings from this stakeholder group.

Interviews with affiliated organisations

Interviews were undertaken with organisations with strong affiliations with MRSP-funded MRIs, including policy, research, and system stakeholders. These interviews gathered perspectives on program relevance, contribution to the broader health and medical research ecosystem, and alignment with research and health priorities.

In total, 3 group interviews were conducted with stakeholders from the following organisations:

- Association of Australian Medical Research Institutes (AAMRI)
- NSW Local Health Districts with an MRI affiliation
- Universities in NSW with an MRI affiliation.

Interviews were conducted in September 2025.

Survey (Director-level) of current MRSP-funded MRIs (Director-level survey and grants administration-level survey)

Structured surveys were administered to all 13 current MRSP-funded MRIs to collect consistent, self-reported data on perspectives on program design, program outcomes, research translation, collaboration, workforce impacts, and administrative burden. Separate survey instruments were used to capture perspectives at different organisational levels, recognising differences in roles and knowledge.

A Director-level survey was distributed to all 13 MRIs, with a response rate of 13 out of 13 (100%).

A grant administration-level survey was distributed to all 13 MRIs, with a response rate of 13 out of 13 (100%).

Surveys were administered between September 2025 and October 2025. Survey instruments are provided in Appendix 4a and 4b.

Case studies

Traditional metrics used to assess research impact do not necessarily capture the full benefits of research infrastructure investments. To address this, the evaluation uses a mixed-method approach and

focuses on exemplars to demonstrate impacts that cannot be easily quantified. A case study approach is more appropriate to examine what is working and how,¹⁷ furthering an understanding of the logic of how the MRSP is achieving the outcomes identified. Case studies were used to provide deeper insight into the degree to which MRSP funding has contributed to outcomes over time.

Case studies were developed using a structured template that required current MRSP-funded MRIs to: (i) describe the MRSP-funded activity; (ii) explain how MRSP funding enabled or strengthened the activity (including the counterfactual scenario and/or an estimate of the MRSP's proportional contribution); (iii) describe resulting impacts with supporting quantitative and qualitative evidence; and (iv) provide references and/or other evidence to verify their case studies.

A two-step process was used to select case studies:

- Case study screening tool: MRIs first completed a screening tool to indicate where they could provide potential case studies across outcome levels (MRI-, system-, and state-wide) and outcome types (e.g. research excellence, translation, infrastructure, collaboration, sustainability, and broader system and state-wide impacts).
- Selection to ensure spread: Based on the screening tools returned, MRIs were then requested to provide a defined set of case studies to support coverage across levels and outcome types and avoid over-representation in any single area.

All current-MRSP funded MRIs (13/13) provided their final case study submissions. In total, 21 case studies were developed for the evaluation.

Data requests

Targeted data requests were issued to OHMR and current MRSP-funded MRIs to obtain additional information not available through existing administrative sources. Data requests were designed to be proportionate and aligned with the evidence matrix to minimise reporting burden.

The additional data requested from OHMR included:

- Dates on funding decisions
- Dates on annual reports
- Resources required to administer the MRSP.

OHMR submitted the requested data.

The data requested from current MRSP-funded MRIs included:

- Grant success rate
- Uplift to grant revenue
- Publications
- Clinical trials
- Translation outcomes

¹⁷ Hogle JA, Moberg DP. Success case studies contribute to evaluation of complex research infrastructure. *Eval Health Prof*. 2014;37(1):98-113. <https://doi.org/10.1177/0163278713500140>

- Additional revenue and/or expenditure
- Purchased assets
- Precinct infrastructure
- Precinct activity and expenditure
- Workforce changes related to the MRSP
- Changes to health practice
- Environmental benefits
- Social and cultural benefits.

A total of 11 of 13 MRIs submitted responses to the data request. As outlined in Section 3.5 (Limitations), the completeness and consistency of responses varied across topics, and some requested data were not available or could not be provided in a form suitable for analysis. This does not reflect shortcomings on the part of the MRIs; rather, the requested data have not historically been collected and are not considered routine metrics.

Data requests opened in October 2025 and closed in December 2025.

Publicly available data

Data were extracted from publicly available sources to support benchmarking and contextual analysis, including information on research activity, and system-level indicators where relevant.

Publicly available data sources included:

- SciVal (research output and citation data)
- NHMRC grants data 2005–2025
- MRFF grants data
- AIHW incidence, prevalence, mortality, survival data by condition
- AIHW Burden of Disease data
- WHO Global Burden of Disease disability weights
- National Hospital Cost Data Collection
- Academic and grey literature on spillover assumptions
- Scopus citation analysis
- Carbon prices as reported by World Bank Group.¹⁸

Publicly available data were collected between August 2025 and January 2026.

¹⁸ World Bank Group. (2025). State and Trends of Carbon Pricing Dashboard, accessed at: <https://carbonpricingdashboard.worldbank.org/compliance/price>.

3.4 Data analysis

The evaluation applied a structured and transparent approach to data analysis to address the KEQs and support robust evaluative judgement. Analysis was guided by the KEQs, the program logic, the methodological approach outlined in Sections 3.1–3.2, and a structured evidence plan (including an internal evidence matrix developed during evaluation design) to support appropriate coverage across the evaluation questions. Quantitative and qualitative data were analysed separately and then synthesised to support triangulation and evaluative judgement at the program, MRI, and system levels.

Process evaluation analysis

Analysis for the process evaluation focused on addressing KEQs 1 and 2, examining the effectiveness and efficiency of the Program's administration, delivery, reporting, and governance arrangements.

Quantitative data drawn from program and administrative sources were analysed using descriptive techniques to identify patterns and trends over time, including changes across funding rounds and variation by MRI characteristics where relevant. This included analysis of funding allocations and expenditure, application and assessment timelines, reporting requirements, and compliance.

Qualitative data from interviews and open-ended survey responses were analysed using thematic analysis. A structured coding framework aligned to the KEQs was applied to identify key themes, areas of convergence and divergence across stakeholder groups, and recurring strengths and challenges in program design and delivery.

Findings were triangulated to validate insights and inform evaluative judgement.

Outcome evaluation analysis

Outcome evaluation analysis focused on addressing KEQ 3, examining the extent to which the MRSP has achieved its intended objectives and contributed to intermediate and longer-term outcomes.

A contribution analysis approach was applied to assess the plausibility of the MRSP's role in observed outcomes. This involved examining the program logic in light of available evidence, considering whether expected outcomes occurred, and assessing alternative explanations or external influences.

Quantitative outcome data, where available, were analysed to identify trends over time and variation across MRIs or outcome domains. These analyses were supplemented by qualitative evidence from interviews, surveys, and case studies, which provided insight into how and why outcomes occurred, including stakeholder perspectives on what may have happened in the absence of MRSP funding.

Findings were synthesised across data sources into a narrative of the MRSP's contribution towards:

- Excellence in research (MRSP Objective 1)
- Excellence in health (MRSP Objective 1)
- Strengthened research infrastructure (MRSP Objective 2)
- Growth in workforce and research capacity (MRSP Objective 2)
- Facilitating research collaborations (MRSP Objective 2)
- Financial stability and resilience of MRIs (MRSP Objective 3).

Economic evaluation analysis

Economic evaluation analysis focused on addressing KEQ 4, examining the costs and benefits of the Program, and whether it represents value for the NSW HMR ecosystem and the people of NSW.

The outcomes and analysis methods used to conduct the economic evaluation are described here. Full details describing the economic evaluation methods are included in Appendix 2.

Outcomes considered in the economic evaluation

It would be expected that there would be multiple rounds of impact as a result of access to the MRSP. In economic parlance, these are referred to as 'direct' impacts to the MRIs and second round¹⁹, 'indirect' impacts to other stakeholders beyond the MRI, including the wider NSW workforce and innovation ecosystem, the NSW health system and the NSW economy.

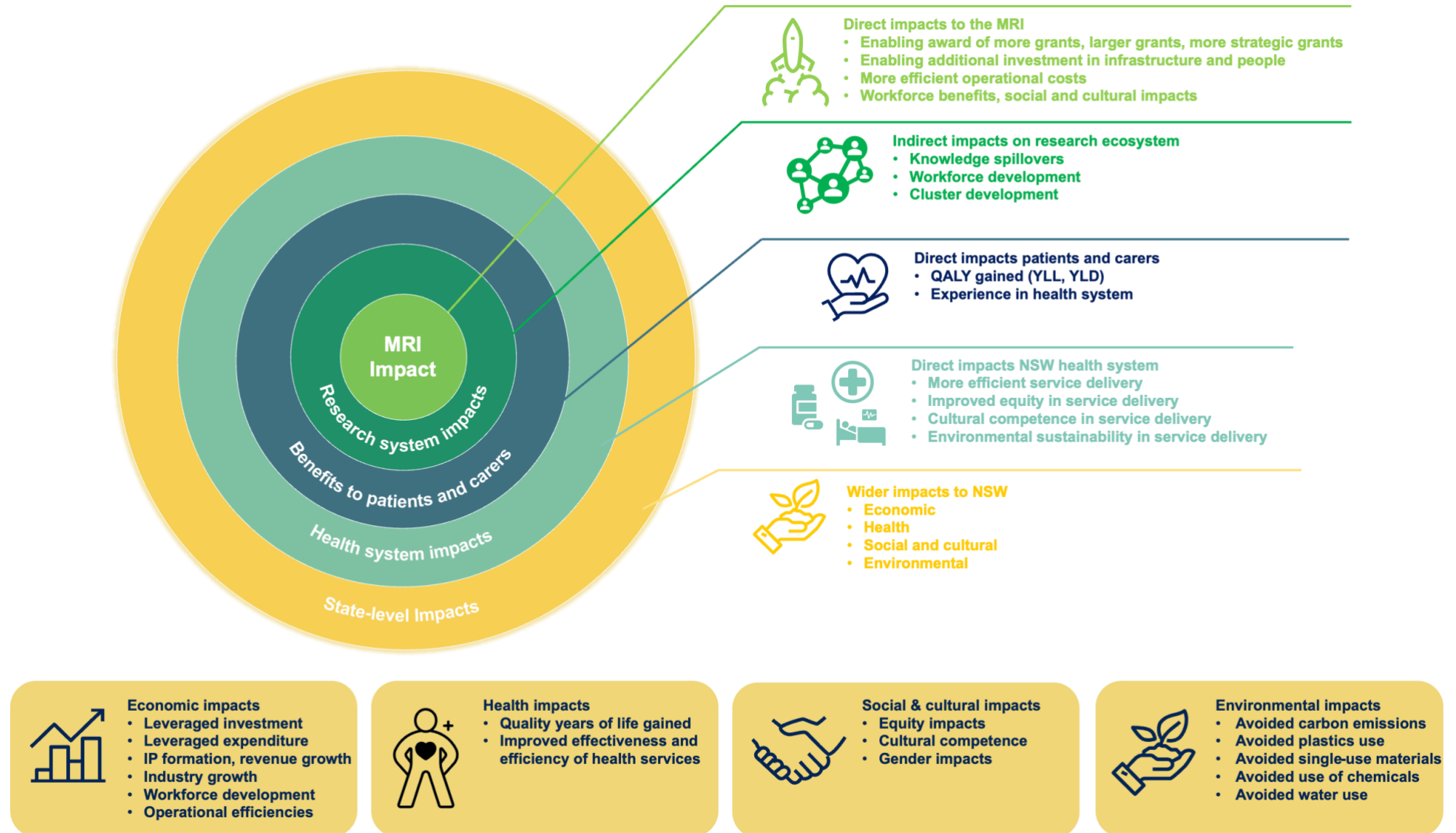
These different types of impacts are shown in Figure 4.

The direct impacts of the MRSP to the MRIs to be explored and quantified where possible are:

- Increase in grant awards from non-NSW funders arising from critical mass, excellence in research capabilities and increased funding predictability
- Increase in strategically significant research projects that may lead to second round investment, expenditure or industry growth
- Development of strategically significant infrastructure that attract future investment
- Avoided turnover of staff
- Increased operational efficiencies
- Increase in publications and citations, especially Tier 1 citations
- Increase in jobs and workforce development, especially for people from priority populations
- IP formation, including patents
- Revenues from IP generated by the MRI
- Change in environmental impact of MRI, either through the avoidance or increase in emissions, chemicals, water usage and/or plastics usage.

¹⁹ The use of 'second round' is economic parlance that refers to a sequence of economic impacts and is not referring to the MRSP funding rounds.

Figure 4. Economic, health, social, cultural and environmental impacts considered in this economic evaluation



Potential second round, indirect impacts to the knowledge ecosystem could include:

- Knowledge spillovers and innovation precinct development
- Growth in wider precinct enabled by research and improved access to infrastructure
- Upskilling of the workforce.

Improvements in health outcomes enabled by the additional research activity undertaken by MRIs that was attributable to the MRSP were also considered. A multi-step process was used to value these additional health outcomes (detailed in Appendix 2).

These bottom-up direct and indirect impacts were aggregated to identify impacts by stakeholder and by key impact dimension including economic, health, social, cultural and environmental impacts. These benefits were compared against the MRSP costs, including both the costs of administering the funds as well as the grant outlays, to determine the benefit-cost ratio and value for money.

Economic impact modelling

Data from the interviews, surveys and MRI-reported data were synthesised together, along with information gathered in the rapid literature and data review, into a summary of data and assumptions for the bottom-up economic impact modelling.

To cope with uncertainty, the economic impact modelling involved the development of three scenarios for impact: a 'central, expected case' as well as low and high impact scenarios.

The economic impact evaluation complied with all key methodological requirements as set out in the NSW Treasury CBA guidelines (TPG23-08), including the use of a social discount rate of 5% with sensitivities of 3% and 7%, the development of cash flows in real value terms, and sensitivity analysis for key variables. Details on the parameters used in the economic impact modelling are shown in the box.

Parameters used in economic impact modelling

- Reporting basis
 - Financial years
- Pricing
 - Real terms (\$2025)
 - Wage uplift (real wage price growth in wages above CPI – WPI)
 - Health services – real price growth above CPI (AIHW)
- Social discount rate
 - 5% (Central case)
 - 3% (Low case)
 - 7% (High case)
- Sensitivity analysis
 - Additionality effects (expected [central] low, high scenarios to be MRI specific)
 - Timing of benefits realisation
 - Attribution of health gains to medical research / MRIs
- Value of QALY gained
 - Taylor, C, 2017, Economic Evaluation <https://australianprescriber.tg.org.au/articles/economic-evaluation-of-medicines.html#r7>

Trend analysis

Trends in other funding support for MRIs was also evaluated, including trends in NSW's share of NHMRC funding and other funding support from the Independent Research Institute Infrastructure Support Scheme (IRIIS) and Research Support Program (RSP).

Ordinary Least Squares (OLS) regression analysis was undertaken to estimate the impact of MRSP funding on NSW Commonwealth grant revenue (NHMRC and MRFF). The analysis used NSW gross state

product (GSP), as well as other Government research support funding, to control for exogenous impacts to NSW grant revenue. Timeseries data of funding to NSW universities and MRIs through IRISS and RSP as part of higher education block grants were used to inform the estimate of other indirect research support funding in addition to the MRSP as enablers of grant funding (NHMRC and MRFF) outcomes.

Data from 2020 and 2021 were excluded from the analysis due to the presence of COVID and its outlier impact on research funding and GSP. Historic CPI was used to adjust all figures into \$2025, to ensure the impact of inflation is accounted for. Data were aggregated over four-year periods that align with the MRSP funding rounds. The total period of analysis was 2004 to 2023 (20 years; five rounds), which includes eight years (two rounds) of data prior to the introduction of the MRSP in 2012, which allowed for the model to account for a meaningful change in government baseline funding when calculating the impact on total NHMRC grant funding.

The OLS model specified the total funding granted to NSW-based institutions by NHMRC and MRFF as a function of MRSP funding, with NSW GSP and other research funding serving as covariates. Multiple potential regression specifications were considered; ultimately, log-log regression was found to be the best fit for the data ($R^2 = 0.95$, which indicates a very strong fit).

Qualitative impact analysis

Where key impacts could not be credibly quantified, case studies were developed to illustrate these impacts, for example:

- Impact of the MRSP for reducing turnover and supporting development of high-performance teams through retention of key roles
- Social impacts – Improved outcomes for priority populations
- Cultural impacts – Cultural competence in research or health services delivery
- Environmental impacts – Reducing footprint of research.

3.5 Limitations

As with any evaluation of a complex, long-running program, there are limitations that should be considered when interpreting the findings. These limitations do not invalidate the results, but they do shape the level of confidence and the way conclusions should be read.

- **Variation in documentation over time**
 - Program documentation, reporting requirements, and administrative systems have evolved across funding rounds. Earlier periods of the Program are characterised by less consistent or less detailed documentation, which limits the extent to which processes can be compared directly over time.
- **Reliance on retrospective accounts**
 - Some insights into program design, governance, and administration relied on stakeholder recollections of past processes. While these perspectives provide valuable context, they may be influenced by recall bias or by subsequent changes to the Program.

- **Time lags between investment and outcomes**
 - Many research, health, and system outcomes emerge over long time horizons. Outcomes associated with more recent funding rounds may not yet be fully realised or observable within the evaluation period, particularly for system- and state-level outcomes where benefits often accrue over many years. In some cases, stakeholders identified likely future impacts. However, as their realisation cannot yet be confirmed, these are not included in the evaluation as outcomes or impacts.
- **Data availability and consistency**
 - The availability, completeness, and consistency of outcome data vary across MRIs and over time, particularly for earlier funding rounds. Changing reporting requirements across periods of the Program and differences in reporting cycles (e.g. financial year versus calendar) have necessitated making assumptions so that data could be aggregated across MRIs. Gaps in data also existed, particularly in the targeted data requests to MRIs, as these data have not historically been collected and are not considered routine metrics. Systems to capture data have also changed over time, with data from earlier years of the Program not readily available across MRIs. These gaps limit the ability to quantify some outcomes consistently and necessitates greater reliance on qualitative evidence and synthesis. Quantitative analyses have been restricted to data that have been reported in a reasonably consistent format over time. Where data are incomplete but still contribute useful confirmatory information or validation, they are reported with the appropriate caveats particularly noting where data from MRIs is incomplete. Caveats around the quality of specific data points and/or sources are noted in the relevant sections of the findings.
- **Self-reported bias**
 - The outcome evaluation draws substantially on information reported by MRIs, which necessarily reflect the perspectives of organisations with a direct interest in the continuation of the program. To address this, the evaluation triangulates MRI-reported information from multiple data sources to identify convergence or divergence in findings. It also applies contribution analysis and evaluative judgement to assess the extent to which observed outcomes can reasonably be attributed to MRSP support.
- **Data gaps in early years of MRSP impacting economic analysis**
 - The estimate of benefits for earlier rounds of the MRSP appeared to be subject to significant uncertainty, with the impacts generally limited to estimates of uplift in funding for grant activity, while in later rounds the reporting became more detailed. As a result, the net benefits of the MRSP by round were estimated to improve through time as MRIs were able to more confidently estimate second round benefits through time. It is recommended that greater weight is given to the BCR outcomes in later rounds of the MRSP as there is higher confidence in the completeness of the reported data.

SECTION 2 – EVALUATION FINDINGS

How to read the evaluation findings

The following chapters present the key findings of the evaluation, organised by each evaluation component and its associated key evaluation question(s).

Evaluation component	Key evaluation questions (KEQs)
Process evaluation	KEQ1 - How effective and efficient are the Program's administration and delivery processes?
	KEQ2 - How effective are the Program's reporting, data collection, and impact metrics, and where are there gaps or opportunities for improvement?
Outcome evaluation	KEQ3 - To what extent has the Program achieved its intended objectives and delivered meaningful outcomes?
Economic evaluation	KEQ4 - What are the costs and benefits of the Program, and does it represent value for the NSW HMR ecosystem and the people of NSW?

Each Review question is addressed in the following structure:



Orientation

Lists the focus areas covered by the Review question.

Lists the data sources used to extract evidence to answer the question.



Summary of findings and evaluative judgement

Lists the key findings that are further elaborated upon in the detailed findings section.



Detailed findings by focus area

Provides a structured entry point for exploring a specific topic area relevant to the key evaluation question

Expands on key aspects of the focus area presenting detailed supporting evidence.

NB: For a brief overview of the evaluation findings, readers can focus on the first 2 sections of each chapter. These sections (around 1-2 pages per chapter) highlight the main take-away messages.

4. Process evaluation findings

4.1 KEQ1: How effective and efficient are the Program's administration and delivery processes?



Key Evaluation Question 1 – How effective and efficient are the Program's administration and delivery processes?

Scope

This evaluation question examines whether the design and operation of the MRSP's administration and delivery processes are fit for purpose (see below for summary of those processes and program inputs). It considers how well the Program's objectives are reflected in its architecture and eligibility settings, the efficiency and proportionality of the application and assessment processes, the clarity and timeliness of communication and decision-making, and the extent to which funding terms, conditions and financial flows support effective and efficient delivery.

Focus areas assessed in this process evaluation section are:

- 4.1.1 Program design
- 4.1.2 Application process
- 4.1.3 Grant awards processes
- 4.1.4 Governance and administration

Data sources used to answer this question

The primary data sources for this evaluation question were consultation data, survey data, grant administrative data and requested data from OHMR.



Key findings and evaluative judgement

1. The MRSP occupies a distinct and valued niche as an infrastructure and indirect-cost scheme that underpins, rather than duplicates, project-based funding and signals NSW's commitment to medical research. However, its role and public value are not yet clearly articulated within NSW Health's broader Research and Innovation Strategy.
2. The main finding of the process evaluation is that the MRSP's objectives and program design have not fully evolved to reflect contemporary research, funding and health system priorities. In particular, there is limited explicit recognition of health system integration or downstream benefits for people in NSW within the objectives and associated criteria. If Government requires the MRSP to drive translation, community impact, and alignment with NSW Health priorities, these need to be articulated more clearly in the program objectives and embedded in design of the program through eligibility criteria, funding allocation and reporting. Elements of the design that require most urgent attention are:
 - a. The objectives, which need to be updated to better align with the NSW Health Research and Innovation Strategy.
 - b. The eligibility criteria – particularly in the characterisation of what constitutes quality research at scale, and the operationalisation of independence – if they are to function as a clear and transparent gateway to MRSP support.
 - c. The funding allocation model, particularly the tier structure which most stakeholders regarded as unfair and an ineffective mechanism for allocating MRSP support. It was viewed as contributing to confusion, perceived inequities and misalignment with achieving outcomes related to sustainability, collaboration and translation, indicating that substantial reform of this element will be required if the design is to function as a coherent and efficient backbone for Program administration and delivery.
3. The flexibility and broad eligibility of MRSP expenditure are a core strength that enhances effectiveness at the MRI level, allowing institutes to target local indirect cost pressures. However, to fully realise the Program's intended contribution and demonstrate public value, this flexibility needs to be complemented by clearer positioning within NSW Health's Research and Innovation Strategy and a stronger (but still proportionate) line of sight between funding, use of funds and system outcomes.
4. The current governance and administrative arrangements are appropriate for a non-competitive, compliance-focused funding Program with clearly defined eligibility criteria, and are generally regarded as fair, efficient and reliable. However, if government wishes to use the MRSP more actively to drive excellence, sustainability, and impact, governance and resourcing arrangements would need to evolve, for example by strengthening analytical capacity, feedback loops and the strategic role of the assessment panel. In that way, current oversight can move beyond procedural compliance towards more deliberate performance and system stewardship, whilst also balancing MRI's independence in driving their own research and strategic direction.



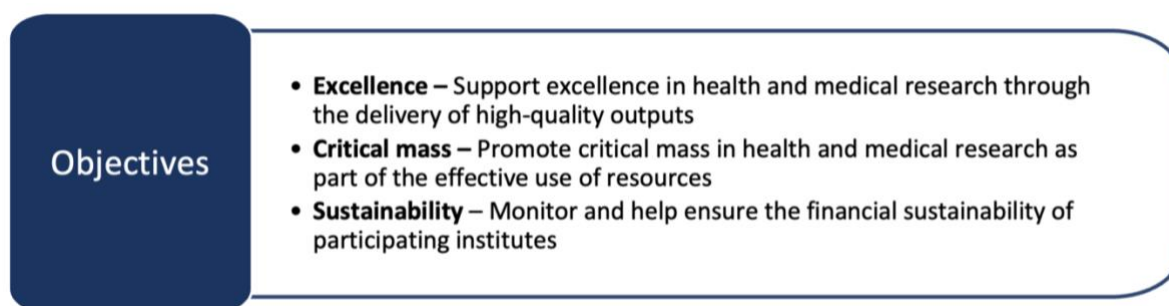
4.1.1 Program design

This section assesses whether the design of the MRSP is appropriate to achieving its stated objectives and to supporting effective and efficient administration and delivery. It focuses on how well the objectives are reflected in the Program’s architecture, the suitability of the eligibility framework, the operation of the tiered funding structure, the MRSP’s positioning within the broader funding landscape, and whether the funding model enables MRIs to use MRSP funds as intended.

Appropriateness of the objectives and alignment with design

Figure 5 provides an overview of the objectives of the Program.

Figure 5. Objectives of the MRSP



Overall, stakeholders generally supported the intent of the MRSP’s existing objectives but questioned whether they remained well aligned with the current research environment and the priorities of the NSW Government. A key message from all stakeholders was that the objectives required modernisation to reflect the current research and funding environment in Australia.

Participants across all stakeholder groups indicated that consideration should be given to expanding the objectives to include community benefit, research translation, and integration with NSW Health priorities. Many MRIs felt the program logic was overly complex and detached from the Program’s core purpose. They suggested that clearer, simpler objectives would allow the Program to demonstrate outcomes more effectively, and would help ensure alignment between strategy, delivery, and evaluation. Program administrators and advisors echoed these concerns about alignment of the Program’s objectives and elements of its design, particularly in the context of significant changes to the research and funding environment.

Findings in relation to each specific objective are

- In relation to **excellence**, the design provides strong indirect support but weak explicit direction. Flexible MRSP funding for indirect costs enabled agility, innovation and investment in platforms that underpin high-quality research, as well as the training and retention of the next generation of researchers, including clinicians. Stakeholders reported that this helped maintain a relatively vibrant MRI sector with world-class capability in specific fields that attracts talent to NSW, primarily through institute-by-institute allocation and decision-making rather than coordinated, sector-wide action. At the same time, the objectives and eligibility criteria do not clearly define

what “excellence” means, nor do they embed explicit expectations or incentives around collaboration, translation or research impact. In practice, excellence tended to be inferred from financial or activity metrics rather than the quality or impact of research outputs. While MRIs are also asked to provide case studies as examples of research excellence, the case studies provided rarely demonstrated a direct link from receipt of MRSP funding to outcomes. These factors limit the extent to which the design actively shapes the behaviours it seeks to promote.

- For **critical mass**, there was broad agreement across stakeholders that building critical mass is important for delivering world-class research. However, stakeholders expressed confusion about how the MRSP intended to achieve this. Some interpreted the objective as signalling an intention to encourage mergers or consolidation, yet judged that the current program design, including the tiered funding structure, have neither driven this outcome nor offered a coherent alternative (such as stronger incentives for shared capability or precinct-level infrastructure). Others questioned whether, within the existing funding envelope, the MRSP could realistically build critical mass without a more explicit focus on collaboration and partnerships.
- On the **sustainability** objective, all stakeholders consistently described MRSP funding as a ‘lifeline’ that covers indirect costs and core infrastructure that other revenue sources do not meet, allowing MRIs to remain operational and competitive. Several stakeholders questioned whether the current funding quantum and design are sufficient to deliver the broader ambition implied by ‘sustainability’, particularly given rising indirect research costs and an increasingly diverse grant landscape. Because the MRSP is focused on indirect costs without an explicit line of sight to research outcomes or community benefit, the sustainability objective is not clearly anchored in a longer-term strategy for system performance or public value.

Appropriateness of the eligibility criteria

Figure 6 provides an overview of the eligibility requirements to demonstrate eligibility for MRSP funding.

Figure 6. Eligibility criteria and requirements for MRSP funding

Eligibility criteria	1. Location	2. Purpose of organisation	3. Organisational independence	4. Conduct high-quality research at sufficient scale	5. Financial viability
Eligibility requirements	Must be located in NSW.	- Conducting health and medical research is the primary purpose of the organisation - Ineligible: organisations where research is a subsidiary function (e.g. pharmaceutical companies)	- Legal recognition as a discrete operational entity - Independent board or equivalent body - Organisational mechanisms to determine research direction and strategy - Identifiable infrastructure & organisational budgets, & control over how funds are spent - Intellectual property policy consistent with NHMRC's policy	- Average annual income from eligible competitive grants of ≥\$3 million over 2021-2023 - Nationally competitive grants from ARC, Cancer Australia, MRFF & NHMRC, awarded for health and medical research - Competitive grants must be advertised nationally and selected competitively by a qualified panel - Additional conditions on income declarations	- Liquidity ratio >1.0 - Low level of debt - Audited financial accounts required as evidence

These eligibility criteria function in place of traditional selection criteria. Currently, if an MRI is deemed eligible, it is funded, as this is a non-competitive scheme.

Interview and survey results were consistent in perceptions of the eligibility criteria (see Figure 7 for survey results). Stakeholders agreed that the current eligibility criteria were broadly appropriate, but that the definitions of several criteria were problematic and required revision. Across stakeholders, there was interest in exploring additional eligibility dimensions that reflect the Program's broader objectives. Many MRIs proposed inclusion of a criterion related to research impact and translation, recognising the challenge of measurement and long lead time to realising potential health impacts but arguing that it would better capture alignment with state priorities and the Program's intent to deliver value to NSW. Program administrators generally supported maintaining the existing framework but emphasised the need for clearer definitions, greater transparency, and periodic review of the eligibility criteria to ensure that they remain relevant to contemporary research and funding contexts.

Findings for each eligibility criterion are:

- **Criterion 1 - Located in NSW.** There was unanimous agreement across all stakeholder groups that the location criterion was appropriate and uncontentious, effectively ensuring that MRSP funds deliver benefit to NSW.
- **Criterion 2 - Purpose of the organisation is health and medical research.** All stakeholders unanimously supported the criterion requiring organisations to have a primary purpose of conducting health and medical research.
- **Criterion 3 - Organisational independence.** There was strong agreement among all stakeholders that independence remained a defining and valuable feature of the MRSP, reflecting a view that the MRSP should support stand-alone MRIs rather than LHD or university-embedded institutes. MRIs emphasised that this criterion protected the distinct role of independent MRIs relative to universities and other research entities, enabling them to remain agile, responsive, and mission driven.

Many acknowledged that independence was difficult to assess given the complex affiliations between MRIs, universities, and local health districts. Although assessing independence at the entity level had improved through refinement of the eligibility criteria, verifying grant ownership and staff attribution at the individual MRI level remained problematic (particularly for assessing eligibility Criteria 4).

- **Criterion 4 - Conduct of high-quality research at sufficient scale.** This was the most contentious eligibility criteria element among all stakeholders. To reduce the risk of very small, unviable institutes being eligible for funding, there was strong support for using competitive grant income as a pragmatic proxy for research scale and capability. Accordingly, there was support for maintaining a minimum income threshold (currently an average of \$3 million per year over 3 years).

However, stakeholders questioned:

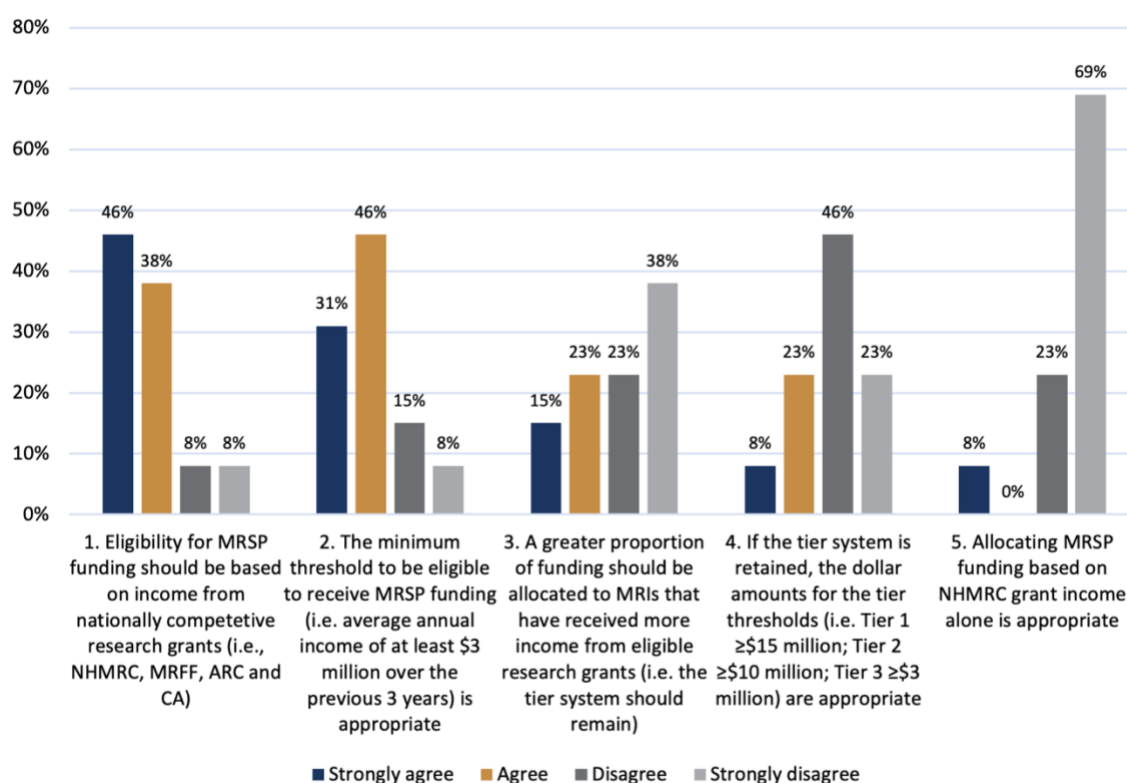
- The narrow set of eligible schemes and the centrality on NHMRC income. This approach was seen to disadvantage smaller or specialist MRIs whose strengths lie in disease-specific research, and reinforces a focus on income (inputs) rather than research quality, outcomes or collaboration. All MRIs queried why income from the four specified grant schemes was considered to determine eligibility and why other reputable grants representing research excellence were not considered. Some MRIs argued that eligibility

should be determined on all research grants, particularly HERDC Category 1 income²⁰ and prestigious international grants.

- The process for deciding which grants count towards eligibility as opaque. Stakeholders raised concerns about inconsistency and potential ‘gaming’ or double counting of grant income arising from challenges with attributing grants to institutions, potentially receiving MRSP funds as well as a portion of infrastructure funding via universities.

5. **Criterion 5 – Financial viability.** Stakeholders largely agreed that financial viability was a necessary and appropriate eligibility criterion, though several described its definition and specific metrics as too narrow and reactive. Currently, it confirms short-term solvency through indicators such as liquidity ratios and audited accounts, but does not systematically test longer-term resilience in the face of rising indirect research costs. External collaborators expressed concern that rising costs and thin reserves could unfairly penalise otherwise strong MRIs, especially smaller ones that remained strategically important to the system.

Figure 7. MRI perspectives on aspects of the eligibility criteria



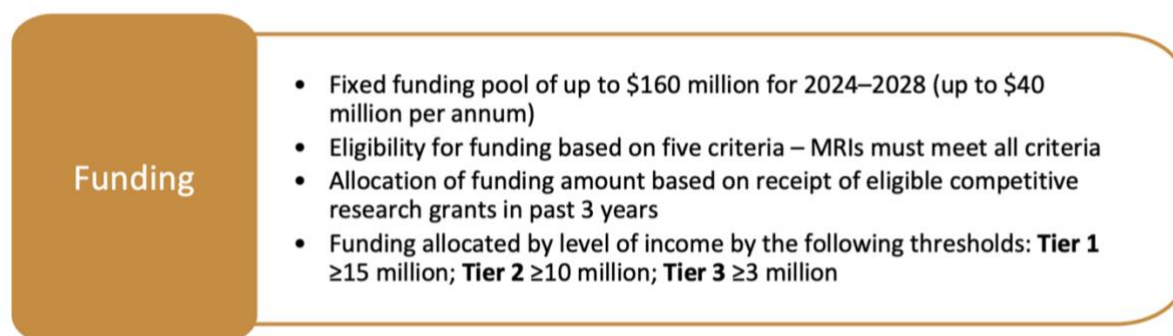
Data source: Director-level survey of currently funded MRSP MRIs

²⁰ Category 1 income refers to income received from programmes listed on the Australian Competitive Grants Register. The HERDC Category 1 grants are highly competitive and have a strong element of peer review.

Tiered funding allocation model

Figure 8 provides an overview of the funding allocation model of the MRSP.

Figure 8. Funding allocation model of the MRSP



Many stakeholders identified that the current tiered funding structure is the least appropriate element of Program design. The tiers were originally intended to reward excellence and build critical mass, but were widely perceived as rewarding size and historical NHMRC income rather than current performance, specialisation or contribution to NSW HMR ecosystem goals. The thresholds, particularly the jump from the \$3 million eligibility floor to the \$10 and \$15 million threshold for higher tiers, were perceived to create ‘cliff edges’ that many smaller and mid-sized MRIs regarded as unattainable, so the structure does not operate as a meaningful incentive to build capability. Some stakeholders considered that the tiers entrench advantage for large, established institutes and disadvantage smaller or specialist MRIs, with implications for equity and diversity across the sector.

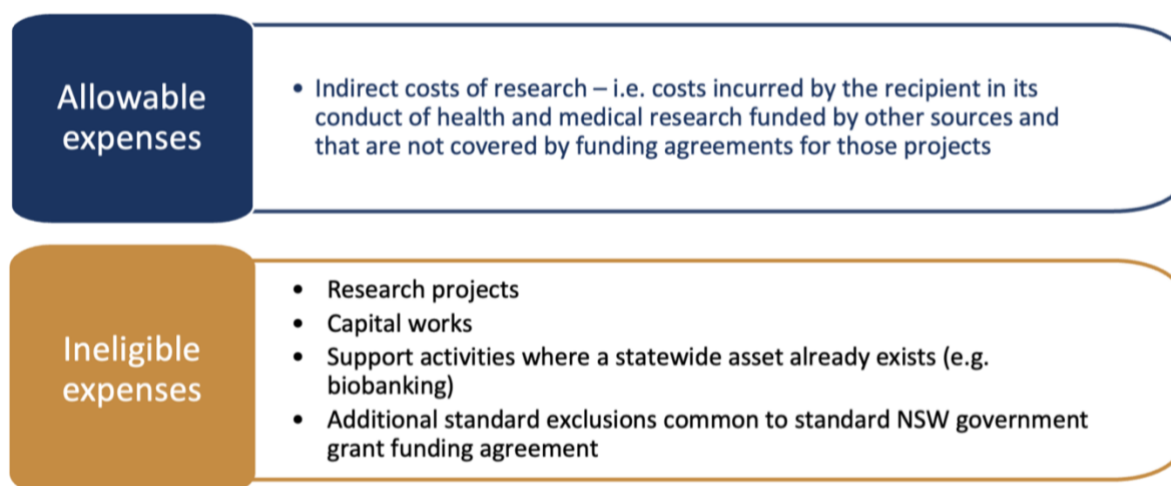
Stakeholders felt that the heavy reliance on NHMRC competitive grant income within the tier model is increasingly misaligned with contemporary funding patterns and with objectives related to translation. As MRFF and other competitive schemes have grown in importance, MRIs reported rising indirect cost pressures without commensurate MRSP support, because these grants contribute to eligibility but not to the allocation of funds across tiers. The focus on NHMRC competitive grant income for funding allocation was viewed as particularly counter-intuitive to any goal related to research translation, given NHMRC’s limited translational focus compared with other competitive funding schemes. Stakeholders described perverse incentives to prioritise NHMRC applications despite low success rates and better prospects elsewhere, competition over grant attribution, and reduced willingness to collaborate where this might dilute an MRI’s counted NHMRC income. Unsurprisingly, almost all surveyed MRI Directors rejected allocating MRSP funding on NHMRC income alone.

A minority of stakeholders, mainly from larger MRIs, argued that some differentiation in funding remains important to recognise disproportionate indirect cost gaps at high levels of activity and to sustain a small number of world-class MRIs. Some suggested that a modernised, performance-based tier model could still be appropriate if underpinned by more contemporary metrics (e.g. those measuring research translation and impact, such as indicators for the number of innovations commercialised and case studies of impact on policy and practice) and a broader view of excellence, collaboration and impact.

Allowable expenses and expenditure

Figure 9 provides an overview of the allowable and ineligible expenses of the MRSP.

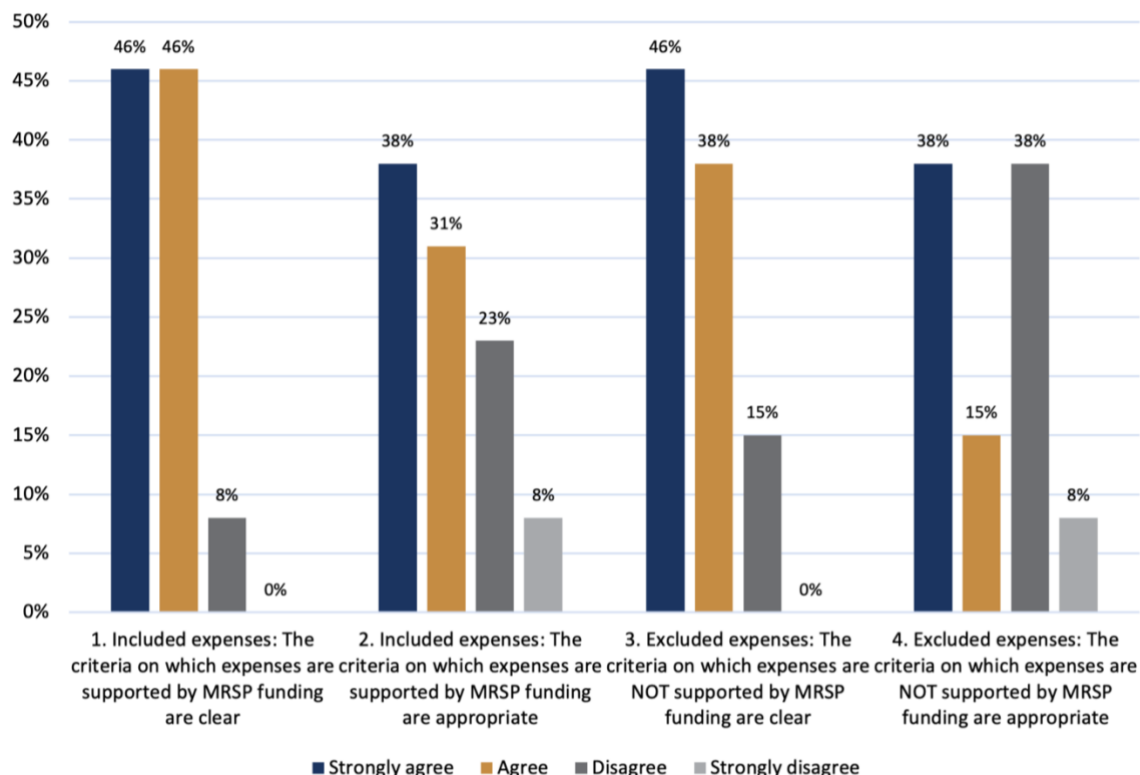
Figure 9. Allowable and ineligible MRSP expenses



Overall, stakeholders agreed that the allowable expenses framework was appropriate and fit for purpose, with its broad and flexible design regarded as one of the Program's greatest strengths. The ability to direct MRSP funding toward indirect and operational costs was seen as essential to sustaining MRI viability and supporting high-quality research. Administrators acknowledged the need for improved transparency and accountability to more clearly identify how MRSP funding was being spent, but cautioned against introducing restrictions that might compromise the flexibility that has made the Program effective and valued across the sector.

MRI leaders broadly understood the permitted uses of MRSP funding. Director-level survey results indicate that most respondents consider the criteria for expenses supported and not supported by MRSP funding to be clear, although views on the appropriateness of these criteria, particularly for excluded expenses, are more mixed (Figure 10). During interviews, some MRIs argued that some restrictions should be reconsidered, particularly the exclusion of certain capital works where it added to long-term research infrastructure, ongoing costs of accessing and using statewide assets like biobanking, and the use of funds for pilot or proof-of-concept research projects that could generate preliminary data to secure larger grants or collaborations.

Figure 10. Perceptions on MRSP expenses



Data source: Director-level survey of currently funded MRSP MRIs

The flexibility to apply MRSP funds across a wide range of indirect costs and shared infrastructure was viewed as critical to MRI sustainability. At the same time, some stakeholders observed that such flexibility makes it more difficult to systematically track how MRSP funds are expended and to link expenditure to performance. Several also considered that the current reporting and metrics framework provided limited assurance on compliance or accountability for how funds were used.

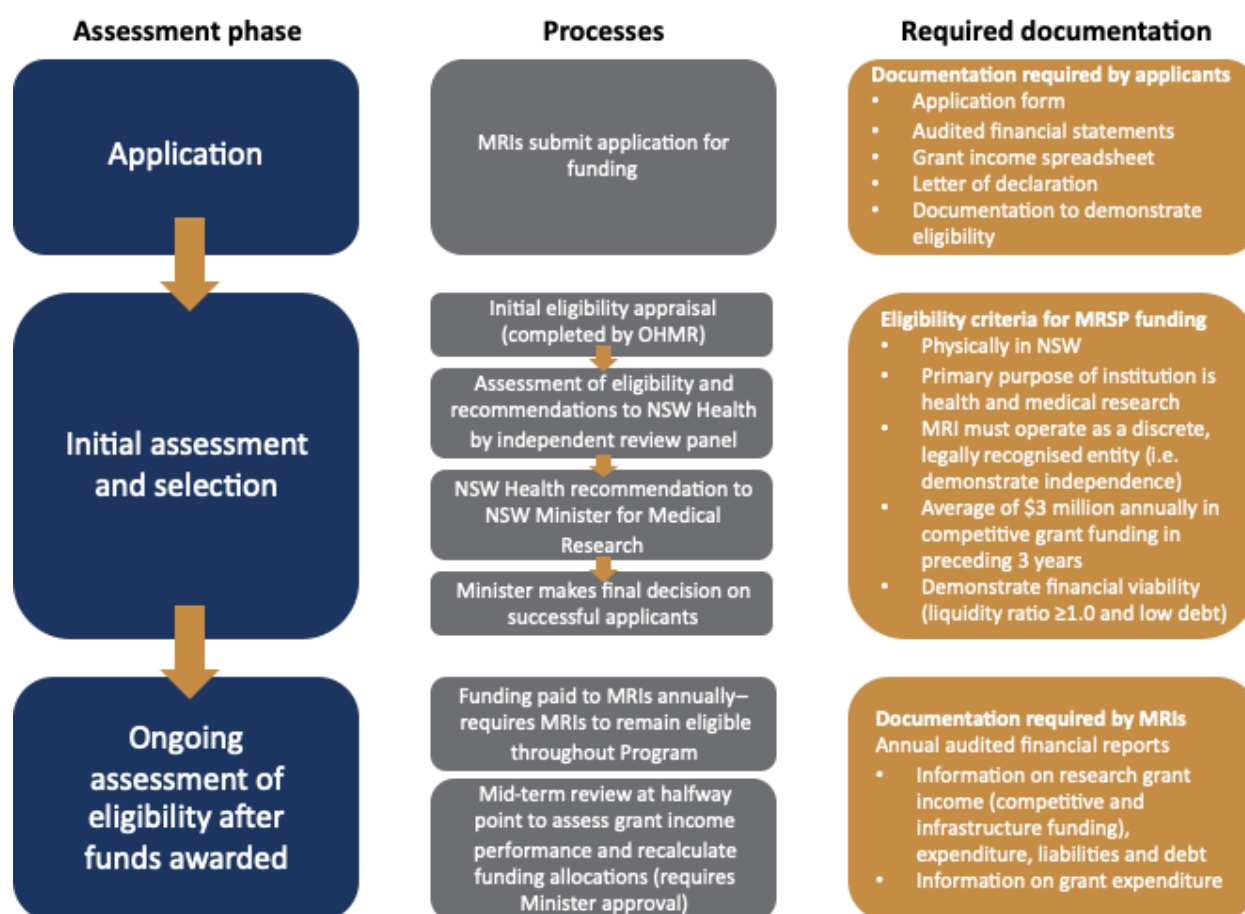


4.1.2 The Program's application process

This section assesses how efficiently the MRSP application process operates in practice, and the extent to which it supports timely, proportionate and administratively workable delivery of the Program. It focuses on the overall burden and navigability of the application, the suitability and operation of documentation and data requirements, and the timeliness of decision-making, contracting and transfer of funds.

Figure 11 provides an overview of the eligibility assessment process and requirements to demonstrate eligibility.

Figure 11. Flowchart illustrating process of assessing MRIs' eligibility for MRSP funding

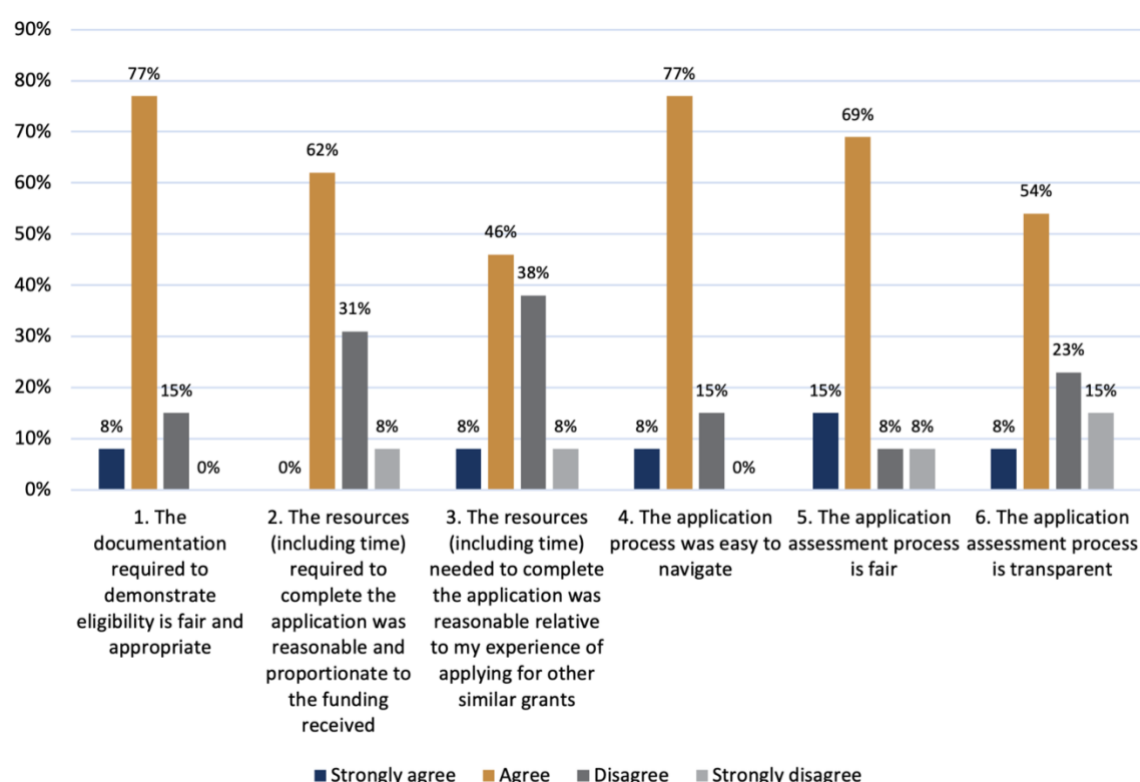


Application burden and process experience

Survey and interview data suggested that the MRSP application process is a substantial but generally accepted element of Program participation. Survey data showed that the majority of MRIs (54%, n=7/13) required more than two weeks to prepare an application, while most others (38%, n=5/13) required one to two weeks from start to completion. Applications usually involved multiple staff across executive leadership, research and grants management, finance and administrative roles, **with a median of 8 staff (range: 2 to 25 people) contributing to a median of 85 hours of work (range: 12 to 600 hours²¹) per MRI**. This indicates that the MRSP application functions as a major periodic task occurring each application cycle (i.e. every four years) rather than a light-touch administrative exercise.

Most survey respondents agreed that the documentation required to demonstrate eligibility is fair and appropriate, and that the application process is easy to navigate. A majority also judged the overall burden to be reasonable relative to the funding received and comparable to other grant processes (Figure 12). However, a sizeable minority considered the burden excessive and almost half (46%, n=6/13) disagreed that the resources needed were reasonable relative to their experience of applying for other similar grants, indicating that experiences of the application process are uneven across MRIs.

Figure 12. MRI perspectives on the application process



Data source: Grant administration-level survey of currently funded MRSP MRIs

²¹ The MRI that estimated 600 hours spent on the MRSP application was noted to be an outlier; all other MRIs provided values <300.

Survey and interview data helped to explain these mixed views. MRIs considered that it was reasonable to provide evidence of organisational independence, research scale and financial viability. Notwithstanding the generally positive perceptions, the key pressure points identified were demonstrating independence and populating the grant-income spreadsheet manually. In the absence of clear guidance on the type and level of evidence required, some MRIs reported submitting extensive governance and workforce documentation, while OHMR staff described validating grant ownership and the status of researchers with multiple affiliations as administratively intensive. These issues were compounded where data fields were not aligned with institutional systems and some information was collected only for the MRSP (e.g., information not routinely collected by MRIs such as broad research area, field of research codes and classifications of collaborative grants), increasing the opportunity cost of staff time.

Overall, the current approach achieves its eligibility objectives but is more resource-intensive than necessary, with scope to tighten guidance, focus data collection on information critical to eligibility and allocation, and modernise the tools used to capture it.

Breakout box 1 summarises concrete options identified through the evaluation, including digitisation of the application, integration with existing grant data sources and rationalisation of spreadsheet content.

Breakout box 1. Suggestions for improving the application process²²

Several respondents suggested enhancements to the communication and submission systems that, while broader than the scope of this process evaluation, may support clearer and more efficient interaction between OHMR and MRIs. These included:

- introducing an online “smart form” with built-in logic, validation rules and pre-populated organisational data to reduce back-and-forth clarification
- providing a single upload portal with a summary view and checklist at lodgement
- committing to an indicative timetable for future rounds and annual reporting templates, and communicating proactively where delays are anticipated.

Data source: Grant administration-level survey of currently funded MRSP MRIs

Timeliness of decision-making and funding

Divergent patterns were found for timeliness of decision-making and funding: front-end assessment has lengthened over time, while post-decision processes have become more efficient, leaving the overall time from the application deadline to first payment largely unchanged. Administrative timelines indicated that time from application deadline to notification of decision has increased from around 8 weeks in 2012–2016 to around 20–21 weeks in the 2 most recent rounds, and this extended assessment period is now the main driver of total elapsed time between submission and first payment. The increase likely reflects the combined effect of assessing the increased evidence required to demonstrate eligibility, more structured assessment and the complexity of validating institutional arrangements and declared grant income. In contrast, contracting and payment processes in recent rounds were relatively streamlined, with most MRIs finalising agreements and receiving first payments within 4 to 6 weeks of

²² While this process evaluation looks retrospectively at the Program, several suggestions raised by MRIs have prospective relevance. The following comments may warrant consideration as part of the forthcoming Review of the MRSP, which will take a broader and more forward-looking view of program design and future rounds.

notification, and longer intervals largely confined to cases involving contract negotiations. Overall, the end-to-end process from application deadline to first payment spanned six to seven months in the most recent round of the Program, with efficiency gains in contracting and payment offset by a lengthened pre-decision assessment phase.

Table 3. Median times for key outcome notifications for the MRSP application

Funding round	Median time from application deadline to notification of decision	Median time from notification to funding agreement	Median time from funding agreement to first payment	Approx. median total time from application deadline to first payment	Notes / data limitations
2012–2016	53 days (~8 weeks)	59 days (~8 weeks)	Not available	Not available	Some funding agreement dates fall in 2014 (likely variations), which slightly elevate the median. No consistent data on first payment dates.
2016–2020	70 days (~10 weeks)	65 days (~9 weeks)	41 days (~6 weeks)	176 days (~25 weeks, ~6 months)	Excludes unsuccessful MRIs. Funding agreements generally signed within 1–3 months of decision, with payments following 3–10 weeks later.
2020–2024	147 days (~21 weeks)	63 days (~9 weeks)	11 days (~2 weeks)	221 days (~32 weeks, ~7 months)	One MRI had a missing agreement date; total time to first payment is calculated from application deadline to first payment date.
2024–2028	142 days (~20 weeks)	6 days (~1 week)	14 days (~2 weeks)	181 days (~26 weeks, ~6 months)	Includes some longer notification–agreement intervals due to contract negotiations, but most MRIs finalised agreements and received first payments within 4–6 weeks of notification.

Data source: Program administrative data



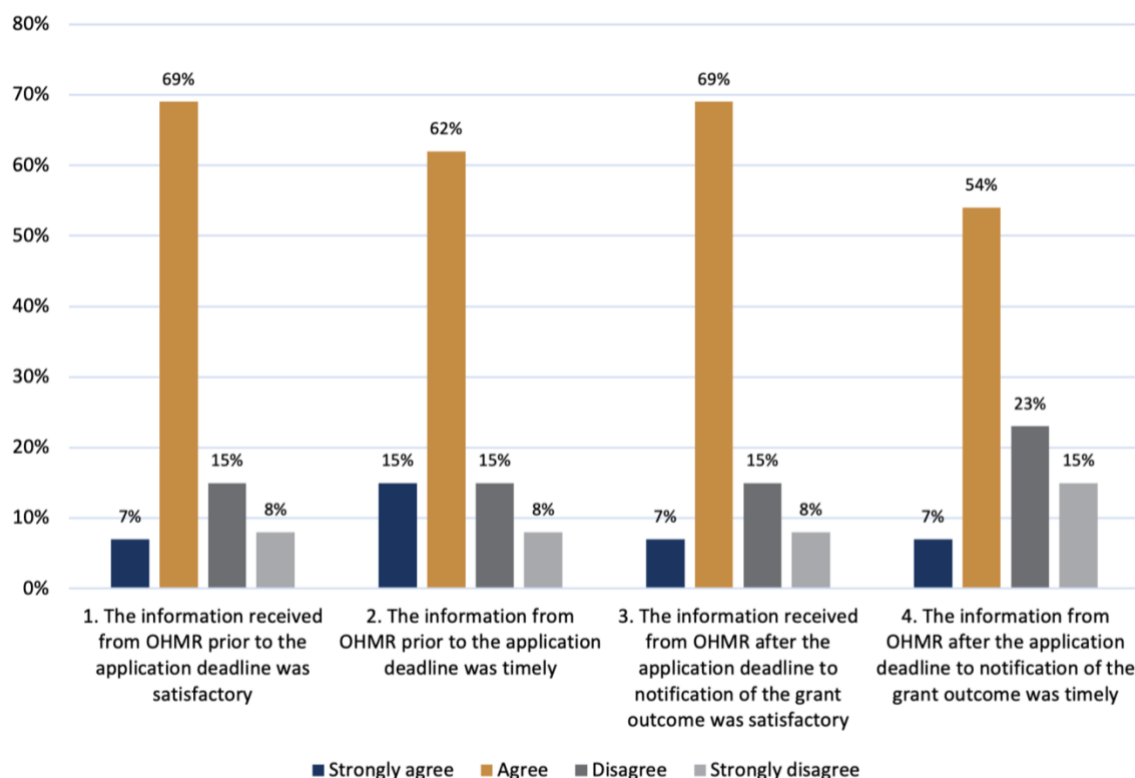
4.1.3 Grant awards processes

This section assesses whether the processes associated with awarding the MRSP grants support effective and efficient administration and delivery. It focuses on how OHMR communicates decisions and expectations to MRIs around the time of award, and on whether the specificity of the terms and conditions of funding is appropriate to the Program’s intent, planning needs and accountability requirements.

Communication processes and funding terms

Communication processes between OHMR and MRIs were generally considered functional and satisfactory but with some criticisms around timeliness of funding decision notifications and changes to reporting requirements. Grant administrator survey data showed that most MRIs rated information provided before and after the application deadline, and the timing of this communication, as satisfactory, although a sizeable minority considered communication between submission and notification of outcomes to be untimely (Figure 13). Qualitative feedback from MRIs pointed to long and uncertain lead times in the 2024–28 round, limited advance information about assessment timelines, and delays and year-to-year changes in annual reporting templates, particularly when rounds commenced mid-financial year. Funded MRIs noted that confirmation of eligibility and funding quantum often arrived too close to award to support proactive financial management, thus affecting MRIs’ budgeting and planning. There were divergent views on communication regarding decisions not to fund an MRI. MRSP administrators indicated that they engaged in dialogue with MRIs and provided clear reasons for why an MRI was ineligible for funding. However, intermittently funded MRIs reported that non-funding decisions were abrupt and lacked explanation. At the same time, day-to-day interactions with OHMR staff were consistently described as positive, suggesting that the main limitations relate to the design and systematisation of communication processes rather than staff capability.

Figure 13. MRI perspectives on communications with OHMR



Data source: Grant administration-level survey of currently funded MRSP MRIs

The terms and conditions governing allowable MRSP expenditure were broadly viewed as appropriate and aligned with the intent to support indirect costs. MRIs valued the MRSP as one of the few funding streams that reliably supports indirect costs and core infrastructure, and generally endorsed broad eligibility criteria supplemented by a clear list of ineligible items, as this allows funds to be directed to local cost pressures. MRIs nonetheless raised concerns about specific exclusions, including some infrastructure-related expenses (such as upkeep costs of buildings that may be excluded as capital expenses) and ongoing costs for statewide assets such as biobanks. While all stakeholders agreed that excluding direct costs of research as an allowable expense is appropriate, some MRIs queried whether spending a small proportion of funds on pilot projects, which may then lead to greater success in acquiring larger grants, could be permitted. However, stakeholders, especially MRSP administrators and advisors, observed that broad criteria make it harder to track how funds are used and to link expenditure patterns to performance within relatively light assurance processes.

Overall, the level of specificity in the funding rules appears well calibrated for a flexible, infrastructure-style Program, but there is scope to clarify a small number of contested restrictions on allowable expenses and to strengthen the alignment between allowable expenditure, compliance processes and performance monitoring without eroding flexibility.



4.1.4 Governance and administration

Governance focus and use of external expertise

The MRSP governance and administrative structures are technically sound and low-risk, but heavily oriented towards procedural assurance. Internal processes for eligibility assessment and decision-making are clear, and the criterion-based, formula-driven allocation model is viewed as simple, predictable and fair.

At the same time, governance is not yet operating as a mechanism for differentiated performance oversight or strategic guidance. Advisors to the Program largely experienced eligibility assessment as a “tick-box” process that confirms compliance but does not distinguish between stronger and weaker performers or draws on the independent panel expertise to inform broader judgements about contribution to Program objectives. Multiple stakeholders, including some MRIs, advocated for including an assessment of MRIs’ performance or contribution to the HMR ecosystem and broader health system during the eligibility assessment process, with reflection on what funded MRIs achieved in the preceding funding cycle. This would allow better judgement of whether the MRSP’s objective of research excellence is being achieved.

Interviewed stakeholders also indicated gaps in feedback and transparency of the assessment process particularly in relation to achievement of desired goals. There was limited structured feedback to the assessment panel or MRIs on what reporting data showed about Program outcomes, trends across the sector, or how the MRSP was contributing to NSW Health research and innovation goals. Public-facing reporting on aggregated outcomes was similarly limited, and there were few formal mechanisms for periodic stocktake of performance relative to desired outcomes or governance review.

Resourcing and workforce to administer the MRSP

The MRSP is administered by OHMR through a lean but clearly defined staffing model namely:

- OHMR data show that a small core team – a Director-level role (Infrastructure and Strategic Investment / Finance, Infrastructure & Performance) at around 0.1 FTE and a Principal Project Officer (Infrastructure) at 0.4–0.6 FTE – carried primary responsibility across 2022–2025, and a Senior Policy Officer (0.7 FTE) in prior years.
- Short, intensive contributions from staffing across business operations, policy and evaluation, legal and executive leadership were added at key points in the cycle (for example, application rounds, eligibility and income verification, mid-term review, contracting). When converted to annualised effort, total OHMR workforce requirements were estimated at around 0.6 FTE in a steady-state year, up to around 0.8–0.9 FTE in years with a new round, and around 1.3 FTE in the mid-term review year.

- OHMR also invested in external financial review. Between 2022 and 2025, O’Connell Financial Services was engaged annually to review MRI financial performance and reports, provide due diligence on new MRIs, and review multi-year data.

Using 2025 NSW Health “thereafter” award rates²³ and with the contract with O’Connell Financial Services, this equated to an estimated total running cost of around \$185,000 per annum in a routine year and around \$280,000 in a more intensive year.

Evidence from consultations indicated that the MRSP was generally perceived as lower-than-average effort to administer compared with other NSW Health grants. It is worth noting that resources were more tightly constrained for functions beyond core administration. There was limited capacity for activities such as more detailed performance analysis, systematic audit and follow-up on outcomes, or enhanced feedback to MRIs and the assessment panel. In practice, this kept administration focused on ensuring compliance with rules, rather than enabling more active performance management or system-level assessment.

Overall, resourcing is judged to be adequate for operating the current formula-based funding scheme with a small number of recipients. However, it is not configured to support an expanded role for the MRSP in strategic oversight or sector development without either additional investment or re-prioritisation.

²³ This does not include on-costs. Roles were costed using 2025 ‘thereafter’ package rates mapped as follows: Project Officer = Grade 7/8, Senior Policy Officer = Grade 9/10, Manager / Principal Project Officer = Grade 11/12.

Director time was costed using a mid-point of the PSSE1 range (\$208,400–\$297,250); Executive Director time was costed using a mid-point of the PSSE2 range (\$316,810–\$354,229).

Figures are indicative and intended to show order of magnitude rather than precise budget estimates.

4.2 KEQ2: How effective are the Program's reporting, data collection, and impact metrics, and where are there gaps or opportunities for improvement?



Key Evaluation Question 2 – How effective are the Program's reporting, data collection, and impact metrics, and where are there gaps or opportunities for improvement?

Scope

This evaluation question section examines how fit-for-purpose the MRSP reporting requirements and metrics are. It considers the extent to which the current metric set meets the information needs of OHMR, government and MRIs; MRIs' ability to account for how MRSP funds are used; burden and timeliness of reporting.

Data sources used to answer this question

The primary data sources for this evaluation question were consultation data, survey data, grant administrative data and requested data from OHMR.



Key findings and evaluative judgement

1. Reporting was often described by MRIs as "voluminous but not illuminating". Data were appropriately collected to demonstrate MRIs' ongoing eligibility to receive funding and compliance with funding conditions, which is necessary to administer the Program. However, a large share of required metrics were seen as difficult for MRIs to compile and of low value to assess outcomes (e.g. detailed publication, collaborator and bespoke financial fields), while key domains such as translation, impact, commercialisation and broader system benefit were not consistently well captured.
2. There is a clear opportunity to rationalise and co-design a streamlined, outcomes-focused metrics framework, aligned with Program objectives and existing MRI data systems, so that reporting supports learning and strategic decision-making alongside compliance and accountability requirements.
3. Overall, the current MRSP metrics framework meets core accountability and transparency requirements and provides reassurance that these funds are being allocated and expended appropriately. However, it is less well suited to supporting performance learning and system-level insight and to assessing the extent to which the Program is delivering value to the health system and people of NSW. The evaluative judgement is not that reporting is unnecessary, but that the balance between compliance-focused data and outcome-oriented, decision-useful metrics is misaligned with Program objectives and imposes avoidable burden on MRIs.



4.2.1 The suitability, usefulness and use of the Program's metrics

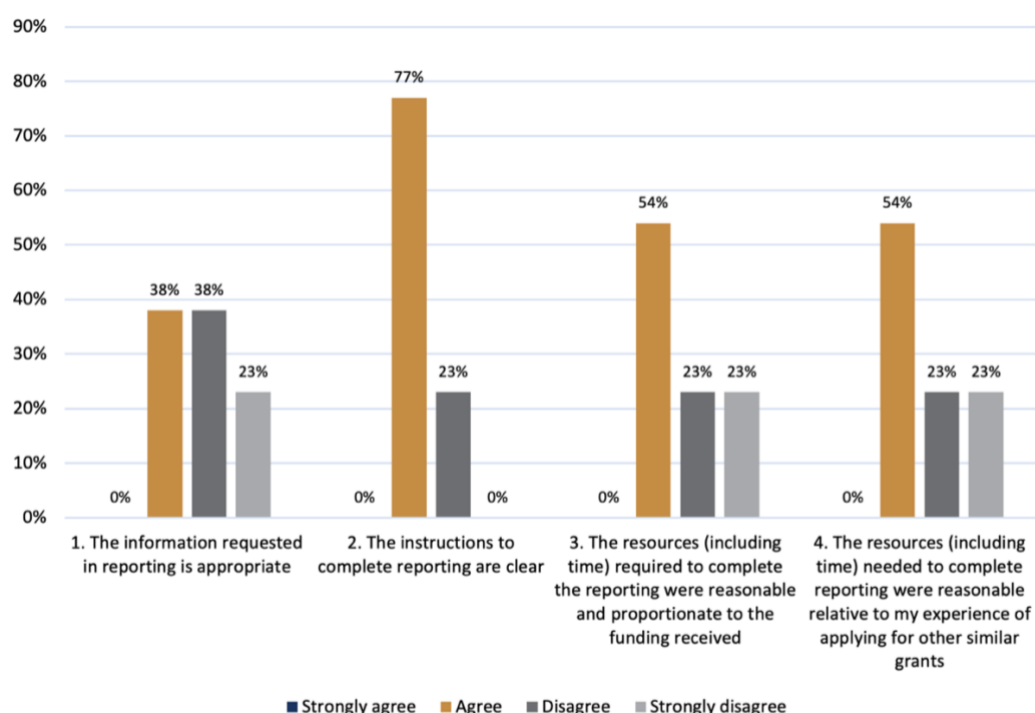
This section assesses whether the MRSP metrics and reporting are suitable and useful for their intended purposes, and how they are used in practice. It focuses on 4 aspects: the burden of reporting; the extent to which MRIs can report on how funds are spent; the timeliness of reporting; and the alignment of metrics with system-level information needs.

Alignment of metrics with system-level information needs

Evidence from all data sources suggested that the current MRSP metrics support the administration of the Program, but were less useful for performance assessment and improvement. Program administrators and advisors emphasised the role of reporting in supporting accountability, ensuring transparency and compliance with NSW government grant administration guidelines, and demonstrating value for money for public funds. However, current metrics were not well aligned with information needs to assess achievement of outcomes that map against the Program's objectives. MRIs in particular viewed reporting as a compliance exercise that lacked feedback loops that enabled system learning. Members of the assessment panel also noted that much of the information submitted during reporting was not considered in subsequent assessments of eligibility for funding.

Survey results (Figure 14) showed a consistent pattern: respondents were positive about the clarity of instructions but were much less likely to agree that the information requested is appropriate or that the resources required were reasonable, either relative to the funding received or to similar grants.

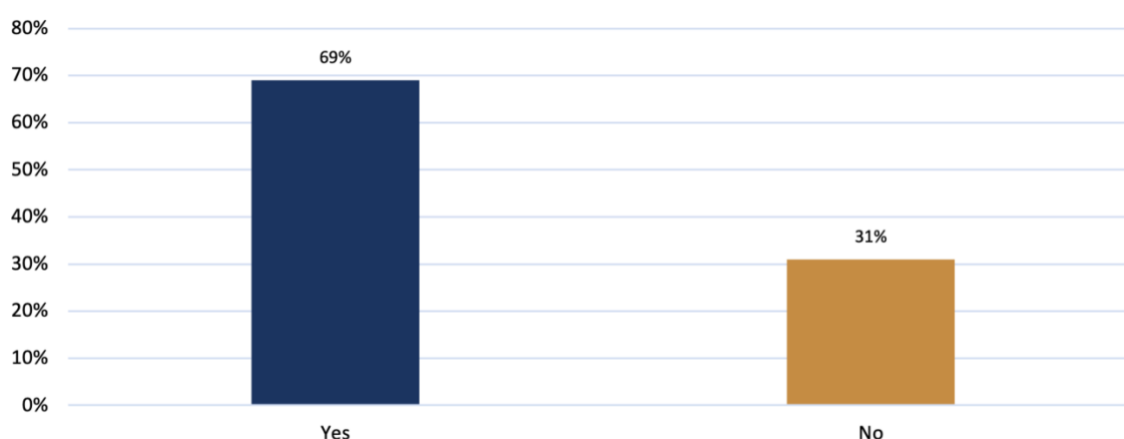
Figure 14. MRI grant administration staff views on clarity, appropriateness and proportionality of MRSP reporting



Data source: Grant administration-level survey of currently funded MRSP MRIs

In parallel, around two-thirds of MRIs indicated that some required metrics were challenging for them to report (Figure 15). Taken together, these results suggest that the core issue lies mostly with what is collected, rather than how reporting is administered.

Figure 15. Proportion of MRIs identifying at least one ‘challenging to report’ metric



Data source: Grant administration-level survey of currently funded MRSP MRIs

Qualitative evidence pointed to specific weaknesses in the current metric set. The evaluation heard repeated concerns about highly detailed but low-value elements, such as publication-level fields (including multiple author-location and policy-citation indicators), long collaborator and partner lists,

bespoke grant income and expenditure splits, and staffing categories that do not match MRI systems. These items were often manually compiled and were not required for other routine reporting. Breakout box 2 summarises the most frequently cited ‘challenging to report’ metrics and the reasons they were perceived as adding little value.

Breakout box 2. Challenging to report metrics per the MRIs²⁴

- **Publication-level data**
Respondents described the publication requirements as highly detailed and labour-intensive. Examples included needing to manually handle hundreds of outputs, add full citations, and complete multiple yes/no fields (e.g. author location, policy citation) that cannot be extracted from standard publication systems. Several MRIs questioned the purpose of this level of detail and suggested that simpler citation-level reporting would be sufficient.
- **Grant income and success metrics**
MRIs viewed the grant income reporting template as cumbersome, with macros and rigid formatting that prevented direct export from grants management systems. Some fields (such as Broad Research Area, Fields of Research Codes, links to workplace agreements, percentage infrastructure support and collaborative status) are not routinely captured, requiring manual work. They also described providing individual evidence of grant success as unrealistic, given that NHMRC and MRFF publish their data, and were unclear of the additional value of providing these data.
- **Financial splits and bespoke classifications**
Several MRIs reported that income by funding stream, the split of operating expenses and expenditure by domain are not recorded in this way for audit or management purposes. Producing these figures involved manual re-classification and, at times, estimation. MRIs acknowledged the need for government to ensure compliance and appropriate use of funds, but described the O’Connell financial spreadsheet and other bespoke classifications as lacking alignment with how MRIs structure their financial data.
- **Staffing and personnel data**
Requests for detailed staffing information, including conjoint appointments and specific MRSP role categories, did not map neatly onto MRI salary structures. Respondents noted that they had to interpret or “guess” where staff fit, and then keep internal records to ensure consistency between reporting rounds, raising concerns about comparability across institutes.
- **Collaborations and partner lists**
Listing all commercial and non-commercial partners, with multiple data fields for each, was reported as particularly time-consuming for MRIs with large numbers of partners. Some institutes noted that their systems did not hold the requested fields, requiring row-by-row manual entry, and questioned whether the benefit of this information justifies the effort.
- **Case studies and policy/practice impact questions**
Some MRIs commented that case study requirements and policy/practice questions did not align well with how MRSP funds are used (i.e. support for infrastructure and enabling functions rather than discrete projects) or with how they usually communicate outcomes to donors and the public. There was uncertainty about how useful the current formats are for government and whether the time invested in tailoring responses was warranted.

Data source: Grant administration-level survey of currently funded MRSP MRIs

²⁴ While this process evaluation looks retrospectively at the Program, several suggestions raised by MRIs have prospective relevance. The following comments may warrant consideration as part of the forthcoming Review of the MRSP, which will take a broader and more forward-looking view of program design and future rounds.

Many MRIs also reported limited visibility and feedback on how metrics are used. MRIs reported that they do not have a clear line of sight to the indicators that matter most to OHMR and Treasury, or to how their own data compared with peers. Other stakeholders also characterised the current dataset as heavily focused on inputs and activity and “voluminous but not illuminating” in relation to outcomes, translation or system benefit. From a Government perspective, however, the reported data did provide assurance on scale, coverage and baseline activity, even as opportunities remain to streamline low-value elements and strengthen outcome-focused insight.

At the same time, breakout box 3 identifies several domains that are important but not well captured by existing metrics as suggested by stakeholders.

Breakout box 3. Enhancements to metrics suggested by MRIs¹⁷

• Alignment with the MRSP program logic ▪ Collect data that maps directly to the program logic (e.g. formal affiliations, network/precinct membership and activity), rather than requiring extensive reporting that is not clearly linked to stated outcomes. • Research translation and impact ▪ Introduce metrics that capture real-world change in policy and practice, pathways to impact and clearer impact narratives, rather than relying predominantly on free-text statements. ▪ Track where research activity (i.e. the MRI’s bodies of work) sits on the research translation pathway and how these shifts over time (e.g. movement from basic/early translational research towards later-stage translation). • Commercialisation and innovation ▪ Include well-established commercialisation indicators such as commercialisation grants, deals, investments and revenue, patents, licences, options and assignments, spin-outs/start-ups and related commercial entities. • Health and research impact metrics ▪ Develop more quantitative measures of health and research impact (beyond narrative statements) that can be tracked over time and that reflect the diversity of medical research conducted in NSW, including basic and early translational research.

Data source: Grant administration-level survey of currently funded MRSP MRIs

On balance, the present metrics framework appears to generate substantial reporting effort without consistently producing clear, actionable impact insights for stakeholders. There was strong support from all stakeholders for rationalising low-value metrics and co-designing a streamlined outcomes and metrics framework that is explicitly aligned with Program objectives and allows MRIs to integrate these requirements within their existing data systems.

Ability to account for and report how funds are spent

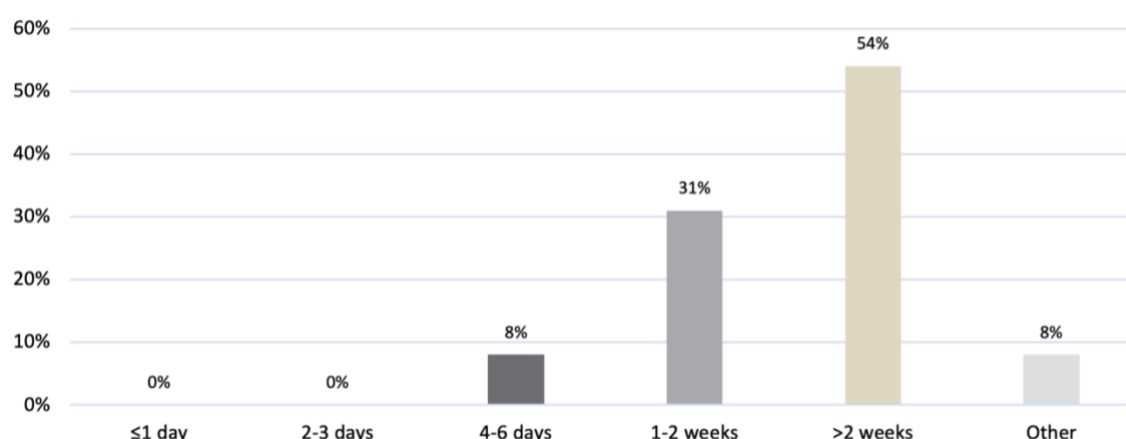
There was limited direct evidence on MRIs' technical ability to report how MRSP funds were spent, reflecting the trade-off between flexibility and traceability. The evaluation did not directly examine MRIs' internal financial systems, so this could only be partially addressed. The available data suggested that while rules on how funds could be expended were understood by MRIs, the current metrics do not provide a strong, structured mechanism for reporting expenditure against those rules.

Analysis of the administrative data found that the core MRSP funding model (i.e., block allocations to eligible MRIs with flexibility over how funds are applied within agreed parameters) was operating as intended²⁵. Analysis of OHMR administrative data and MRI financial reports from 2020 onwards showed strong alignment between the MRSP funds allocated, the MRSP revenue recognised in MRI accounts, and the amounts reported as expended. For the 2020–24 funding round, most MRIs reported MRSP revenue that closely matched OHMR's record of allocations, and acquittal statements indicated that these funds were subsequently expended. Where data are available for the early years of the 2024–28 round, the emerging pattern was similar.

Burden and timeliness of MRI reporting

Survey findings suggest that the MRSP reporting was a substantial and multi-week task for most MRIs. As shown in Figure 16, no respondents reported completing the annual report in 3 days or less; most indicated that it took more than a week from commencement to submission, with around half indicating more than 2 weeks. Responses for the midterm report followed a similar pattern, suggesting that both reporting points were experienced as sustained pieces of work rather than discrete administrative tasks.

Figure 16. Annual reporting time



Data source: Grant administration-level survey of currently funded MRSP MRIs

²⁵ Minor discrepancies between OHMR allocation records, MRI-reported MRSP revenue and expended funds were small in magnitude and can plausibly be attributed to differences in accounting practice rather than to flaws in Program design. Examples included rounding differences, variations in reporting periods (financial versus calendar year) and instances where MRSP was captured within broader research cost centres rather than as a discrete line item. There was no evidence of systematic under-expenditure or accumulation of large unspent balances.

Using OHMR administrative data, MRI reporting was nevertheless generally timely, while OHMR has also taken steps over time to provide longer lead times for completion. For the 2022–2024 reporting years, all MRIs submitted annual reports. Where reports were submitted after the due date, delays were typically on the order of days to a few weeks rather than months, and often followed an agreed extension. The lead time between OHMR’s request and the reporting deadline increased over successive reporting cycles. In 2022 and 2023, MRIs commonly had around 2 to 3 weeks between notification and the due date; from 2024 onwards, this increased to around 6 to 8 weeks, with a standard notification in at the start of October and a deadline at the end of November, and a similar window for 2025 reporting cohorts. These changes likely supported timely submission and may have mitigated some process pressures. However, they do not address the underlying concerns about the content and structure of metrics described above, which are the main drivers of perceived burden and limited usefulness.

The burden was distributed across multiple roles. Survey data indicated that the MRSP annual reporting typically involved a median of 7–8 staff per MRI (IQR: 4 to 9; range: 3 to 50 people, noting the response indicating 50 was an outlier), primarily executive leaders, grants and finance staff, with additional input from senior researchers, administrative staff and, in some cases, governance and data teams. While the median reported effort was 49 hours per annual report (IQR²⁶: 40 to 250), a range of 10 to 900 hours was required across MRIs, indicating complex internal coordination or broader interpretations of what is counted as reporting effort. Together, these data indicated that the MRSP reporting involved leadership, research and corporate functions, and represents a material draw on MRI resources.

From a process perspective, the current metrics and reporting design generated a level of documentation burden that many MRIs considered disproportionate and, in parts, avoidable. Stakeholders offered a range of practical suggestions to reduce this burden and improve the reporting process, which are summarised in breakout box 4.

Breakout box 4. Suggestions for improving the reporting process²⁷

- **Streamlining and focusing the process**
Several MRIs suggested simplifying reporting requirements, so they are easier to complete alongside other demands. Suggestions included targeting requests for case studies with greater clarity on how they will be used and reviewing highly granular elements to ensure that effort is proportionate to the value of the data collected.
- **Aligning with existing reporting and data structures**
MRIs recommended closer alignment with other routine requirements (such as AAMRI surveys and statutory accounts) so that MRIs can draw on existing datasets rather than creating MRSP-specific classifications. Some also noted that annual financial classifications for the MRSP would benefit from clearer guidance and closer alignment with how institutes structure their financial data.
- **Improving tools, templates and user experience**
The current Excel-based templates were described as “clunky”, with macros that do not work reliably for all users. MRIs proposed moving to an online reporting tool or survey platform that can import data from existing systems (for example GrantConnect, SmartyGrants or publication databases) and reduce manual manipulation of spreadsheets.

Data source: Grant administration-level survey of currently funded MRSP MRIs

²⁶ IQR = interquartile range (i.e. spread of the middle 50% of data values)

²⁷ While this process evaluation looks retrospectively at the Program, several suggestions raised by MRIs have prospective relevance. The following comments may warrant consideration as part of the forthcoming Review of the MRSP, which will take a broader and more forward-looking view of program design and future rounds.

5. Outcome evaluation findings

5.1 KEQ3: To what extent has the Program achieved its intended objectives and delivered meaningful outcomes?



Key Evaluation Question 3 – To what extent has the Program achieved its intended objectives and delivered meaningful outcomes?

Scope

This evaluation question examines the extent to which the Program has achieved the outcomes expected to flow from its objectives, as set out in the evaluation program logic. It considers evidence of outcomes and the contribution of MRSP funding to those outcomes.

Objectives

- **Excellence** – Support excellence in health and medical research through the delivery of high-quality outputs
- **Critical mass** – Promote critical mass in health and medical research as part of the effective use of resources
- **Sustainability** – Monitor and help ensure the financial sustainability of participating institutes

Outcomes evidence to
test achievement of
objectives

MRI level

1. Strengthened research infrastructure
2. MRI financial position, stability and resilience
3. Building workforce and capacity
4. Excellence in research (including strategically significant projects)
5. Increasing research collaboration

Systems level

6. Contribution to health and medical research ecosystem
7. Contribution to the health system and health benefits

State-wide level

8. Economic/industry benefits
9. Social and cultural impacts
10. Environmental impacts

Evidence of outcomes, together with evidence of the contribution of MRSP funding, informs the evaluative judgement about whether the Program is achieving its intended objectives. This chapter presents the evidence on outcomes and the contribution of MRSP funding. Section 3 provides the detailed contribution analysis and sets out the evaluative judgement.

Focus areas covered in this outcome evaluation section are:

- 5.1.1 Evidence for MRI-level outcomes
 - Contribution towards strengthened research infrastructure
 - Contribution towards improving the financial position of MRIs and supporting their financial stability and resilience
 - Contribution towards building the research workforce and capacity
 - Contribution towards excellence in research
 - Contribution towards increasing research collaboration
- 5.1.2 Evidence for system-level outcomes
 - Contribution towards the health and medical research ecosystem
 - Contribution towards the health system and health benefits.

NB: The state-wide impacts of the MRSP are addressed in Chapter 6 through the economic evaluation.

Data sources used to answer this question

The primary data sources for this evaluation question were consultation data, survey data, grant administrative data, requested data from MRIs including case studies and publicly-available data (namely SciVal).

This section details the findings of analyses of these data. Additional case studies demonstrating how the MRSP has contributed to the outcomes described in this chapter are included in Appendix 5.



Key findings and evaluative judgement

1. **The MRSP is essential to the financial viability and stability of MRIs.** The MRSP fills the gap between the true cost of conducting research and what other income streams will fund. Financial data confirmed that it covers essential indirect costs, provides predictable and stable funding, and enables MRIs to plan, operate and grow strategically with confidence. Overall, this strengthens the position of MRIs within the health and medical research ecosystem, contributing towards a thriving ecosystem that positions NSW more competitively in the national and international context. Without the MRSP, MRIs could face contraction and reduced autonomy. MRSP-funded MRIs consistently reported that in the absence of the MRSP, they would be forced to reduce scale, seek alternative funding such as philanthropy or commercial partnerships, or embed within universities, thereby reducing their ability to drive their own research agendas. Experiences from MRIs that received intermittent funding echoed these risks.
2. **The MRSP enables investment in critical physical and organisational research infrastructure.** Stable funding allowed MRIs to invest in both physical infrastructure (laboratories, technologies, pharmacies), research enablers (e.g. clinical trials capability, research development, governance, expertise to operate complex equipment) and non-research functions (grants management, commercialisation, finance and human resources). A substantial proportion of the investment is therefore in the non-research workforce. These investments, in turn, improve research quality, competitiveness, innovation and workforce capability.
3. **The MRSP may contribute to collaboration, though impacts vary.** MRIs reported that MRSP-enabled infrastructure and capabilities attract national and international collaborators, and support partnerships with health services and precincts. However, some stakeholders reported an unintended effect of the MRSP, which measured success against grant income, thereby incentivising competition rather than collaboration among MRIs. Real-world experiences with collaboration varied among MRIs: one MRI that lost MRSP funding described increased reliance on shared infrastructure, leading to more efficient collaboration. Overall, there was limited evidence that the MRSP supports collaboration, and impacts are context dependent.
4. **MRIs demonstrate broader health system impacts, but direct attribution to the MRSP is not possible.** MRIs provided multiple examples of research influencing policy, clinical practice, models of care and patient outcomes. While MRSP-funded infrastructure and workforce underpin these achievements, the effects are distal, thus making it difficult to identify the discrete contribution between MRSP funding and the specific health system outcomes.
5. **In summary, the evaluation provides evidence that the MRSP has progressed towards its objectives in the following ways,** as described below.

Objective 1: Excellence – Support excellence in health and medical research through the delivery of high-quality outputs

The MRSP has likely to have contributed meaningfully to research excellence by providing the stable, flexible funding base for infrastructure required to conduct high-quality research. MRIs used the MRSP to invest in critical research platforms, attract and train research talent, and maintain the capability needed for world-class outputs and international collaboration. The financial stability afforded by the MRSP enabled MRIs to build their capabilities, which then enabled further research activity. While the Program’s role in enabling research excellence is mostly indirect, acknowledging that the funded MRIs have longstanding roles in research that predate the Program, it is likely to have underpinned research performance across NSW.

Objective 2: Critical mass – Promote critical mass in health and medical research as part of the effective use of resources

The objective of achieving “critical mass” has been interpreted inconsistently, creating challenges in assessing the extent to which it has been achieved. While the idea of critical mass as achieving scale in capability and resources to sustain high-quality research and subsequent outcomes was alluded to, the Program’s objective of critical mass was most often interpreted as institutional consolidation via merging MRIs.

Overall, the MRSP supports MRI capability and scale at an individual MRI level, but does not actively promote critical mass at a system level. At an individual institutional level, the funding has contributed to internal functional critical mass by sustaining research teams, infrastructure platforms, and capability clusters that underpin high-quality research. However, MRIs generally did not see the MRSP as a mechanism for driving institutional consolidation, noting that perceived incentives built into the Program design had not resulted in institutions merging. Additionally, the Program has not contributed towards encouraging collaboration between MRIs or building shared facilities, assets and resources that may reduce operational burden. While there was evidence of some benefits to precincts, these were context-specific and were not observed consistently across precincts with funded MRIs.

Objective 3: Sustainability – Monitor and help ensure the financial sustainability of participating institutes.

The MRSP supports the financial viability of NSW MRIs. The MRSP sustains the sector in a reactive rather than strategic way by filling the structural gap between the true cost of research and what competitive grants, philanthropy and commercial income can cover. MRIs consistently described the MRSP as “keeping the lights on,” enabling them to meet some indirect costs, stabilise their operations, and leverage additional revenue.



5.1.1 Evidence for MRI-level outcomes

"It's a bucket of white paint and you drop, you know, a few drops of red paint into it, everything's pink. And that's really how I see MRSP, it colours everything."

MRI Director

Figure 17. MRI-level outcomes



In the sections that follow, we present findings from all data sources that provide evidence for each of the MRI-level outcomes listed above in Figure 17, including evidence of the MRSP's contribution to the outcomes observed.

The table below provides a snapshot of the areas where MRI Directors reported the MRSP had the greatest impact. Directors were asked to rank a set of MRI-level outcomes by the extent of the MRSP's contribution, with higher rankings indicating stronger perceived impact. The highest-ranked areas were financial stability and viability, the quality of research conducted, the establishment of new research infrastructure and the ability to attract and retain both research and non-research workforce (Table 4).

Table 4. MRIs' perceptions of which outcomes the MRSP had the greatest impact on at the MRI level

Rank	Outcome at the MRI level where the MRSP was perceived to have the greatest impact
1 ²⁸	Financial stability Financial viability
2	Quality of research conducted
3	Establish new research infrastructure
4 ²⁹	Recruit researcher talent Retain non-research workers Ability to win nationally competitive research grants
5	Recruit non-research workers at the MRI

Data source: Director-level survey of currently funded MRSP MRIs

²⁸ Outcomes were tied for ranking 1.

²⁹ Outcomes were tied for ranking 4.

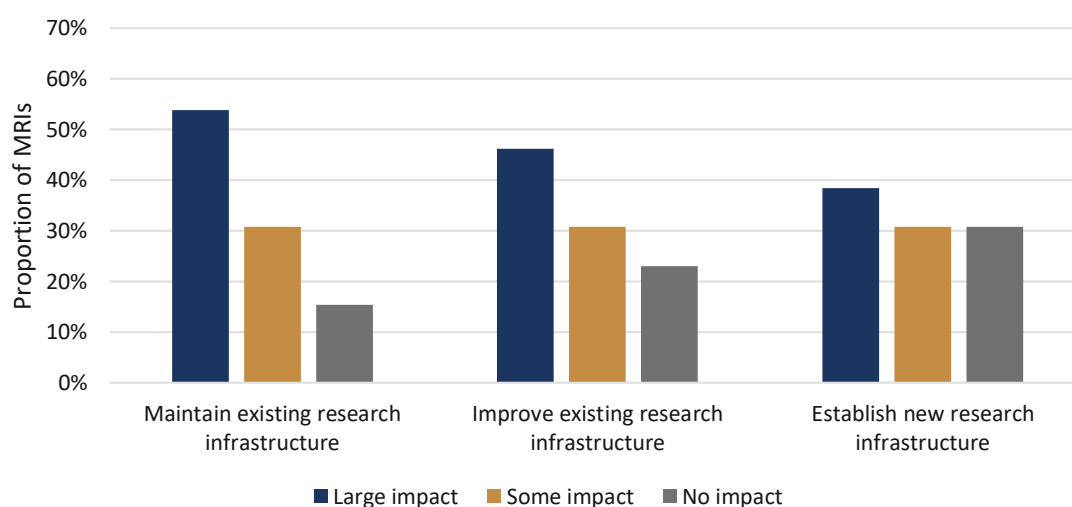
Contribution towards strengthened research infrastructure

"The last 4, 5, 6 years, there's been a huge transition to seeing us all come together to solve big problems, and that might be within <MRI>, but also across the state. And many of the projects and programs that operate within government within the MRI sector are now huge multi-institutional challenges, and they're often built around sort of core infrastructure, you know, trying to solve big ideas, but using core infrastructure that have to be built. And often that infrastructure has been built through funding such as the MRSP, you know, didn't come from government necessarily all the time. We had to have that flexible funding to build that infrastructure to enable these bigger programs of activity. And I think those programs, you know, they operate across the state and across Australia and work internationally. And without that sort of funding that untied support, we would never have been able to build... that infrastructure to be competitive to be able to apply for this, these sort of major initiatives and deliver on those."

MRI Director

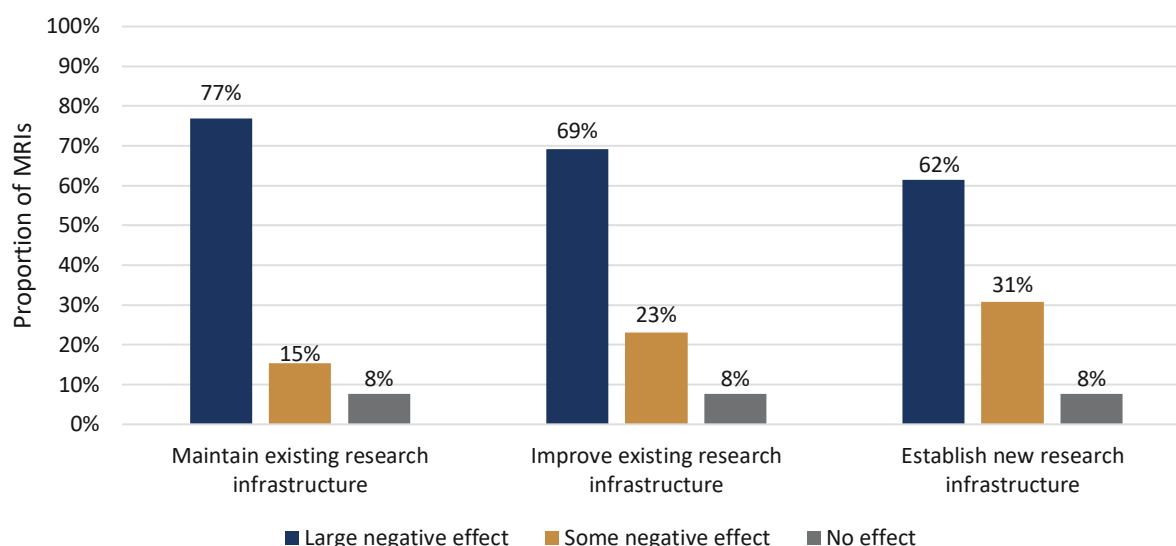
MRIs consistently described the MRSP as crucial for sustaining and advancing infrastructure, describing it as the "backbone of the institute". Almost all (12 of 13) perceived that MRSP funding had an impact on maintaining, improving or establishing new infrastructure, and that their ability to do so would be diminished if they were to lose MRSP funding (especially improving and maintaining existing infrastructure) (see Figures 18 and 19). At a regional level, the MRSP was viewed as providing vital support where access to metropolitan infrastructure was limited, reducing inequities in research capabilities across NSW.

Figure 18. MRI perceptions of the incremental benefits of the MRSP on research infrastructure at their MRI



Data source: Director-level survey of currently funded MRSP MRIs

Figure 19. MRI perceptions of the impact of ceasing the MRSP on research infrastructure at their MRI



Data source: Director-level survey of currently funded MRSP MRIs

Summary: How the MRSP contributed towards strengthened research infrastructure

MRSP funding is directly used to invest in a range of both physical and non-physical research infrastructure, for which funding is generally not available from other sources:

- Running costs of maintaining existing equipment and laboratory spaces
- Increasing research enablers and platforms, such as statistical support and clinical trials capabilities, that are used by multiple research groups across the institute
- Hiring teams of non-research workforce who provide the supportive services necessary to run a business and to enable translation activities and advance income generation
- Supporting the purchase of new equipment particularly in the context of rapidly evolving technologies.

Supporting Evidence A – MRI examples of how they invested in research infrastructure using the funding for vital physical equipment and technical and scientific services

MRIs used funding to invest in both physical and digital platforms that facilitated high-quality, collaborative research, ranging from digital platforms like AI-enabled trial systems to core and specialised laboratories, data science and statistical support, and health economics support units. Many MRIs highlighted that the MRSP enabled investment in essential organisational infrastructure such as research governance, regulatory, and ethics functions, all of which improved grant quality and success rates. These infrastructure investments then supported researchers, leading to the examples of excellence described in Table 5 below. Additionally, several described examples of investing MRSP funds in core business and support services that had enabled translation and generation of further income, particularly through generating additional revenue streams through philanthropy and commercialisation.

Table 5. Exemplars of the MRSP's contribution to research infrastructure

Type of infrastructure	Exemplars
Research facilities and equipment (e.g. laboratory space, imaging equipment, tissue culture)	- MRSP funding has been used to support the running costs of a specialised Physical Containment Level 3 (PC3) facility involving animal models, the only one of its kind in NSW, which is used in research for COVID-19 and tuberculosis vaccines. This facility has enabled significant outcomes, including securing US\$13 million in funding from the National Institutes of Health to test various adjuvant and antigen combinations in animal models, with the most promising combinations intended for advancement to non-human primate studies and phase 1 clinical trials. - An MRI secured a \$3 million MRFF 2023 National Critical Research Infrastructure Grant for a precision-medicine initiative developed in partnership with research and industry collaborators. This success was enabled by prior investment, including MRSP funding, into laboratory infrastructure and genomic technologies that underpin the MRI's research capabilities.
Research enablers (e.g. statistical support, human research ethics committees, bioinformatics, clinical trials)	- An MRI's investment in digital mental health capabilities, including the development of a digital platform and an AI-enhanced platform to support clinical trials, has enabled widespread use across multiple internal research groups as well as external collaborators within NSW and nationally. This infrastructure has reportedly contributed to success in securing several NHMRC grants and the establishment of centres of research excellence built around these capabilities. - Investment in dedicated statistics and economics platforms has enabled researchers to model the population-level impacts of implementing specific initiatives at scale. These capabilities have contributed to securing an estimated \$20 million in NHMRC and MRFF funding over the past 5 years and have been used to inform health services research and evaluations of public health programs. - Investment in an onsite pharmacy, clinical trials infrastructure, research governance office and processes to ensure a steady patient pipeline enabled rapid trial start-up and efficient patient recruitment, making the MRI an attractive collaborator, particularly for industry partners seeking speed and reliability.
Core support services (e.g. IT, data management, human resources, finance, procurement, legal & compliance, grants management, commercialisation,	One MRI increased operating revenue from commercialisation nearly 20-fold within a 5-year period. This growth was enabled by investing MRSP funds in specialised expertise and frameworks to identify, secure, develop and commercialise intellectual property, culminating in collaboration with a leading global company specialising in HIV therapeutics and creating opportunities for near-term licensing.

Type of infrastructure	Exemplars
fundraising & philanthropy)	With funding from the recent round, an MRI has established a Commercialisation Committee and lodged a patent related to the detection of high-risk (unstable) atherosclerotic plaque, which may support the diagnosis of individuals at elevated risk of acute cardiovascular events.

Data source: Consultation data and case studies submitted by currently funded MRSP MRI

Some MRIs, particularly those with a stronger focus on basic science, highlighted the rapid pace of technological change and the importance of accessing cutting-edge platforms to remain competitive and at the forefront of their fields. While they were often able to secure funding to purchase equipment, they had far fewer options to cover the ongoing operating costs of these technologies. These included expenses associated with running the equipment, maintaining these spaces, and employing skilled staff to operate them, for which they relied heavily on MRSP funding.

While there was evidence that MRIs were acquiring and operating research infrastructure using MRSP funds to further their research goals, there was limited anecdotal evidence that these research assets were being shared across the sector. Assets appeared to be held by MRIs with collaboration occurring due to synergies in research goals, rather than being viewed as a state-wide asset that could be accessed by any MRI or researcher. In other words, increased infrastructure capacity and capabilities are occurring to further MRIs' individual research agendas rather than with the intent of building the collective research infrastructure across the ecosystem.

MRIs perceived that investments enabled through the MRSP, coupled with their relationships with health services particularly through precincts, were generating returns to the health system several fold over. However, stakeholders from affiliated organisations, particularly from LHDs, were more cautious in their assessment of the extent to which these benefits had been realised. They were, nonetheless, more positive about the value of precinct-based collaboration, viewing it as a more efficient model for translating research benefits across the broader health sector.

Case study 1. Innovations in robotics: IIMR's Centre for Robotics & Health Technology

MRI activity

The Ingham Institute established the Centre for Robotics and Health Technology (Perich Centre) in 2025. The Centre was established to accelerate the equitable, evidence-based adoption of robotics, automation and AI within the NSW health system. One of its flagship programs is an AI-in-Health Incubator. Early translational research activities include a surgical robotics clinical effectiveness study. These activities were designed to support clinician-led innovation, rigorous evaluation, and alignment with NSW Health priorities, particularly in a high-need and culturally diverse region.

Impact

The Centre is in its early stages since activation. It is envisioned that the Centre will contribute to patient and community benefits through digital initiatives such as a multilingual discharge summary solution supporting clearer communication and culturally appropriate care. Anticipated health system benefits include earlier discharge planning, reduced readmission risk, and improved continuity of care enabled through structured clinical entity extraction and better GP handover workflows. Rapid prototyping and on-site sandbox testing are set to reduced reliance on high-cost vendor AI products, preventing technological debt and enabling sovereign capability.

At an ecosystem level, the creation of an innovation cluster around the AI Incubator is anticipated. Within the first 6 months, there have already been new industry partnerships (valued at \$500,000), increased grant income (valued at \$700,000) and strengthened workforce capabilities through clinicians and researcher training in AI literacy.

Contribution of the MRSP

"Without MRSP, the Centre would exist only as a physical space with no operational capacity to run programs, engage clinicians, or undertake research."

While philanthropic funding enabled the capital fit-out of the Centre, the MRSP provided the essential operational capacity required to make the Centre functional and research-active. MRSP funds supported salaries for skilled personnel across research support and governance, technical support such as biostatisticians, and support for collaboration, events and marketing. Indirectly, the MRSP helped to support a dedicated philanthropy and partnerships function, which is now securing long-term sustainability and leveraging new external funding.

"The MRSP effectively bridged the gap between capital investment and functional activation, ensuring that NSW received immediate translational value from the philanthropic build."

Data source: Case study provided by MRI

Case study 2. Strengthening research governance and facilities to attract clinical trials

MRI activity

The Woolcock Institute invested their MRSP funds in research governance infrastructure to support the efficient and compliant conduct of clinical trials and other research studies. This includes a two-stage governance process managed through digital workflow platforms, enabling systematic review of project alignment, risk, ethics and contractual requirements. This process is overseen by a dedicated Governance and Information Manager role.

In parallel, the Institute maintains a large, centrally managed volunteer database with more than 8,500 interested research participants, supporting timely participant recruitment across its research portfolio. Together, these systems enable the MRI to manage a high volume of concurrent studies and demonstrate robust oversight to collaborators and insurers.

Impact

This governance infrastructure underpins research activity across the institute that allows it to act as a sponsor for clinical trials. It has delivered research and system-level impacts, including:

- Enabling more than 50 active research projects at any one time and supporting high research productivity, with over 1,800 publications produced in the past 5 years.
- Attracting international clinical trials to NSW, the total leveraged value of which was estimated to be more than \$6 million in international clinical trial income.

This investment has led the Institute to gain an international reputation as a place to conduct clinical trials, particularly for narcolepsy treatment. Narcolepsy is a rare condition with an estimated prevalence of between 2 and 5 per 1,000 people, making participant recruitment challenging. Without this infrastructure, they would not be able to successfully recruit for such a study and this research would likely never have been conducted in Australia.

Contribution of the MRSP

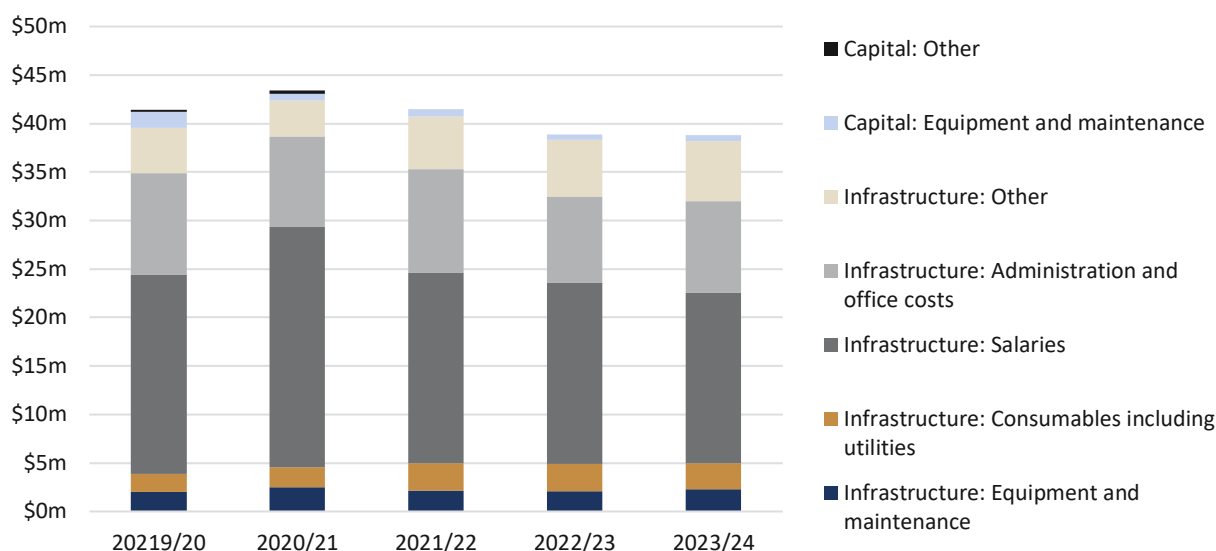
MRSP funding contributes support towards the Governance and Information Manager position and licensing key digital platforms required to operate governance and volunteer management systems, at an estimated cost of around \$200,000 per year. Without MRSP support, study approvals would be slower, fewer studies could operate concurrently, recruitment would be less efficient, and insurance costs would likely be higher. MRSP funding therefore elevated the scale, efficiency and credibility of the MRI's clinical research activity, enabling impacts that would otherwise have been substantially constrained.

Data source: Case study provided by MRI

Supporting Evidence B – proportion of investment into research infrastructure

Assessment of data on MRSP expenditure showed that MRIs spent the majority of funds on salaries followed by administration and office costs, supporting their claims of using the MRSP towards research enablers and core support services within their institutes (Figure 20).

Figure 20. Total MRSP expenditure for all MRIs by expense type



Data source: Program administrative data

Contribution towards improving the financial position of MRIs and supporting the financial stability and resilience of MRIs

"The money that we get to support those sort of core, just keeping the Institute open, means that's more time that we can spend on getting grant money, getting the philanthropic support to support the actual research activities, which is what we're good at doing. And that's what we should be doing rather than, you know, trying to rattle, you know, little cans to raise money to support the, you know, keeping the lights on in the institute. So yeah, that level. I just think it's just that core funding is really key to enable us to focus on what really matters."

MRI Director

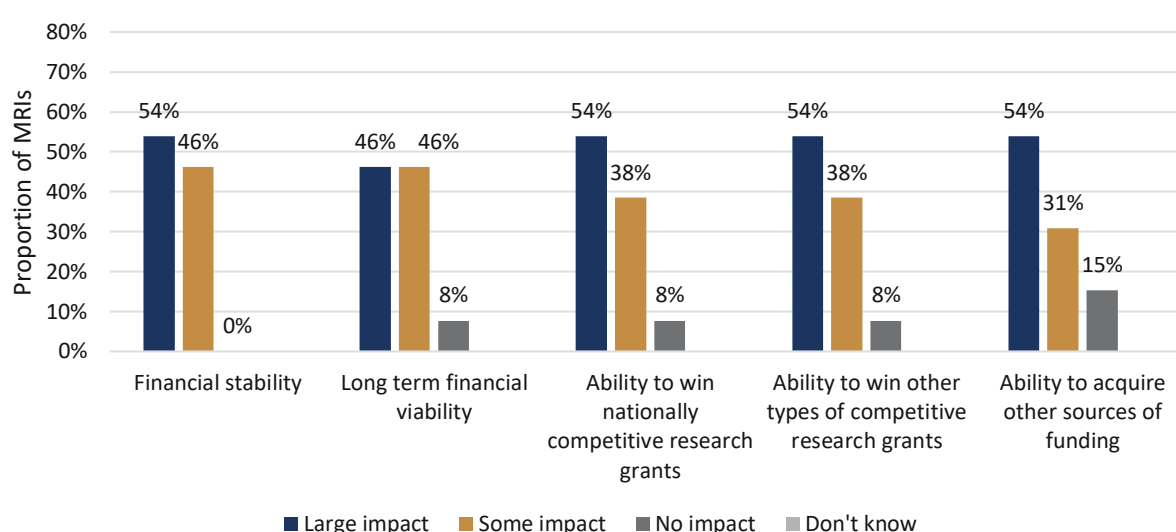
There was consensus that MRSP funding was critical to bridging the true cost of research and sustaining MRI operations. The objective of financial sustainability and its role in covering the gaps in the full cost of research was viewed by MRIs as the most important contribution of the MRSP (see Figure 21). MRIs consistently described it as a core funding stream that allowed them to remain viable and "keep the lights on" amid rising business costs and limited alternative funding sources to cover the full costs of research. MRIs highlighted the importance of the MRSP in the prosperity and survival of individual MRIs as well as the vibrancy of the wider sector. Other stakeholders, namely program administrators and advisors and organisations affiliated with MRSP-funded MRIs, agreed that the MRSP had achieved its sustainability objective by maintaining the viability of NSW MRIs.

While the MRSP was perceived to contribute towards achieving institutional financial stability, its hypothetical loss was perceived to likely have an immediate and strong negative impact (see Figure 22). When questioned on a hypothetical counterfactual, several MRIs perceived that they would be unable

to survive more than a few years without the MRSP. Others perceived that they would shrink substantially as institutions due to forced cutbacks and would have to turn to alternative sources of funding, such as philanthropy and industry.

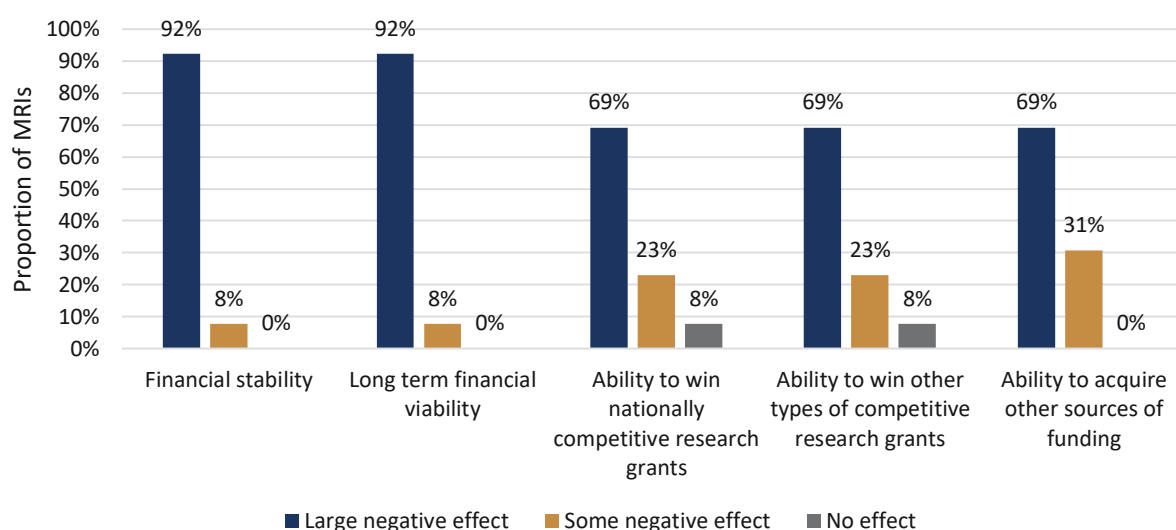
Based on findings from the interviews and survey of MRIs, the MRSP appears to contribute substantially towards MRIs' financial stability in the short-term but is insufficient to achieve long-term financial stability. However its loss would have an immediate destabilising effect, likely resulting in attrition of staff and potentially decreasing their investment in specific programs of work.

Figure 21. MRI perceptions of the incremental benefits of the MRSP on their MRI's financial stability and viability



Data source: Director-level survey of currently funded MRSP MRIs

Figure 22. MRI perceptions of the impact of ceasing the MRSP on their MRI's financial stability and viability



Data source: Director-level survey of currently funded MRSP MRIs

Summary: How the MRSP contributed towards improving the financial position of MRIs and supporting the financial stability and resilience of MRIs

Overall, the evidence indicates that the MRSP plays a central role in sustaining the financial health of MRIs, enabling them to maintain operations, manage financial risk, and expand research activity with greater confidence.

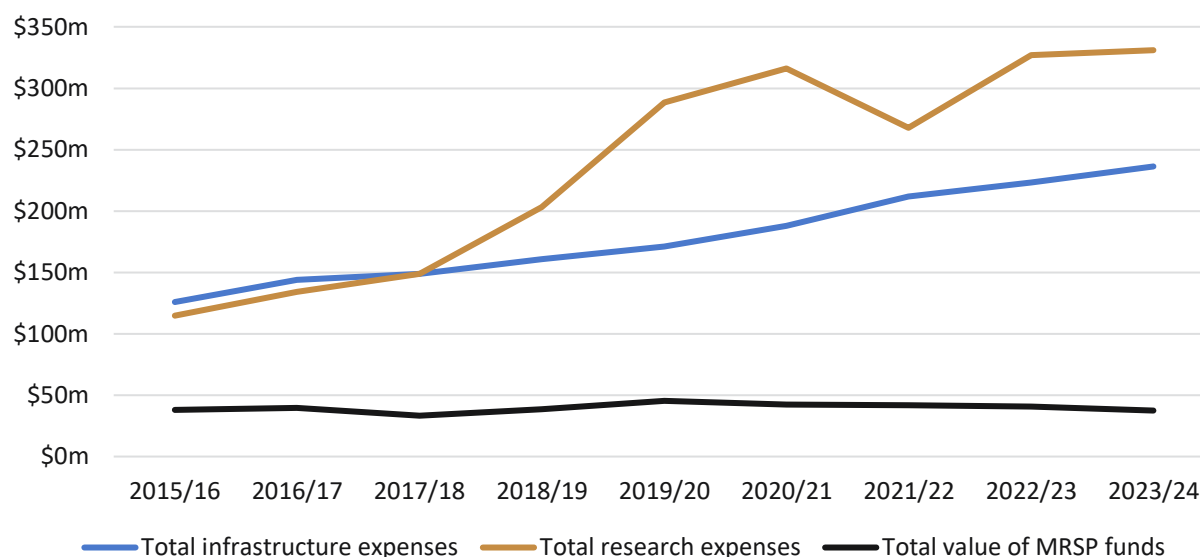
The MRSP strengthened MRI financial resilience by:

- Providing a stable, flexible funding base that covers essential indirect costs and enables them to “keep the lights on”.
- Underpinning growth and diversification of revenue, with financial data showing that while MRIs have expanded income from grants, philanthropy and other sources, the MRSP remains a reliable anchor as total activity increases.
- Allowing MRIs to use other funding sources more strategically, including directing philanthropic and fundraising income to research rather than core operations.
- Enabling investment in critical business, commercialisation and research development functions, which support institutional sustainability and help secure additional funding.
- Supporting workforce stability, as MRIs reported that without the MRSP they would need to reduce core staff, leading to decreased research productivity and organisational resilience.

Supporting Evidence A – the MRSP provides a vital component of funding to MRIs

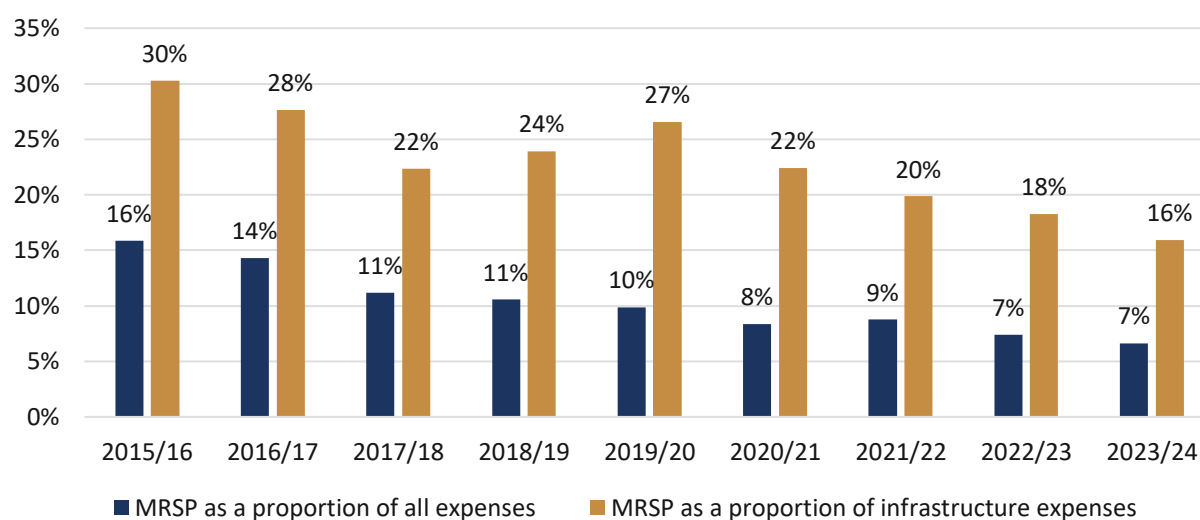
Across the MRIs, MRSP funding represented an important component of their financial base. MRI feedback indicated that the MRSP accounted for a substantial share of revenue in some MRIs, while others reported that, even where it represented a smaller proportion, it covered a significant share of indirect costs, in some cases up to 30 per cent. Over the same period, MRI expenditure on research and infrastructure grew while MRSP allocation remained stable (see Figure 23), resulting in the MRSP comprising a decreasing proportion of total expenses (see Figure 24).

Figure 23. Total infrastructure and research expenses relative to MRSP funding for all MRIs³⁰



Data source: Annual financial reporting by MRIs to OHMR (as per the requirements for receiving MRSP funding)

Figure 24. Proportion of MRI expenses relative to MRSP funding for all MRIs³¹



Data source: Annual financial reporting by MRIs to OHMR (as per the requirements for receiving MRSP funding)

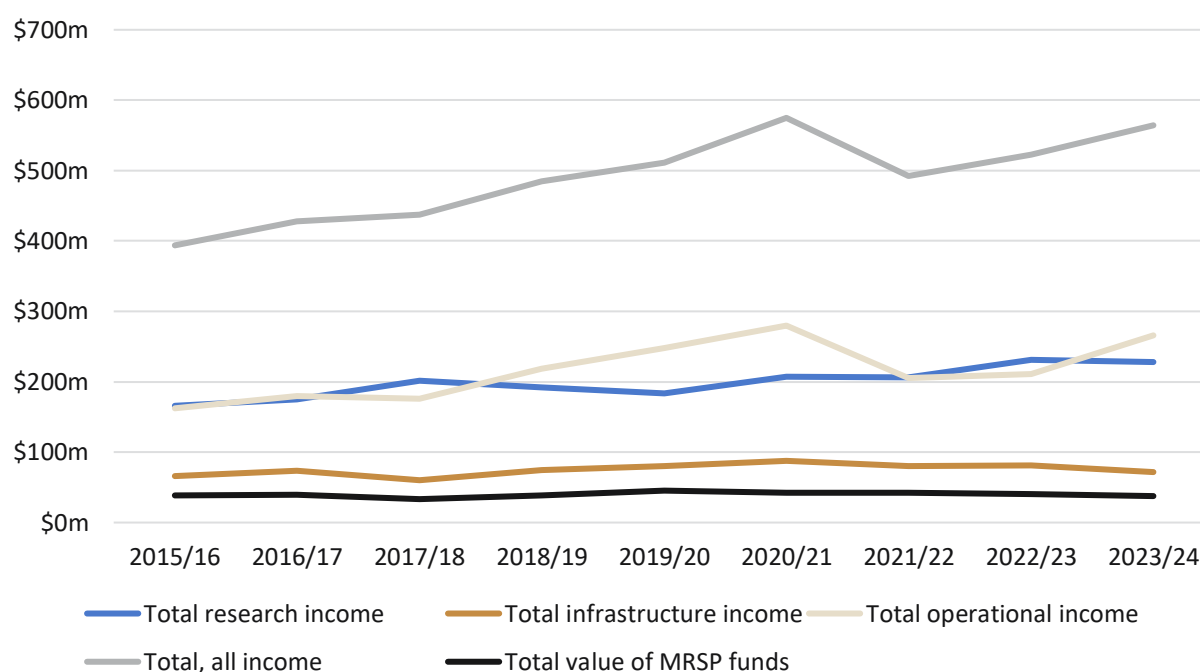
³⁰ Included data from 12 MRIs funded for the entire duration of the period shown

³¹ Included data from 12 MRIs funded for the entire duration of the period shown

Supporting Evidence B – the MRSP has contributed towards increasing revenues from other income streams

MRIs discussed that the MRSP allows them to invest in revenue-generating activities and leverage the MRSP to secure additional funding from a diversity of sources including grants, philanthropy, and commercialisation. Analysis of financial data from 12 MRIs funded across the full period showed that MRIs have substantially expanded both their revenue base (Figure 25a) over time. Total income has increased, driven largely by growth in research grant funding and fundraising revenue, while commercialisation income rose for several years before declining following the sale of a commercial arm by one MRI (Figure 25b). Over this period, income from the MRSP has remained constant. This likely suggests that the MRSP provides a stable foundation that enables MRIs to grow and diversify funding sources and expand research activity. In one example exemplifying how the MRSP contributes to increased revenue and research activity, the business development team prepared the documentation and sought funding via strategic unsolicited proposals to governments, including the federal government, to fund a large precision medicine program for childhood cancer.

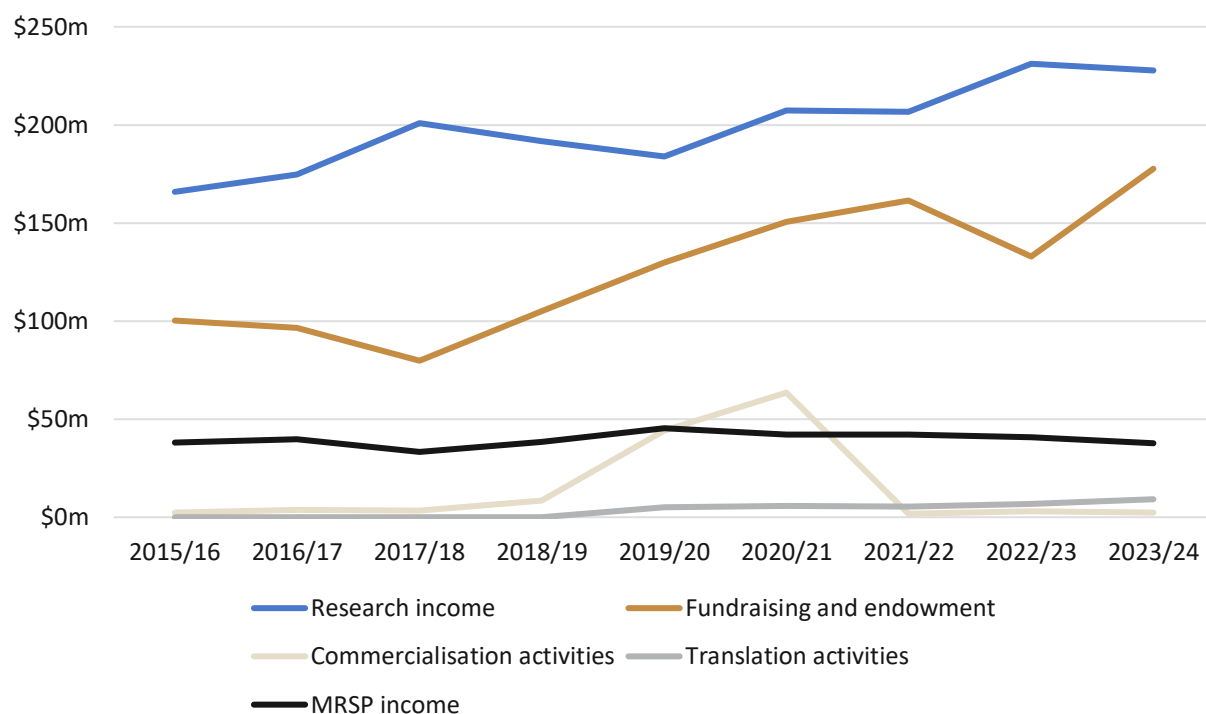
Figure 25a. Total income for all MRIs³² by income type



Data source: Annual financial reporting by MRIs to OHMR (as per the requirements for receiving MRSP funding)

³² Included data from 12 MRIs funded for the entire duration of the period shown.

Figure 25b. Total income for all MRIs³³ by income streams



Data source: Annual financial reporting by MRIs to OHMR (as per the requirements for receiving MRSP funding)

³³ Included data from 12 MRIs funded for the entire duration of the period shown.

Case study 3. Leveraging the MRSP to improve financial stability

MRI activity

The Children's Cancer Institute used MRSP funding to strengthen its core operational capacity and enable growth. MRSP support covered essential corporate functions, including finance, human resources and administrative functions, providing organisational stability and enabling efficient day-to-day operations. This stability allowed unrestricted funding, largely sourced through philanthropy, to be redirected towards strategic priorities.

One notable area of growth has been the institute's business development and government advocacy capabilities. These functions supported structured intellectual property audits, prioritisation of commercially viable research projects, and more systematic engagement with industry and government partners, diversifying income sources and strengthening translational research.

Impact

Enhanced government advocacy yielded further investment in research and healthcare for children's cancer, including:

- Establishment of the ZERO Childhood Cancer Program, Australia's national paediatric precision medicine initiative, which has enrolled nearly 3,000 children and young people across all 9 metropolitan paediatric oncology centres, improving access to genomic-guided treatment for high-risk and relapsed cancers. The Program has attracted more than \$200 million in federal funding to date.
- Development of the Minderoo Children's Comprehensive Cancer Centre, a \$658 million integrated paediatric cancer facility built in collaboration with the Sydney Children's Hospital Network and University of New South Wales, due to open in 2026. This Centre is supported by Commonwealth and NSW Government funding and philanthropic investment and has secured unprecedented levels of government investment in paediatric cancer research and care. This includes \$100 million by the federal government.

Additionally, the Institute has increased industry engagement and commercialisation, establishing structured IP audits, prioritising commercially valuable projects, and building strong partnerships. This has generated new revenue streams, including licensing income exceeding \$2.2 million in 2025–26 and projected contract research income of more than \$500,000 in 2026.

Contribution of the MRSP

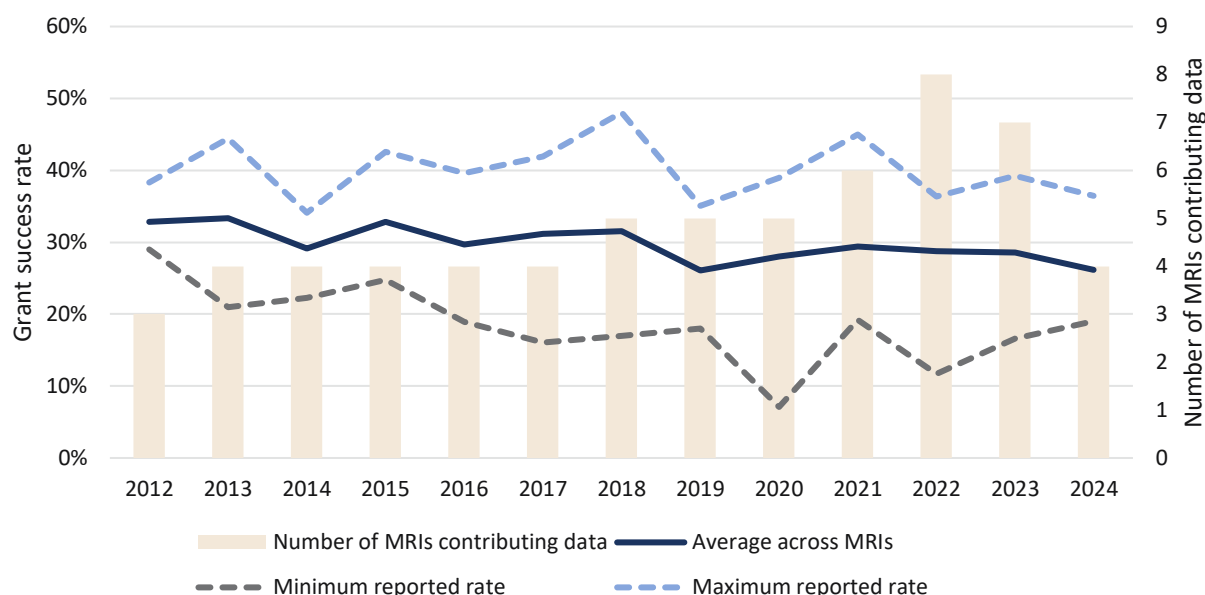
MRSP funding played a critical enabling role by underwriting core operational costs and freeing unrestricted funds for investment in business development and advocacy. This capacity was central to securing large-scale government investment, expanding industry partnerships, and diversifying income sources. In doing so, the MRSP contributed to improved financial sustainability and positioned the MRI to deliver ongoing translational and clinical impact beyond individual funding cycles.

"MRSP funding is not merely sustaining operations; it is catalysing growth, innovation, and impact. By underpinning core functions, the MRSP empowers the Institute to deploy unrestricted resources towards initiatives that expand commercialisation, strengthen industry engagement, and secure transformative government support – ultimately advancing our mission to improve outcomes for children with cancer."

Data source: Case study provided by MRI

Despite increasing grant income, data provided by MRIs indicates a slight declining trend in grant success rates, likely reflecting the increasing competitiveness for research dollars. However, the limitations of these data should be noted, particularly that not all MRIs were able to provide these data and reported on success rates for different categories of research.

Figure 26. Average grant success rates for all reporting MRIs ³⁴



Data source: Data requested from MRIs for the purpose of this evaluation

Summary: How MRIs leverage MRSP funds to generate further income

- Funding salaries for staff specialising in commercialisation, leading to generation of commercialisation income
- Investing in salaries for philanthropy and fundraising teams who generate further funds
- Funding salaries for staff in business development teams who identify and acquire other sources of non-research income e.g. government proposals
- Increasing the availability of infrastructure which improves research quality, therefore attracting researcher talent, collaborations and partners, all of which generate further opportunities for funding and increased research output
- Leveraging research infrastructure and the expertise of research grants managers to improve the quality of grant applications, leading to greater grant success than would be otherwise possible.

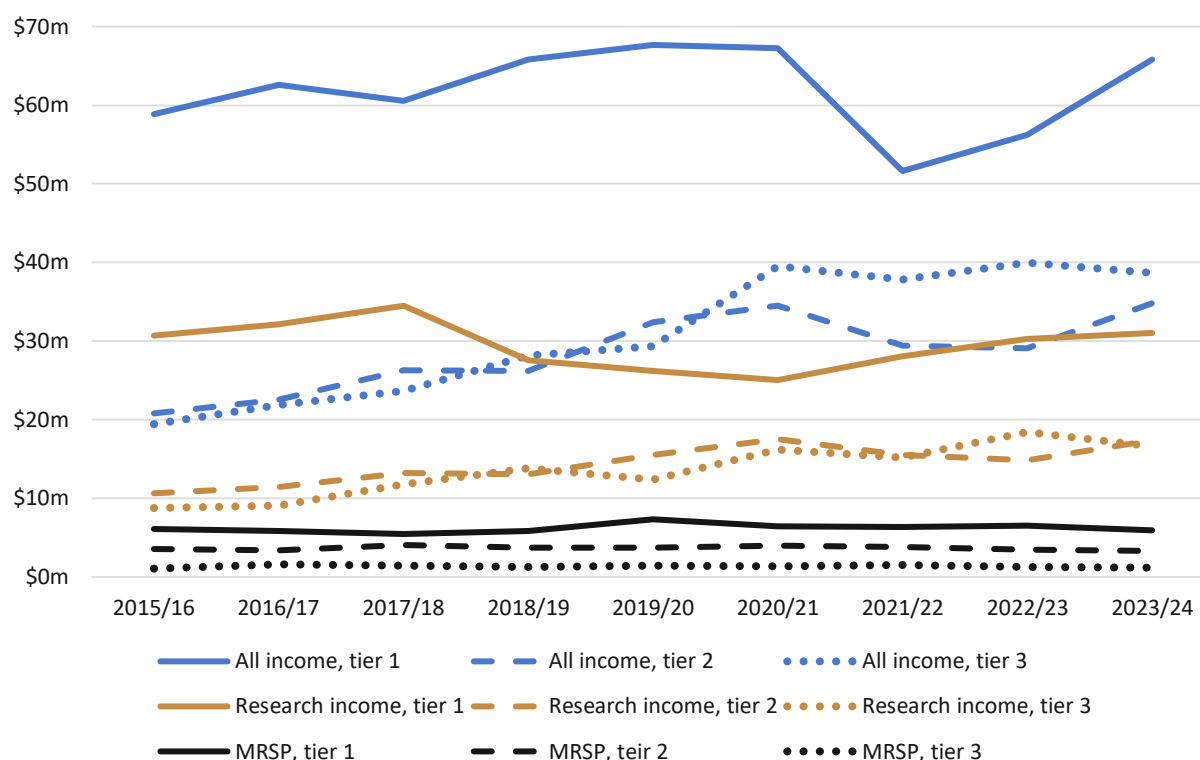
Supporting Evidence C – MRIs leverage MRSP funding to varying extents

Analysis of data on average MRI income by MRI tier (see Figure 27) found minor variations in trends observed for total revenues for all MRIs – while a general increasing trend in total revenue and research income was still observed, it was most apparent for MRIs categorised as tier 3. Mean values for total income were higher for tier 3 MRIs relative to tier 2 MRIs from 2020/21 onwards. Average research

³⁴ Not all MRIs reported data for the entire period requested. The number of MRIs contributing data are shown for each year. Additionally, some MRIs reported success rates for all grants, while some reported it for specific grants only. Data reported here are as per what the MRIs have provided in the request for data.

income remained largely the same for tier 1 MRIs across the analysed period (noting data on research income was missing for one MRI), and average total income declined in 2021/22 for both tier 1 and tier 2 MRIs (for tier 1 MRIs, this was driven by a decline in operational income, encompassing philanthropic, commercial and contract income). This decline was not observed for tier 3 MRIs. The level of operational income also increased for tier 3 MRIs from 2020/21 onwards.

Figure 27. Mean MRI income (total, research and MRSP) by MRI tier funding level³⁵



Data source: Annual financial reporting by MRIs to OHMR (as per the requirements for receiving MRSP funding)

Tier 1 and 3 MRIs appeared to have more diverse sources of income, with a greater proportion derived from operational rather than research income (see Figure 28). Tier 2 MRIs were slightly more reliant on research income. MRSP funding makes up a smaller proportion of income for tier 3 MRIs compared with tier 1 and 2 MRIs.

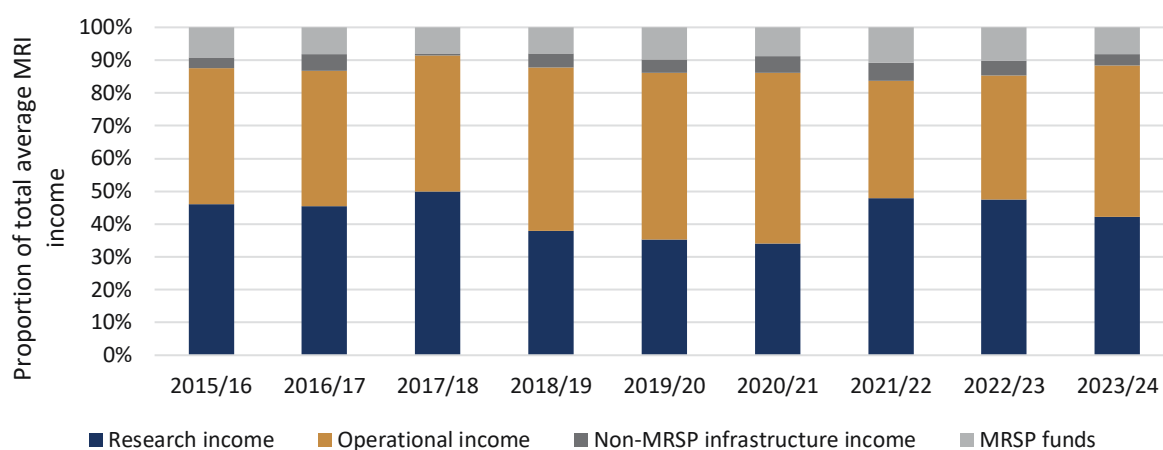
Taken together, tier 3 MRIs appear to be leveraging MRSP funds to increase income from other sources most effectively.

Additional supporting graphs are shown in Appendix 6.

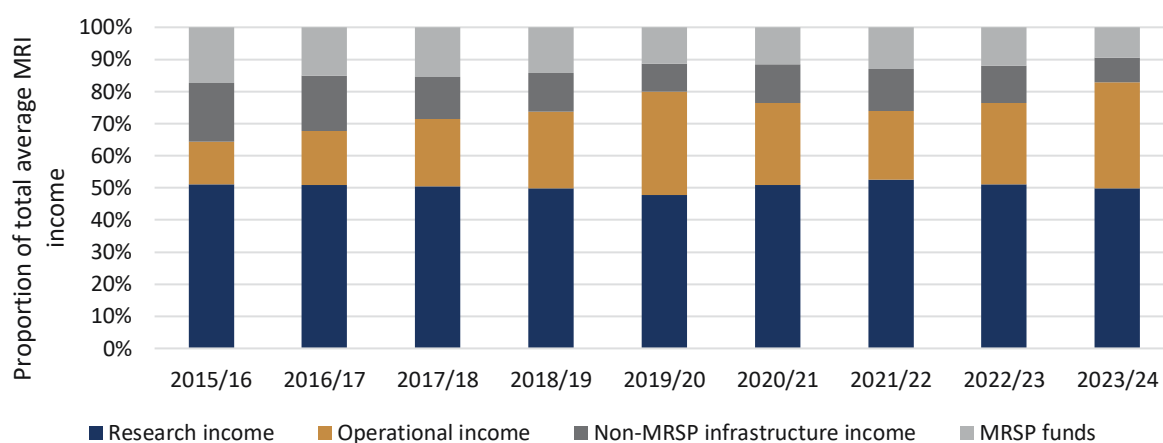
³⁵ 11 MRIs contributed data towards research income. 12 MRIs contributed data for all other income types including total income.

Figure 28. Proportion of average MRI income by income type and tier

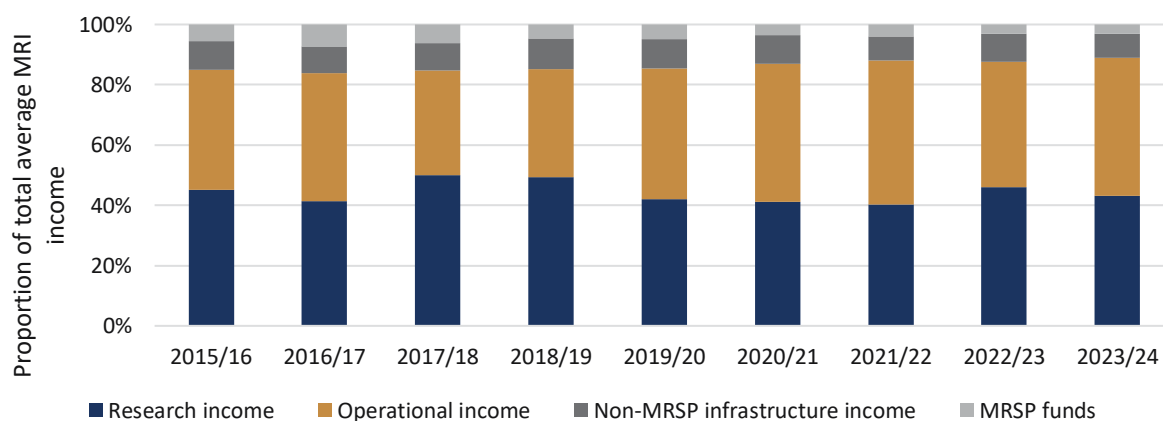
Tier 1



Tier 2



Tier 3



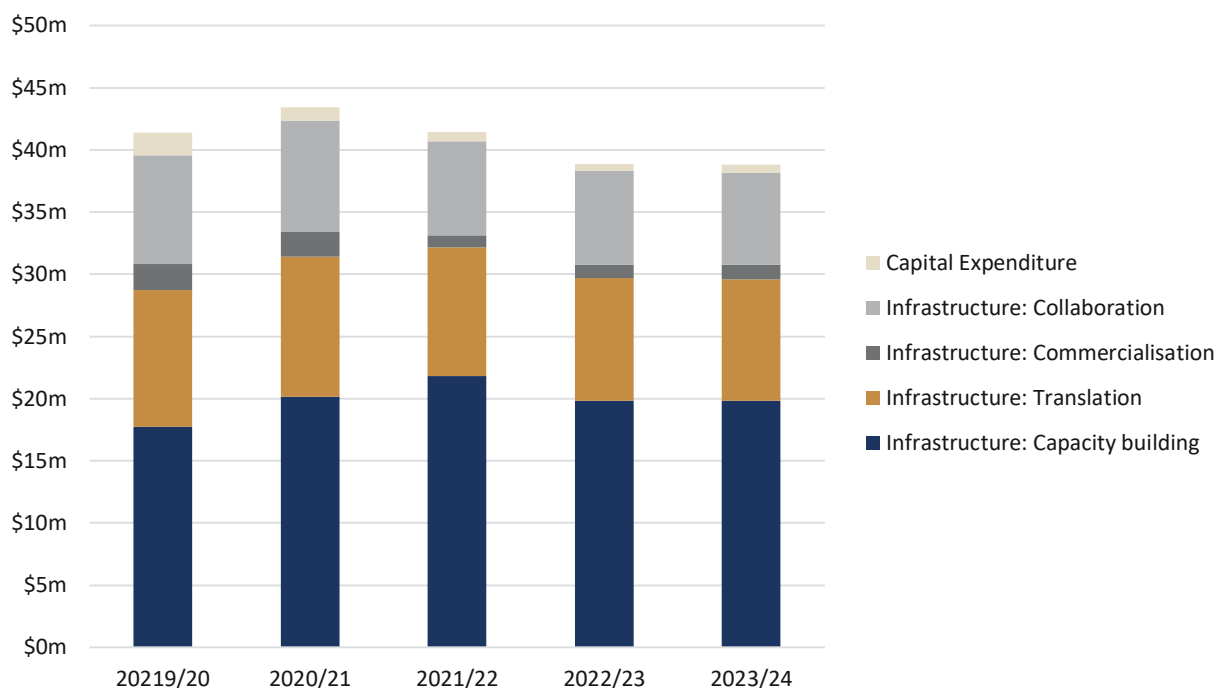
Data source: Annual financial reporting by MRIs to OHMR (as per the requirements for receiving MRSP funding)

Supporting Evidence D – Flexibility in allowable expenses enhances stability and revenue generation

Funded MRIs described that one of the primary benefits of the MRSP was their ability to spend it on core costs that other sources of funding would not cover. MRIs noted that often philanthropic donors provide funds for specific initiatives that are meaningful for them and do not wish for their funds to be spent on core business expenses – *“that’s not something that motivates people to put their hand in their pocket”*. With MRSP funding, they have greater freedom to use other sources of funding, such as funds raised through philanthropy and fundraising, directly for research.

The flexibility to spend MRSP funds meant that MRIs invested in core business functions such as personnel for research development, business development, finance, commercialisation and translation. This was reflected in examination of how MRSP funds are expended by MRIs (Figure 29). MRIs also claimed that without this funding, core business staff would have to be cut back, which meant that researchers would be spending more of their time on administration, finance management and human resource management, reducing their research productivity.

Figure 29. Total MRSP expenditure for all MRIs by activity type



Data source: Annual financial reporting by MRIs to OHMR (as per the requirements for receiving MRSP funding)

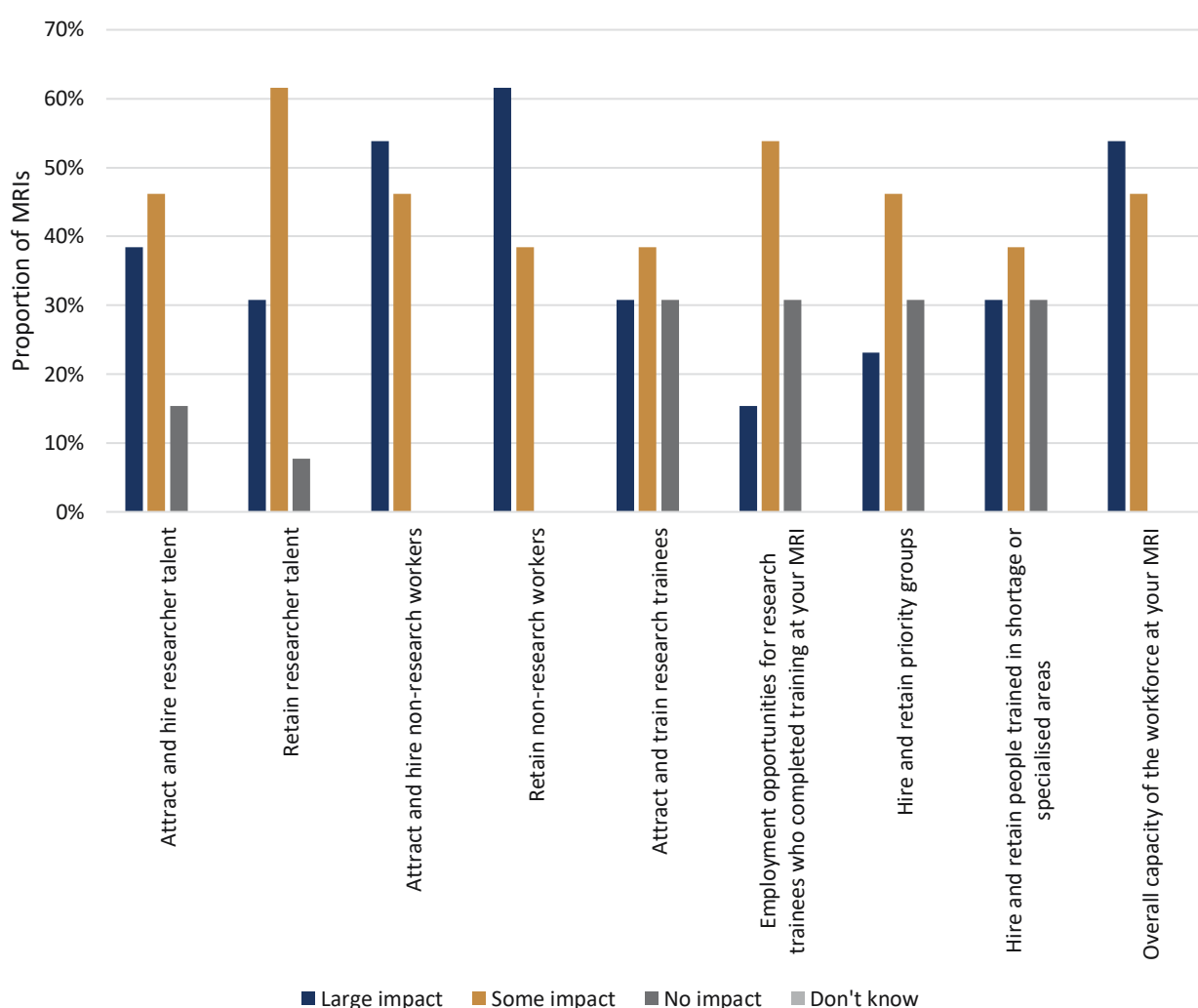
Contribution towards building the research workforce and capacity

"Staffing costs are by way the largest single item in what we do. There's fixed costs that we can't get around, in terms of the way our research is structured, building and outgoings and all that sort of stuff. So our biggest lever are people, so we'd lose people. That's without any doubt, and we'd lose opportunity."

MRI Senior Executive

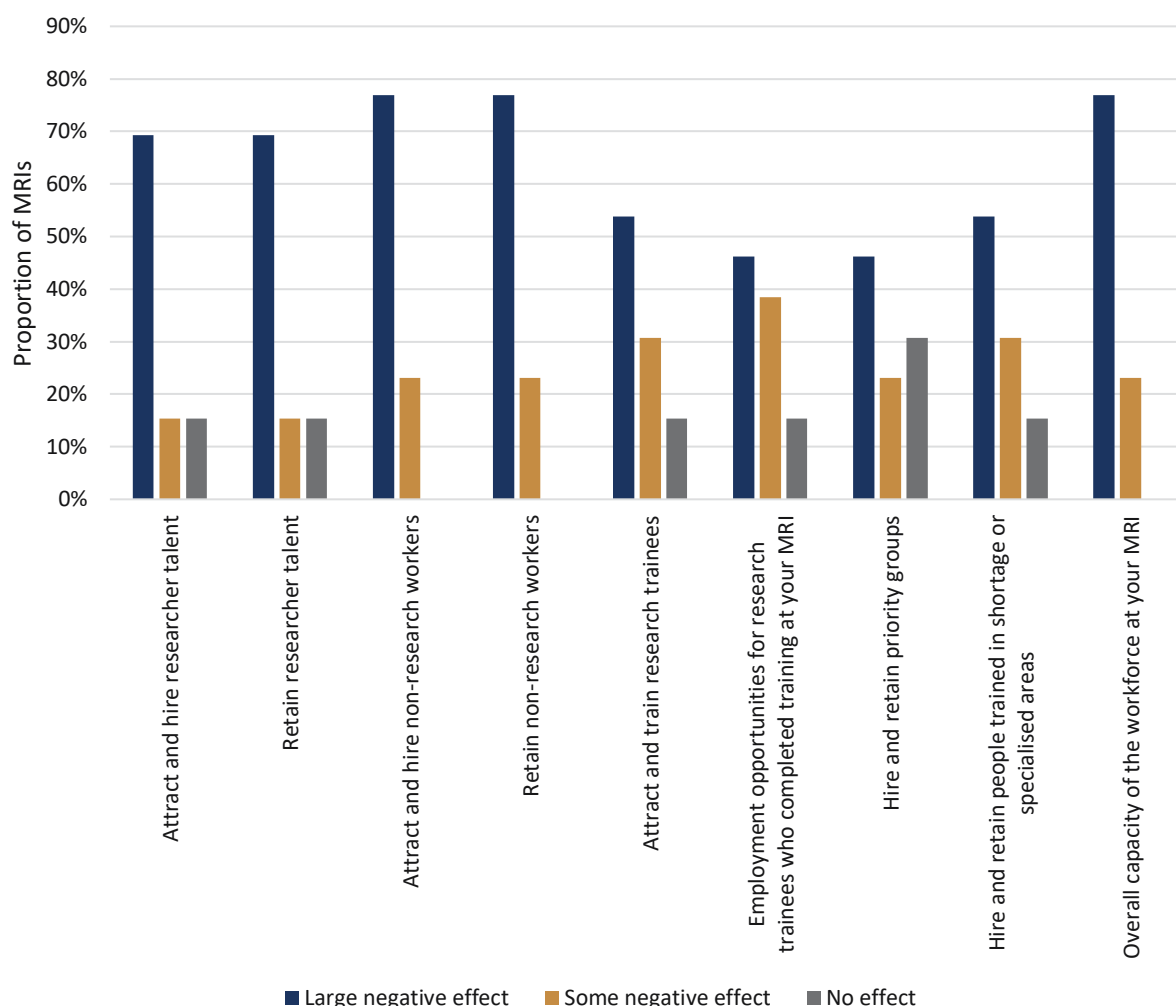
MRIs described the MRSP as crucial for research and especially for non-research workforce. This was reflected in survey responses about the MRSP's impact on workforce at MRIs (see Figures 30 and 31).

Figure 30. MRI perceptions of the incremental benefits of the MRSP on the workforce capacity and capability at their MRI



Data source: Director-level survey of currently funded MRSP MRIs

Figure 31. MRI perceptions of the impact of ceasing the MRSP on their workforce capacity and capability



Data source: Director-level survey of currently funded MRSP MRIs

Summary: How the MRSP contributed towards the research workforce and capacity

- MRSP funding directly supports salaries for non-research workforce who contribute enabling core support infrastructure to MRIs, i.e. operational and translational roles
- A strengthened and stable non-research workforce enables improved opportunities to acquire research funding and improve research quality
- Opportunities availed by these core support services and investment in technological and physical infrastructure attracts world-class research talent
- The flow on effects include additional researchers, including research trainees, being attracted to NSW MRIs
- The MRSP has also been invested in workforce initiatives such as diversity, equity and inclusion initiatives

Supporting Evidence A – Benefits for non-research workforce and overall capacity of MRIs

"Our infrastructure is our people."

MRI Director

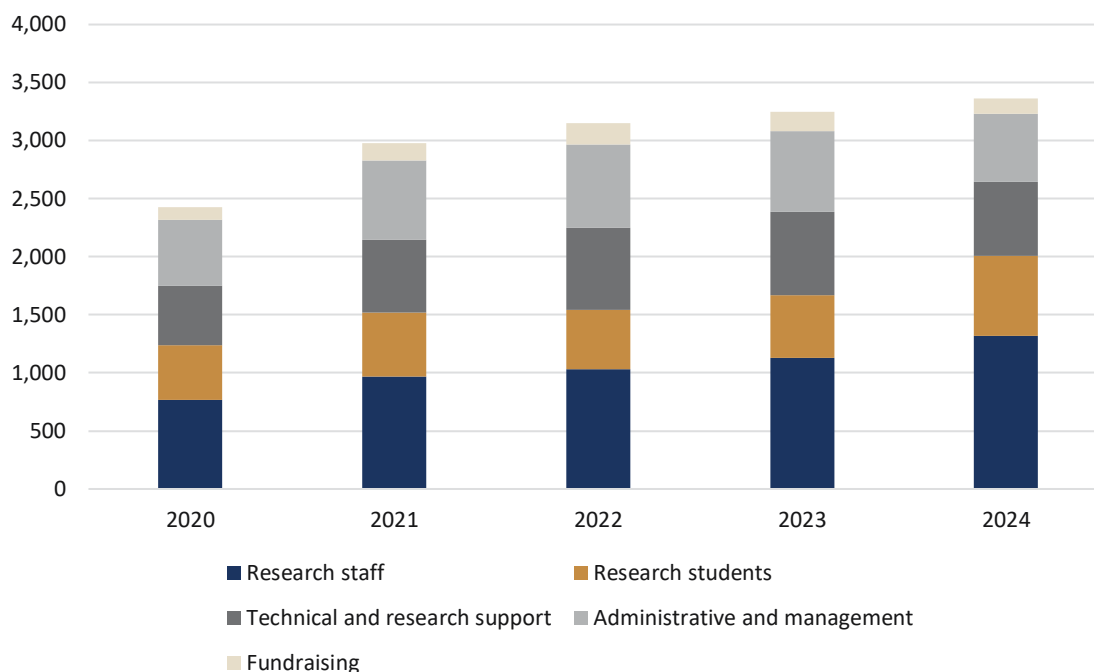
During interviews, MRIs convey that the MRSP directly supported salaries for personnel in operational and translational roles, such as business development, grants management and administration, research governance, information management, clinical trial coordination, and commercialisation, linking workforce development with institutional sustainability and diversification of income streams. Some institutes directed MRSP funds towards translation and impact teams working alongside researchers, helping to enable translation. This investment in the back-office support was perceived as being necessary to elevate the quantity and quality of research conducted by MRIs, in turn attracting additional research funding, opportunities and talent. MRIs emphasised that talented researchers are only attracted to institutes where these back-office support mechanisms are in place. This can be seen in Figure 32, where MRSP investment allowed for stability in hiring non-research workforce across the period of time with incremental increases in the numbers of research workforce.

MRIs with a commercialisation focus emphasised that technology transfer offices required specialised resourcing with personnel who knew how to navigate and file patents, manage patents and leverage them to licenses that could generate a stream of income.

MRIs stated that the MRSP directly supported salaries for these back-office functions, therefore loss of MRSP funding would mean the loss of these functions with flow on effects for research quality, translation, commercialisation, and income from grants and other sources. All MRIs stated that the MRSP had increased their capacity to hire and retain non-research workforce, and that there would be substantial negative impacts if the funding was lost.

A few institutes said that they invested some of their funds in workplace programs to support diversity and inclusion in research, such as diversity, equity and inclusion initiatives, women in science programs and travel and carers grants.

Figure 32. Total number of full-time equivalent staff (FTEs) by type of staff for all MRIs³⁶



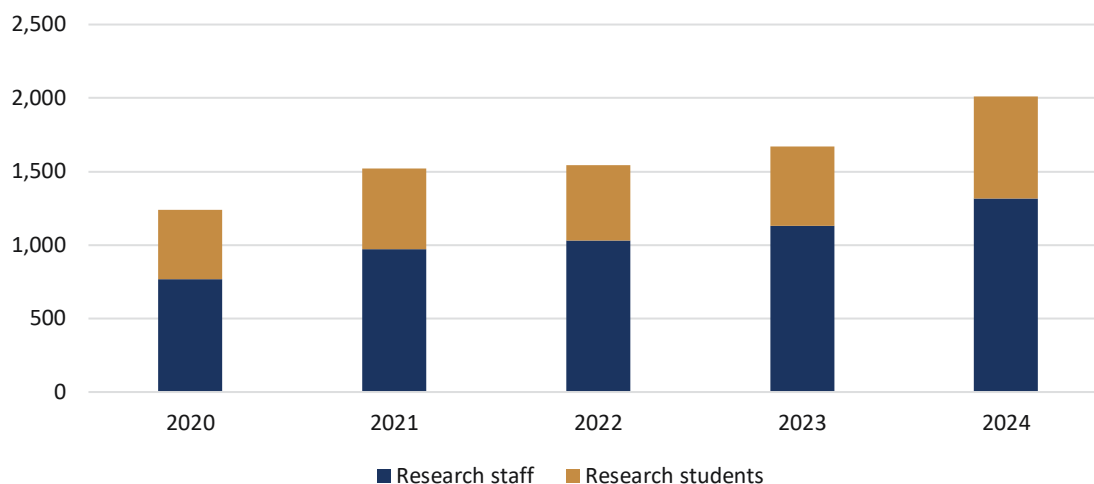
Data source: Annual reporting by MRIs to OHMR (as per the requirements for receiving MRSP funding)

Supporting Evidence B – Benefits for increasing and sustaining research workforce size

MRIs claimed that the MRSP has helped **to attract researchers** to their institutions and compete with universities for the best and brightest researchers, resulting in increases in the research workforce size across MRIs (see Figure 33). Enabling MRIs to access cutting edge technology creates opportunities for researchers, therefore attracting research talent to those institutions. Sustained investment in research infrastructure at the state-level by the NSW Government through the MRSP has signalled that NSW is “open to business” for researchers. This has helped to attract and retain high-calibre researchers to NSW MRIs, enabling NSW to compete nationally and internationally for talent, placing NSW as a hub for world-class research. One MRI that had previously struggled to attract researchers noted substantial organisational growth, i.e. approximately 300% in the past 7 years, that could be traced back to the MRSP. They further stated that demand for trainee positions had increased to the point that they were now turning applicants away.

³⁶ Caution should be applied in interpreting these data as data were missing for some MRIs in some years. All workforce data were unavailable for 2 MRIs for 2020. For another 2 MRIs, data on research workforce were missing for certain periods (2020-2022, and 2020-2023) as research staff at those MRIs had conjoint appointments.

Figure 33. Total number of full-time equivalent staff (FTEs) for research staff at all MRIs³⁷



Data source: Annual reporting by MRIs to OHMR (as per the requirements for receiving MRSP funding)

Supporting Evidence C – Benefits for increasing research workforce capacity

In some precincts, MRIs provide protected research time for clinicians based within LHDs, directly strengthening the research-active clinical workforce with implications for the quality of research conducted within health facilities and building clinical trial capabilities. Some MRIs used funds from their operational or discretionary budgets to cover salary gaps for researchers particularly where there was a gap in coverage between grants, providing researchers with some stability and job security and reducing attrition to other institutions or universities.

Institutes used funds to support postgraduate training, support early and mid-career researchers, and establish research team leaders that enabled succession planning. For example, MRSP funds was used for a team leaders' program at one institute, whereby emerging researchers were mentored to become future leaders. This initiative was only able to be operated due to MRSP funds; in recent years, this initiative has ceased as increasing cost pressures have eroded any surplus of funds, with MRSP funding redirected towards other unavoidable operational costs.

Breakout box 5. Example of the MRSP's impact on ability to attract world-class researchers to NSW MRIs leading to increased opportunities for capacity growth

An MRI's advanced imaging facility, which includes high-end MRI and other technical capabilities, was seen as pivotal in attracting a world-leading psychiatrist and neuroscientist specialising in systems-level neuroscience to its neuroscience and brain health program. This appointment generated several flow-on effects, including attracting visiting researchers, hosting symposia and workshops, and catalysing a growing dementia research program that includes trialling new treatments. The presence of a leading researcher has also strengthened collaborations and networks, creating opportunities for growth and mentorship for junior and emerging researchers in a regional setting.

Data source: Consultation with a currently funded MRSP MRI

³⁷ Caution should be applied in interpreting these data as data were missing for some MRIs in some years. All workforce data were unavailable for 2 MRIs for 2020. For another 2 MRIs, data on research workforce were missing for certain periods (2020-2022, and 2020-2023) as research staff at those MRIs had conjoint appointments.

Case study 4. Investing in scientific skills and capability to further research and innovation: Establishment of the NSW Organoid Innovation Centre (CMRI)

MRI activity

The Children’s Medical Research Institute (CMRI) is a founding partner in establishing the NSW Organoid Innovation Centre, a state-wide platform designed to advance organoid and regenerative medicine research in NSW. Building on more than a decade of MRSP-supported capability, CMRI expanded its Stem Cell and Organoid Facility in 2023 with new expert staff, automated culture systems, biobanking, and computational imaging and analysis pipelines. These capabilities supported the development and standardisation of multiple organoid systems, including brain, retinal, intestinal, liver and kidney models, under robust quality and biosafety frameworks. The Centre enables precision medicine research, disease modelling, gene therapy validation and drug discovery, and provides a shared infrastructure that supports collaboration across universities, hospitals and industry.

Impact

The Centre has delivered significant scientific, translational and economic impacts, including:

- Support for research into paediatric neurological disorders, retinal dystrophies, congenital metabolic conditions and cancer.
- Validation of gene therapy constructs and genome-editing approaches, contributing to progression of rare disease programs, including progressing an OTC-deficiency gene therapy to clinical trial.
- Increased grant competitiveness, driving significant grant income generation by strengthening applications requiring advanced functional genomics or disease modelling capability.
- Anchoring collaborations and contributing to the NSW research ecosystem by providing shared equipment, bioinformatics, automated imaging, and high-throughput analysis capacity, supporting skilled jobs, shared infrastructure and reduced duplication across the Westmead precinct.

Contribution of the MRSP

MRSP funding underpinned an estimated 25–30% of the Centre’s foundational staffing and operational base, enabling recruitment and retention of highly specialised technical and scientific roles that cannot be supported through short-term grants. The MRSP particularly supported the recruitment of highly specialised facility workforce underpinning the Centre, including senior scientists, bioengineers and technologists. The MRSP also covered essential operational, compliance and maintenance costs critical to sustained, high-quality organoid production. Without this stable funding, the Centre would not have achieved its current scale or state-wide role, and the scientific and translational impacts would have occurred at a substantially reduced scale or not at all.

“Without MRSP, NSW would lack a large-scale, sovereign organoid capability. CMRI would have been limited to small research-level organoid experiments, severely reducing translational potential, limiting collaborations and slowing therapeutic development.”

Data source: Case study provided by MRI

Support Evidence D – The counterfactual

MRIs claimed that without the MRSP, both their research and non-research workforce size would shrink, substantially reducing capacity to conduct research and translate its benefits.

Breakout box 6. An example of the impact of losing MRSP funding on workforce capacity

One institute that lost MRSP funding for a period of time recalled that their ability to recruit any personnel, research and non-research, was severely constrained during the period without MRSP funding. Researchers who could not be reappointed were lost, with a number of long-term research groups being affected. By the time they had sufficient funding to hire them back, those researchers had found employment elsewhere.

Data source: Consultation with a currently funded MRSP MRI

Contribution towards excellence in research

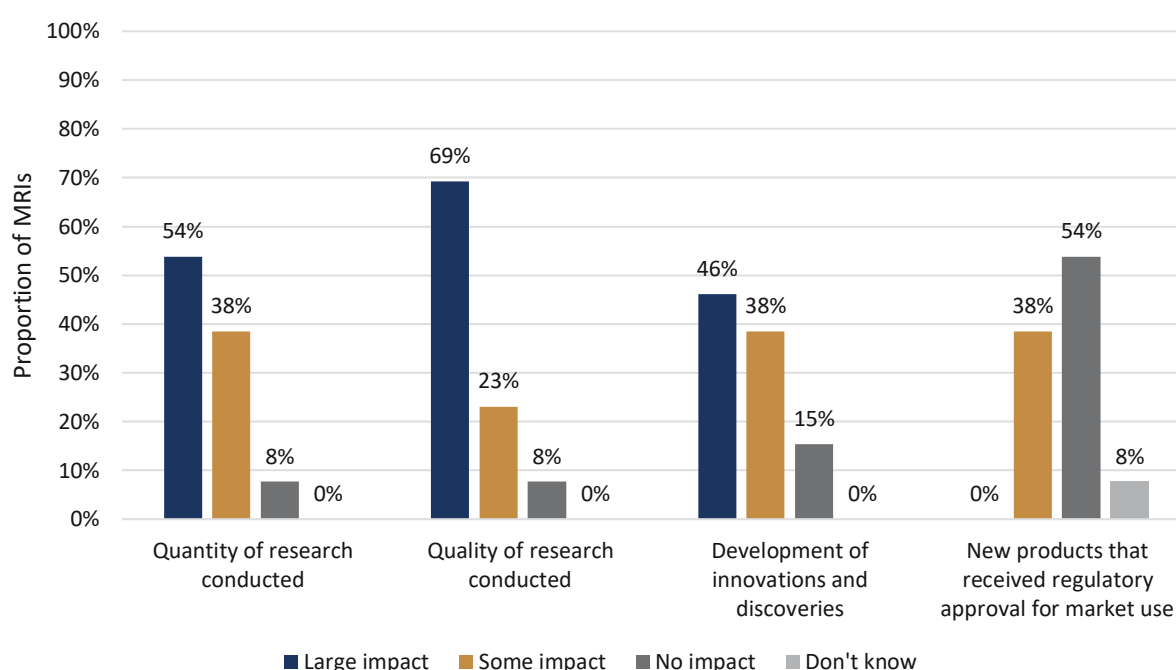
"These types of initiatives, some might have existed, but you can't say the totality of what we're doing wouldn't have existed without this support."

MRI Director

MRIs highlighted the role of the MRSP in strengthening both the quantity and quality of their research. Across MRIs, the MRSP was widely regarded as having strengthened research excellence by allowing institutes to take a more deliberate and strategic approach to their research programs. With certainty of funding, MRIs were able to be more strategic in the research areas that they targeted and invest in platforms that enhanced scale, quality and competitiveness. This improved their ability to be successful in acquiring research and philanthropic income (as detailed in the section on impact on the financial stability of MRIs), enabling them to conduct further research.

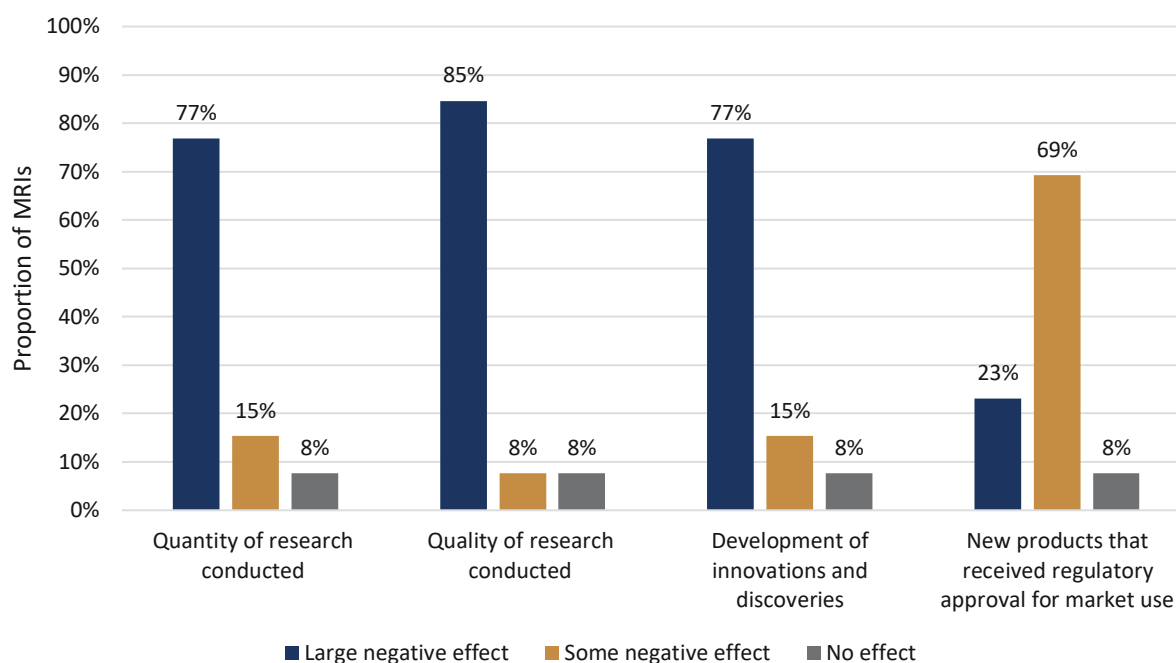
MRIs claimed that in the absence of the MRSP, they would have to operate at a reduced capacity, and the quantity and quality of the research itself would be at risk despite funding for research coming from other sources. This is a result of the flow-on effects of reduced operational capacity, reducing their ability to be competitive and acquire grant and other funding for research, leading to reduced research outputs. These findings are reflected in the MRI surveys, with the vast majority (12 of 13 MRIs) perceiving that the MRSP had an impact on the quantity and quality of research (see Figures 34 and 35). Additionally, MRIs ranked the quality of research as one of the top areas that the MRSP had impacted.

Figure 34. MRI perceptions of the incremental benefits of the MRSP on research outputs at their MRI



Data source: Director-level survey of currently funded MRSP MRIs

Figure 35. MRI perceptions of the impact of ceasing the MRSP on their research outputs



Data source: Director-level survey of currently funded MRSP MRIs

Summary: How the MRSP contributed towards achieving research excellence

- Allowed investment in business functions, such as research grants management and research governance, that improved the quality of the research and grants
- Allowed investment in strategic platforms and research enablers, such as data sciences, statistical support and core facilities and laboratories, that support and enhance research across the institute
- Contributed to infrastructure, particularly running costs, that allow innovative, cutting-edge research to be conducted
- Contributed to fund blue sky strategic work and pilot projects where funds were limited, strengthening their positioning for subsequent nationally competitive funding
- Filled shortfalls in indirect costs, freeing funding from other sources, such as philanthropy, to be allocated directly towards research, thereby expanding both the scale and diversity of research conducted.

Supporting Evidence A - MRIs used MRSP funding to invest in infrastructure to support research programs

"The MRSP provides the underlying functionality of the Institute, which primarily is for NHMRC, MRFF and some other types of things. But because it's there, and it has to be there to achieve those things, we can use that same resource and functionality to springboard into other growth areas, which is what we've done in this context. So not it's not a super direct relationship, it's kind of, I guess, a few steps along the way to see how it works. But if we didn't already have that in place, we wouldn't be able to do the other work."

MRI Director

As described in the section on the MRSP's contribution to research infrastructure, MRIs described investing their MRSP allocation towards platforms and capabilities that supported research across multiple programs at MRIs. These included data sciences, health economics, statistical support units, core facilities and laboratories, and clinical staff to bridge institutes with health services. They additionally invested in core business services to support research, such as a research grants office. This capability helped to improve the quality and competitiveness of grant applications, therefore improving success in obtaining grants. Examples are provided in the table on Exemplars of the MRSP's contribution to research infrastructure in [Supporting Evidence A for the benefits of the MRSP towards improved research infrastructure](#). Additional examples of research excellence are provided in the table below and in Appendix 5.

Table 6. Exemplars of research excellence tied to infrastructure underpinned by MRSP funding

Broad research area	Exemplar
Basic science research	• Researchers have developed PROTEUS, a patented platform that enables directed evolution of proteins directly within mammalian cells, providing a more effective and biologically relevant alternative to traditional methods performed in bacteria or yeast. A proof-of-concept study showed significant improvements ($p < 0.001$) across different protein types, including a transcription factor for potential gene-therapy applications and a nanobody capable of visualising the tumour suppressor p53 in living cells. Commercial opportunities for the platform are being explored. • A large world-first research program involving and led by MRSP-funded MRIs has built the world's largest cancer proteomics database, analysing tens of thousands of tumour samples to develop a library of information that can enable new discoveries in personalised cancer diagnosis. The MRSP did not contribute directly to this work, but is indirectly linked due to funding used for core business capabilities, such as IT and cybersecurity, that underpinned the ability to undertake this work. • A breast cancer research consortium has combined unique patient sample cohorts with leading expertise and technologies to generate the largest and most detailed single-cell and multi-omic dataset describing breast cancers and their surrounding ecosystem.

	A specialised innovation centre has established advanced stem-cell production and high-throughput cardiac screening facilities, enabling rapid, scalable modelling of heart disease, genetic variant interpretation and early drug safety testing. These capabilities have supported clinical decision-making in inherited cardiac conditions, contributed to international drug-safety initiatives, advanced non-animal research approaches, and underpinned nearly 100 research projects and substantial competitive grant income.
Clinical medicine and science research	- The development of the world's first low-dose, fixed-dose combination therapy for hypertension used a novel approach that enabled strong IP protection despite the monocomponents being older molecules. The product has recently received US Food and Drug Administration (FDA) approval and has been licensed to multiple companies across several countries. - A regional neuroimaging centre established the first research-grade magnetic resonance imaging facility in regional NSW, enabling advanced neuroimaging and cardiovascular imaging across more than 70 research projects spanning cardiology, oncology, respiratory medicine, musculoskeletal health and mental health, and has involved collaborations across local, national and international partners.
Health services research	- A major program of work in diabetes and obesity integrates research, education and clinical services in partnership with hospitals, health districts and primary care networks, contributing towards improving diabetes prevention, screening and management. This program includes landmark studies on early gestational diabetes screening and treatment, long-term outcomes, lifestyle interventions across multiple countries, and the development of evidence that has informed national and international clinical guidelines. - A binational hip fracture registry supports hospitals across Australia and New Zealand to benchmark care against national standards and drive quality improvement, with data contributed by more than 100 hospitals. The registry has underpinned national clinical guidelines and contributed to measurable improvements in hip fracture care, including increased use of nerve blocks, earlier mobilisation after surgery, improved cognitive and delirium assessment, and reduced unwarranted variation in care.
Public health research	A lifespan suicide-prevention trial, based on the World Health Organization (WHO) suicide-prevention model and implemented in NSW, brought together 152 organisations for coordinated implementation and research. More than 25,000 health professionals, educators, students and community members were trained to recognise and respond to suicide risk or received support for suicidal distress. The trial demonstrated reductions in intentional self-harm through an integrated, systems-based approach.

Data source: Consultation data and case studies submitted by currently funded MRSP MRI

Case study 5. Fostering research excellence through the Victor Chang Innovation Centre's Stem Cell Production, and Cell Function and Screening Facilities

MRI activity

Two out of the 8 core components of the Victor Chang Cardiac Research Institute's Innovation Centre are:

The Stem Cell Production Facility (SCPF), a PC2-certified laboratory equipped with advanced robotics and automation (Hamilton Microlab STAR, Liconic incubators, Sartorius Ambr 250 bioreactor) for high-throughput generation and differentiation of human iPSCs and 2D/3D models, production of cell therapies and broad range of bioprocessing applications. This enables scalable, reproducible stem cell production for disease modelling, drug screening, and regenerative medicine.

The Cell Function & Screening Facility (CFSF), which houses Australia's only suite of high-throughput electrophysiology instruments (automated patch clamp, Micro Electrode Array, kinetic imaging cytometer), enabling rapid assessment of genetic mutations and drug candidates for disease understanding, cardiac safety, and efficacy. Analyses that once took weeks can now be completed in hours, accelerating research into arrhythmias, sudden cardiac death, and drug-induced cardiotoxicity.

These facilities have contributed research towards:

- Inherited heart rhythm disorders: Validated rapid laboratory tests to assess genetic variants linked to inherited arrhythmias, helping clinicians reclassify uncertain genetic findings and improving guidance used in clinical practice internationally.
- Drug safety: Developed models and assays for early drug safety assessments, contributing to international drug safety initiatives and informing regulatory decision-making.
- Non-animal research models: Advanced the use of human stem-cell-based models to study heart disease and test new therapies, positioning VCCRI as a co-lead of the NSW Government's Non-Animal Technologies Network (NAT-Net), reducing reliance on animal models and accelerating drug discovery.

Impact

The facilities have delivered significant clinical, research and economic impacts, including:

- improved clinical decision-making in inherited cardiac conditions by enabling more accurate assessment of genetic variants linked to sudden cardiac death.
- Reduced uncertainty around previously unclear genetic findings and strengthened early drug safety screening through high-throughput laboratory assays, supporting the development of safer therapies and more efficient drug discovery pathways.
- Supported nearly 100 research projects and over 30,000 hours of infrastructure use.
- Generated nearly 30 peer-reviewed publications and leveraged approximately \$7 million in competitive grant funding across 15 grants.

Contribution of the MRSP

MRSP funding has covered essential indirect costs underpinning the operation and growth of these facilities, sustaining the facilities' workforce, infrastructure and quality systems. It has contributed to the continuous upgrade of these facilities and operational support that enabled the Innovation Centre to attract additional NCRIS, philanthropic, and commercial funding. The funding has enabled operations at a scale and level of reliability not achievable through project grants alone. Without MRSP support, access, training, service provision and collaborative research would have been substantially reduced.

Data source: Case study provided by MRI

Supporting Evidence B – The MRSP contributed towards research innovation and leadership

Several MRIs stated that MRSP funding provided the financial stability that underpinned innovation, enabling them to pivot into emerging fields and technologies with direct clinical applications. This contributed towards positioning NSW MRIs as recognised leaders globally. MRIs also indicated that investments possible through the MRSP had helped to facilitate new discoveries. For example, one MRI highlighted that the MRSP had underpinned some of their flagship research programs and landmark discoveries such as the BiVACOR artificial heart and spider-venom research benefiting cardiac patients. In the survey, 11 of 13 MRIs perceived that the MRSP had at least some impact on developing innovations and discoveries, while 10 of 13 perceived there would be a large impact on innovation and discovery if the MRSP were not available (see Figures 34 and 35). Additional detailed examples are provided in the examples below and in Appendix 5.

Breakout box 7. Example of MRSP's contribution towards innovation

An MRI used MRSP funding to advance key enabling technologies in stem cell science, genomics and artificial intelligence, and to build the physical infrastructure required to support this work, most notably the Human Applications Laboratory. This facility houses the largest clean rooms in NSW, where cell therapies are manufactured. MRSP funds contribute towards covering their operating costs, which are significantly higher than typical laboratory spaces. The laboratory has been central to the development and trialling of therapies for lymphoma and leukaemia, several of which are now being pursued by international consortia aiming to produce these treatments at a fraction of the cost of commercial pharmaceutical manufacture. The facility has supported the development and clinical testing of T-cell therapies for opportunistic infections, which are now approaching Therapeutic Goods Administration (TGA) licensure. The institute's work has also earned them an international reputation of excellence for their work on transplant and renal research, with researchers serving as members of international steering committees.

Data source: Consultation with a currently funded MRSP MRI

Case study 6. MRSP-funded infrastructure that supports research innovation for real-world impact

MRI activity

Breast cancer is highly heterogeneous, with substantial variation between patients and within individual tumours, complicating treatment and contributing to therapy resistance. The Garvan Institute leads the Breast Cancer Cellular Atlas (BCCA), an international research initiative designed to address this challenge by mapping breast tumours at unprecedented cellular and molecular resolution. Building on more than a decade of foundational work, the BCCA integrates single-cell and spatial transcriptomics, whole-genome sequencing, proteomics and detailed clinical annotation to characterise tumour ecosystems and their interaction with the immune microenvironment. Led by Garvan in collaboration with leading international partners including University of Melbourne, Broad Institute (MIT), University of North Carolina, KTH Royal Institute of Technology (Sweden) and others, the program represents a step-change in how breast cancer biology is studied and translated into precision oncology.

Impact

Early pilot studies established the value of ecosystem-level tumour profiling, generating a globally referenced “mini-atlas” that has been downloaded by more than 30,000 researchers, cited over 1,200 times, and had associated datasets accessed more than 7,000 times across 17 countries. Over the past decade, BCCA-affiliated work has resulted in 37 publications with more than 4,300 citations, alongside extensive international dissemination through invited keynote presentations at major scientific forums. These outputs reflect substantial methodological advances, including new approaches to tumour stratification, identification of novel biomarkers and therapeutic targets, and improved understanding of treatment resistance. The program has also strengthened research infrastructure through specialised tumour biobanking, shared technology platforms, and workforce capability in single-cell and spatial genomics, establishing the Atlas as a foundational global resource for precision oncology.

By transforming how breast cancer is understood and treated, the BCCA is delivering meaningful real-world impact for patients and the health system. By moving beyond broad molecular subtypes to classify tumours based on their cellular ecosystems, the program enables more precise, personalised treatment decisions. Integrated single-cell, spatial and genomic analyses will inform therapy selection, reducing unnecessary overtreatment, and revealing tumour-microenvironment interactions that drive disease progression. These insights are now shaping clinical trial design and supporting the development of new combination therapies progressing to early-phase trials, while open data sharing continues to position Australia as a leader in cancer omics research.

Contribution of the MRSP

MRSP funding was foundational to the BCCA, contributing an estimated 30% of the initial technological and workforce capacity required to establish the program that led to the reported impacts. MRSP support enabled:

- acquisition and sustained operation of cutting-edge single-cell and spatial analysis platforms, with funding directly supporting the purchase of cutting-edge single-cell and spatial analysis equipment (such as 10X Visium HD and Xenium)
- recruitment of specialist scientific and bioinformatics expertise necessary to pioneer the complex single-cell methodology and perform the advanced data analysis.

Without this long-term, stable funding, the pilot atlas, methodological breakthroughs and subsequent leverage of major international funding, including a US\$6 million US Department of Defence grant, and securing further capital investment (e.g. additional 10X Xenium and Bruker MALDI-2 mass spectrometry equipment) would not have been possible.

Data source: Case study provided by MRI

Supporting Evidence C – The MRSP enabled MRIs to conduct research in under-researched and underfunded areas

Some MRIs reported investing in programs of research where they identified a specific need or demand for it, despite incurring a loss to conduct this work. Examples included investment in clinical trials in a socio-demographically diverse area where access to clinical trials was previously limited, and enabling technological platforms for genomics research available to external researchers with the MRSP crucial to cover the balance of costs to run this equipment.

Case study 7. A genome sequencing platform for Indigenous Australians

MRI activity

Indigenous Australians are among the most under-represented populations in global genomics research, creating a major gap in both equitable genomic medicine and understanding of human genetic diversity. The Garvan Institute led a landmark genomics study, published in *Nature*, using advanced long-read sequencing technologies to analyse genomes from individuals in 4 remote Aboriginal communities. This work represented the most comprehensive genomic survey of Indigenous Australians to date. This research forms the foundation of a long-term national Indigenous Genomics program, co-led with the Australian National University, designed to engage Indigenous communities and support more inclusive genomic medicine. The study identified extensive previously uncharacterised genetic variation, including over 300 unique large ‘structural’ gene variants per individual, and genetic differences between communities. The findings highlighted the depth of genomic diversity within Australia and challenged assumptions of a single, homogenous Aboriginal genetic ancestry.

Impact

This work addresses a critical inequity in genomic healthcare arising from the absence of Indigenous Australians from international reference datasets that underpin clinical genetic interpretation. Without representative genomic data, individuals from Indigenous communities face increased risk of misdiagnosis or missed diagnoses, limiting access to appropriate treatments and clinical trials. By characterising previously undocumented genetic variation, the study provides an essential foundation for improving diagnostic accuracy and ensuring Indigenous Australians can benefit from advances in genomic medicine. Beyond health equity, the research fills a major gap in global understanding of human genomic variation, given Australia’s unique population history. The program has also established a trusted, community-engaged framework for ongoing national research, promoting equitable and inclusive genomic healthcare in Australia.

Contribution of the MRSP

MRSP funding was critical to enabling this work, contributing an estimated 30% of the initial technological and workforce capacity required. The support contributed to establishing the advanced, shared long-read sequencing genomics infrastructure at Garvan. This infrastructure included resource-intensive, cutting-edge equipment necessary for the landmark *Nature* study, such as the Oxford Nanopore PromethION P48 for high-throughput long-read sequencing and the Diagenode Megaruptor 3 for precise DNA shearing. Without sustained MRSP funding, the technical capacity and specialised expertise to operate it would not have been available, preventing or delaying the deployment of long-read sequencing and the characterisation of the complex structural variants unique to Indigenous Australians.

Data source: Case study provided by MRI

Supporting Evidence D – Evidence of increased research outputs

Data on publications and citations metrics for the 13 currently funded MRIs showed an increasing trend for the number of publications since the commencement of the MRSP in 2012 across all MRIs (see Figure 36). The increasing trend began prior to commencement of the program but appeared to accelerate after 2012. These data provided some strength to claims that the MRSP has increased MRIs' capacity to conduct research.

The proportion of publications published in the top 1% of journals in their respective fields serves as a measure of research quality. This metric varied over time and by MRI, but generally remained in the range between 1% and 15% of all publications since 2012. Similarly, the proportion of publications published in the top 10% of journals ranged between 24% and 61% since 2012. As these statistics are proportions, the overall absolute number of publications in the top 1% and 10% of journals is increasing. Table 7 shows key statistics on publications for the year 2024.

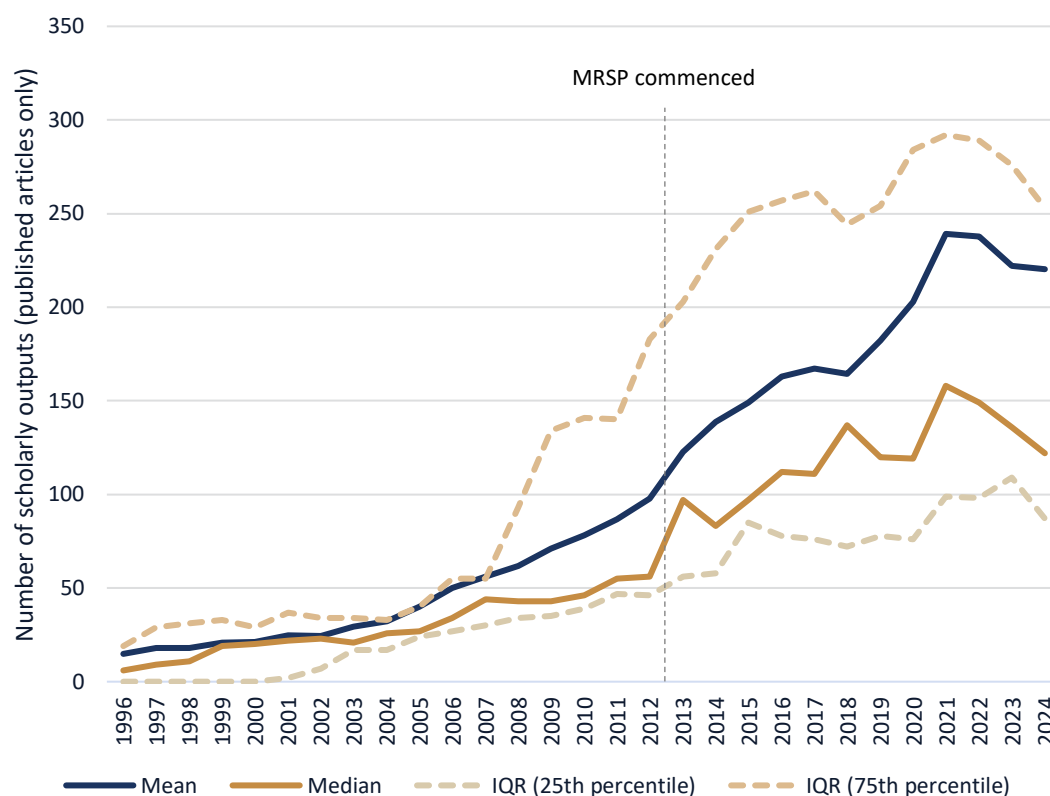
Citations provide another measure of research quality and impact, indicating how widely other researchers are utilising research published by the MRIs. The average number of citations per publication varied widely by MRI and year, likely reflecting key pivotal papers that may have been published by MRIs in specific years. All MRIs had field-weighted citation impact values of greater than 1 for each year of the program, supporting claims of impactful research³⁸.

Methodological note

Data on publications and citation metrics for the 13 currently funded MRIs were extracted from SciVal (Elsevier). In interpreting the findings, the limitations of these data should be noted. Data on numbers of publications obtained directly from MRIs indicated that SciVal does not accurately capture all publications, and the degree of discrepancies vary by MRI. The data captured by the SciVal database which may be affected by changes in indexing of articles over time. Thus, these data are indicative trends only and the absolute values are underestimates. Additionally, any findings, such as the increasing trend in the number of publications or evidence of highly cited research, are difficult to attribute directly to the MRSP, as several factors (such as successfully acquiring research funding and growth in the workforce) contribute towards publication and citation numbers.

³⁸ Field-weighted citation impact measures how citations from a specific institute compare with the world average. It is calculated as the ration of citations received related to the expected world average for the subject field, publication type and publication year. A score of 1 indicates that the institute's publications have been cited exactly as would be expected based on the global average for similar publications. A score of greater than 1 indicates citations above the global average, and a score of less than 1 indicates citations below the global average.

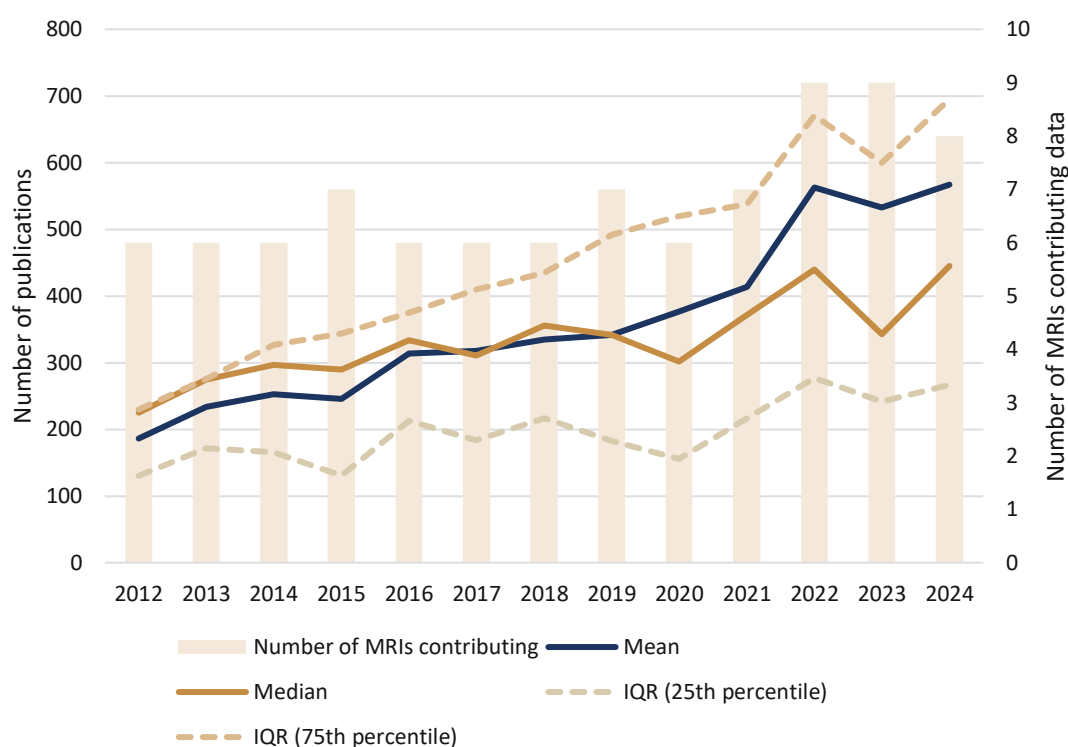
Figure 36. Mean and median annual numbers of publications across the 13 currently-funded MRIs, 1996–2024



Data source: SciVal

We requested data on publications directly from MRIs to validate the findings from data extracted from SciVal. We generally found that the data in SciVal underestimated the number of publications, with MRIs reporting higher numbers of publications than what is reported in SciVal. However, not all MRIs provided data on publications for all years (Figure 37 shows the number of MRIs contributing data for each year). The direction of bias in these data is unclear. However, they do validate the trend identified in the analysis of data from SciVal, i.e. that there has been an increase in the number of publications annually over the duration of the MRSP.

Figure 37. Mean and median numbers of publications based on data provided directly by MRIs, by year, 2012–2024



Data source: Data requested directly from MRIs

Table 7. Key data on scholarly research outputs across the 13 currently funded MRIs in 2024 (extracted from SciVal)

Metric	Median (IQR) ³⁹	Range
Number of scholarly outputs (all types)	182 (136–335)	80 to 916
Number of scholarly outputs (articles only)	122 (87–253)	70 to 706
Proportion of publications in top 1% of journals	6.5% (4.7%–11.6%)	3.8% to 13.3%
Proportion of publications in top 10% of journals	45.4% (37.5%–52.7%)	30.0% to 54.4%
Field-weighted citation impact [#]	2.2 (1.7–3.2)	1.2 to 8.2

Data source: SciVal

There was evidence that some MRIs used MRSP funds to invest in infrastructure that increased the capacity to conduct clinical trials in NSW. The case study below provides an illustrative example of this.

³⁹ IQR = interquartile range (i.e. spread of the middle 50% of data values)

Case study 8. Infrastructure that enables clinical trials: an onsite pharmacy

MRI activity

The Woolcock Institute invested in maintaining specialist clinical trials infrastructure, particularly its on-site research pharmacy, to support investigator-initiated and industry-sponsored drug trials. Operating the pharmacy encompasses maintaining compliant temperature-controlled storage, monitoring and safety systems including backup generators and keeping the pharmacy operational between studies. The costs of establishing the pharmacy were estimated at \$50,000, with running costs estimated at \$10,000 to \$15,000 annually. The Institute sustained this infrastructure during the COVID-19 pandemic, despite a temporary reduction in trial activity, ensuring continuity of facilities, systems and staff capability. As a result, when international borders reopened and clinical trial activity resumed, the Institute was well positioned to rapidly initiate new trials and expand its clinical trials portfolio, including participation in major global drug development programs.

Impact

The research pharmacy facility has been key to undertake pivotal drug studies and kickstart significant and strategically important programs of research. There has been a cascading effect, with initial studies leading to multiple follow-on protocols and longer-term research programs. It has enabled the Institute to act as a lead Australian or global site for pivotal late- and early-phase clinical trials in sleep and respiratory medicine, developing the Institute's national and international reputation in this field of work.

Examples of research studies conducted include:

- The Surmount-OSA study: a pivotal randomised trial of tirzepatide for obstructive sleep apnoea in people with overweight or obesity. The study showed a 59% reduction in apnoea-hypopnoea index compared with 3% for placebo, with up to half of treated participants achieving disease remission, and provided the evidence supporting regulatory approval in the US and Australia.
- Alixorexton Phase 1b study: a phase 1b trial of alixorexton in narcolepsy, involving an intensive inpatient protocol with repeated dosing and objective sleep monitoring. Patients remained at the Woolcock Institute for 10 consecutive nights. The study demonstrated marked improvements in daytime alertness and reduction in disease-associated disability that inhibited the ability to work and drive.

Contribution of the MRSP

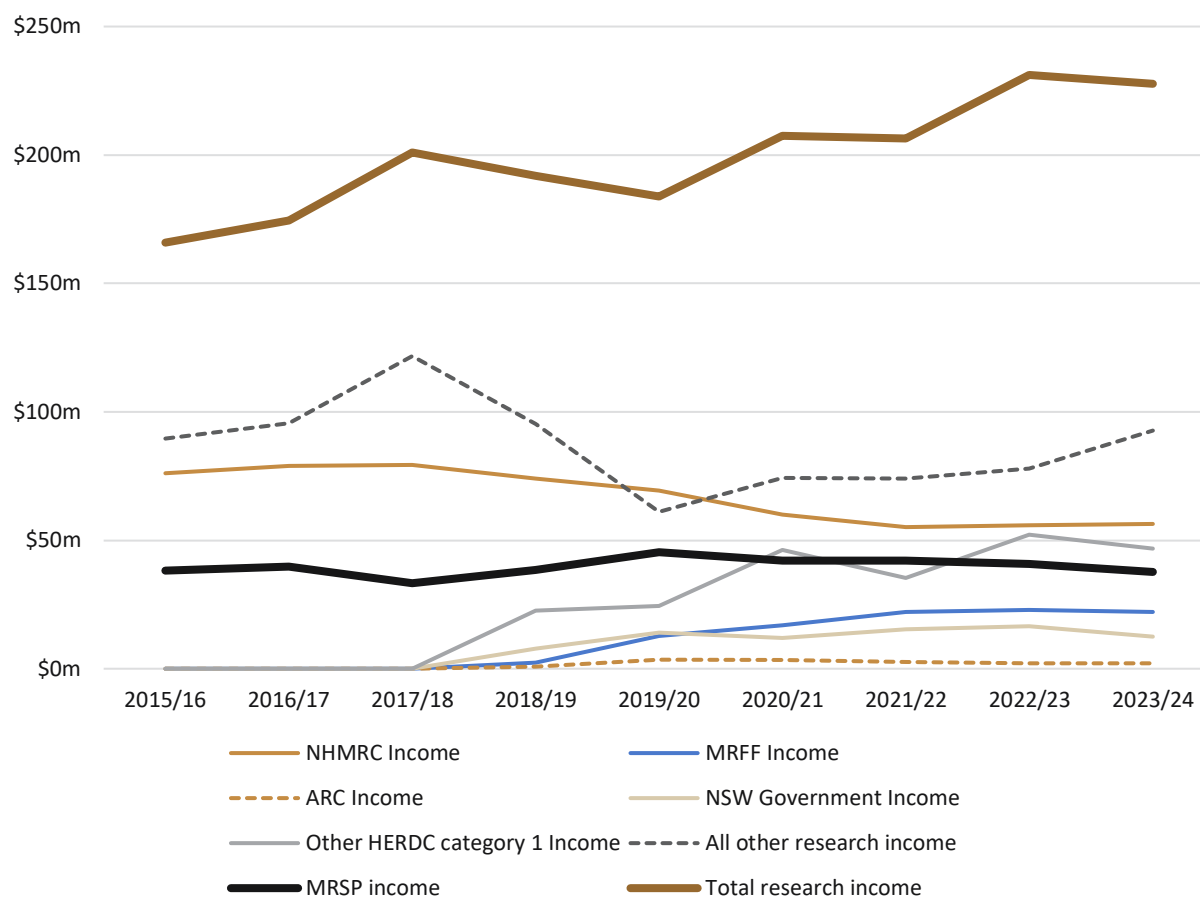
MRSP funding contributed the costs to establish the pharmacy and the annual operating costs, with additional support from active trial budgets. This funding enables the facility to remain operational during periods between studies, when trial budgets alone would be insufficient. Without MRSP support, the facility would be at risk of being decommissioned between trials, significantly reducing the Institute's ability to attract internationally sponsored studies, meet feasibility requirements, and commence new trials in a timely manner.

Data source: Case study provided by MRI

Supporting Evidence E – Category 1 income funding trend

Among research income streams, income from NHMRC grants has decreased over time. Income from other grants, particularly MRFF, NSW Government research funding and other category 1 research income has increased.

Figure 38. Total MRI income from research streams for MRIs⁴⁰



Data source: Annual financial reporting by MRIs to OHMR (as per the requirements for receiving MRSP funding)

Breakout box 8. Example of the MRSP's contribution towards investing in infrastructure to support research programs

An institute's success in developing a gene therapy using infrastructure that has invested MRSP funding is now undergoing clinical trials worth upwards of \$10 million.

Data source: Consultation with a currently funded MRSP MRI

⁴⁰ Included data from 12 MRIs funded for the entire duration of the period shown

Contribution towards increasing research collaboration

"I sort of, you know, mentioned the opportunity to intersect with multiple MRIs, and I think one of the benefits of the MRSP might be to encourage that collaboration across the institutes. You know, I think, we have to be alert to not creating perverse incentives with these types of funds. We really want to be opening it for an open collaboration, and I tend to be a bit concerned that, with some of these arrangements and reducing funding, we create a little bit of an environment of competition. And I think, from a NSW perspective, I wonder how we incentivise better collaboration at scale across those institutes."

LHD representative

There were mixed views on the extent to which the MRSP contributed towards collaboration.

MRSP funding was seen as an enabler of collaboration, both among MRIs and with broader health-sector partners (see Figures 39 and 40). Most MRIs (11 of 13) perceived that the MRSP had at least some effect in increasing research collaborations. Some MRIs cited partnerships between MRIs that had emerged in part due to the MRSP and in an effort to avoid duplication of work and inefficient use of infrastructure and resources.

Figure 39. MRI perceptions of the incremental benefits of the MRSP on research collaborations at their MRI

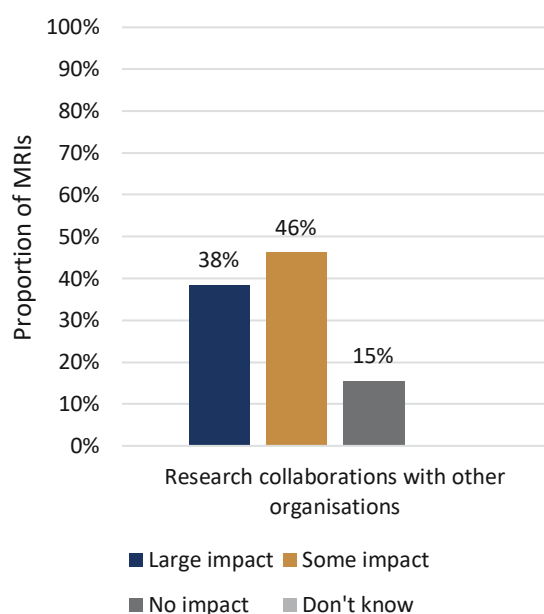
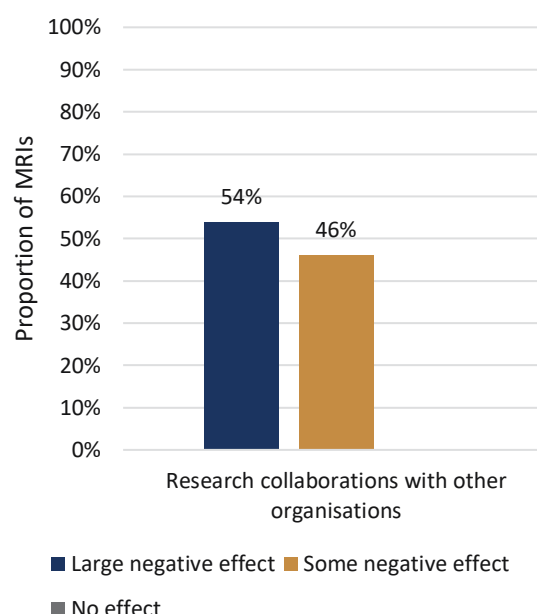


Figure 40. MRI perceptions of the impact of ceasing the MRSP on research collaborations at their MRI

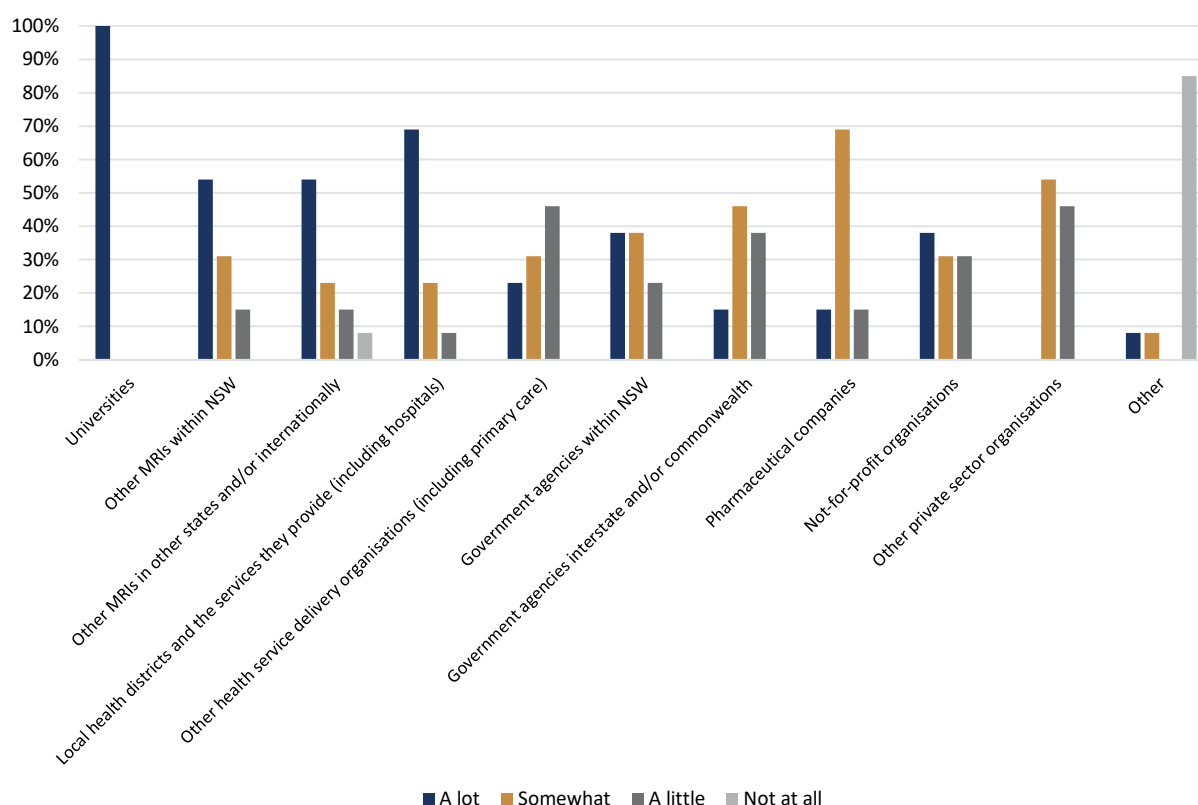


Data sources: Director-level survey of currently funded MRSP MRIs

All MRIs collaborated with multiple collaborators, but the extent and nature of collaboration varied (see Figure 41). Collaborations with universities, LHDs and other MRIs (in NSW or interstate) were the most

common. Collaboration with government agencies and health service delivery organisations outside of LHDs was lower. Overall, this likely indicates that MRIs were most often collaborating with other organisations on individual research projects.

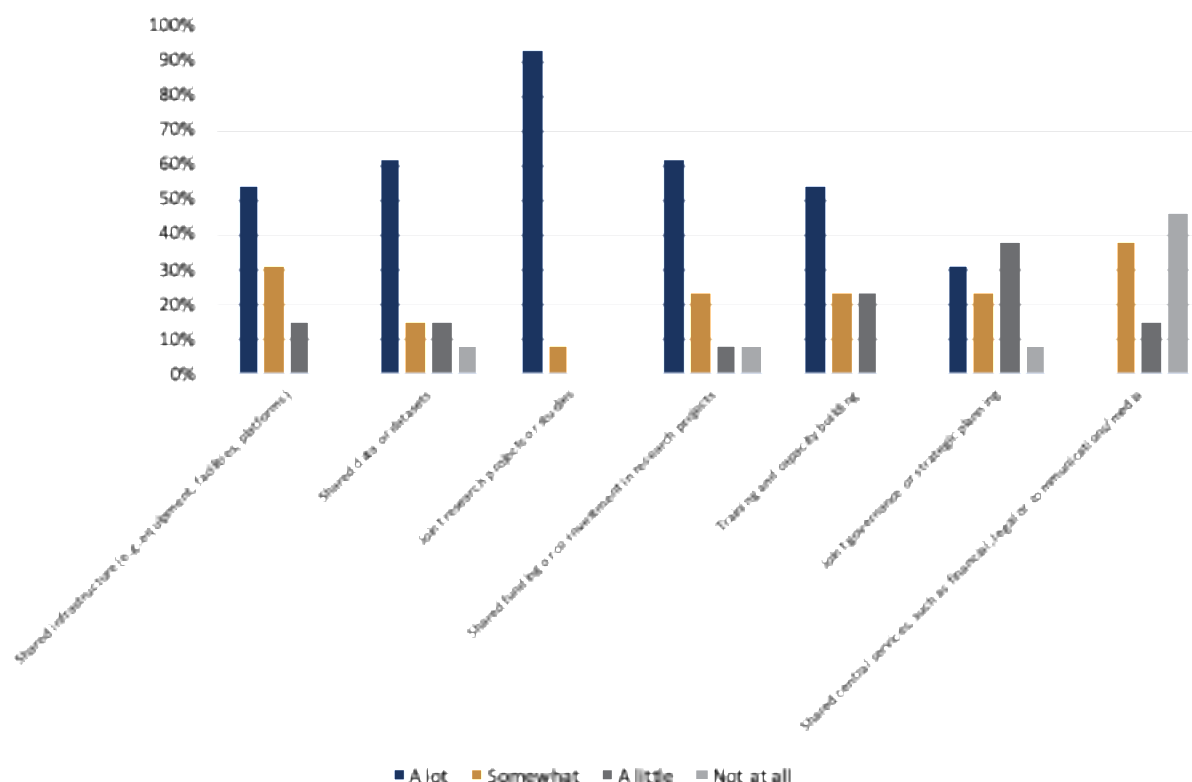
Figure 41. Proportion of MRIs who collaborate with other organisations, by type of collaborator



Data source: Director-level survey of currently funded MRSP MRIs

All MRIs collaborated on joint research projects (see Figure 42), consistent with the findings above. Most MRIs indicated sharing infrastructure and data to some extent, presumably for the purposes of joint research projects. Activities related to training and capacity building were also common. Few institutes shared central service functions, demonstrating limited sharing of operational infrastructure.

Figure 42. Nature of MRI collaborations: Proportion of MRIs who engage in types of collaborations with other organisations



Data source: Director-level survey of currently funded MRSP MRIs

Summary: How the MRSP contributed towards research collaboration

MRIs engage in a wide range of research collaborations that enhance the quality and relevance of their research. These collaborations are largely driven by broader MRI activities and strategic priorities. As a result, there is limited evidence that MRSP funding directly supports research collaboration, and any contribution is likely to be indirect.

Supporting Evidence A – MRSP-funded infrastructure led to national and international research collaboration

MRIs provided examples of how MRSP-funded infrastructure was used by external researchers and also led to national and international collaborations (see Table 8). See Appendix 5 for additional case studies.

Table 8. Exemplars of MRIs' collaborations with other organisations

Collaborator type	Exemplars
Other MRIs or researchers	MRSP funding has been used to support the ongoing costs of operating key technological platforms, including specialised equipment and highly skilled personnel, required for work in single-cell and long-read genomics. Sustained investment in these platforms over more than a decade has enabled extensive collaboration and the attraction of major grant funding, including the National Breast Cancer Foundation's \$25 million collaborative research accelerator grant.
LHDs / health services	- Investment in specialised laboratory infrastructure and the expertise to operate it, combined with an active role within their local health precinct, positioned an MRI to effectively collaborate with NSW Pathology and other health partners to train staff and support the establishment of COVID-19 testing during the pandemic. - The MRSP funded a research nurse to act as a liaison officer between the MRI and hospital which was necessary to set up a cardio-oncology alliance. - MRSP funding supported the operational infrastructure that established Australia's first interprofessional oral health research centre, enabling the development, evaluation and scale-up of integrated oral health models across midwifery, diabetes, pharmacy and Aboriginal health settings, with programs adopted nationally and internationally and evidence informing health policy in Australia and multiple international jurisdictions.
Pharmaceuticals	Collaborations enabled through access to a PC3 facility, supported in part by MRSP funding to cover running costs, include partnerships with the Coalition for Epidemic Preparedness Innovations, ExcellGene and Bharat Biotech on the development of COVID-19 and tuberculosis vaccines.
International collaborations	- Tissue from a brain bank (which uses MRSP funds to cover running costs) has been used by national and international researchers in several high-impact research projects, one of which is research led by Emory University in USA to drive their Alzheimer's program. - One MRI partnered with more than 100 research organisations worldwide and established a UK-based collaboration with a university and a hospital to advance gene therapies for childhood metabolic diseases.

Data source: Consultation data and case studies submitted by currently funded MRSP MRI

Case study 9. Increasing collaboration via the Cardio-Oncology Alliance

MRI activity

The Heart Research Institute (HRI) established the Cardio-Oncology Alliance, an interdisciplinary program addressing the growing burden of cardiovascular toxicity associated with cancer treatment. In less than 18 months, the Alliance has brought together oncologists, cardiologists and research scientists across NSW and internationally to develop novel personalised diagnostics (complex cardiac organoids), and new treatment modalities (cardio-protective therapies that do not compromise chemotherapy).

Impact

Despite its early stage, the program has delivered 2 patent filings (2024 and 2025), international commercial interest and investment, and partnerships to apply AI-enabled risk prediction using large clinical datasets. The Alliance has also attracted internationally recognised researchers and aligned follow-on grant applications, and has an active consumer group.

Contribution of the MRSP

MRSP funding supported the cost of establishing the alliance, including collaborative colloquia, access to patient samples, engagement with consumer groups, and patent development. Indirectly, it has signalled to members of the Alliance that NSW supports these ambitious projects with significant investment of a period of time.

Data source: Case study provided by MRI

While program administrators and organisations affiliated with MRSP-funded MRIs acknowledged the role of the MRSP in successfully sustaining MRI operations and contributing to their infrastructure, their view was that the MRSP itself had not incentivised collaboration nor that it had demonstrably advanced research collaborations. Some MRIs argued that the Program's design, particularly its reliance on NHMRC income for eligibility and allocation, discouraged collaboration by incentivising competition for grants rather than collaborative approaches. Organisations affiliated with MRSP-funded MRIs echoed this view, and instead noted that precincts could offer a more effective and sustainable model to enable sector-wide collaboration and potentially increase research translation.

While there were case studies of shared use of assets especially where there was mutual benefit, there did not appear to be any incentives for concerted efforts to systematically and routinely consolidate or share research infrastructure across the sector. This gap has been recognised, with the introduction of the collaborative research infrastructure pilot funded in 2025 under the most recent round of the MRSP.

Breakout box 9. Sector-wide collaboration through the Collaborative Research Infrastructure Enablement Pilot

The Collaborative Research Infrastructure Enablement Pilot is a 3-year initiative between the NSW Ministry of Health and AAMRI which commenced in late 2025 and is funded within the MRSP's budget. It aims to increase collaboration and networking amongst MRIs, thereby uplifting the value of the sector's infrastructure, enhancing research and improving efficiencies through the reduction of indirect costs of research. A range of projects will be supported aimed at:

- Improving AAMRI NSW members' responses to emerging health and research opportunities
- Developing 'open assets' practices
- Responding to the full rising costs of research
- Improving communication and networking within the sector.

Data source: Program administrative data

Supporting Evidence B - MRIs stated that MRSP funding enabled linkages with the health sector and health precincts, such as through training placements for clinical staff

MRIs discussed the benefits of collaborating within precincts, particularly through co-location in the same area, which also lead to stronger grant applications and therefore additional grant funding. Some MRIs argued that infrastructure funding via the MRSP was vital for precincts to function at a high level; e.g. one precinct was entirely funded by its members, requiring a certain level of funding within the MRI to make the costs of administration feasible. As these precincts involve collaborations with the health sector, there is a benefit back to the health ecosystem.

"(We're) working hand in hand with the Western Sydney Local Health district, supporting research that takes place at that hospital and providing infrastructure, world class infrastructure and a nurturing research environment with the necessary risk management and research development infrastructure to enable that research to have clinical impact."

MRI Director

Supporting Evidence C – Hypothetical counterfactual

All MRIs perceived that withdrawal of the MRSP would adversely impact their ability to collaborate. Real-world experience of cessation of MRSP funding provided illustrative yet contrasting examples of its impact on collaboration within the sector. One MRI shared their experience of losing MRSP funding, which involved having to pull back from collaborative research projects particularly with the hospital as they could not pay for the staff time.

However, for another MRI, loss of MRSP support necessitated greater reliance on shared infrastructure and external partnerships, fostering more collaborative and resource-efficient research models. Over time, this was viewed as a positive adjustment that improved connectivity and efficient use of shared research infrastructure across the broader health and medical research system.



5.1.2 Evidence for system-level outcomes

Figure 43. System-level outcomes

Systems level	6. Contribution to health and medical research ecosystem 7. Contribution to the health system and health benefits
---------------	--

In the sections that follow, we present findings from all data sources that provide evidence for the system outcomes listed below in Figure 43, including evidence of the MRSP's contribution to the outcomes observed.

Contribution towards the health and medical research ecosystem

"I think without MRSP funding we would be at a considerable disadvantage. We're in a highly competitive research funding environment. So I think this sort of infrastructure support places us well, almost more competitively places us to access more of that kind of Commonwealth money for investment in research and the benefits of research for NSW."

MRI Director

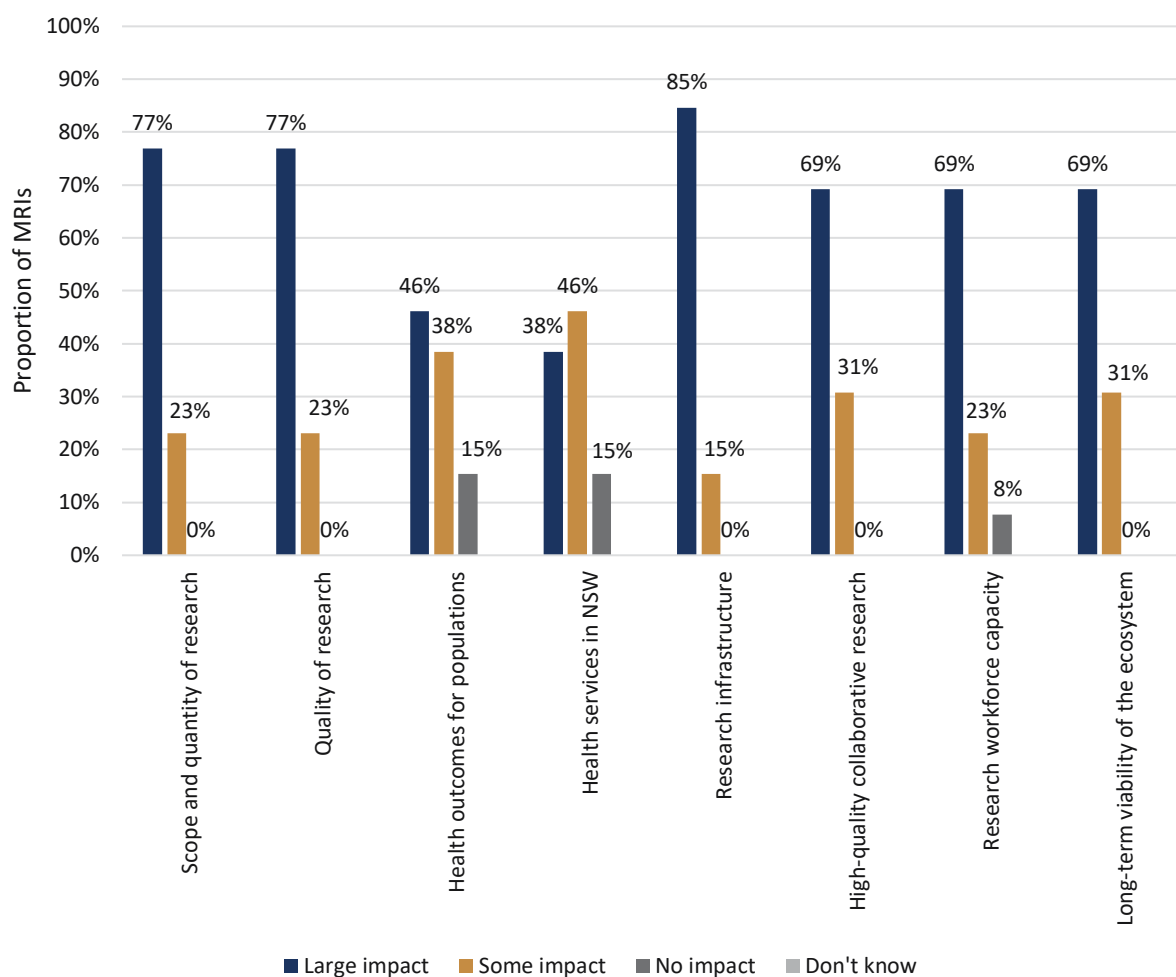
"It's an independent signal that the government values independent medical research institutes. It makes us feel an important part of the whole scheme of NSW."

MRI Director

MRIs agreed that the MRSP had underpinned a vibrant and resilient research ecosystem in NSW, helping institutes to maintain research excellence and train the next generation of researchers despite increasingly challenging financial conditions. The Program was seen as being critical to financially sustain the MRI sector, which collectively allowed MRIs to contribute towards a broad spectrum of medical research and public benefit. The collective impact of increasing infrastructure, workforce capacity and thus research outputs and excellence were viewed as evidence of the MRSP's role in striving for critical mass. MRIs perceived that if the MRSP were to cease, research productivity would decline, particularly for basic and discovery research. This was supported by the survey results (shown in Figures 44 and 45).

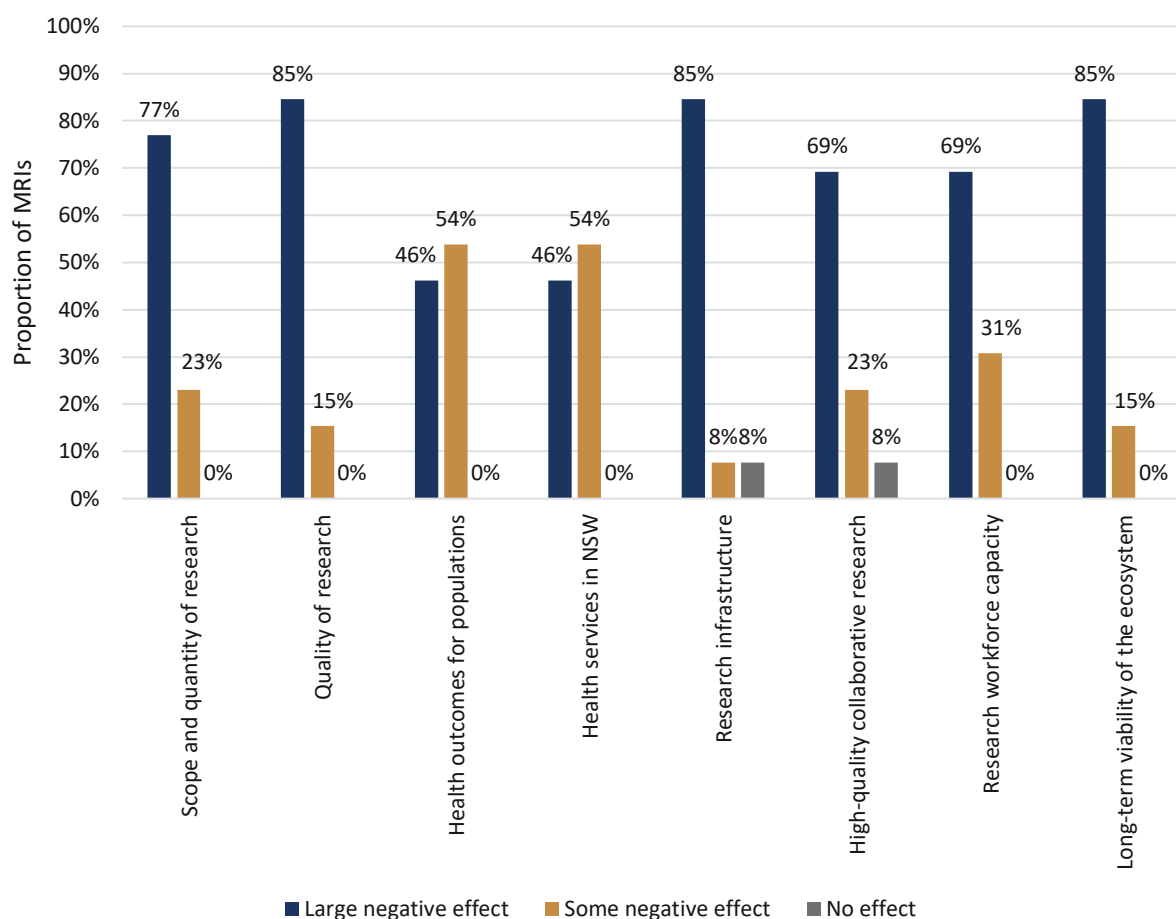
Similar to MRIs, program administrators and advisors viewed the MRSP as a strong strategic signal that NSW values and invests in the medical research sector. However, they acknowledged the challenges of identifying how funding translated into tangible improvements in health outcomes or research translation, suggesting a need for clearer articulation of its contribution to NSW Health's broader research and innovation strategy.

Figure 44. MRI perceptions of the incremental benefits of the MRSP on the health and medical research ecosystem



Data source: Director-level survey of currently funded MRSP MRIs

Figure 45. MRI perceptions of the impact of ceasing the MRSP on the health and medical research ecosystem



Data source: Director-level survey of currently funded MRSP MRIs

When asked in the survey, MRIs ranked the long-term viability of the NSW health and medical research ecosystem and research infrastructure as the outcomes where the MRSP had the greatest sector-wide impact (see Table 9). The quality, scope and quantity of research across the sector were also considered to be amongst the outcomes that were most impacted by the MRSP.

Table 9. MRIs' perceptions of where the MRSP had the greatest impact on the NSW health and medical research ecosystem

Rank	HMR ecosystem impact
1	Long-term viability of the NSW health and medical research ecosystem
2	Research infrastructure
3	Quality of research conducted across the NSW health and medical research ecosystem
4	Scope and quantity of research conducted across the NSW health and medical research ecosystem
5	Health outcomes for individuals and/or population (e.g. disease prevention, survival and quality of life of patients in the health system)

Data source: Director-level survey of currently funded MRSP MRIs

Summary: How the MRSP contributed towards strengthening the NSW health and medical research ecosystem

- Contributing to financial stability of MRIs, ensuring their survival and continued contributions to health and medical research
- Increasing the size and stability of the research workforce, reducing job losses and building skills and expertise that benefit other organisations
- Increasing research infrastructure across the sector
- Enabling improved quality, scope and diversity of research
- Lifting the national and international reputation of NSW as a place to conduct health and medical research.

Supporting Evidence A – the MRSP's contribution to financial stability of MRIs

During interviews, all stakeholders highlighted the role of the MRSP in ensuring the long-term viability of the NSW health and medical research ecosystem. Several MRIs emphasised that, without the MRSP, a number of MRIs were likely to become unviable, which would have flow on effects including job losses and economic impacts for the state. MRIs would likely have to enter into agreements with universities and effectively become departments within universities, reducing their independence to set their own research agenda and ability to pivot and respond to emerging health research priorities. While some stakeholders suggested that there might be some consolidation of the sector in the absence of the MRSP, most were doubtful about this given that the current design of the MRSP had not incentivised mergers thus far.

Supporting Evidence B – the MRSP’s contribution to stabilising and building workforce capacity

MRIs and affiliated organisations tied the financial stability of MRIs in the sector to research workforce capacity, perceiving that removing the MRSP would reduce research workforce in NSW due to job losses, reducing economic returns to the state. Furthermore, they noted that this contribution went beyond workforce capacity within MRIs as staff trained and/or working at MRIs often went on to other roles in other parts of the sector, such as public service, industry and clinical services. Thus, they viewed themselves as contributing to the skillset and expertise of the broader sector. As discussed under the section on the MRSP’s contribution to workforce, MRIs indicated that they provided protected research time for clinicians employed within the LHDs, strengthening the research-active clinical workforce. Reviews examining clinician engagement in research have demonstrated positive impacts for healthcare processes and patient outcomes;⁴¹ however, this evaluation could not determine the extent to which these flow-on benefits were achieved.

"It's that these centres that generate talented folks that end up in all directions, and that includes clinicians you know, with research training clinicians who may not be doing research any longer, but understand what research looks like and how it's conducted."

MRI Director

"These independent MRIs are a sort of the engine for workforce that doesn't necessarily end up just in research. They end up in multiple other roles, including going back to public service as well as into industry and into, you know, other roles."

MRI Director

Supporting Evidence C – Evidence of the role of MRIs in contributing to research excellence across the sector

In discussing the role of the MRSP in ensuring the survival and vibrancy of the sector, MRIs often reflected on their value and role in the NSW health and medical research ecosystem. They viewed themselves as being based between universities and hospitals, addressing aspects and roles in the sector that those organisations could not fulfill well.

MRIs viewed the MRSP as increasing the scope, quantity and quality of research conducted across the sector. Stakeholders emphasised the diversity of NSW MRIs as a system strength, noting that each institute contributed distinct expertise and focus areas that, together, enriched the state’s research capability. Without this diversity and the MRSP’s support for it, the ecosystem would be narrower in scope. MRIs provided examples where patients would face fewer options for research-driven care and innovation, such as the clinical trials program and innovations for patients with sleep apnoea and enabling access to clinical trials and health services for socioeconomically and demographically diverse patients who historically face disadvantages in accessing them.

⁴¹ Boaz et al. If health organisations and staff engage in research, does healthcare improve? Strengthening the evidence base through systematic reviews. Health Res Policy Syst 2024;22(1):113. doi: 10.1186/s12961-024-01187-7

MRIs also perceived that the MRSP had been critical to building and maintaining research infrastructure in the state. MRIs ranked this as the second most important outcomes delivered by the MRSP for the state (see Table 9). This was reaffirmed by affiliated organisations (particularly universities and LHDs), who noted their benefits particularly within precinct models.

Case study 10. Facilitating collaboration through the Westmead Research Hub

MRI activity

The MRI is a founding member and core contributor to the Westmead Research Hub (WRH), one of Australia's longest-standing and most integrated health research precincts. Established in 2004, WRH brings together research, clinical services, education and industry across the Westmead Health Precinct. Founding partners comprised Westmead Institute for Medical Research (WIMR), Westmead Hospital, The Children's Hospital at Westmead, and Children's Medical Research Institute, with subsequent expansion to include the University of Sydney (2011), NSW Health Pathology (2020), CSIRO (2021) and Western Sydney University (2025).

WRH coordinates collaborative research activity across the Westmead Health Precinct. It provides shared research governance, facilitates access to core facilities and advanced technologies, and supports multidisciplinary collaboration between clinician-scientists and researchers. The Hub also enables investigator-initiated and industry-partnered clinical studies by aligning research infrastructure with hospital and university partners.

Impact

MRSP-enabled precinct activity has delivered impacts across health policy, clinical practice and research, including:

- Health policy influence: Research led by precinct investigators has contributed to discoveries in liver disease, renal immunology and cardiac repair. It has also informed global and NSW policy and clinical guidelines in areas such as fatty liver disease, viral hepatitis and liver cancer surveillance, including work published in several of the *Nature* journal family.
- Clinical innovation: Research has led to development of a non-invasive blood test for early transplant rejection, precision biomarkers for neurodegenerative disease, and personalised approaches to autoimmune disease using single-cell and spatial omics. It has also delivered novel therapies such as Australia's first clinical phage therapy program, treating more than 50 patients with otherwise untreatable infections, and advancing antimicrobial resistance policy and practice.
- Translational research at scale: MRSP-supported Core Facilities now serve 1,000+ active users from 55 organisations, enabling high-impact investigator-initiated trials and reducing duplication of infrastructure across NSW.

Contribution of the MRSP

WIMR plays a central role in the precinct by providing the foundational research governance, laboratory infrastructure and core facilities that enable collaboration across partners. Supported by MRSP funding, WIMR leads the shared governance and operation of 9 of the 10 Core Facilities within the precinct, which are housed at WIMR. WIMR contributes approximately 75% of Core Facility costs, with the remaining 25% funded by Hub partners, and is responsible for maintenance, staffing, compliance and leveraging philanthropic and national infrastructure funding. MRSP funding, which represents around 30% of WIMR's operating budget, underpins the specialist workforce, advanced technologies and shared platforms that support translational research and investigator-initiated clinical trials across the precinct. Without MRSP support, Core Facilities would be significantly smaller, access to advanced technologies would be constrained, and the scale and complexity of clinical and translational research undertaken across NSW would be reduced.

Data source: Case study provided by MRI

Supporting Evidence D – the MRSP’s role in influencing NSW’s reputation in research excellence

MRIs described the Program’s broader value in enhancing NSW’s global research reputation. The perceived ability to remain agile, innovative, and internationally competitive was viewed as a direct outcome of MRSP support, helping to attract and retain research talent – particularly important in remaining competitive with other jurisdictions with similar research infrastructure support programs such as Victoria, Queensland, and Western Australia. Some discussed the opportunity for NSW to be a leader in providing the technological base for research,⁴² but that sustained investment was required.

Case study 11. PrecisionGo™: a national precision medicine pipeline

MRI activity

Precision medicine relies on access to advanced technologies, integrated data analytics and specialist expertise, capabilities that are often fragmented across institutions and unevenly accessible. The Westmead Institute of Medical Research (WIMR) leveraged MRSP funding to strengthen its Core Facilities and, in collaboration with Westmead Research Hub partners, establish PrecisionGo™, a nationally significant, end-to-end precision medicine technology platform. It is a national facility that incorporates genomics, cytometry, biobank, imaging, histology, bioinformatics, and data science capabilities (including AI-driven analytics) with the objective of developing and integrating precision medicine across multiple disciplines and fast-tracking the new approaches into clinical practice. PrecisionGo™ will introduce precision medicine training programs which are accessible to all researchers and students in Australia, fostering knowledge dissemination and skill development.

Impact

Since implementation, PrecisionGo™ has supported a rapidly expanding portfolio of projects, with 23 completed, 60 underway and 7 upcoming, involving 22 collaborating research and industry groups across 11 institutions nationally and internationally and more than 30 disease areas, including cancer, neurodegenerative disease, cardiovascular disease, renal disease, immunology, musculoskeletal disorders, metabolic and liver disease, ophthalmic / retinal biology, infectious diseases and ageing and longevity. In 2025, the platform contributed to 12 national and international conference presentations. The facility has enabled high-resolution cellular and spatial profiling, accelerated biomarker validation, and supported development of new diagnostics and therapies, including CAR-T and precision oncology applications. Ultimately it will lead to individualised treatments based on a precise understanding of the genetic and molecular pathways driving individual patient pathology. PrecisionGo™ has also delivered workforce and system impacts through education programs, data-analysis workshops and national engagement activities, contributing to improved AI literacy and precision medicine capability among clinicians and researchers.

Contribution of the MRSP

PrecisionGo™ is a project of the Westmead Research Hub’s Core Facilities housed at WIMR, who are responsible for its upkeep and contribute 75% of costs. Given that the MRSP covers 30% of WIMR’s operating budget, an estimated 23% of the total costs of this platform are covered by MRSP funding. The funding supported salaries of highly skilled technical staff and operational costs associated with housing PrecisionGo™. Without this support, Core Facilities for the Westmead Research Hub would be much smaller, and such a facility would not have been developed. All the associated benefits would also have been lost, such as the attraction of research groups to NSW and the national \$3 million MRFF Critical Research Infrastructure Grant.

Data source: Case study provided by MRI

⁴² There is increasing evidence of NSW’s influence in the medical technology field, e.g. 35% of all MedTech businesses are in NSW, making NSW the state with the largest MedTech ecosystem in Australia (source below). Additionally, data on patents (received from OHMR) show that 72% of patents for medical devices in Australia were granted to NSW-based institutions. Source: <https://www.nsw.gov.au/departments-and-agencies/investment-nsw/focus-sectors/life-sciences-and-healthcare>

Contribution towards the health system and health benefits

"I think health and medical research has a lot to contribute, and MRIs are really well placed because they're nimble, they can act very swiftly. They are the translational engine between the academic centres in the universities and the hospitals. All of MRIs work with hospitals, so they're all attached to patient outcomes."

MRI Director

Summary: How the MRSP is linked with health system and health benefits

- The MRSP enables investment in business functions and personnel to support research translation and commercialisation.
- MRIs provided examples of the translation of research into improvements in the health system and benefits to people
- However, attribution of these benefits to the MRSP is problematic, and stakeholders raised doubts about the extent of the MRSP's contribution towards these outcomes.

Supporting Evidence A – Evidence of research translation to health policy and practice

MRIs provided individual examples of building programs of research that led to patient and population health benefits and investing funds in supporting personnel to bridge the gap between research and implementation. Some MRIs described how they aligned their business model and partnerships with health services to better enable them to integrate their work into the health system to benefit patients, discussing a "benchtop to policy and practice" model. Other institutes provided examples of their work having an impact on health policy, with the research being underpinned by investments in infrastructure made possible by the MRSP. Other institutes also provided examples of research demonstrating effective new treatments that have led to regulatory approvals, with translation tied to their investment of MRSP funding in commercialisation activities. Some MRIs expressed that without the MRSP, they would have to reconsider their investment in commercialisation activities.

Table 10 highlights examples of MRIs' work, underpinned by the MRSP, that has been translated to health policy and practice. Further detailed case studies are provided in Appendix 5.

Table 10. Examples of translation of excellence in research to health policy and practice

Type of benefit	Examples
Changes to clinical practice, guidance or models of care	- Research conducted by an MRI has resulted in changes to screening protocols for obstetric care and to post-heart attack protocols for specific communities. Their co-location at a hospital and having a majority of clinician scientist researchers means that they have been able to work with government to trial initiatives such as “hospital in the home” with orthopaedic patients, where a cohort of patients’ post-hip fracture received care via an allied health approach. - A program of work at an MRI used postmortem samples of people who died unexpectedly to determine genetic causes of heart disease. This work was published in the New England Journal of Medicine and resulted in changes to national and international practices around postmortem specimens and screening protocols for families of the deceased.
Increased capacity and capabilities for health service provision	- One MRI’s investment in specialised laboratory infrastructure and skillsets needed to run them, alongside their active role in their precinct, meant that they were well-positioned to work with NSW Pathology to train staff in pathology labs and contribute towards establishing laboratory testing for COVID-19 virus during the pandemic. - A regional diabetes program reversed the traditional care model by bringing specialist expertise into primary care and community settings, achieving sustained improvements in glycaemic control and cardiovascular risk factors while delivering high-volume, culturally safe care to regional, rural and Aboriginal communities.
Changes to health policies	- Research conducted at an institute’s falls laboratory, supported by the MRSP, resulted in changes to falls prevention policies in hospitals. - Trials conducted with managers in workplaces on having conversations with workers on mental health reduced sickness and absenteeism, resulting in a substantial economic return on investment. It has resulted in changes in workplace policies in NSW.
Increased availability of products for health care	- An MRI had conducted research into new treatments for depression using existing medications, namely ketamine, for novel therapeutic purposes, and subsequently advocated for changes to Medicare item numbers and provided clinician training to support their uptake in clinical practice. - Research into genomics conducted in highly specialised laboratories housed and maintained by an MRI has resulted in innovative treatments for cancer patients and patients’ post-transplantation involving CAR T-cells, which are now being tested in clinical trials. - Research at one MRI has resulted in development of a new drug using proteins from spider venom for heart attack patients and heart transplant recipients. This drug has been proven in preclinical studies to prevent

Type of benefit	Examples
	long-term damage to the heart and to increase the viability of donor hearts. Plans to trial this treatment in humans are now underway. • Clinical trials for sleep apnoea treatments conducted in partnership with a major pharmaceutical company have led to TGA and FDA approval, including an additional indication for sleep apnoea paired with overweight or obesity. Ongoing investment in translation includes developing education initiatives for GPs and sleep clinicians on how to use this new treatment effectively. • Researchers identified a novel biomarker of coronary plaque instability and developed a clinically viable PET-based diagnostic probe to detect high-risk atherosclerotic plaques, progressing the discovery toward a new imaging tool for cardiovascular risk assessment. • A low-dose, once-daily triple antihypertensive single-pill combination was developed and progressed from concept to regulatory approval, making a new, affordable treatment option available for routine management of high blood pressure in diverse healthcare settings particularly for indigenous and lower-income populations.

Data source: Consultation data and case studies submitted by currently funded MRSP MRI

Case study 12. The impact of MRSP funding on commercialisation activities

MRI activity

Researchers at the Heart Research Institute identified myeloperoxidase (MPO) activity as a key driver of coronary plaque instability and developed a novel approach to detect extracellular MPO as a marker of high-risk plaques. This work initially led to a US patent using MRI-based detection; however, subsequent assessment demonstrated that MRI had limited clinical and commercial feasibility for coronary imaging due to constraints in temporal resolution and patient tolerability. Building on this foundational discovery, the Institute, in collaboration with international partners, pursued the development of a PET-based probe targeting extracellular MPO, offering a more clinically viable and scalable diagnostic approach.

Impact

A new patent covering the PET-based MPO probe has recently been submitted. This work is ongoing and impacts are yet to be realised.

Contribution of the MRSP

MRSP funding has supported laboratory support services, patent development (particularly the costs of patent lawyers), and CEO support. Without MRSP support, the associated patent submission would not have proceeded.

Data source: Case study provided by MRI

Supporting Evidence B – Limited evidence of sector-wide impacts on health outcomes, noting challenges of attribution to the MRSP

Stakeholders acknowledged that demonstrating tangible impact from MRSP funding on health system and patient or population level outcomes was inherently difficult, given that the Program predominantly

covered indirect and enabling costs. While the MRSP's benefits were evident in sustaining infrastructure, workforce, and institutional capacity, these outcomes were not easily linked to discrete health outcome metrics (e.g. "lives saved").

Similarly, MRIs were also cautious about the direct causal pathway between the impact of the MRSP on these outcomes compared with those related to benefits to the health and medical research ecosystem. Organisations affiliated with MRSP-funded MRIs similarly agreed that the Program's benefits to the health of patients and communities and evidence of measurable improvements in population outcomes was lacking. They additionally noted that while individual examples existed, the extent of research translation and whether it was occurring consistently across the sector was questionable. Furthermore, they argued that the MRSP lacked an explicit framework or accountability mechanism for translation and impact or a mechanism to accurately evaluate any benefits.

One MRI noted that the reliance on grant earnings as a measure of success incentivised "chasing funding" as an objective rather than striving to achieve health outcomes. This unintended consequence of the MRSP design could undermine achieving improvements in health system and population outcomes.

"This metric (i.e. grant earnings) inadvertently places the emphasis on generating the next grant rather than on delivering tangible benefit to the health service and community. It drives researchers and MRIs into a cycle of chasing funding rather than prioritising translation, collaboration, or health outcomes. Over time, this risks narrowing the ecosystem's focus to grant throughput instead of impact, undermining the very intent of the program to strengthen the NSW health and medical research system."

MRI Director

6. Economic evaluation findings

6.1 KEQ4: What are the costs and benefits of the Program, and does it represent value for the NSW HMR ecosystem and the people of NSW?



Key Evaluation Question 3 – What are the costs and benefits of the Program, and does it represent value for the NSW HMR ecosystem and the people of NSW?

Scope

The economic evaluation assesses the costs and benefits of the Program and its overall value for money to the people of NSW. Specifically, this requires the assessment of the additional or incremental economic, health, environmental, social, and cultural costs and benefits of the Program for key stakeholders and in aggregate, relative to a hypothetical counterfactual (or 'base case') where the program did not exist.

The economic impact evaluation has been developed in alignment with NSW Treasury guidelines for cost benefit analysis (TPG23-08).

Focus areas assessed in this economic evaluation section are:

- 6.1.1 Trend analysis: The role of the MRSP relative to other funding sources for NSW MRIs
- 6.1.2 Economic impact modelling: Key data, assumptions and scenarios
- 6.1.3 Estimated total cost of the MRSP including administrative costs
- 6.1.4 Direct economic impacts of the MRSP on MRIs
- 6.1.5 Economic impact of the MRSP on NSW medical research ecosystem
- 6.1.6 Economic impact of the MRSP on patients and carers in NSW and beyond
- 6.1.7 Qualitative analysis: social, cultural, environmental and other workforce impacts
- 6.1.8 Putting it all together: the impact of the MRSP for NSW

Data sources used to answer this question

Data sources for the economic evaluation included a literature review, consultation data, survey data, grant administrative data, requested data from MRIs including case studies and publicly available data.



Key findings and evaluative judgement

- **The MRSP has delivered a net economic benefit, even excluding an evaluation of downstream health benefits, and represents value for money to the NSW HMR ecosystem and people of NSW.** Overall, the net present value (NPV) of all direct and ecosystem benefits (net of program costs) over the life of the MRSP (2012–2025) was estimated to be \$1.2 billion in \$2025, which translates into a BCR of 2.6, before any additional benefits of the contribution to improved health outcomes are considered.
- **Because MRIs deploy MRSP funding in a variety of ways depending on their specific needs, the impacts of the program on MRI activity and in turn, health, economic, social and cultural impacts were also found to be heterogenous.** Some MRIs reported the MRSP was a significant enabler of additional research activity, while others reported the MRSP had little or no effect on the volume or value of research activity. Instead, some MRIs reported the funds had been used to improve the translation and commercialisation of research that would have otherwise occurred. The impact on research funding activity was estimated to range from 0% to 100%, with 20% being the raw average additionality effect across all rounds of the program. The weighted average, accounting for the volume of MRSP funding by MRI was 22% over the life of the Program.
- **The estimate of benefits for earlier rounds appeared to be subject to significant uncertainty.** The net benefits of the Program by round were estimated to improve through time as MRIs were able to more confidently estimate second round benefits through time:
 - BCR for Round 1 (2012–2016): 1.3
 - BCR for Round 2 (2016–2020): 2.5
 - BCR for Round 3 (2020–2024): 2.8
 - BCR for Round 4 (2024–2028, partial): 8.8
 - BCR for life of program (2012–2025): 2.6
- **The economic impact on the uplift in research funding was the largest economic impact reported (65% of the net benefits realised over the life of the program), followed by the impact of additional clinical trial activity (15% of the net benefit effect over the life of the program).** An additional \$1,229.8 million in \$2025, NPV_{5%} terms of research activity and funding was estimated to be attracted to NSW as a result of the MRSP over the life of the program. The other major benefit streams included operational efficiencies realised from the avoided turnover of staff (10% of the net benefit effect over the life of the program, or \$200.8 million in \$2025, NPV_{5%} terms) and benefits from the uplift in revenues from the commercialisation of research compared to what would have otherwise occurred (\$186.0 million in \$2025, NPV_{5%} terms).
- **The strongly net positive impact of the MRSP on research outcomes estimated in the bottom-up economic analysis was also consistent with the top-down trend analysis of research funding which showed that the MRSP has had a significant positive impact on research activity in NSW.** Top-down trend analysis showed that the MRSP has helped NSW to increase total

NHMRC grant revenue as NSW has seen a decline in other indirect research funding support (IRIIS) over the life of the program. OLS regression analysis found that, for each 1% increase in MRSP funding, there was a 0.73% uplift in total NHMRC and MRFF funding to NSW. This suggests that there is a significant, positive relationship between NSW Government indirect cost funding through the MRSP and the amount of competitive grant money acquired by NSW-based researchers.

- **Citation analysis also indicated the MRIs contribute to high impact research, with MRIs strongly represented in the top tiers of journals in their respective fields.** MRSP-funded MRIs accounted for 3.9% of citations in the top 1% of journals and 25% of citations in the top 10% of journals. This, combined with the case study analysis, suggests the MRIs have had a strongly positive impact on the health system. Given that the MRIs are delivering high impact work across most health conditions, from cancer to diabetes to mental health, the benefits over time are likely to be extensive for people living in NSW — and for people across Australia and globally.
- **Beyond economic impacts some important social, cultural and environmental benefits were also reported, but these tended to be limited and sporadic across the MRIs.** There were benefits, for example, of research focused on improving outcomes for key disadvantaged populations, including Aboriginal and Torres Strait Islander people, people of Asian descent and people in regional areas. There were also some limited studies focused on improving the environmental footprint of research, but overall, the primary impacts reported included uplift in research activity compared to what would have otherwise occurred and associated second round benefits to the NSW research ecosystem.

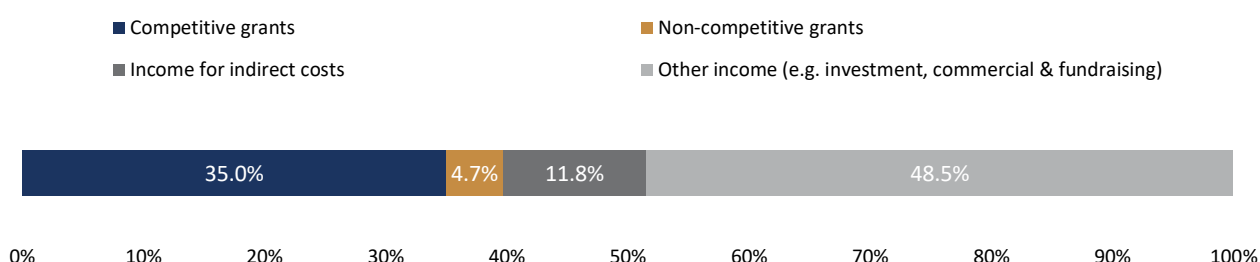


6.1.1 Trend analysis: The role of the MRSP relative to other funding sources for NSW MRIs

Finding A – Trends in NSW MRI’s sources of income and expenditure

MRIs are supported by a combination of Commonwealth and state grants, income earned through research activity, fundraising and philanthropy income. Of this, funding from competitive grants is the largest source of income. In 2023, based on data reported by AAMRI, 35% of Australian independent MRIs’ revenues came from competitive grants: the largest share by a significant margin (Figure 46). Fundraising and philanthropy, and commercial income contributed a further 16.3% and 15.2%, respectively, while income for indirect costs accounted for only 11.8% of total revenue (Figure 46).⁴³

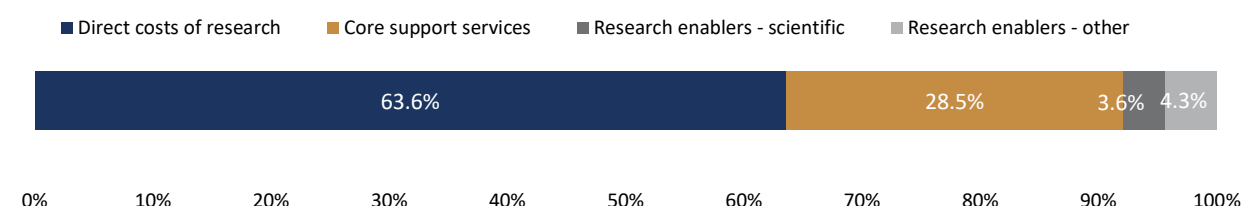
Figure 46. Income sources among Australian independent MRIs, 2023



Source: Association of Australian Medical Research Institutes. [2024 AAMRI Report: Representing and benchmarking Australia’s medical research sector](#). December 2024. AAMRI.

Conversely, 36.4% of expenditure by Australian independent MRIs in 2023 was on indirect costs of research (Figure 47), which includes 28.5% on core support services, such as information systems, human resources, facility costs and compliance.⁴⁴

Figure 47. Direct and indirect costs of research among Australian independent MRIs, 2023



Source: Association of Australian Medical Research Institutes. [2024 AAMRI Report: Representing and benchmarking Australia’s medical research sector](#). December 2024. AAMRI.

Australia-wide, there was a \$406.2 million shortfall in funding for indirect costs, which translates to a 31-cent shortfall per research dollar.⁴⁵

⁴³ Association of Australian Medical Research Institutes. [2024 AAMRI Report: Representing and benchmarking Australia’s medical research sector](#). December 2024.

⁴⁴ Ibid.

⁴⁵ Ibid.

Finding B – Government funding for indirect costs for NSW MRIs

State and Commonwealth governments are key providers of indirect cost support to the medical research sector. However, the vast majority of this support is given to universities through Research Block Grants (RBGs), with relatively little being accessible directly by MRIs. RBGs comprise two programs:

- The Research Support Program (RSP), which provides funding to higher education providers to support the systemic costs of research such as libraries, laboratories, consumables, computing centres and the salaries of support and technical staff.
- The Research Training Program (RTP), which provides funding to higher education providers to support the training of domestic and overseas students undertaking research doctorate and research masters degrees.

In 2026, the Federal Government is expected to provide \$2.37 billion in RBG funding to Australian universities: \$1.11 billion through the RSP and \$1.26 billion through the RTP.

RBG funding is determined by universities' total research income, which includes not only competitive grant revenue, but also R&D income generated from other public sector sources, industry and Cooperative Research Centres (CRC). Data are collected annually by the Department of Education. Independent MRIs can access indirect cost support through RBGs by partnering with universities on research projects.

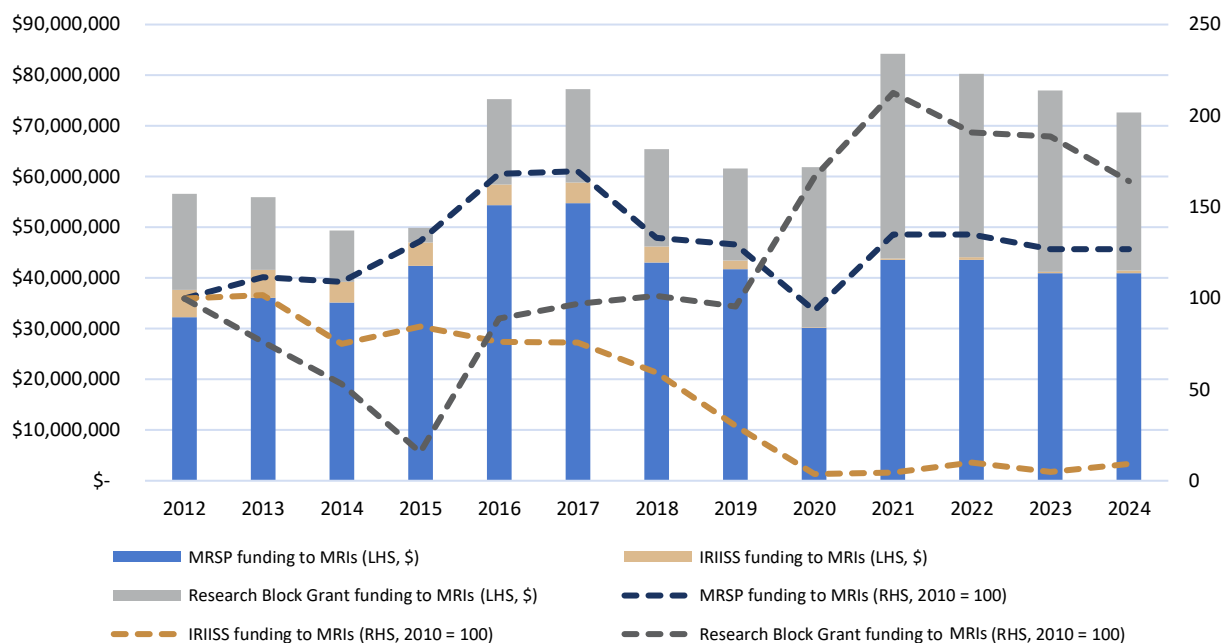
For independent MRIs, the largest source of Commonwealth funding for indirect costs is the Independent Research Institute Infrastructure Support Scheme (IRIIS), which is operated by NHMRC and is designed to provide MRIs with indirect funding equivalent to the RBG funding received by universities. IRIIS provides funding for the development and maintenance of infrastructure associated with competitively awarded NHMRC research grants. Unlike with RBGs, which is determined by universities' total research income, *only* NHMRC grant revenue is included in the calculation of indirect cost support. This means that MRIs who receive the bulk of their grants through MRFF, international grants or other revenue sources are not compensated for their full costs of research.

Since the introduction of the RSP and RTP programs in 2017, NSW's total share of RBG funding has remained relatively constant at around 30% among both programs. Within this, however, NSW MRIs have grown the amount of RBG funding they receive through partnerships with universities (see Figure 5). Over the 2012–2024 period, total RBG funding to MRIs rose by 64% (from \$19 million to \$31 million). Conversely, the amount of IRIIS funding received by NSW MRIs over the same period fell by around 91%, from more than \$5.4 million in 2012 to around \$501,000 in 2024. Over the same period, the amount of MRSP funding to MRIs increased by 27%, from just over \$32 million to almost \$41 million.

The net effect has been that MRIs have increased total funding for indirect research costs from just under \$57 million in 2012 to almost \$73 million in 2024—an uplift of 28%.

The data also show that given the limitations inherent to other forms of governmental indirect cost funding, the MRSP is a crucial part of how NSW MRIs manage indirect costs. Since its introduction, the MRSP has been the largest state or federal Government contributor to MRIs' independent costs, accounting for 56% of indirect cost funding in 2024, a share that has not fallen below 49%. Figure 48 provides greater detail on NSW MRIs' indirect cost funding from the MRSP, IRIIS and RBG funding.

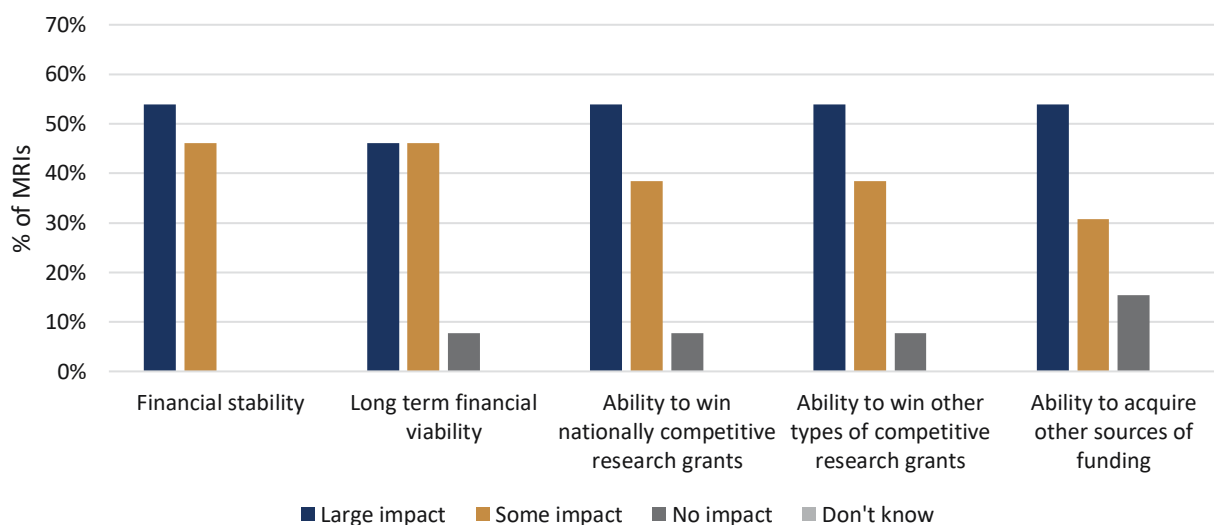
Figure 48. Government funding for indirect costs received by NSW MRIs by source (2010-2024)



Source: IRIISS data obtained from publicly available NHMRC data. MRSP data obtained from OHMR. Research Block Grant data is obtained from MRIs and represents only the funding received by The MRSP participants. Non-MRSP participating MRIs may have received RBG funding, but that is not accounted for.

This finding is consistent with the survey findings, which showed that more than half of the MRIs indicated the MRSP had a significant impact on financial stability, long-term viability and the ability to win additional grants and funding (Figure 49).

Figure 49. MRI perceptions of the incremental benefits of the MRSP on their MRI's financial stability and viability



Data source: Director-level survey of currently funded MRSP MRIs.

Finding C – The estimated impact of MRSP funding on NSW’s research output: Findings from the Ordinary **Least** Squares regression analysis

With other avenues of baseline funding in decline, and NSW MRIs increasingly reliant on partnerships with universities, the MRSP has an increasingly important role in ensuring the financial viability and long run stability of the MRIs. However, it is important to recognise that the MRSP is not the only indirect cost support provided to MRIs, and analysis of the impact of the MRSP must account for the presence of these other programs.

To better understand the impact of the MRSP on MRIs, Ordinary Least Squares (OLS) regression analysis was undertaken, evaluating the relationship between NHMRC grant revenue and MRSP funding over time. This OLS analysis provides a ‘top down’ perspective of the uplift in grant revenue as reported by the MRIs and is a sense check on the results reported by the MRIs.

The OLS model determines the total funding granted to NSW-based institutions by NHMRC and MRFF as a function of NSW Government funding for MRIs, with NSW GSP and other research support funding serving as covariates. Controlling for these variables allows the analysis to isolate the impact of MRSP funding, independent of the state of the NSW economy or the presence of other funding sources.

The estimated model found that, for each 1% increase in MRSP funding, there was a **0.73% uplift in NHMRC and MRFF funding to NSW**. This suggests that there is a significant, positive relationship between NSW Government indirect cost funding through the MRSP and the amount of competitive grant money acquired by NSW-based researchers.



6.1.2 Economic impact modelling: key data, assumptions and scenarios

Impacts reported by the MRIs

MRSP funding allows MRIs to organise themselves and undertake work that they otherwise would not have been able to do. The nature of this unlocked activity, however, is different for each MRI. As a result, these benefits manifest in different ways for each institution, based on their size, location and area of research.

For example, some MRIs, such as the Centenary Institute, CMRI and HMRI have used MRSP funding to invest in research infrastructure, yielding benefits both for the MRI directly and for the ecosystem at large; for example:

- The Centenary Institute indicated that they have used baseline funding to support their cytometry facilities in partnership with the University of Sydney. This facility is used for flow cytometry, cell sorting, image cytometry, mass cytometry and genomic cytometry, all of which serves the MRI, the university and the wider ecosystem.
- Similarly, CMRI established the NSW Organoid Innovation Centre using MRSP funding, creating Australia's first large-scale hub for regenerative medicine and organoid research.
- HMRI has used MRSP funding to support their neuroimaging centre, building a profile for their local ecosystem and creating a first-ever Australian First Nations fellowship scheme.

Other MRIs, however, have used MRSP funding to primarily support the translation and commercialisation of their research. For example:

- The Black Dog Institute noted that MRSP funding supports their research translation arm, providing researchers with policy development, education, digital resource development and other necessary tools for commercialisation.
- HRI indicated that during the period they did not receive the MRSP, they devoted fewer resources to commercialisation activities. With the funding from the most recent round, however, they have established a Commercialisation Committee and have already lodged a patent.

Still more MRIs identified the beneficial impact of MRSP funding on their financial stability. The George Institute, for example, has noted that the MRSP contributed significantly to covering back-office costs, allowing other income streams to be invested into research and development. NeuRA, similarly, has indicated that MRSP funding has let them offer secure lab space, core equipment, IT and HR support and mentoring programs without taking funds away from awarded grants.

Because there is significant flexibility in how recipients can spend money received from the MRSP, there is no 'top-down' approach to analysing direct effects that captures the breadth of benefits. As a result, when quantifying the benefits enjoyed directly by MRIs, a 'bottom-up' analysis for each institute was conducted, and then aggregated across all institutes.

The data used in the calculation of economic benefits was taken from a combination of financial data reported by MRIs and data requests to provide non publicly available information on the relevant MRIs.

Appendix 7 provides a complete account of all provided data, de-identified from the specific MRI. Where data were not available, an assumptions-based approach was taken. These assumptions are further discussed below.

Finding B – The impact of the MRSP on additional research activity varied across MRSP-funded MRIs

MRIs were also asked to report on the extent to which there has been additional activity that would not have been undertaken but for the presence of MRSP funding. This is shown in Table 11.

Consistent with the discussion above, some MRIs reported the MRSP was a significant enabler of additional research activity, while others reported the MRSP had had little or no effect on the volume or value of research activity while others reported it had had a significant impact on outcomes. A value of 0% indicates that the MRI did not think the MRSP had any impact on grant outcomes or wider research activity; a value of 100% would indicate that the MRI would have ceased operations in the absence of the MRSP.

The impact on research funding activity was estimated to range from 0% to 100%, with a raw average additionality effect across all rounds of the MRSP estimated to be 20%. The weighted average, accounting for the volume of MRSP funding by MRI was estimated to be 22% over the life of the MRSP.

These additionality assumptions were used firstly to determine the impact of the MRSP on the uplift in grant revenue enabled by the MRSP by MRI; they also informed the uplift in wider MRI activity except where more detailed impact assumptions were available. Key exceptions included the valuation of an uplift in revenues from infrastructure and commercialisation where effectively every MRI provided specific revenue estimations; for these impacts, additionality effects were not applied.

Table 11. Additionality of MRSP funding – reported by MRIs

MRI	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
	MRSP round 2012–2016					MRSP round 2016–2020				MRSP round 2020–2024			MRSP round 2024–2028*	
A	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%
B	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%
C	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%
D	0%	0%	0%	0%	10%	10%	10%	10%	10%	20%	20%	20%	20%	0%
E	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
F	10%	10%	10%	10%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
G	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
H	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
I	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
J	10%	10%	10%	10%	10%	20%	20%	20%	20%	20%	20%	20%	20%	20%
K	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
L	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%
M	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Source: Data provided by MRIs. Note data for the 2024–2028 round was only available to 2025; this is partial analysis.

Because of the nature of data collection, the quality of the data received by MRIs is of variable quality generally, but improves in quality over time, with more recent data being more complete and reliable.

In interpreting results, greater reliance should be placed on the more recent funding rounds, with some caution exercised for the very early rounds of funding where data reporting was sparse due to the more limited and narrow guidance provided at the time for the impact analysis.

Impacts scenarios and sensitivities considered

Because of the high degree of variability in the reported rates of additionality among MRIs, sensitivity analysis was conducted where top-down additionality assumptions were applied to all MRIs. The following impact scenarios and sensitivities were considered:

- Central case based on additionality as reported by the MRIs (see Table 21 above)
- Low additionality case – 10% uplift *only* among MRIs that indicated the MRSP had an impact on grant outcomes
- High additionality case – 30% uplift *only* among MRIs that indicated the MRSP had an impact on grant outcomes.

The central case results are presented here and the Low and High additionality scenarios are considered in Appendix 8. Appendix 8 also presents break-even analysis for the MRSP.

Other key assumptions

For consistency, all data are presented in financial year terms. Where data were reported by calendar year, it was assumed that transactions occurred uniformly across the year, and so financial year data were calculated by taking a simple average of the calendar years either side of the relevant financial year. For example, financial year data for 2023-24 was calculated by taking an average of data from 2023 and 2024.

Financial data are also presented in real terms (2025 dollars), inflated at historic CPI.

To estimate some impacts, additional assumptions were made where data were unavailable. These included:

- *Program administration costs* – The total cost of the MRSP to NSW included not only grant outlays but also program administration costs. The cost of administering the MRSP was estimated based on data provided by OHMR, which estimated a total running cost of around \$185,000 per annum in a routine year and around \$280,000 in a more intensive year in real terms. Administration costs borne by MRIs themselves were also calculated by taking MRI-reported survey data on the average number of hours taken to complete the MRSP documentation, and inferring the value of that time using MRI-reported salary data.
- *The economic impact of clinical trials* – While MRIs were able to identify the number of trials, there was limited data on phase, as well as on expenditure and jobs. MTPConnect data⁴⁶ was used to estimate the economic impact of a clinical trial, which was applied as a top-down assumption to the number of trials reported by MRIs.
- *Knowledge spillovers* – The economic impact of knowledge spillovers generated by a given MRI was assumed to be proportional to that MRI's grant revenue, at an elasticity of 0.0003, consistent with the estimates in Palangkaraya and Webster (2015)⁴⁷ within 4-digit ANZSIC codes. Anchor tenants, or MRIs whose presence acts as an enabler for their research ecosystem, were assumed to generate a 60% larger economic impact from knowledge spillovers compared to non-anchor MRIs (Agrawal 2002)⁴⁸.
- *Health and health system impacts* – As noted above, it was assumed that research impact can be determined through citation analysis of MRIs, with an emphasis on the tier of journal in which research has been published. Due to inconsistency and uncertainty in reporting, a series of case studies were developed to demonstrate the additional value that would be expected in addition to the other benefits quantified in the economic impact analysis. It was conservatively assumed benefits were realised with a lag of 17 years unless the research focus was the

⁴⁶ MTPConnect. (2024). Australia's Clinical Trials Sector, accessed at: <https://mtpconnect.org.au/wp-content/uploads/2025/07/MTPConnect-2024-Australias-Clinical-Trials-Sector-Report.pdf>

⁴⁷ Palangkaraya, A. and Webster, E. 2015. Measuring R&D spillovers from Australia industry: Uses and limitations of using the Extended Analytic Business Longitudinal Database (EABLD), accessed at: <https://www.swinburne.edu.au/media/swinburne.edu.au/research/research-centres/cti/reports/Measuring-RD-spillovers-from-Australia-industry-2015.pdf>

⁴⁸ Agrawal, A. and Cockburn, I.M. (2002), University Research, Industrial R&D and the Anchor tenant Hypothesis, NBER Working Paper Series, National Bureau of Economic Research, accessed at: https://www.nber.org/system/files/working_papers/w9212/w9212.pdf#:~:text=We%20develop%20and%20test%20the%20hypothesis%20that%20the,be%20an%20important%20channel%20for%20transmission%20of%20spillovers.

development of clinical guidelines. Also consistent with NHMRC *Measuring Up* (NHMRC 2020⁴⁹), it was assumed that 50% of the health gains were attributable to medical research. The contribution of the MRI to the health gain was assumed to be within a range based on the MRI's citation rate in the top 1% and 10% of journals; citation data were extracted from SciVal.

All assumptions used in economic modelling can be found in Appendix 8.

⁴⁹ NHRMC, 2020, *Measuring Up*, accessed at: <https://www.nhmrc.gov.au/about-us/publications/measuring-2018>



6.1.3 Estimated total costs of the MRSP including administrative costs

MRSP funding costs were provided directly by MRIs, and these data were checked for consistency in reporting by year. As detailed above, administrative costs were distinguished into those borne by NSW Government through the MRSP and those borne by MRIs directly. Additionally, historic CPI was used to inflate past costs and benefits to 2025 dollars, which is denoted in the following way: \$2025.

Table 12. The MRSP cost calculations (\$'000s)

Costs (\$ '000s)	2012–2016	2016–2020	2020–2024	2024–2028*	Life of MRSP (2012–2025)
Grant costs	\$100,479	\$143,558	\$168,430	\$39,451	\$451,918
Admin costs (OHMR)	\$617	\$666	\$730	\$366	\$2,378
Admin costs (MRIs)	-	\$145	\$257	\$70	\$472
Subtotal	\$101,096	\$144,368	\$169,417	\$39,887	\$454,768
Adjust to \$2025	\$137,393	\$181,701	\$194,561	\$40,809	\$554,464
Compound to present value (NPV_{5%})	\$241,668	\$263,350	\$231,663	\$42,831	\$779,513

Source: MRI reported data and OHMR estimated program costs. *Partial data to 2025 only.

A social discount rate⁵⁰ of 5% was used to determine the present value of the MRSP costs, which yields a value of \$780 million, again in \$2025 dollars. The conversion of these costs into 'present value' terms allows for 'like-for-like' comparisons of cost relative to benefit in NPV and BCR analysis.

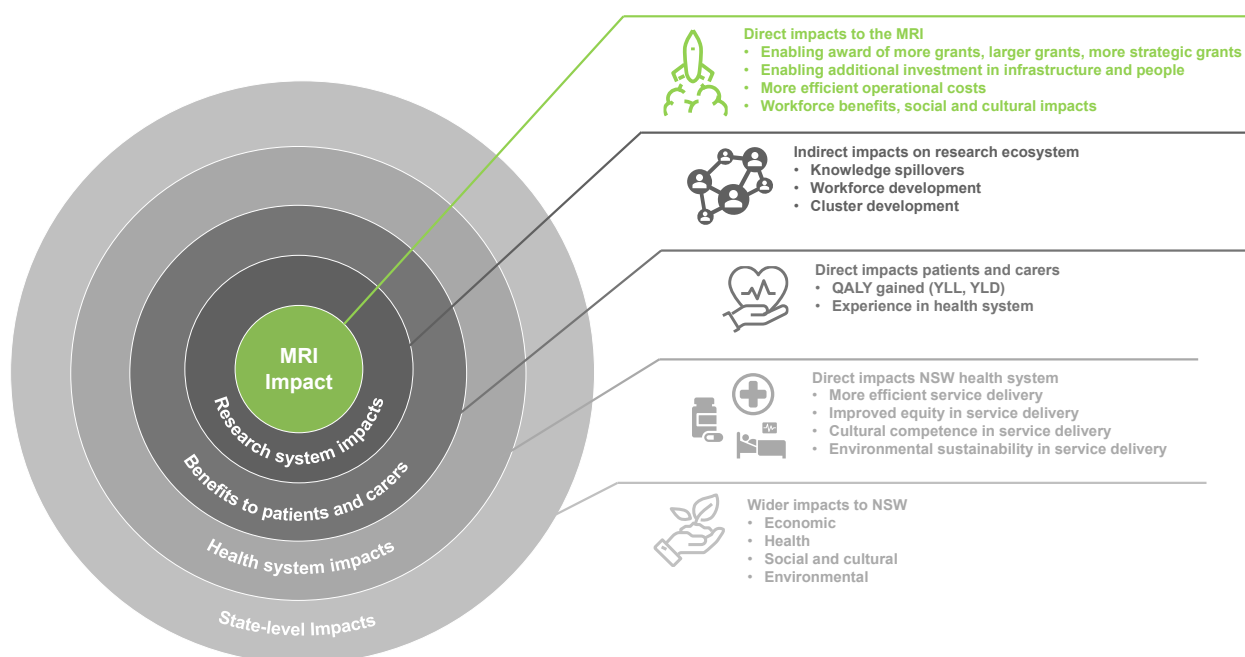
⁵⁰ A social discount rate is used to account for the time value of money. Generally speaking, a dollar today is worth more than a dollar tomorrow because investors or decision makers have the potential to use that money to generate a return or an outcome over time. Adjusting cash flows to present value terms allows decision makers to compare investments that may have different timelines for cost and/or benefits realisation. A social discount rate is simply the 'risk free' rate.



6.1.4 Direct economic impacts of the MRSP on MRIs

As outlined in Section 3.4, the MRSP impacts directly on MRI activity and outcomes in a number of ways, including:

- Contributing to an uplift in grant funding for novel and transformative research compared to what would have otherwise been the case
- Enabling the realisation of additional income from MRSP-enabled infrastructure compared to what would have otherwise been the case
- Expanding commercialisation and translation of MRI research compared to what would have otherwise been the case
- Avoidance of turnover compared to what would have otherwise been the case, leading to operational efficiencies.



The MRSP reported data indicated that **the impact on the uplift in grants revenue was the largest direct impact of the MRSP on the MRIs**. These types of direct economic impact are discussed below in turn.

Finding A – Impact on grant and other research funding

The largest direct impact that the MRSP had on NSW MRIs was an expansion of their ability to attract grant and other non-NSW government funding for research activity; this accounts for 65% of the total impact observed over the life of the MRSP so far.

The Ingham Institute for Applied Medical Research, for example, outlined a clear value pathway, where MRSP income has led them to increase investment in research services and support, which has, in turn, led to a growth in competitive research income.

Grant funding uplift includes both Australian and international grants, in an effort to capture the full suite of inflows into NSW. The impact on grant funding was calculated through the product of the grant revenue for each MRI and the self-reported additionality rate.

Based on data reported by MRIs, uplift in grant funding consistently generated benefits in excess of program costs in each MRSP funding round. Critically, the benefits from grant and other revenue uplift alone was sufficient to generate a positive NPV and a BCR greater than 1, both within each funding round and across the life of the MRSP. Across all benefit streams, the uplift in grant revenue is the largest calculable benefit, accounting for 65% of the total benefits realised from the MRSP.

These benefits were distributed proportionally between larger (Tier 1 & 2) and smaller (Tier 3) MRIs, with larger institutes driving \$856 million worth of benefits over the life of the MRSP, compared to \$460 million among smaller MRIs.

Table 13. Uplift in grant and other revenue funding (\$2025, '000s, NPV5%)

Benefits (\$ '000s)	2012-2016	2016-2020	2020-2024	2024-2028*	Life of MRSP (2012-2025)
All tiers	\$308,244	\$574,652	\$349,482	\$83,659	\$1,316,036
Tiers 1 & 2	\$202,824	\$413,078	\$194,437	\$45,222	\$855,561
Tier 3	\$105,420	\$161,574	\$155,045	\$38,436	\$460,475

Source: Analysis of MRI-reported data. *Partial data to 2025 only.

Finding B – Revenue from MRSP-enabled infrastructure

Alongside an uplift in the ability of MRIs to attract additional grant revenue, MRSP funding was also used to invest in infrastructure that generated revenue for the MRI (Table 14).

For example, the Ingham Institute operate their Centre for Robotics & Health Technology, which has led projects including a cost-effectiveness study of robotic surgery in public hospitals, and an analysis of remote diagnostics and therapeutics to improve healthcare access for people living in rural and regional areas. The work conducted using this infrastructure provides a steady stream of revenue for MRIs, as well as broader benefits for the research ecosystems (as is discussed later in this report).

While the size of this benefit stream is some orders of magnitude less than the benefits from grant revenue uplift, capturing these benefits is an important part of understanding the full suite of impact generated by the MRSP. Revenue from MRSP-enabled infrastructure accounted for just over \$7 million in benefits over the life of the MRSP. The bulk of these benefits (\$5.4 million) accrued to larger institutes (Tiers 1 & 2), with smaller MRIs accounting for just below \$1.8 million.

The data used to estimate these benefits was limited by the quality of data provided by MRIs. In this case, only 2 MRIs provided data to inform the calculation of these benefits. As a result, it was assumed the infrastructure revenue received by other MRIs is zero. As a result, there is a risk of understating the total value of infrastructure-related revenue received by all MRIs.

Table 14. Revenue from MRSP-enabled infrastructure (\$2025, '000s, NPV5%)

Benefits (\$ '000s)	2012–2016	2016–2020	2020–2024	2024–2028*	Life of MRSP (2012–2025)
All tiers	\$2,617	\$2,286	\$1,364	\$957	\$7,223
Tiers 1 & 2	\$2,617	\$1,268	\$817	\$726	\$5,428
Tier 3	-	\$1,018	\$546	\$231	\$1,795
<i>No impact reported</i>					

Source: Analysis of MRI-reported data. *Partial data to 2025 only.

Finding C – Revenue from commercialisation and translation of IP, research

MRSP funding was also used by MRIs to more effectively translate and commercialise research, thereby generating revenue for the MRI (and potentially improving the timeliness of the realisation of health benefits). For example, HRI noted that the funding from the most recent round of the MRSP enabled them to establish a Commercialisation Committee, which has overseen the submission of a patent that may assist in the diagnosis of subjects at elevated risk of an acute cardiovascular event. Similarly, the Black Dog Institute has indicated that MRSP funding directly supports their translation arm, which allows them to dedicate resources towards policy, education and digital resource development and commercialisation.

As shown in Table 15 (below), increased commercialisation and translation of research led to significant, if inconsistent, benefits to MRIs. The magnitude of these benefits depends on the commercial value of the research conducted by institutes, and the extent to which commercialisation and translation activity is driven by MRSP funding. Most MRIs did not provide data to suggest that they had received commercialisation revenue as a result of MRSP funding. Over the life of the MRSP, MRIs were estimated to benefit from commercialisation by just over \$186 million. Most of these benefits (\$185 million) were attributable to data from one large (Tier 1 or 2) institute in the two funding rounds of 2020–2024 and 2024–2028. This value includes revenue generated from an asset sale; this is included because this is again new money into NSW that would not have otherwise occurred that can be reinvested in NSW research or distributed to NSW households as profits.

Table 15. Revenue from commercialisation (\$2025, '000s, NPV5%)

Benefits (\$ '000s)	2012–2016	2016–2020	2020–2024	2024–2028*	Life of MRSP (2012–2025)
All tiers	\$750	\$289	\$76,417	\$108,550	\$186,006
Tiers 1 & 2	\$506	\$0	\$76,089	\$108,432	\$185,027
Tier 3	\$243	\$289	\$328	\$118	\$978

Source: Analysis of MRI-reported data. *Partial data to 2025 only.

Not only do MRIs benefit directly from the commercialisation and translation of their research, this process also generates wider health benefits as new technologies and practices are made available for commercial use.

Finding D – Benefits from the avoidance of turnover of research and administrative staff

Another key benefit of the MRSP was the increased predictability of funding, which supports the MRIs' ability to retain both research and administrative staff at a higher level than they otherwise would be able to. Indeed, MRIs noted that MRSP funding allowed them to avoid staff turnover, generating a benefit enjoyed both by MRIs themselves and by their employees.

Benefits from avoided turnover of research and administrative staff were driven by MRI-reported estimates of the number of FTE employees that have avoided turnover, as well as estimates of the average salary of research and non-research staff members. As shown in Table 16, MRIs experienced more than \$200 million worth of benefits from avoided turnover of staff, with \$125 million of that coming from tier 3 MRIs.

Table 16. Benefits from avoided turnover (\$2025, '000s, NPV5%)

Benefits (\$ '000s)	2012–2016	2016–2020	2020–2024	2024–2028*	Life of MRSP (2012–2025)
All tiers	-	\$89,178	\$87,019	\$24,562	\$200,759
	<i>No impact reported</i>				
Tiers 1 & 2	-	\$36,636	\$29,799	\$9,295	\$75,730
Tier 3	-	\$52,542	\$57,220	\$15,267	\$125,028

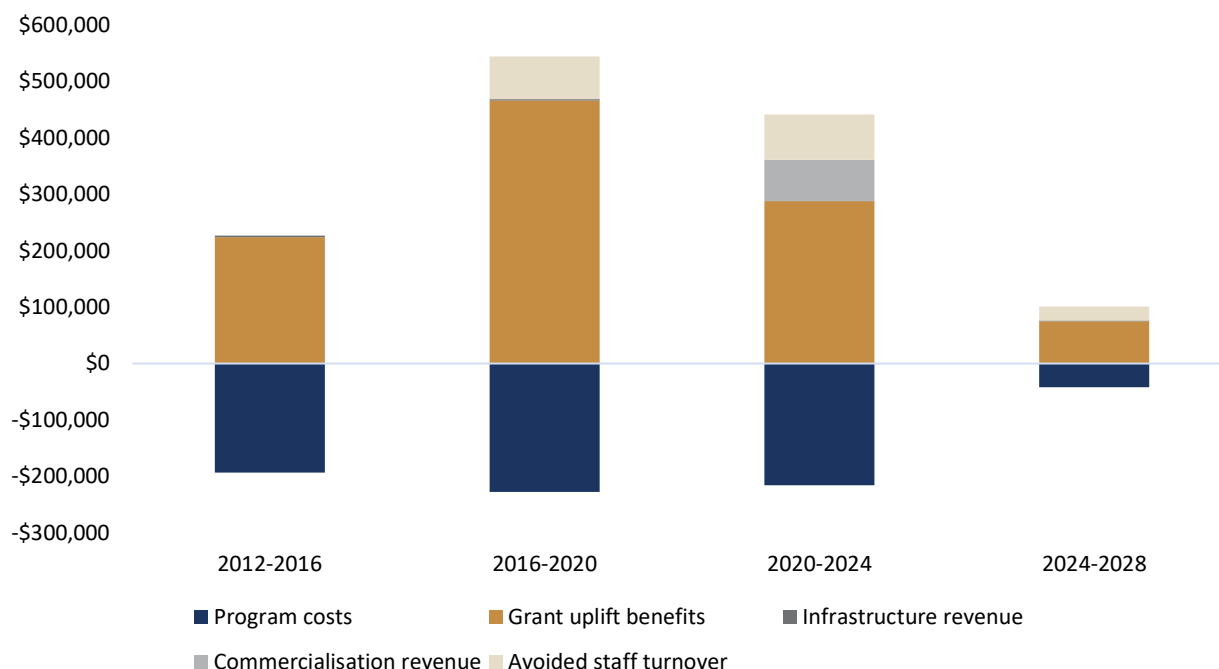
Source: Analysis of MRI-reported data. *Partial data to 2025 only.

Finding E – Benefit cost ratios based on the direct impact to MRIs

Based on MRI reported outcomes, the uplift to competitive grant funding enabled by the MRSP was estimated to be the largest source of benefits to the MRIs in aggregate. This was followed by impacts of additional income from infrastructure and commercialisation as well as benefits of avoided turnover of staff.

Even on this limited basis alone, the MRSP was assessed to have had a net positive impact, with a positive NPV and BCR greater than one within each of the funding rounds. Figure 50 (below) demonstrates this graphically, showing the size of the benefits enjoyed by MRIs relative to the costs of delivering the MRSP.

Figure 50. Direct MRI benefits and costs of the MRSP (\$2025, '000s)



Source: MRI-reported data and Insight Economics analysis

On the basis of direct impacts to MRIs alone, the MRSP maintained a BCR greater than one over the life of the MRSP, with more recent periods having relatively higher BCRs (Table 17):

- In the first round (2012–2016), the MRSP was estimated to realise a BCR of 1.3 on the basis of direct impacts to MRIs alone
- In the second round (2016–2020), the MRSP was estimated to realise a BCR of 2.5 on the basis of direct impacts to MRIs alone
- In the third round (2020–2024), the MRSP was estimated to realise a BCR of 2.2 on the basis of direct impacts to MRIs alone
- In the first two years of the fourth round (2024–2028), the MRSP was estimated to realise a BCR of 5.1 on the basis of direct impacts to MRIs alone.

Over the entire reference period, the direct MRI benefits accruing to the MRSP are 2.2, implying that the MRSP generates almost double the value in benefits relative to the costs of delivery.

Table 17. Direct benefits to MRIs only (partial analysis) (\$2025, '000s, NPV_{5%})

Direct Benefits (\$ '000s)	2012–2016	2016–2020	2020–2024	2024–2028*	Life of MRSP (2012–2025)
MRSP costs (NPV_{5%})					
Total program costs	\$241,668	\$263,350	\$231,663	\$42,831	\$779,513
MRSP benefits (NPV_{5%})					
Grant uplift	\$308,244	\$574,652	\$349,482	\$83,659	\$1,316,036
Infrastructure revenue	\$2,617	\$2,286	\$1,364	\$957	\$7,223
Commercialisation revenue	\$750	\$289	\$76,417	\$108,550	\$186,006
Avoided turnover of staff	\$0	\$89,178	\$87,019	\$24,562	\$200,759
Total benefits (NPV_{5%})	\$311,610	\$666,405	\$514,281	\$217,728	\$1,710,024
Net benefits (NPV_{5%})	\$69,942	\$403,055	\$282,618	\$174,896	\$930,511
BCR (partial analysis, direct impacts to MRIs only)	1.3	2.5	2.2	5.1	2.2

Source: Analysis of MRI-reported data. *Partial data to 2025 only.



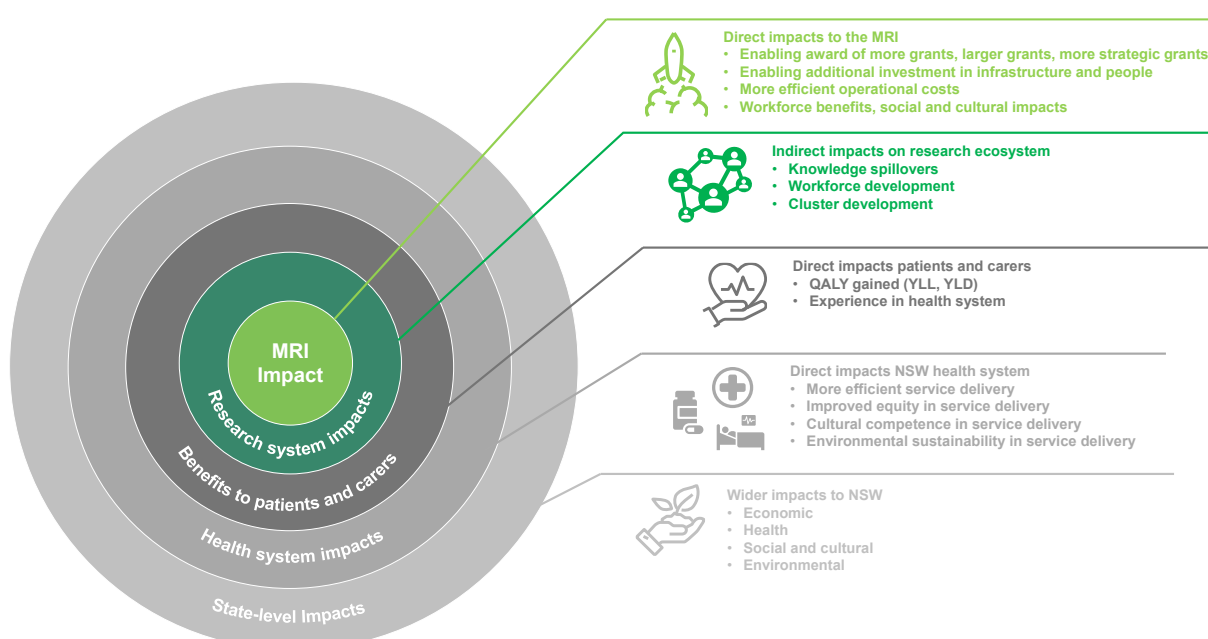
6.1.5 Economic impact of the MRSP on NSW medical research ecosystem

Beyond the benefits enjoyed by participating MRIs, MRSP funding enabled other, second round⁵¹, indirect benefits to be realised across the broader NSW research ecosystem, through investment in infrastructure that can be accessed by other members of a research precinct and knowledge spillovers from additional research conducted by MRIs.

As with the calculation of direct MRI benefits, a bottom-up approach for each MRI was taken, and aggregated across all institutes. MRIs provided information for the following benefit streams:

- Impacts on research excellence
- Benefits from workforce development through the creation of roles and training for additional research and administrative staff
- Benefits from running clinical trials
- Benefits from access to infrastructure by other institutions and industry in the precinct that would not otherwise be available
- Impact of knowledge spillovers.

MRIs were asked about wider industry and innovation precinct activity enabled by research and infrastructure that can be accessed by other research institutes within a precinct, but no MRI was able to provide examples of industry growth or investment enabled by their activity. This is an area for improvement in future reporting to better understand some of these other indirect effects.



⁵¹ Not to be confused with MRSP funding rounds, just noting sequencing of economic impacts.

Finding A – Benefits of the MRSP on research excellence

In the latest available NHMRC *Measuring Up* report (2020),⁵² Australia's share of all world biomedical journal publication output was 3.6% in 2008–2012, up from 3.1% in 2005–2009. Given Australia's small population size (0.33%) and the relatively lower investment in R&D compared to other OECD nations (Australia's share of R&D investment estimated to be 1.6% in 2023),⁵³ this demonstrates Australia is among the top contributors to medical research output globally and outperforms relative to its developed nation peers.

In research, however, it is high impact research, measured by citation performance in the top journals that has been shown to translate into significant improvements in health and medical research advances and outcomes. For this reason, citation analysis of performance in the top 1% and 10% of journals in a given field have been identified as metrics of high impact research.

The NHMRC consistently funds high impact research and, in its latest impact report, reported outperforming global benchmarks, with NHRMC-funded research accounting for 2.9% of citations in the top 1% of journals and 19.7% of citations in the top 10% of journals. Relative to Australia's population size and investment in R&D compared to other developed nations, this points to Australia's NHRMC program consistently funding globally leading research, significantly outperforming its peers.

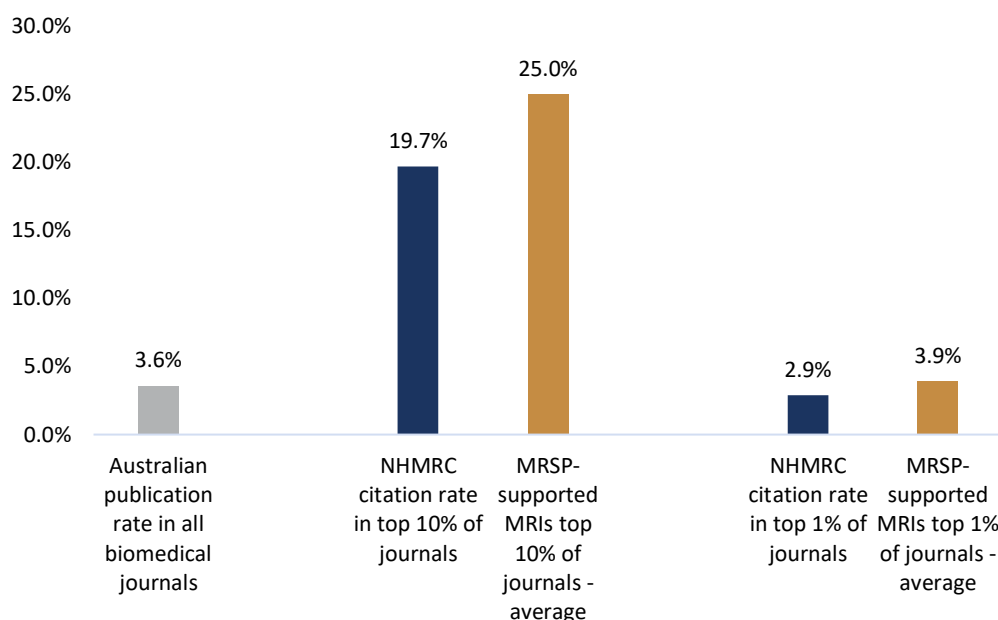
Citation analysis showed the MRSP has supported research programs that outperform even these impressive NHMRC benchmarks, with MRSP-funded MRIs accounting for 3.9% of citations in the top 1% of journals and 25% of citations in the top 10% of journals (Figure 51).

This further underlines that the MRSP has contributed to research excellence by helping high performing institutions to perform more research than would otherwise be the case.

⁵² NHRMC, 2020, *Measuring Up*, accessed at: <https://www.nhmrc.gov.au/about-us/publications/measuring-2018>

⁵³ It is estimated that Australia invests 1.68% of GDP in R&D compared to an OECD average of 2.7%, See: https://www.apph.gov.au/About_Parliament/Parliamentary_departments/Parliamentary_Library/Research/Research_Papers/2024-25/RandD_and_innovation_in_Australia_2024_update, which indicates Australia contributes approximately 1.6% of research by advanced OECD nations based on 2023 estimates of GDP (See: <https://www.macrotrends.net/datasets/global-metrics/countries/oed/oecd-members/gdp-gross-domestic-product>).

Figure 51. Citation analysis: MRSP-supported MRIs compared to all NHMRC-funded research



Source: NHRMC, 2020, *Measuring Up*, accessed at: <https://www.nhmrc.gov.au/about-us/publications/measuring-2018> and Insight Economics analysis of SciVal citation rates in the top 1% and 10% of journals over 2012–2024.

Finding B – Benefits from job creation and talent attraction

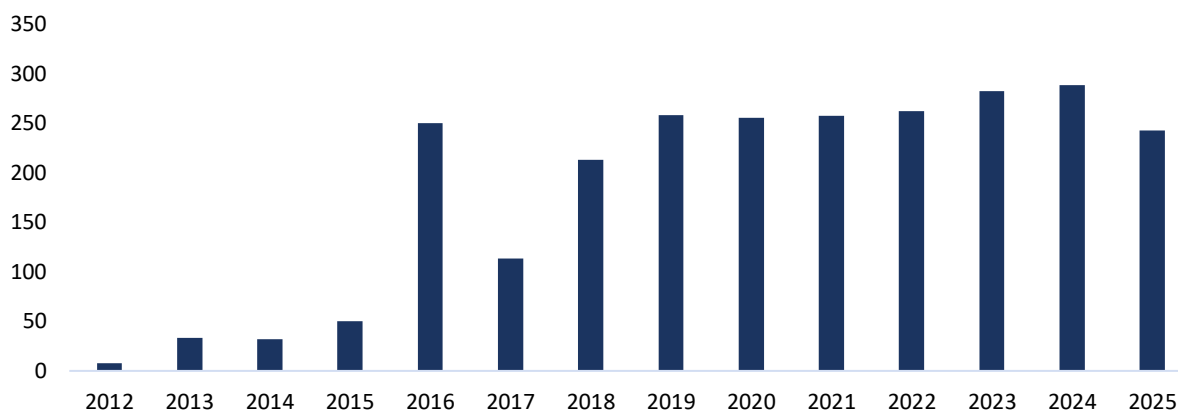
While difficult to quantify, one benefit stream that impacts both MRIs and their research ecosystems is the creation of new jobs and training in areas of skills shortage, and the ability of MRIs to attract research talent. The MRSP is well positioned to support both of these objectives, because of its position as baseline funding.

MRIs discussed how MRSP funding has enabled them to bring in new talent to drive their research output:

- HRI, for instance, indicated that they were able to recruit a researcher with expertise in lipidomics and spatial lipidomics, which are unique skills in NSW.
- Similarly, WIMR noted that a researcher in their hire is an internationally acclaimed hepatologist whose landmark research and leadership in liver cancer and fatty liver disease have shaped global practice and established NSW as a world leader in liver health.
- The impact of talent attraction is heightened for regionally based MRIs, such as HMRI, where the presence of an independent MRI and an ecosystem around it creates highly skilled jobs within a market that would otherwise be underserved. HMRI also noted that they have leveraged MRSP funding on platforms such as their neuroimaging centre to attract and retain exceptional researchers and their teams.

These FTE estimates should be considered qualitatively alongside the other calculated benefits (including avoided turnover which is factored into the BCR). Over the life of the MRSP, the MRSP has been responsible for creating 2,550 FTE jobs for NSW MRIs, an average of 182 each year. The trajectory of MRI job creation over time is shown in Figure 52 (below).

Figure 52. MRI jobs created through MRSP support (FTE)



Source: MRI-reported data and Insight Economics analysis

Finding C – Benefits from clinical trial investment and expenditure

Australia is a globally competitive destination for clinical trials, accounting for around 5% of global industry-sponsored trials.⁵⁴ NSW itself accounts for 30% of clinical trials conducted in Australia⁵⁵, cementing the state as a significant contributor to international research, particularly in early-phase studies. MRIs play a crucial role in maintaining this world leading position. For example, the Ingham Institute partnered with South West Sydney Local Health District to establish SWS Clinical Trials, whose offerings included 134 clinical trials across 25 therapeutic areas. Additionally, the Woolcock Institute used MRSP funding to operate an onsite pharmacy, which supported clinical trials. Their chronobiology suite has allowed them to do intensive extended research, such as with studies of narcolepsy drug treatment.

Based on the additionality impact on research, it was estimated that the MRSP enabled an uplift of 350 trials over the life of the MRSP, including 5 in Round 1 (2012–2016), 144 in Round 3 (2020–2024) and 201 so far in Round 4 (2024–2028). These additional trials were estimated to have a benefit of \$8 million, \$133 million and \$157 million, respectively (see Table 18). No trials were estimated to have been attracted over Round 2 (2016–2020).

Over the life of the MRSP, benefits from clinical trials accounted for 299 million in benefits, \$292 million of which came from Tier 1 and 2 institutes.

⁵⁴ MTPConnect. 2021. Australia's Clinical Trial Sector: Advancing innovative healthcare and powering economic growth. Department of Industry, Science, Energy and Resources. Accessed at: https://clinicaltrialsalliance.org.au/wp-content/uploads/2021/07/MTPConnect_2021ClinicalTrialsReport.pdf

⁵⁵ Invest regional. 2024. Clinical trials in the Hunter New England. Department of Primary Industries and Regional Development. NSW Government. Accessed at: https://www.investregional.nsw.gov.au/sites/default/files/publications/2024-07/Clinical-Trials-Fact-Sheet_0.pdf

Table 18. Benefits from running clinical trials (\$2025, '000s, NPV_{5%})

Benefits (\$ '000s)	2012–2016	2016–2020	2020–2024	2024–2028*	Life of MRSP (2012–2025)
All tiers	\$7,998	- No impact reported	\$133,451	\$157,238	\$298,687
Tiers 1 & 2	\$7,998	-	\$128,808	\$155,532	\$292,339
Tier 3	-	-	\$4,642	\$1,706	\$6,349

Source: Analysis of MRI-reported data. *Partial data to 2025 only.

Finding D – Benefits from infrastructure that can be accessed by other research institutes within a precinct

MRIs consistently described the MRSP as crucial for sustaining and advancing infrastructure, describing it as the “backbone of the institute”. Almost all (12 of 13) perceived that MRSP funding had some or a large impact on maintaining, improving or establishing new infrastructure, and that their ability to do so would be diminished if they were to lose MRSP funding (especially improving and maintaining existing infrastructure). At a regional level, the MRSP was viewed as providing vital support where access to metropolitan infrastructure was limited, reducing inequities in research capabilities across NSW.

The development of this infrastructure benefited the precinct more widely than the MRI alone. For example, CMRI established the NSW Organoid Innovation Centre, Australia’s first large-scale hub for regenerative medicine and organoid research. HMRI, conversely, invested in their neuroimaging centre, which has facilitated intra- and cross-disciplinary collaborations and built a profile for their local regional ecosystem. This infrastructure was available to be accessed by other institutes and industry in the precinct.

However, MRIs found it difficult to describe or value the benefits that access to this infrastructure had provided to third parties and were only able to identify revenue from its use (as quantified above). MRIs also had poor visibility of any start-up, spinoff or other industry or innovation activity that may have been enabled from the use of this infrastructure.

Finding E – Impact of knowledge spillovers

Knowledge spillovers represent how research conducted by MRIs (through the aid of the MRSP) can flow through to other institutions in the medical research ecosystem or in the state at-large. As discussed above, there is considerable literature linking spending on R&D with an uplift in output among similar firms. Palangkaraya and Webster (2015)⁵⁶ provide estimates of the elasticity of firm output with respect to R&D expenditure by similar firms. This was used to estimate the sensitivity of other institutes’ research output with respect to additional investment by MRIs.

Some MRIs hold a critical mass of knowledge, infrastructure and research output, and provide an outsized impact on all participants within a research ecosystem. These institutes are the anchor tenants of the major medical research ecosystems around NSW.

⁵⁶ Palangkaraya, A. and Webster, E. 2015. Measuring R&D spillovers from Australia industry: Uses and limitations of using the Extended Analytic Business Longitudinal Database (EABLD), accessed at: <https://www.swinburne.edu.au/media/swinburneeducu/research/research-centres/cti/reports/Measuring-RD-spillovers-from-Australia-industry-2015.pdf>

Table 19. Benefits from knowledge spillovers (\$2025, '000s, NPV_{5%})

Benefits (\$ '000s)	2012–2016	2016–2020	2020–2024	2024–2028*	Life of MRSP (2012–2025)
All tiers	\$129	\$257	\$156	\$36	\$577
Tiers 1 & 2	\$97	\$198	\$92	\$21	\$409
Tier 3	\$32	\$59	\$63	\$15	\$168

Source: Analysis of MRI-reported data. *Partial data to 2025 only.

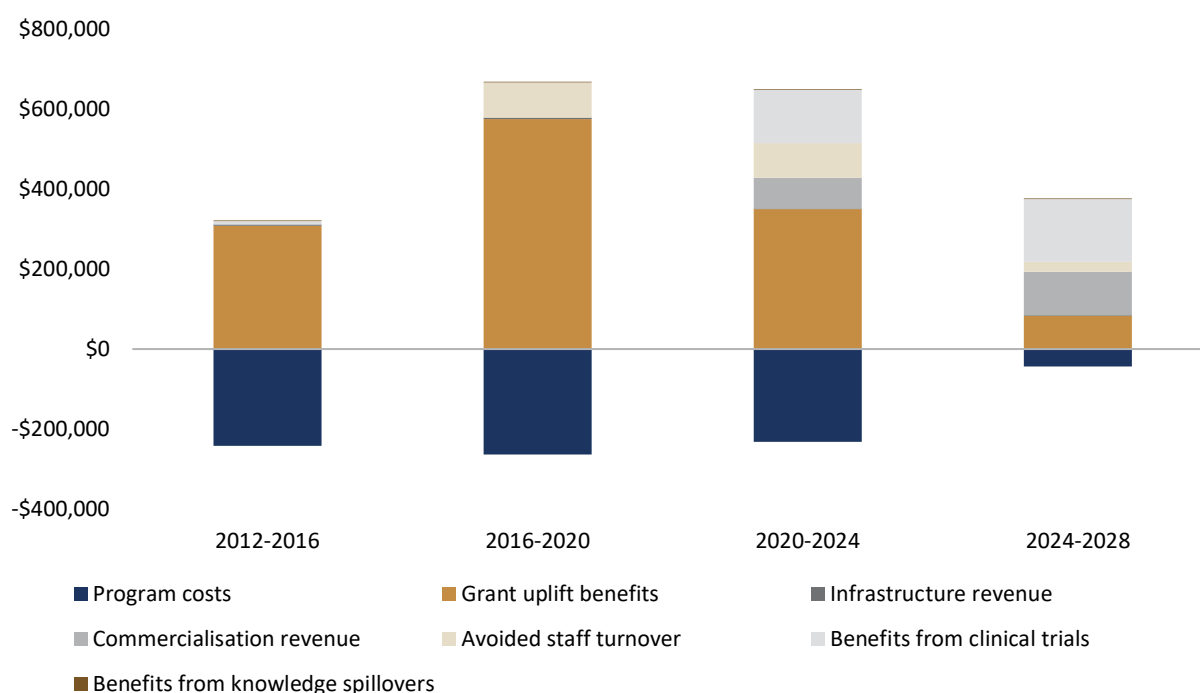
As can be seen in Table 19, these benefits were relatively small compared to other benefit streams, accounting for around \$577,000 worth of benefits over the reference period. \$409,000 worth of benefits came from larger tier 1 and 2 firms, \$257,000 of which was realised in the 2016–2020 period.

Finding F – Benefit cost ratios based on impact to research ecosystems

The addition of indirect benefits, specifically benefits that accrue to the research ecosystems within which MRIs operate, increased the magnitude of benefits in each funding round and over the life of the project.

As can be seen in Figure 53, grant uplift remained the largest category of benefit impact from the MRSP and accounted for 65% of the benefits realised. This was followed by an uplift in clinical trials, which contributes almost \$300 million in present value terms over the life of the MRSP (15% of benefits over the life of the MRSP), avoided turnover (10% of the benefits) and an uplift in commercialisation activity (9% of benefits over the life of the MRSP).

Figure 53. Direct and indirect ecosystem benefits (\$2025, '000s, NPV_{5%})



Source: MRI-reported data and Insight Economics analysis

The addition of ecosystem-level benefits improved the NPV and BCR of the MRSP in each funding period, as well as over the entire MRSP funding period as a whole. As with the direct benefits, the size of the BCR improves over time, increasing from 1.3 in 2012–2016 to 8.8 in 2024–2028.

Over the whole of the period, the MRSP was assessed to have a BCR of 2.6, indicating that the size of the benefits enjoyed by MRIs and NSW medical research ecosystems is more than double the cost of the MRSP, in NPV_{5%} terms. Due to significant gaps in reporting in the early rounds of the program, however, the most recent round of funding is likely to be more representative of the indicative impacts due to more comprehensive reporting by the MRIs. It is recommended that greater weight is given to the more recent rounds of funding.

Table 20. MRI ecosystem benefits (\$2025, '000s, NPV_{5%})

Direct & indirect Benefits (\$ '000s)	2012–2016	2016–2020	2020–2024	2024–2028*	Life of MRSP (2012–2025)
MRSP costs (NPV_{5%})					
Total program costs	\$241,668	\$263,350	\$231,663	\$42,831	779,513
MRSP benefits (NPV_{5%})					
<i>Direct MRI benefits</i>	\$311,610	\$666,405	\$514,281	\$217,728	\$1,710,024
Benefits from clinical trials	\$7,998	\$0	\$133,451	\$157,238	\$298,687
Knowledge spillovers	\$129	\$257	\$156	\$36	\$577
Total benefits (NPV_{5%})	\$319,737	\$666,661	\$647,888	\$375,002	\$2,009,288
Net benefits (NPV_{5%})	\$78,069	\$403,311	\$416,224	\$332,171	\$1,229,775
BCR	1.3	2.5	2.8	8.8	2.6
Level of data uncertainty / risk of gaps in reporting	H	L-M	L	L	

Source: Analysis of MRI-reported data. *Partial data to 2025 only.
H = High; L = Low; M = Medium

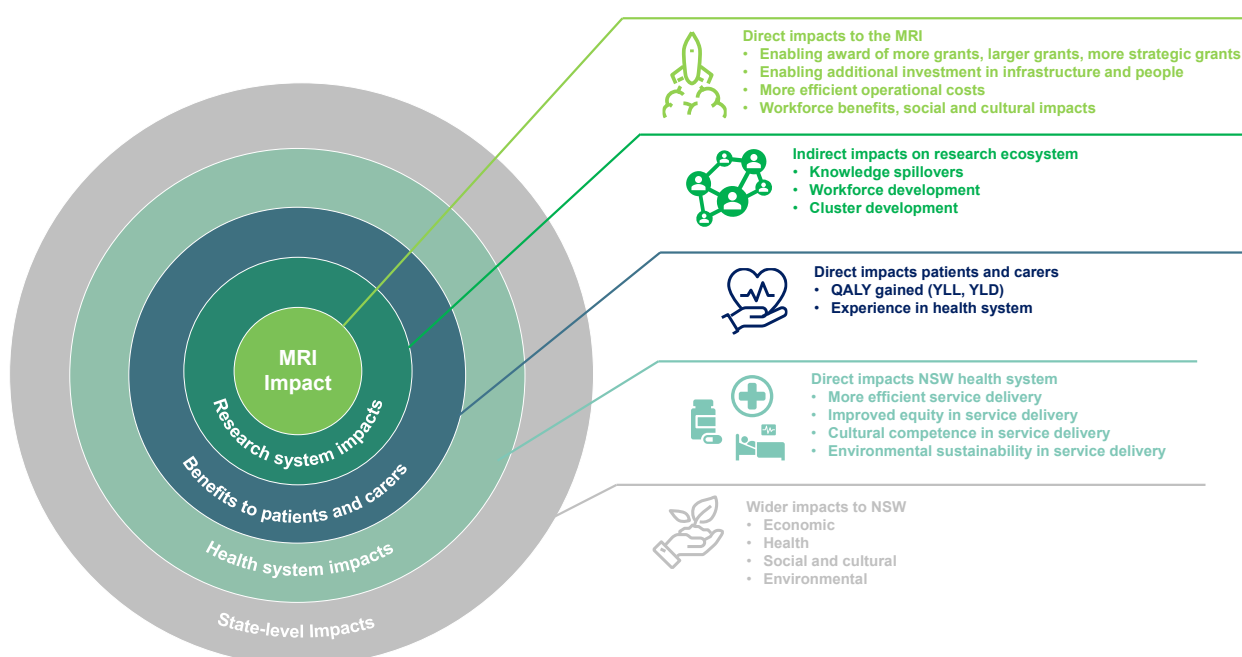
The analysis conservatively points to a minimum BCR of 2.5 or 2.8, based on the direct impacts to the MRIs and wider knowledge precincts alone.

Health and economic benefits through improved health care would be expected to be additional to this, as well as social, cultural and other environmental benefits.



6.1.6 Economic impact of the MRSP on patients and carers in NSW and beyond

In addition to the economic benefits of the MRSP to the MRIs and wider innovation ecosystem, the additional research undertaken would be expected to have benefits for patients and carers in NSW and beyond.



Overall, the citation analysis indicated that the MRIs contribute to high impact research, with MRIs strongly represented in the top tiers of journals in their respective fields (see Finding A under Section 6.1.5 above). Given that the MRIs are delivering high impact work across most health conditions, from cancer to diabetes to mental health, the benefits over time are likely to be extensive for people living in NSW — and for people across Australia and globally.

However, reporting has focused on raw publication statistics rather than identifying the specific additional research enabled as a result of access to MRSP funds. Therefore, reporting against this metric was inconsistent and best evaluated through a case study approach. Case studies of major research being undertaken by the MRIs identified are detailed below. Taken together, these examples show that the MRSP-funded MRIs are working on a range of significant health challenges that have and will continue to progressively deliver significant improvements in health outcomes to both the people of NSW and beyond.

Case Study A – The Black Dog Institute: Reducing self-harm hospitalisations

The Black Dog Institute identified research to reduce self-harm hospitalisations as an area that was enabled by the MRSP research. Hospitalisations for intentional self-harm, where individuals are admitted following attempted suicide or other self-injurious behaviour, represent a measurable component of the broader economic and health burden in NSW, and more broadly across Australia. For

example, AIHW data shows hospitalisation rates for intentional self-harm in NSW (73.4 per 100,000 males and 120.6 per 100,000 females on average over the FY09–FY24 period) constitute thousands of admissions each year,⁵⁷ giving rise to substantial treatment costs through emergency and inpatient care. Comprehensive Australian studies on self-harm treatment indicate that hospitalisations carry significant per-episode costs (for example, youth hospitalised for self-harm averaged around A\$4,649 per episode)⁵⁸ and contribute meaningfully to health system spending.

The Black Dog Institute’s LifeSpan model has been shown to reduce self-harm hospitalisations by 13.8%⁵⁹ and was recently cited as a model that would be explored and implemented in future by the Mental Health Commission of NSW.⁶⁰ Based on expected rates of hospitalisation for males and females in NSW, a 13.8% reduction was modelled with the benefits commencing 17 years from the 2019 publication, phasing into full effect over a four year horizon. Over the 2026–2046 horizon alone, more than 12,900 self-harm hospitalisations could be prevented through such a model across the state, at a value of \$41 million to NSW in avoided hospitalisations in \$2025, NPV_{5%} terms. Based on an assumption of 50% of the benefit arising from the research⁶¹ (as distinct from wider policy reform and implementation science) and that the Black Dog Institute accounted for between 4.2% and 24% of the research impact based on its share of citations in the top 1% and 10% of journals⁶², respectively, this suggests that the value of this research to the wider NSW health system is in the order of \$0.9 to \$4.9 million alone.

Of course, the model of care would be expected to improve outcomes for patients nationally and potentially beyond Australia as well. For example, to the extent this research improves outcomes across Australia, the benefits to health systems and patients would be substantially larger. Over the 2026–2046 horizon, more than 45,000 potentially preventable hospitalisations from self-harm could be avoided, at a value of \$143.8 million to the Australian health system (\$2025, NPV_{5%}). Allowing for a 50% attribution of this value to research and between 4.2% and 24% to be attributed to the Black Dog Institute, this would equate to a value of \$3.1 million to \$18 million in \$2025, NPV_{5%} terms.

Case Study B – The Heart Research Institute: Preventing strokes from atrial fibrillation

The Heart Research Institute identified improved screening for atrial fibrillation (AF) as a major area of research enabled by the MRSP, including for cohorts that may engage with the health system less than other cohorts, such as Australians of Asian descent or backgrounds. Undiagnosed atrial fibrillation in the NSW community significantly contributes to the burden of stroke and premature mortality, as atrial fibrillation greatly increases the risk of ischaemic stroke and AF-related strokes tend to be more severe

⁵⁷ AIHW. (2025). Intentional self-harm hospitalisations by states and territories, 2023-24 latest data. Accessed at: <https://www.aihw.gov.au/suicide-self-harm-monitoring/service-use/hospitalisations/hospitalisations-by-states-and-territories>.

⁵⁸ Kinchin, I., Russell, A. M. T., Byrnes, J., McCalman, J., Doran, C. M., & Hunter, E. (2020). The cost of hospitalisation for youth self-harm: differences across age groups, sex, Indigenous and non-Indigenous populations. *Social psychiatry and psychiatric epidemiology*, 55(4), 425–434. <https://doi.org/10.1007/s00127-019-01807-6>

⁵⁹ Shand F, Torok M, Mackinnon A, Burnett A, Sharwood LN, Batterham PJ, et al. (2025). Effect of the LifeSpan suicide prevention model on self-harm and suicide in four communities in New South Wales, Australia: a stepped-wedge, cluster randomised controlled trial. *BMJ Mental Health*. 2025;28:e301429. <https://doi.org/10.1136/bmjment-2024-301429>

⁶⁰ Mental Health Commission of NSW. (2025). Shifting the Landscape for Suicide Prevention in NSW A whole-of-government: Strategic Framework for a whole-of-community response 2022-2027, accessed at: https://www.nswmentalhealthcommission.com.au/sites/default/files/2022-10/The%20Framework%20-%20Shifting%20the%20Landscape%20for%20Suicide%20Prevention%20in%20NSW%202022-2027_0.PDF, p 14.

⁶¹ NHMRC. (2020). Measuring Up 2018.

⁶² SciVal citation analysis as of December 2025 provided courtesy of OHMR.

than non-AF strokes. AIHW data estimate atrial fibrillation accounts for tens of thousands of years of healthy life lost (approximately 70,800 DALYs nationally, combining YLL and YLD), reflecting both premature death and long-term disability from stroke and other AF-related complications such as heart failure.⁶³ While state-based estimates are not published for AF specifically, based on population estimates, this would have equated to roughly 22,000 DALYs in NSW in 2025. Moreover, a substantial proportion of people with AF remain unaware of their condition, with estimates suggesting that around 30% of Australians with AF are undiagnosed, meaning many miss the opportunity to receive anticoagulant therapy that can reduce stroke risk by more than 60%.⁶⁴

The Heart Research Institute's work has estimated the prevalence of unsuspected and undetected AF among people aged 65+ years old to be 0.2%, leading to an estimated stroke risk of 2.25% per year and a risk of heart failure of 21% over 10 years in patients. Because the consequences of undetected diagnoses are so high in both health care costs and premature death, HRI's research found that screening among people aged 65–75 was cost effective, with a cost per QALY gained of €30,361 in \$2022, which is equivalent to A\$44,463 in \$2025 based on World Bank PPP conversion rates and adjusting for inflation. In NSW, approximately 60 strokes would be prevented, which, with a lifetime cost per stroke estimated to be \$350,000 in \$2023,⁶⁵ translates into more than \$13 million in health and economic benefits over the 2026–2046 horizon in \$2025, NPV_{5%} terms. Assuming that the research accounts for only 50%, with HRI contributing between 4.2% and 26.4% based on citation analysis for HRI, this equates to a value of between \$0.3 million and \$1.7 million in \$2025, NPV_{5%} terms.

Extrapolated out nationally, such an approach could be expected to prevent more than 213 strokes nationally that would have been otherwise undetected, at a value of just over \$46.1 million in \$2025, NPV_{5%} terms. Allowing for a 50% attribution of this value to research and between 4.2% and 26.4% to be attributed to HRI, this would equate to a value of \$1.0 million to \$6.1 million in \$2025, NPV_{5%} terms.

Case Study C – Hunter Medical Research Institute: Novel models of care to prevent chronic disease among regional Australians

Diabetes is a major preventable chronic illness impacting millions of Australians. In 2020–21, more than 1.3 million Australians were estimated to be living with diabetes, with an estimated cost of \$3.4 billion in the Australian health system, representing 2.3% of total disease expenditure.⁶⁶ Australians living in regional and remote areas are more likely to develop diabetes, with age-standardised prevalence rate of diabetes in Remote and Very Remote areas at 1.3 times the rates of people living in Major Cities. In NSW, it has been estimated, for example, that 100,000 people in the Hunter New England region of NSW alone are living with diabetes, but of this, approximately 30% are estimated to be undiagnosed while their disease is advancing.

⁶³ AIHW. (2025). Heart, stroke and vascular disease: Australian facts, accessed at: <https://www.aihw.gov.au/reports/heart-stroke-vascular-diseases/hsvd-facts/contents/impacts/burden-of-cvd>

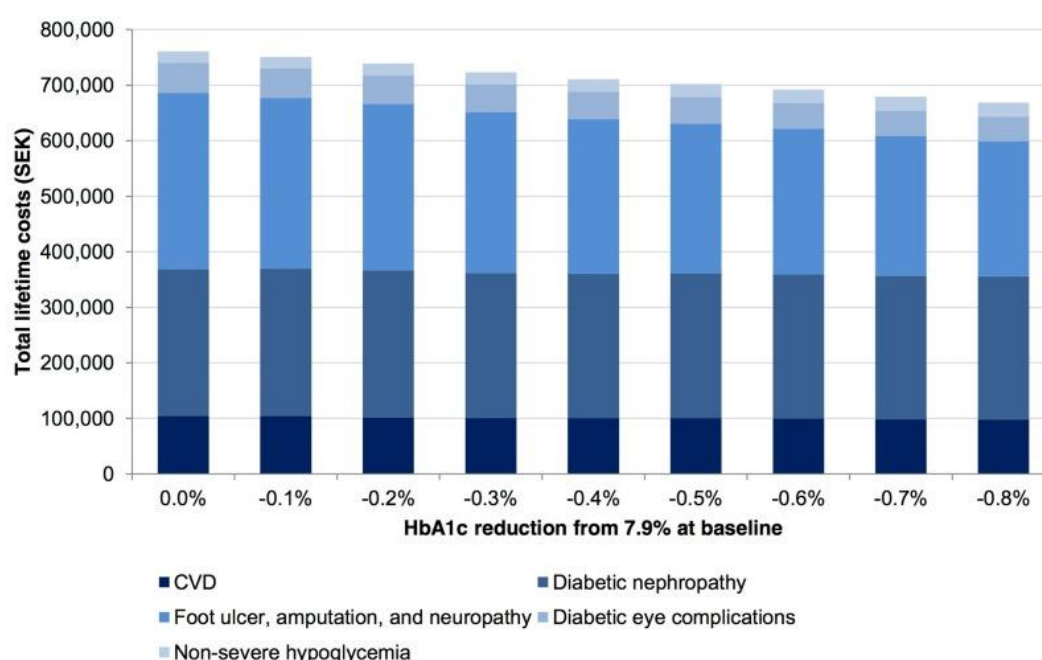
⁶⁴ Australian Institute of Health and Welfare. (2020). Atrial fibrillation in Australia. Retrieved from <https://www.aihw.gov.au/reports/heart-stroke-vascular-diseases/atrial-fibrillation-in-australia/contents/what-is-atrial-fibrillation> and Deloitte Access Economics. (2011). Offbeat: Atrial fibrillation and the cost of preventable strokes. Retrieved from: <https://www2.deloitte.com/au/en/pages/economics/articles/atrial-fibrillation-cost-preventable-strokes.html>

⁶⁵ Stroke Foundation. (2024). Economic Impact of Stroke Report 2024, accessed at: <https://strokefoundation.org.au/what-we-do/research/economic-impact-of-stroke-in-australia>

⁶⁶ AIHW. (2024). Diabetes: Australian facts accessed at: <https://www.aihw.gov.au/reports/diabetes/diabetes/contents/how-common-is-diabetes/all-diabetes>

Enabled by the MRSP, HRMI has joined part of a wider research and health services consortium to improve and expand models of care for these regional Australians, including the development of a Medibus model. Since its establishment in 2015, the Medibus has provided care to more than 6,500 patients via face-to-face and virtual clinics.⁶⁷ Research of the interventions in regional areas improved the probability of patients receiving screening tests at or above the recommended intervals by 41%–45% ($p < 0.0001$).⁶⁸ There were also significant improvements in clinical outcomes observed for weight (absolute mean difference: -1.38 kg), blood pressure (systolic - 1.12 mmHg, diastolic - 1.18 mmHg), HbA1c (-0.03% at the mean), total cholesterol (-0.11 mmol/L), and triglycerides (-0.02 mmol/L) ($p < 0.05$). Early diagnosis enables timely treatment and complication prevention (e.g., heart disease, kidney disease, blindness), which reduces hospitalisations, emergency care and high-cost procedures that are responsible for much of this expenditure as well as improving quality of life for patients.⁶⁹ For patients seeing meaningful and sustained improvements in diabetes control, the long-term benefits are significant in health and economic terms (Figure 54). Research has shown that the first 10 years of control at an HbA1c level 7.1% (54.1 mmol/mol) relative to 7.9% (62.8 mmol/mol) resulted in an improvement of 0.579 undiscounted QALYs, while the subsequent 10 years resulted in an additional gain of 0.432 QALYs and the final 30 years of control (to the time horizon of the analysis) improved life expectancy by an additional 0.239 QALYs, or an undiscounted lifetime benefit of A\$62,500 per person.

Figure 54. Costs of adverse events and long-term diabetes complications with decreasing HbA1c - Lifetime costs potentially avoided through early diabetes diagnosis



Source: Jendle, J., Ericsson, Å., Hunt, B., Valentine, W. J., & Pollock, R. F. (2018).⁷⁰

⁶⁷ Diabetes Alliance Program+. (2025). Diabetes Alliance Program+ MediBus: Bringing Specialist Diabetes Care to You, accessed at: <https://www.dapplus.org.au/dap-medibus>

⁶⁸ Acharya, S., Taylor, R., Parsons, M. *et al.* (2024). Spillover effects from a type 2 diabetes integrated model of care in 22,706 Australians: an open cohort stepped wedge trial. *BMC Endocr Disord* 24, 183. <https://doi.org/10.1186/s12902-024-01692-4>

⁶⁹ Jendle, J., Ericsson, Å., Hunt, B., Valentine, W. J., & Pollock, R. F. (2018). Achieving Good Glycemic Control Early After Onset of Diabetes: A Cost-Effectiveness Analysis in Patients with Type 1 Diabetes in Sweden. *Diabetes therapy : research, treatment and education of diabetes and related disorders*, 9(1), 87–99. <https://doi.org/10.1007/s13300-017-0344-6>

⁷⁰ Ibid.

Case Study D – NeuRA: ANZ Hip Fracture Registry

The risk of falls and fractures increases with age, leading to potentially serious injury and health service utilisation, including ambulance services, hospitalisations and emergency and outpatient departments, rehabilitation, limited aged care and community services. Each year, approximately 19,000 patients in Australia present with a new hip fracture nationwide, with total annual costs exceeding \$1.01 billion.⁷¹ Twenty-five per cent of people die within one year of hip fracture, many do not regain their function, and 11% of cognitively healthy and 46% of cognitively impaired people transition from home to residential aged care facilities following a fracture. Moreover, the health services costs of surgery and readmission are substantial. The length of hospital days due to hip fractures has increased from 6.9 days to 10.3 days (for people aged 50–69 years) from 2012 to 2023, at an average cost of \$31,965 per episode.⁷² For patients experiencing readmission due to complications the costs can increase exponentially. For example, among older patients hospitalised after a hip fracture, patients that experienced complications had higher hospital costs (median \$84,779) compared to patients without complications (median \$60,137) and a 43% longer length of stay in hospital.⁷³

According to NSW HealthStats data, in the 2022–23 financial year, there were 6,156 hospital admissions for hip fractures serious enough to require hospitalisation among NSW residents aged ≥65 years and more than 11,000 among people aged ≥50 years.⁷⁴ Similarly, in the three-year period October 2021 – June 2024, 11,948 patients had 12,172 hospitalisations for hip fracture surgery and among this group there were 1,143 readmissions within 30 days.⁷⁵ The NSW 30-day unadjusted readmission rate was 9 per 100 hospitalisations, and ranged from 5 to 16 per 100 hospitalisations across hospitals. Of those patients that were readmitted, 6% of readmissions were for the same condition (hip fracture), 15% were for a reason specifically related to hip fracture surgery (e.g. complications such as wound infection), 46% were for a condition potentially related to hospital care; and 33% were for other reasons.

Enabled by the MRSP, NeuRA provides in-kind support to the ANZ Hip Fracture Registry (ANZHFR), which brings together data from more than 106 hospitals (84 hospitals in Australia and 22 in New Zealand) to benchmark care, inform policy, and improve patient outcomes. Data from more than 15,000 patients (15,387) has been entered to date. Through the registry, the ANZHFR can help to identify opportunities to better prevent serious falls and improve the quality of care. For example, a recent study of early participating hospitals found year-on-year improvements were demonstrated against a number of quality indicators,⁷⁶ with the main advances including an increase in cognitive assessments and

⁷¹ How the Hip Fracture Registry is improving outcomes for patients, accessed at: <https://insightplus.mja.com.au/2024/12/how-the-hip-fracture-registry-is-improving-outcomes-for-patients/>

⁷² Mudiyansele, SB. Watts, JJ. Gebremariam, K. and Abimanyi-Ochom, J. (2023). Osteoporosis and fractures in Australia. A burden of disease analysis 2023 – 2033, accessed at: <https://healthybonesaustralia.org.au/wp-content/uploads/2024/09/bod-2024-digital-isbn-final.pdf>.

⁷³ Mitsutake, S., Lystad, R. P., Okuba, T., Long, J. C., Braithwaite, J., Hirata, T., & Mitchell, R. (2025). Effect of hospital-acquired complications on hospital length of stay and cost for older adults after a hip fracture in New South Wales, Australia.

Osteoporosis international : a journal established as result of cooperation between the European Foundation for Osteoporosis and the National Osteoporosis Foundation of the USA, 36(7), 1267–1275. <https://doi.org/10.1007/s00198-025-07536-8>

⁷⁴ Bureau of Health Information. (2025). Readmission and returns to acute care following hospitalisation for eight clinical conditions October 2021 – June 2024, accessed at: [https://www.healthstats.nsw.gov.au/indicator?name=-inj-fall-hip-hos&location=NSW&view=Trend&measure=DSTRate&groups=Age%20\(years\),Hip%20fractures,Sex&compare=Age%20\(years\),Hip%20fractures,Sex&filter=Age%20\(years\),All%20ages,65%20years%20and%20over,85%252B%20years,65-74%20years,75-84%20years&filter=Hip%20fractures,Fall-related%20hip%20fractures>Total%20hip%20fractures&filter=Sex,Persons](https://www.healthstats.nsw.gov.au/indicator?name=-inj-fall-hip-hos&location=NSW&view=Trend&measure=DSTRate&groups=Age%20(years),Hip%20fractures,Sex&compare=Age%20(years),Hip%20fractures,Sex&filter=Age%20(years),All%20ages,65%20years%20and%20over,85%252B%20years,65-74%20years,75-84%20years&filter=Hip%20fractures,Fall-related%20hip%20fractures>Total%20hip%20fractures&filter=Sex,Persons)

⁷⁵ https://www.bhi.nsw.gov.au/_data/assets/pdf_file/0004/1024087/BHI_Readmission_2021-2024_Report.pdf

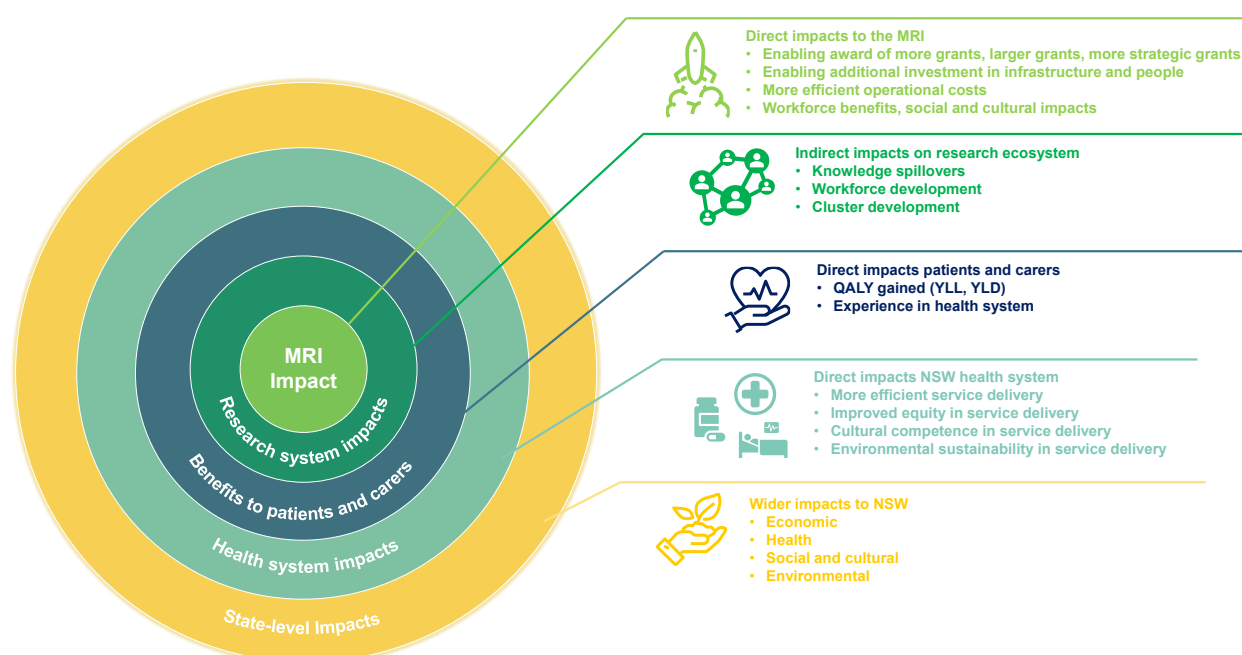
⁷⁶ Taylor ME, Ramsay N, Mitchell R, et al. Improving hip fracture care: A five-year review of the early contributors to the Australian and New Zealand Hip Fracture Registry. *Australas J Ageing*. 2024; 43: 31-42. doi:10.1111/ajag.13270

implementation of nerve blocks prior to surgery. Areas for improvement included reducing emergency department stays of less than 4 hours, consistent assessment of pain within 30 minutes of presenting at the emergency department, surgery within 48 hours and consistent prescription of bone protection medication on discharge from the hospital, as well as improving clinical care to reduce hospital-acquired pressure injury. Through improved transparency, accountability and support to improve clinical practice, the registry can improve survival and quality of life for patients through the receipt of clinical best practice care.



6.1.7 Qualitative analysis: Social, cultural, environmental and other workforce impacts

Beyond the economic impacts to the MRIs, impacts from the MRSP on social, cultural, and environmental were less consistently reported, and depended heavily on the research focus of the organisation.



Finding A – Social benefits

Medical research ultimately contributes to better health outcomes. The way these health improvements are distributed can create social benefit, particularly when provided to underprivileged communities. MRIs also engage in charitable work and community outreach, providing different avenues to these benefits.

Social benefits identified by the MRIs included:

- More than 129,000 community members were engaged by CMRI in 2023 to support national charitable campaigns such as Jeans for Genes and the Great Cycle Challenge, raising funds and awareness for children's genetic diseases.
- The novel low-dose fixed-dose treatment for hypertension developed by the George Institute, in partnership with its spin out company, George Medicines, is intended to be distributed to underserved populations, both within Australia and to lower income countries, with an aim to ensure equity of access.
- The Ingham Institute has emphasised the benefits of interdisciplinary coordination in reaching priority populations, including maternity, paediatrics, disability, aged care, mental health and Aboriginal health.

Finding B – Cultural benefits

Some of the research undertaken by the MRIs worked to address inequities in the health system.

For example, despite some important improvements, First Nations peoples do not enjoy the same health outcomes or access to healthcare as the non-First Nations population.⁷⁷ MRIs create cultural benefits through their work in improving outcomes for Aboriginal and Torres Strait Islander NSW residents. Key cultural benefits realised by work enabled by the MRSP identified by the MRIs included:

- HMRI conducted research into adherence and acceptability of nicotine replacement therapy and behavioural supports for Aboriginal and Torres Strait Islander people.
- The Ingham Institute launched programs such as the Midwifery Initiated Oral Health and the Nursing Initiated Perinatal Oral Health, specifically to address needs in Aboriginal families and underserved communities.
- HRI put in place a reconciliation action plan that was approved by Reconciliations Australia, and coordinated with cultural leaders to present to non-indigenous researchers on cultural responsiveness and exchange cultural capability.

Looking more broadly, HRI also conducted research into improving screening for AF among Australians of Asian descent.

Finding C – Environmental benefits

The healthcare sector is estimated to be responsible for approximately 5% of global greenhouse gas emissions; if it were a country, it would be the fifth highest emitter on the planet.⁷⁸ Some of the research enabled by the MRSP that was undertaken by the MRIs was identified to have improved environmental outcomes in medical research and the wider health system, though like cultural benefits, the results reported were sporadic and limited. Environmental benefits identified by the MRIs included:

- CMRI maintains a sustainability committee, and has started to build a new Gene Technologies Building with a minimum 4 Green Star rating.
- VCCRI was awarded the CitySwitch National Design Award in 2020 by reducing its carbon footprint by 407.5 tonnes at one of its sites, equivalent to taking 80 cars off the road. At a value of \$35/tonne in \$2025 based on the World Bank Carbon Pricing Report for 2025,⁷⁹ this equates to an additional \$220,000 in benefits in \$2025, NPV_{5%} terms.
- HMRI worked with Siemens on implementing Chiller optimisation, a demand flow solution project designed to reduce electricity consumption.

⁷⁷ NSW Health. *NSW Aboriginal Health Plan 2024-2034*. Oct 2024. NSW Government.

⁷⁸ Baid H, Damm E, Trent L, McGain F. Towards net zero: critical care *BMJ* 2023; 381 :e069044 doi:10.1136/bmj-2021-069044, Prasad PA, Joshi D, Lighter J, et al. Environmental footprint of regular and intensive inpatient care in a large US hospital. *Int J Life Cycle Assess* 2022;27:38-49. doi:10.1007/s11367-021-01998-8 .CrossRefGoogle Scholar

⁴Lenzen M, Malik A, Li M, et al. The environmental footprint of health care: a global assessment. *Lancet Planet Health* 2020;4:e271-9. . doi:10.1016/S2542-5196(20)30121-2 pmid:32681898CrossRefPubMedGoogle Scholar

⁴Health Care Without Harm. Health care climate footprint report. 2019. <https://noharm-global.org/documents/health-care-climate-footprint-report>

⁷⁹ World Bank Group. (2025). State and trends of carbon pricing, accessed at:

<https://openknowledge.worldbank.org/bitstreams/152de0c2-e2be-49d6-aec1-3be8ebad4f74/download> and the World Bank Group. (2025). Carbon Pricing Dashboard accessed at: <https://carbonpricingdashboard.worldbank.org/compliance/price>.



6.1.8 Putting it all together: The impact of the MRSP for NSW

The evidence and analysis show that the MRSP has delivered a net economic benefit to NSW, even excluding an evaluation of downstream health benefits. With benefits exceeding the costs of the MRSP by a factor of at least 2 and likely greater than 3, this represents value for money to the NSW ecosystem and people of NSW.

Overall, the NPV for all direct and ecosystem benefits (net of program costs) over the life of the MRSP (2012–2025) was estimated to be \$1.2 billion, which translates into a BCR of 2.6, before any additional benefits of the contribution to improved health outcomes are considered (see Table 21). This BCR estimate is consistent with other studies that similarly show a strong benefit from high impact medical research, and suggests the MRSP is an important component to the conduct of that research by MRIs in NSW.

Importantly, MRIs were nuanced in their reporting of impact, and the analysis showed that the impacts by MRI varied significantly due to the significant flexibility allowed in MRSP expenditure. Some MRIs reported the MRSP funding was an important enabler of research funding uplift while others reported that the MRSP had been used to improve the translation and commercialisation of research that would have otherwise occurred.

The impact on an uplift in research funding was the largest economic impact reported (65% of the net benefits realised), followed by the impact of additional clinical trial activity (15% of the net benefit effect), avoided turnover of employees (10%) and revenues from uplift in commercialisation (9%). The strongly net positive impact of the MRSP on research outcomes estimated in the bottom-up economic analysis was also consistent with the top-down trend analysis of research funding which showed that the MRSP has had a significant positive impact on research activity in NSW.

The estimate of benefits for earlier rounds appeared to be subject to significant uncertainty. The net benefits of the MRSP by round were estimated to improve through time as MRIs were able to more confidently estimate second round benefits through time.

- BCR for Round 1 (2012–2016): 1.3
- BCR for Round 2 (2016–2020): 2.5
- BCR for Round 3 (2020–2024): 2.8
- BCR for Round 4 (2024–2028, partial): 8.8
- BCR for life of the MRSP (2012–2025): 2.6.

Table 21. Summary of impacts by MRSP funding round

	2012–2016		2016–2020		2020–2024		2024–2028*		Life of program (2012–2025)	
	Marginal impact	% of total benefits	Marginal impact	% of total benefits	Marginal impact	% of total benefits	Marginal impact	% of total benefits	Marginal impact	% of total benefits
Program costs	\$241.7		\$263.3		\$231.7		\$42.8		\$779.5	
Grant and other revenue uplift benefits	\$308.2	96%	\$574.7	86%	\$349.5	54%	\$83.7	22%	\$1,316.0	65%
Infrastructure revenue	\$2.6	1%	\$2.3	0%	\$1.4	0%	\$1.0	0%	\$7.2	0%
Commercialisation revenue	\$0.7	0%	\$0.3	0%	\$76.4	12%	\$108.5	29%	\$186.0	9%
Benefits from avoided turnover	\$0.0	0%	\$89.2	13%	\$87.0	13%	\$24.6	7%	\$200.8	10%
Benefits from clinical trials	\$8.0	3%	\$0.0	0%	\$133.5	21%	\$157.2	42%	\$298.7	15%
Benefits from knowledge spillovers	\$0.1	0%	\$0.3	0%	\$0.2	0%	\$0.0	0%	\$0.6	0%
Total benefits	\$319.7		\$666.7		\$647.9		\$375.0		\$2,009.3	
Net benefits (Benefits – Costs)	\$78.1		\$403.3		\$416.2		\$332.2		\$1,229.8	
BCR (Benefits / Costs)	1.3		2.5		2.8		8.8		2.6	
Level of data uncertainty / risk of gaps in reporting	H		L-M		L		L			

Source: Analysis of MRI-reported data. *Partial data to 2025 only.

H = High; L = Low; M = Medium

Beyond economic impacts some important social, cultural and environmental benefits were also reported, but these tended to be limited and sporadic across the MRIs, with the primary effects being the uplift in high impact research. There were benefits, for example, of research focused on improving outcomes for key disadvantaged populations, including Aboriginal and Torres Strait Islander people, people of Asian descent and people in regional areas. There were also some limited studies focused on improving the environmental footprint of research. Overall, however, the primary impacts reported included uplift in research activity compared to what would have otherwise occurred and associated second round benefits to the NSW research ecosystem.

The strongly net positive impact of the MRSP on research outcomes estimated in the bottom-up economic analysis was also consistent with the top-down trend analysis of research funding which showed that the MRSP has had a significant positive association with research activity in NSW. Top-down trend analysis showed that the MRSP has helped NSW to increase total NHMRC grant revenue as NSW has seen a decline in other indirect research funding support (IRIIS) over the life of the MRSP. OLS regression analysis found that each 1% increase in MRSP funding was associated with a 0.73% uplift in total NHMRC and MRFF funding to NSW. This suggests that there is a significant, positive relationship between NSW Government indirect cost funding through the MRSP and the amount of competitive grant money made available for NSW-based researchers.

While a significant positive relationship between MRSP funding and total NHMRC and MRFF funding to NSW was identified, it should be noted that OLS regression alone does not establish causation. This means that the analysis cannot, by itself, prove that changes in MRSP funding caused changes in NSW grant revenue. That said, the timing of the funding decisions is relevant. MRSP funding is determined by the NSW Government at the start of each funding round, so grant revenue in that same round could not have influenced the MRSP funding decision. This makes reverse causation within the same round unlikely. Taken together, the findings suggest that higher MRSP funding may contribute to higher competitive grant revenue to NSW, but the regression results should be interpreted as showing a strong association rather than definitive proof of cause and effect.

Citation analysis indicates the MRIs contribute to high impact research, with MRIs strongly represented in the top tiers of journals in their respective fields. This, combined with the case study analysis, suggests the MRIs have had a strongly positive impact on the health system. Evidence provided by the MRIs with respect to the impact on the health system was less consistently and confidently reported. For that reason, these impacts were evaluated primarily through a case study format with limited quantitative analysis. Given that the MRIs are delivering high impact work across most health conditions, from cancer to diabetes to mental health, the benefits over time are likely to be extensive for people living in NSW — and for people across Australia and globally.

Taken together, the evidence suggests the MRSP is strongly positive, delivering value for money to the people of NSW, supporting the attraction of high impact research to NSW that would not have otherwise occurred, building innovation precincts and improving the health and wellbeing of people living in NSW.

SECTION 3 – Evaluative judgement and recommendations

7. Evaluation synthesis

7.1 Testing the program logic: evaluative judgement of the program logic pathway

This section tests the hypothesised program logic (Figure 55a; see Section 2.2 for *a priori* design rationale) against the evaluation evidence (Sections 4, 5 and 6) to assess how the MRSP is operating in practice across MRIs. Figure 55b presents our evaluative judgement of the actual program pathways observed.

The purpose of this test is to illustrate, based on the evidence, where outcomes are demonstrated, where MRSP funding clearly contributes, where contribution is less certain, and where elements of the logic may require strengthening or simplification.

How we used the evidence to form evaluative judgement

Figure 55b details 2 aspects of our evaluative judgement about the evaluation evidence that are described in more detail below.

- Boxes – Our assessment of the evidence of funded items, outputs, intermediate outcomes and longer-term outcomes is illustrated by the colours of the boxes (see Figure 55b and legend for the boxes). The rationale for the assessment of the evidence we present in the program logic moving from left to right is detailed below
- Arrows – Arrows indicate the **strength of the MRSP's contribution** between elements of the logic. Judgements are informed by triangulation across data sources and consideration of attribution and additionality (see Section 7.1). Arrows reflect contribution, not sole causality.

Classifications and arrow type	Description
1. Direct contribution Solid arrow → Direct contribution	Clear and consistent evidence that MRSP funding directly contributes to the outcome, supported by multiple data sources, a clear line of sight between investment and outcome, measurable or observable improvement in outcomes, and limited alternative explanations.
2. Indirect contribution Dashed arrow ----▶ Indirect contribution	Evidence suggests MRSP funding contributes through mediated or enabling pathways (e.g. capability, leverage, collaboration) alongside other factors, with plausible alternative explanation

Narrative summary and rationale for Figure 55b

Overall, the evidence indicates that the MRSP functions as an enabling investment within a complex research and health system, rather than a program that directly causes longer-term system-level outcomes.

The dominant logic observed is as follows:

1. MRSP funding is essential to the viability, stability and core capability of MRIs, enabling investment in critical physical, operational research infrastructure and core business functions.
2. This, in turn, enables MRIs to undertake research activity, including a subset of work and increased research workforce capacity that would not otherwise have occurred in the absence of MRSP funding.
3. These enabled activities contribute, to varying degrees, to broader research ecosystem and health system impacts, depending on the nature, quality and translational focus of the research.

This logic is illustrated in Figure 55b, moving from left to right, and is summarised below.

MRSP funded items

There is strong and consistent evidence that MRSP funding was directly used for:

- Research infrastructure and shared research services
- Operational expenses
- OHMR administration of the funding program.

There is partial evidence that MRSP funded infrastructure is being used collaboratively via research partnerships and health and research networks (e.g. precincts). However, there is no compelling evidence that indicates an intent to invest MRSP funding for the purpose of building assets for open access across the research ecosystem. Collaboration is usually a product of shared research interests and goals and a desire to be more competitive for research funding, rather than an effort to build the collective infrastructure and reduce duplication and inefficiencies across the health and medical research ecosystem. Additionally, “shared infrastructure” usually referred to physical assets – there was no evidence that infrastructure services such as capabilities in health economics, commercialisation and translation abilities were shared across MRIs.

While MRSP funding supported assets within individual MRIs and there are some limited examples of informal sharing and stated intentions of making them available to other researchers, there is no verifiable evidence of systematic coordinated, cross-MRI asset development. This is likely because collaboration and creation of system-wide assets was not an explicit funding requirement. Evidence also suggests that competitive funding dynamics may disincentivise sharing. More broadly, effective collaboration requires additional enablers beyond funding alone (e.g. incentives, governance, access arrangements, liability and insurance).

MRI outputs

There is strong and consistent evidence that MRSP funding directly supported:

- Non-physical infrastructure, including human capital, specialist research support units and technical capabilities, and administrative and operational capability
- Physical infrastructure, including equipment, laboratory space and research facilities

There is no evidence that MRSP funding was used to systematically develop research translation plans. While MRIs cited examples of translating research fundings, this was not a consistent or systemic feature of the program, reflecting the absence of an explicit requirement over the ten-year period.

MRI intermediate outcomes

There is strong and consistent evidence that MRIs achieved the following outcomes, with MRSP funding making a direct contribution to a proportion of these:

- Increased research outputs
- Strengthened research infrastructure and workforce
- Improved financial and operational sustainability of MRIs. Of note here is that the economic impact on the uplift in research funding was the largest economic impact reported (65% of the net benefits realised over the life of the program), providing strong evidence of the MRSP's role in increasing research activity among MRSP-funded MRIs.

There is partial evidence of an indirect contribution to enhanced research translation capacity. Isolated examples were reported by MRIs, particularly for commercialisation capabilities. However, organisations affiliated with MRSP-funded MRIs were more circumspect particularly about the extent of translation to health system and population benefits, indicating variability across the sector.

There was partial evidence that MRSP funding resulted in improved governance within individual MRIs via investment in business and research operation functions. However there was limited evidence that the MRSP resulted in sector wide collaboration. As with collaborative assets, this reflects the absence of explicit program requirements in this area.

Longer term system-wide outcomes

There is evidence that MRIs contribute to:

- Scientific knowledge generation
- Translation of research into health, economic and social benefits
- Strengthened HMR ecosystem and research capability

The link between these contributions and MRSP funding was indirect. MRIs provided multiple examples of research influencing policy, clinical practice, models of care and patient outcomes. While MRSP-funded infrastructure and workforce underpin these achievements, the effects are distal, making it difficult to isolate the MRSP's discrete contribution to specific system-level outcomes.

There was evidence that MRIs undertook activities that could build the overall workforce skill and capacity to conduct research in NSW through training of individuals in healthcare and policy roles, which

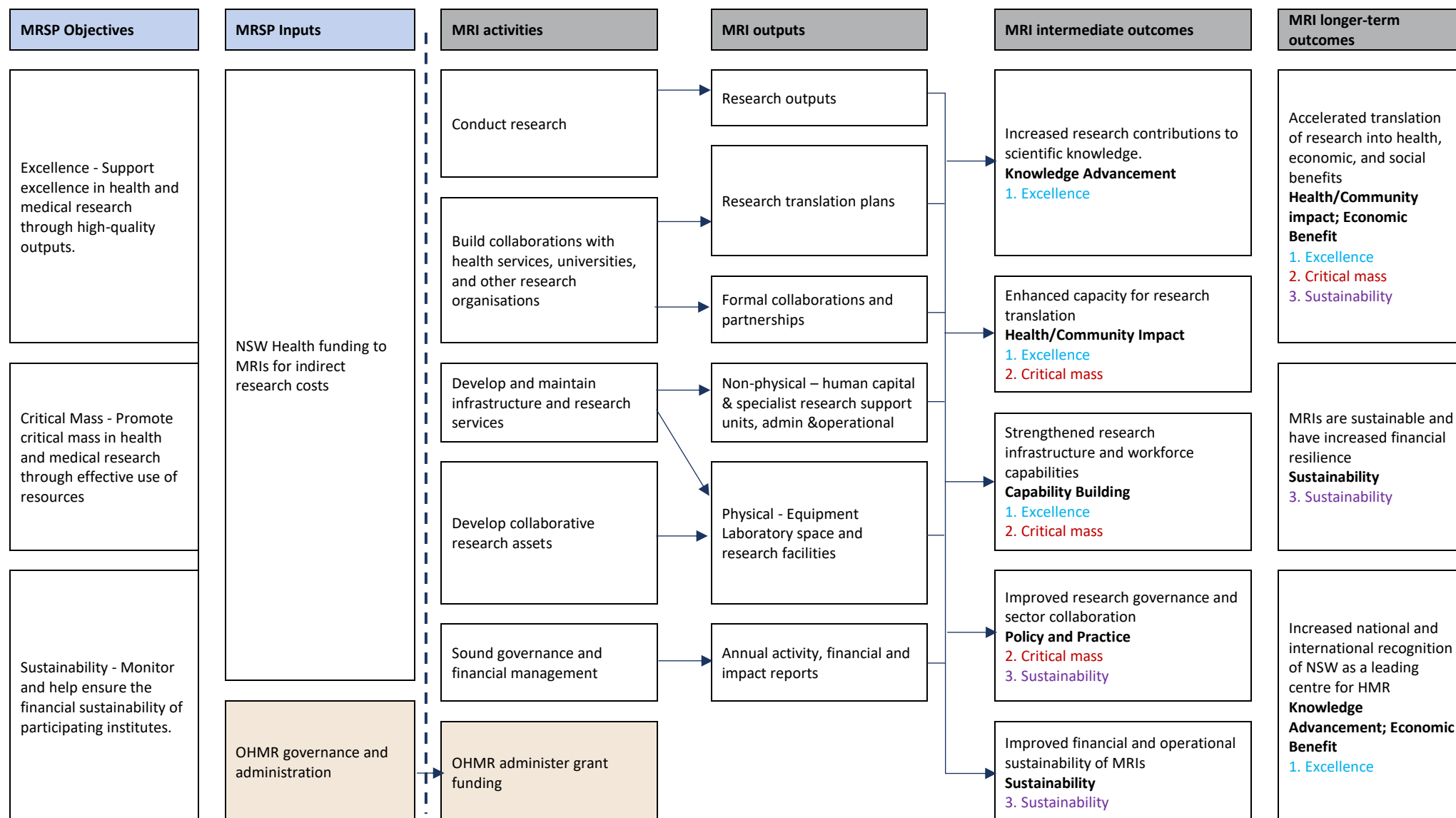
could lead to improvements in healthcare delivery.⁸⁰ However, evidence of these flow-on effects to the broader health system could not be verified by this evaluation.

Overall, the MRSP has delivered a net economic benefit, even excluding an evaluation of downstream health benefits, and represents value for money to the NSW HMR ecosystem and people of NSW. the net present value (NPV) of all direct and ecosystem benefits (net of program costs) over the life of the MRSP (2012–2025) was estimated to be \$1.2 billion in \$2025, which translates into a BCR of 2.6, before any additional benefits of the contribution to improved health outcomes are considered.

There is insufficient evidence to determine whether the MRSP has contributed to increased national or international recognition of NSW as a leading centre of health and medical research.

⁸⁰ Boaz et al. If health organisations and staff engage in research, does healthcare improve? Strengthening the evidence base through systematic reviews. *Health Res Policy Syst* 2024;22(1):113. doi: 10.1186/s12961-024-01187-7

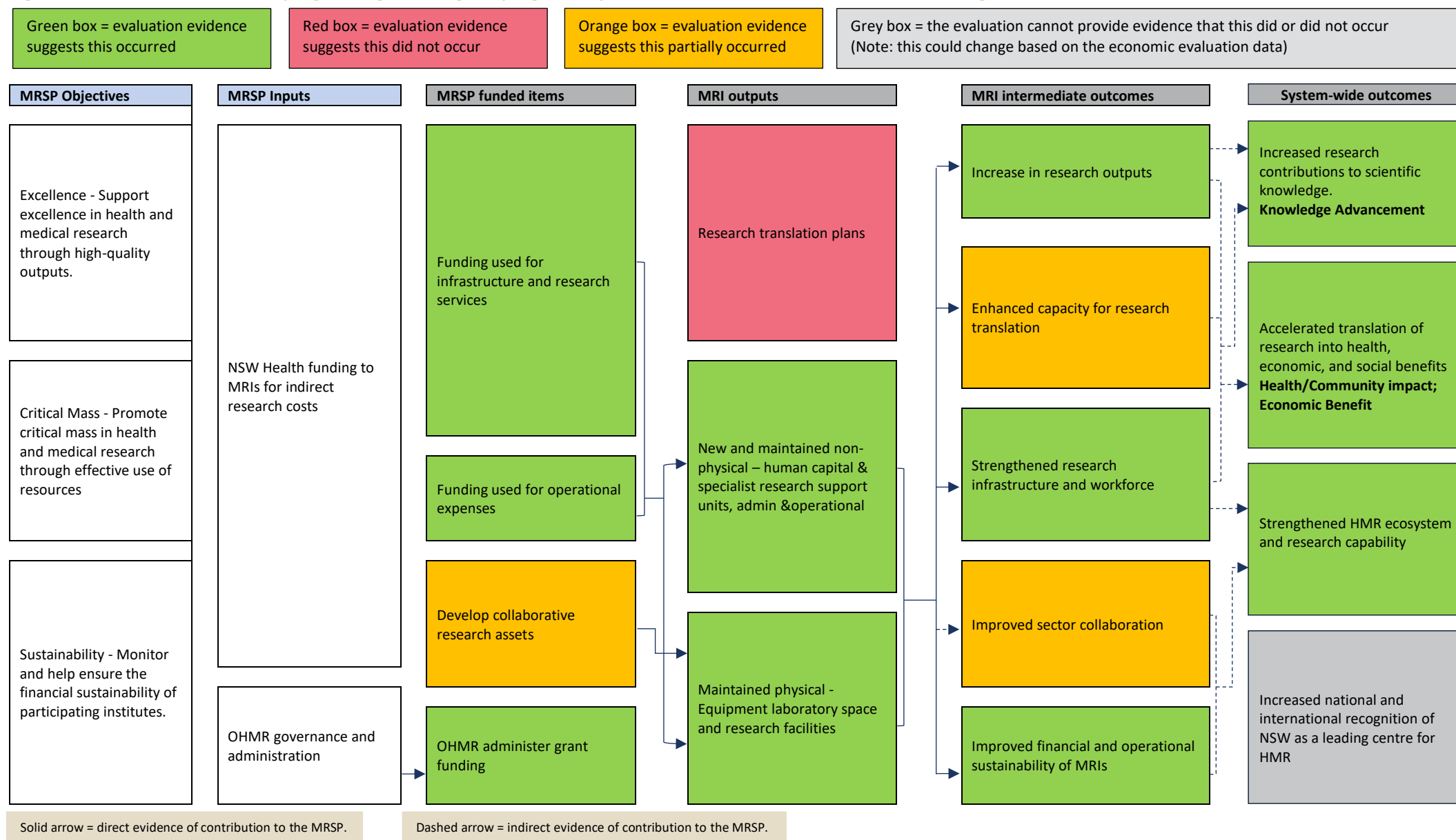
Figure 55a. Hypothesised current-state program logic: linking the program objectives to the MRSP indirect research funding



Notes:

- Each interim and long-term outcome is mapped to one or more OHMR's 6 domains of benefit.
- Interim outcomes are defined as within 5-7 years and longer-term outcomes are greater than 5-7 years.
- Peach box is OHMR
- Outcomes are colour coded by the MRSP objective
 - 1. Excellence** - Support excellence in health and medical research through high-quality outputs
 - 2. Critical Mass** - Promote critical mass in health and medical research through effective use of resources
 - 3. Sustainability** - Monitor and help ensure the financial sustainability of participating institutes.

Figure 55b. Actual Current-state program logic: linking the program objectives to the MRSP indirect research funding



7.2 Assessment of attribution and additionality

The nature of research infrastructure funding and the complexity of the research system meant that a central methodological challenge for the evaluation was assessing which observed outcomes could reasonably be attributed to the MRSP over and above what would have occurred in its absence.

Given this challenge, the evaluation adopted a contribution-focused approach, recognising non-linear pathways from funding to outcomes and explicitly addressing attribution and additionality challenges⁸¹. Rather than focusing solely on observed change, which is affected by multiple factors, the evaluation examined how and to what extent MRSP funding contributed to those changes. It draws conclusions on which outcomes can be directly attributed to the MRSP, and which outcomes were enabled (i.e. indirect contribution) by the MRSP.

Main overall assessment

The MRSP functions as an enabling investment. It supports MRI infrastructure, viability and workforce, which in turn directly enables greater research capacity and capability and the ability to attract more research income. This leads to greater research activity than would otherwise be possible. Collectively across MRIs, this contributes to creating a thriving health and medical research ecosystem that is nationally and internationally competitive.

In its absence, the totality of research currently produced by the MRSP-funded MRIs would not occur, which would likely have flow on effects for the NSW health system and people of NSW. Without the MRSP (a hypothetical counterfactual), MRIs would likely face contraction and reduced autonomy. MRSP-funded MRIs consistently reported that in the absence of the MRSP, they would be forced to reduce scale, seek alternative funding such as philanthropy or commercial partnerships, or embed within universities, thereby reducing their ability to drive their own research agendas. Experiences from MRIs that received intermittent funding echoed these risks.

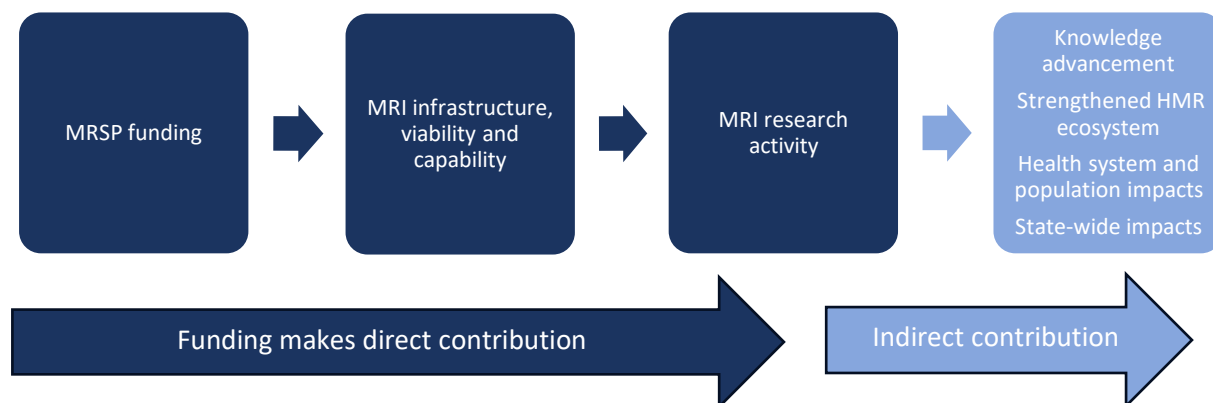
While MRIs contribute towards achieving broader health system and state-wide impacts, estimating the precise direct contribution of these impacts to the MRSP is challenging. Specifically, it is not possible to identify which specific health, social and/or economic benefit would not have occurred without the MRSP, as these benefits occur in a complex ecosystem. Nevertheless, based on the outcomes reported, it is clear that the MRSP has had a role in generating economic value for the health and medical research sector by uplifting research activity (particularly through increased research funding) and clinical trials activity, reducing turnover of employees, and increasing revenues from commercialisation.

Overall, the evaluation provides evidence supporting a direct link (i.e. direct attribution) from MRSP funding though to MRI research activity. While there is evidence that increased research activity has led to system-wide outcomes, the link from the MRSP to these outcomes is indirect. This is illustrated in Figure 56.

⁸¹ These terms are defined as:

- Attribution of outcomes to the MRSP, i.e. the extent to which observed outcomes can be directly linked to MRSP funding
- Additionality, i.e. the extent to which MRSP funding enabled activities or outcomes that would not have occurred, or would have occurred to a lesser extent or later, in the absence of the Program, recognising that outcomes arise from interacting inputs within a complex research system.

Figure 56. The contribution of the MRSP to MRI and system wide outcomes



8. Conclusions and recommendations

8.1 Conclusions

Conclusions for each of the key evaluation questions (KEQs)

KEQ1 - How effective and efficient are the Program's administration and delivery processes?

Overall, the evaluation found that the MRSP's administration and delivery processes are partially effective in achieving the Program's objectives. The Program's current design illustrates the MRSP's distinct and valued role in underpinning MRI viability through flexible support for indirect costs and core research infrastructure that are not easily covered through other funding sources. However, the evaluation found that the MRSP's objectives and core design features have not fully kept pace with contemporary research and health system priorities, limiting a clear line of sight between funding, strategic intent and broader system outcomes. Notwithstanding this, the Program's administration and delivery processes are generally lean and efficient for a non-competitive, compliance-focused infrastructure funding program, using minimal resources relative to the funding investment. Administration costs were between 0.4% and 0.7% of the annual total of MRSP funding, which is substantially less than a guide of 5–10% to administer funding grants.⁸² Further efficiencies are possible, as resources are largely dedicated toward manual administrative processes to determine eligibility rather than assessing and ensuring Program objectives are being met.

KEQ2 - How effective are the Program's reporting, data collection, and impact metrics, and where are there gaps or opportunities for improvement?

Overall, the evaluation found that the MRSP's reporting, data collection and impact metrics are partially effective, meeting core accountability and transparency requirements but providing limited insight into outcomes, impact and system benefit. Stakeholders consistently described reporting as being of low strategic value, with key domains measuring health system impacts such as translation, policy and practice changes, and commercialisation not being consistently captured. While the available data supported an assessment of compliance with the intended purpose of the funds, for this evaluation it had very limited utility in assessing the extent to which the Program objectives are being met or contributing to broader goals for the NSW health system. There was limited evidence that the data were being used to adjust and adapt the Program to optimise its benefits. As a result, the current metrics framework supports accountability more effectively than learning or decision-making, indicating a misalignment between reporting requirements and the Program's stated objectives.

⁸² This threshold of 5% is sourced from best practice guidance on grant administration in the public sector in Victoria https://innovationnetwork.vic.gov.au/sites/default/files/BetterGrantsByDesignGuideWoVG_131119.pdf

Additionally, the NSW government advises that administration costs of large scale projects totalling more than 10% of funding should not be funded, providing an indication of acceptable administration costs. <https://www.nsw.gov.au/grants-and-funding/pathway-1-grants>

KEQ3 - To what extent has the Program achieved its intended objectives and delivered meaningful outcomes?

Overall, the evaluation found that the MRSP has partially achieved its intended objectives, with strong and consistent evidence of success in supporting the financial viability, stability and core capability of MRIs through predictable funding for essential indirect costs and research infrastructure. The Program has enabled MRIs at an individual level to build and sustain research infrastructure, operational capacity and workforce capability, which has leveraged additional funding for research and enabled both a greater volume and excellence in research. However, these benefits have largely occurred at an individual MRI level. While individual MRI successes have collectively enabled a thriving health and medical research ecosystem in NSW, the Program has not achieved the objective of building collective infrastructure assets and capacity and associated efficiencies at a system level. Its contribution to collaboration remains variable and context dependent. While MRIs demonstrate meaningful impacts on policy, clinical practice and health outcomes, the MRSP's contributing role is enabling rather than causal, with broader health system outcomes unable to be directly or discretely attributed to the MRSP.

KEQ4 - What are the costs and benefits of the Program, and does it represent value for the NSW HMR ecosystem and the people of NSW?

The MRSP represents value for money for the NSW health and medical research ecosystem and the people of NSW. Over 2012–2025, the Program delivered an estimated \$1.2 billion in net economic benefits (\$2025 dollars) with a benefit–cost ratio of 2.6, even before downstream health benefits are considered. Because MRIs deploy MRSP funding in a variety of ways depending on their specific needs, the impacts of the program on MRI activity and in turn, health, economic, social and cultural impacts were also found to be heterogeneous. The net benefits of the Program by round were estimated to improve through time as MRIs were able to more confidently estimate second round benefits through time. The Program's impact on an uplift in research funding was the largest economic impact reported (65% of the net benefits realised), followed by the impact of additional clinical trial activity (15% of the net benefit effect), avoided turnover (10%) and revenues from uplift in commercialisation (9%). The strongly net positive impact of the MRSP on research outcomes estimated in the bottom-up economic analysis was also consistent with the top-down trend analysis of research funding which showed that the MRSP has had a significant positive impact on research activity in NSW. For each 1% increase in MRSP funding, there was a 0.73% uplift in total NHMRC and MRFF funding to NSW. Beyond economic impacts, some important social, cultural and environmental benefits were also reported, but these tended to be limited and sporadic across the MRIs, with the primary effects being the uplift in high impact research.

8.2 Future looking – NSW Health Research and Innovation Strategy

In May 2025, NSW Health released the NSW Health Research and Innovation Strategy. This evaluation does not assess the Program’s historical performance against this strategy because it was not in place when the MRSP was designed.

The MRSP predates the Strategy by approximately 2 decades and was developed in a markedly different policy and funding context. Accordingly, the analysis below is forward-looking in intent. It examines the extent to which the MRSP, in its current form, aligns with the Strategy’s 6 outcome areas, with a view to informing potential future program redesign, rather than judging the appropriateness of the Program’s original objectives or design.

Table 22. Alignment of the MRSP with NSW Health Research and Innovation Strategy strategic outcome areas

NSW Health Research and Innovation Strategy strategic outcome areas	How the MRSP supports this outcome
1. A thriving ecosystem – adopting a coordinated, collaborative and inclusive approach to research and innovation	Partially supports. The MRSP sustains the viability of independent MRIs and contributes to ecosystem stability, but its design does not actively incentivise collaboration, shared capability, or coordinated system planning
2. Strategic investment – building a portfolio of investment to target areas where NSW is well positioned to harness current and future opportunities	Partially supports. The MRSP provides predictable, untied funding enabling MRIs to invest strategically in infrastructure, workforce, and emerging areas (e.g., AI, genomics, trials platforms). However, the allocation method is not linked to State priorities or future-focused fields. Funding is tied to historical grant income, so it cannot shape strategic portfolio direction.
3. An open assets philosophy – developing and mobilising assets to accelerate research and fully harness emerging innovations	Has not supported. The MRSP does not explicitly require, promote or monitor open access arrangements, shared platforms, or asset mobilisation across NSW. However, some MRIs use MRSP-funded infrastructure across precinct or cross-institution collaborations.
4. A place-based foundation – driving synergies and integration through a statewide network of precincts and place-based initiatives	Indirectly supports. The MRSP stabilises MRI operations located within major precincts and therefore contributes to precinct viability, particularly through infrastructure and workforce supported by the MRSP. However, the MRSP does not have a place-based design, does not differentiate funding based on precinct role, and does not explicitly foster LHD–MRI–university integration.

NSW Health Research and Innovation Strategy strategic outcome areas	How the MRSP supports this outcome
5. A pipeline approach – generating value from our research investments by addressing real system problems and progressing innovation to scale	Indirectly supports. MRSP funding often enables pipeline activities indirectly, such as translation teams, pilot data generation, proof-of-concept work, and commercialisation offices. But the MRSP does not have translational objectives, does not track pipeline outcomes, and does not use criteria that recognise translational success, impact, or alignment with NSW system problems. MRIs do engage in system translation but it is not a Program requirement.
6. Research and innovation for all – supporting better use, translation and creation of research and innovation across healthcare settings to improve outcomes, equity of access and system efficiency	Indirectly supports. While MRSP-funded institutions produce research that benefits NSW residents, the Program does not target health service research, equity of access, statewide capability uplift, regional innovation, or integration with clinical care settings. System-level benefits are therefore indirect and uneven.

8.3 Recommendations

The MRSP provides essential, stabilising investment that sustains NSW's independent MRIs and underpins research excellence, infrastructure and workforce capability. At the same time, the evidence highlighted opportunities for the forthcoming Review to examine whether the Program's design remains fit for purpose in light of the contemporary research environment and the NSW Health Research and Innovation Strategy 2025–2030.

The recommendations below are provided as guidance for OHMR to consider. They draw on the evaluation findings and the professional judgement of the evaluation team. They are intended to support NSW Health in:

- clarifying and strengthening the Program's overarching purpose and objectives
- modernising and simplifying the design settings and funding model
- strengthening transparency, governance and processes
- developing and implementing a more contemporary outcomes and reporting framework

The recommendations are grouped under 4 domains. Each represents an area for Review consideration, not a prescriptive course of action.

Table 23. Strategic recommendations to inform the MRSP Review

1. Clarifying and strengthening the Program's overarching purpose and objectives
Recommendation 1.1 - Establishing a clearer overarching purpose for the MRSP Why this may be useful The existing purpose and objectives are outdated. A clearer overarching purpose could assist in aligning future design elements and ensure relevance to the NSW Health Research and Innovation Strategy and that it delivers value to the people of NSW.
Recommendation 1.2 - Refresh the programs objectives and program logic to align with the overarching purpose Why this may be useful Refreshing the Program's objectives and program logic will ensure they clearly reflect the MRSP's overarching purpose and provide a coherent foundation for future design, decision-making and performance monitoring. Objectives should be clearly defined to avoid ambiguity and misinterpretations of the intentions of the Program, and streamline monitoring and assessment of success.
2. Developing and implementing a more contemporary outcomes and reporting framework
Recommendation 2.1 – Develop an outcomes framework linked to the updated objectives and the statewide HMR outcomes indicators that align with the refreshed program logic. Why this may be useful The current reporting framework is burdensome and focused on inputs. A streamlined outcomes approach drawing on already existing and available data could strengthen accountability and demonstrate value while minimising the administrative burden. Reporting should capture desired outcomes that deliver value to the health system and people of NSW, such as impacts on innovation and benefits to precincts, while acknowledging that desired outcomes may be quite distal for some MRIs due to the nature of their work.

Recommendation 2.2 – Consider mechanisms for sector learning, transparency and feedback Why this may be useful Stakeholders highlighted the absence of feedback and the limited use of reported data. Improving transparency may strengthen trust, alignment and system learning.
3. Modernising and simplifying the design settings and funding model
Recommendation 3.1 - Test options for clarifying and updating eligibility criteria Why this may be useful Eligibility criteria need to be aligned with the refreshed purpose and objectives of the Program and address the concerns raised by the sector. As they currently operate in practice they do not fully reflect contemporary funding patterns or MRI roles.
Recommendation 3.2 - Explore alternative approaches to the current tiered allocation model Why this may be useful The tiered model was consistently viewed as inequitable, outdated and misaligned with Program objectives. The Review is well positioned to determine whether, and how, allocation could be modernised.
Recommendation 3.3 – Consider opportunities to maintain flexibility while strengthening transparency on allowable expenses Why this may be useful Flexibility is a major Program strength. OHMR could examine how to preserve this while improving transparency and assurance.
4. Improving the transparency, administration, governance and processes
Recommendation 4.1 – Assess whether strengthened governance arrangements would improve strategic oversight Why this may be useful Current governance is procedural rather than strategic. Enhanced governance oversight could support Program evolution and alignment with statewide priorities.
Recommendation 4.2 – Examine options to strengthen communication and engagement with MRIs Why this may be useful Stakeholders emphasised communication gaps and limited visibility of processes. OHMR could consider approaches to build stronger two-way engagement and joint collaborative endeavours.
Recommendation 4.3 – Explore modernisation of administrative systems and data management Why this may be useful The Program is lean and efficient but relies on manual processes that do not necessarily represent the most effective use of OHMR's resources. Modernisation could reduce administrative burden and support a more outcomes-focused approach and greater visibility (and therefore accountability) of outcomes achieved and the contribution of the MRSP towards outcomes.

9. Appendices

Appendix 1. Grant processes for the MRSP

Eligibility criteria

To receive funding under the MRSP, MRIs must meet all the following criteria:

- The MRI must be physically based in New South Wales.
- HMR must be the institution's primary purpose, as demonstrated in mission statements or annual reports. Entities where HMR is secondary (e.g. commercial manufacturers) are not eligible.
- The MRI must operate as a discrete, legally recognised entity with:
 - An independent board not controlled by a university or health service
 - Authority to determine its own research strategy
 - Control over budgets and expenditure
 - An IP policy aligned with NHMRC's national principles
- MRIs must have received an average of at least \$3 million annually in eligible nationally competitive HMR grants from the preceding 3 years (e.g., 2021–2023 for the 2024–2028 MRSP).
- MRIs must demonstrate a liquidity ratio ≥ 1.0 and low debt, supported by audited financial statements.

Ineligible MRIs include:

- Informal affiliations or consortia
- Facilitating bodies not conducting research directly
- Sub-units or controlled entities of larger organisations

Application and selection process

Applications to the MRSP are submitted using a standardised form and accompanying documentation, including audited financial statements, a grant income spreadsheet, and a letter of declaration. All submissions are assessed against clearly defined eligibility criteria.

The selection process involves multiple stages. First, OHMR conducts an initial eligibility appraisal, and may request further information from applicants to confirm or clarify submitted material. Regardless of the outcome of this initial review, all applications are submitted to an independent review panel for consideration. An independent review panel, chaired by the Executive Director, OHMR, and comprising the Chief Financial Officer, NSW Ministry of Health, and 3 independent members (including one interstate member), then reviews all applications, including those flagged by OHMR as potentially ineligible, to confirm eligibility and assess merit.

The panel provides recommendations to the NSW Minister for Medical Research on applicants and proposed funding tier allocations for the initial funding period⁸³. Once a decision is made by the Minister for Medical Research, all applicants are formally notified of the outcome, and successful applicants proceed to establish funding agreements with NSW Health. The Minister's decision is final and not subject to appeal.

Funding conditions

MRSP funding is awarded over a four-year term, delivered in 2 periods of 2 years each. Initial funding allocations (Period 1) are determined at the start of the term. Continued funding for the second half of the term (Period 2) is subject to a mid-term review.

Funds are paid annually to successful MRIs in accordance with the funding agreement. As outlined in the agreement, unspent funds may require a documented plan for future use, and variations to funding may occur based on mid-term review outcomes.

The mid-term review occurs at the halfway point of the MRSP funding term assesses each institute's NHMRC grant income performance over the preceding 3 years, using updated income data to recalculate funding allocations for the second Period. For example, in the 2024–2028 MRSP round, initial allocations for Period 1 are based on average NHMRC income for 2021–2023. The mid-term review, to be held in 2026, will use average income data from 2023–2025 to determine allocations for Period 2. Institutes must also demonstrate continued compliance with Program requirements, including governance arrangements and financial accountability. Review outcomes are approved by the Minister for Medical Research and may result in adjusted allocations for the remainder of the funding term.

Funding is contingent upon MRIs meeting and maintaining all eligibility criteria throughout the Program.

Funding reporting

MRIs funded under the MRSP must meet annual and periodic reporting obligations, as set out in the funding agreement with NSW Health. These requirements support transparency, financial accountability, and monitoring of Program outcomes.

Funded MRIs are required to:

- Maintain compliance with all MRSP eligibility criteria throughout the funding term and report any changes that may affect eligibility.
- Use MRSP funding solely for eligible research infrastructure activities conducted within NSW.
- Submit annual audited financial statements and financial accountability reports to demonstrate appropriate use of funds and ongoing institution viability.
- Provide annual reports on research activity, using the reporting template issued by NSW Health. This includes providing information on research progress against policy and practice change and capability building, research outputs, and case studies.
- Respond to additional reasonable information requests from NSW Health, including on matters such as environmental sustainability.

⁸³ The 2024-2028 application guidelines and program details advise that the independent assessment panel make a recommendation on the proposed funding allocation for Period 1. However, in practice, this occurs internally with OHMR.

- Participate in a mid-term review, which informs adjustments to funding allocations for the second half of the Program term.
- Acknowledge that all information provided may be subject to external audit, including workplace agreements where relevant.

Appendix 2. Framework and methods for the economic evaluation

This economic evaluation addresses KEQ 4 by assessing the costs and benefits of the MRSP over the 2012–2025 horizon and its overall value for money to the people of NSW and to Australia (through improvements in healthcare) through time.

This requires the assessment of the ‘*additional*’ or incremental economic, health, environmental, social, and cultural costs and benefits of the MRSP for NSW relative to a hypothetical counterfactual (or ‘base case’) where the MRSP did not exist.

The economic impact evaluation has been developed in alignment with NSW Treasury guidelines for cost benefit analysis (TPG23-08). The economic impact analysis also maps back to the wider program logic and evidence matrix (activity 1.2) developed for the MRSP.

Framework for the economic evaluation: overview

The MRSP is an *enabler* of medical research in NSW

Numerous previous studies have shown that research undertaken by Australia’s MRIs deliver both improvements to health outcomes and wider economic growth; for example:

- In 2018, a report from KPMG quantified economic impact in terms of both the direct health gains from medical research, as well as the broader economic benefits across Australia. The report found that the estimated benefit-cost ratio (BCR) was between 1.8 and 4.2, depending on the area of research.⁸⁴
- In 2023, the WA Chapter of the Association of Australian Medical Research Institutes (AAMRI) worked with Deloitte Access Economics to calculate the economic impacts of the WA medical research sector at-large.⁸⁵ The analysis found WA’s medical research sector contributed \$322.9 million in value added, and created 2,632 FTE jobs.
- In 2025, Biointelect was commissioned by AAMRI NSW to investigate the current financial position of NSW MRIs and assess the rationale for additional NSW Government investment and support for MRIs.⁸⁶ They found that, for every \$1 invested in NSW health and medical research generates \$6.40 in economic output. Additionally, the report concluded MRIs significantly outperform sector averages in competitive grants and translation impact, making them a high-return strategic asset for NSW’s health and innovation economy.

⁸⁴ KPMG (2018). Economic Impact of Medical Research in Australia. Associated of Australian Medical Research Institutes. Accessed at: <https://www.aamri.org.au/wp-content/uploads/2018/10/Economic-Impact-of-Medical-Research-full-report.pdf>

⁸⁵ Deloitte Access Economics (2023). Economic value of the health and medical research sector in Western Australia. Australian Medical Research Institutes – WA Chapter. Accessed at: <https://aamri.org.au/wp-content/uploads/2023/11/Deloitte-Report-Economic-value-of-the-health-and-medical-research-sector-in-Western-Australia-Dec-23.pdf>

⁸⁶ Biointelect (2025). Future scenarios for NSW Medical Research Institutes – The case for investing in NSW’s medical research institutes and unlocking health, social and economic benefits.

- In 2024, the Victorian Chapter of the AAMRI engaged Nous Group to produce an estimate of the impacts of the funding gap for the full cost of research among Victorian MRIs.⁸⁷ The report estimated the total gross economic contribution of MRIs in Victoria to be in the order of \$742.4m each year.
- A 2018 study of medical research funding in the UK found the value of additional health gains, as well as broader economic uplift, was equivalent to an annual rate of return of between 15% and 18%.⁸⁸
- A 2016 UK report attempted to quantify the extent to which Government and charity funding of medical research stimulates private sector R&D funding; the study found a 1% increase in public sector expenditure is associated with a 0.81% increase in private sector expenditure.⁸⁹

These reports collectively demonstrate that in addition to identifying breakthroughs that improve survival and quality of life for people across a range of conditions, medical research is also a major driver of economic growth.

As an indirect infrastructure funding program, the MRSP is an *enabler* of medical research in NSW. It works to reduce funding gaps for indirect research costs and improve the predictability of funding for MRIs in NSW. This enables MRIs to build critical mass and invest in the key capabilities and high-performance teams that help them to attract more research funding into NSW. The intent is to catalyse a virtuous cycle whereby the MRI is able to publish higher impact research, improve research translation and commercialisation, and attract more funding and investment than would otherwise have been the case, which in turn drives the growth of wider innovation and industry precincts or health precincts.

The economic impact analysis is therefore focused not on valuing the impact of medical research in aggregate (as the above reports do) but rather on identifying, and quantifying where possible, the *additional* activity that was *enabled* by the MRSP compared to a counterfactual where the MRSP did not exist. The additional research and commercialisation activity enabled by the MRSP are expected to help realise additional economic, health, social, cultural and environmental impacts for the people of NSW compared to what would have otherwise been the case. In economic theory, this is known as ‘additionality’ (see Box A2.1).

For example, potential additional or incremental impacts of the MRSP are likely to include:

- Economic impacts, such as an uplift in additional grant funding won by the MRI and additional private sector investment in the MRI, as well as ‘second round’⁹⁰ growth in innovation and industry cluster research productivity, private sector investment and/or improved efficiency in health services

⁸⁷ Nous Group (2024). The Impacts of the Funding Gap of the Full Cost of Research. Association of Australian Medical Research Institutes – Victorian Chapter. Accessed at: <https://aamri.org.au/wp-content/uploads/2025/03/Nous-Report-for-AAMRI-VIC-Modelling-the-gap-between-funding-and-true-cost-of-research.pdf>

⁸⁸ Grant, J., and Buxton, M. J. (2018). Economic returns to medical research funding. BMJ Open. Accessed at: <https://bmjopen.bmj.com/content/8/9/e022131>

⁸⁹ Sussex, J., Feng, Y., et al. (2016). Quantifying the economic impact of government and charity funding of medical research on private research and development funding in the United Kingdom. Accessed at: <https://link.springer.com/content/pdf/10.1186/s12916-016-0564-z.pdf>

⁹⁰ Note that in this case ‘second round’ refers to a sequence of economic impacts rather than MRSP funding rounds.

- Health impacts, including for example improvements in clinical practice leading to improved survival and/or quality of life for patients and their families or improved patient experience and trust in the health system
- Social and cultural impacts, including improvements in training and employment opportunities, particularly for First Nations people, women, culturally and linguistically diverse communities or from disadvantaged (low socioeconomic status) backgrounds
- Environmental impacts, including avoided carbon emissions or other environmental impacts enabled by access to more sustainable systems, infrastructure, equipment and/or consumables.

Box A2.1. Understanding additionality in economic evaluation

Economic impact assessments are concerned with the change in outcomes from a hypothetical counterfactual where a policy or investment did not occur. This can include changes in economic, health, social and environmental outcomes.

For an activity to have an economic impact, it must introduce *new* money to the NSW economy that would not have otherwise occurred; this is the ‘additionality’ principle.

It is assumed, for example, that if the NSW government does not spend money on the MRSP, that it would be spent elsewhere within the NSW health system, and therefore NSW government funding for the MRSP does not in itself create an economic benefit because this is not new money to the NSW economy.

However, where the supported MRI attracts or leverages other Australian government monies into the economy, say through an uplift in grant funding for research from non-NSW government sources, this represents new money into the NSW economy and an economic benefit to the state. Funding for additional research could come from:

- The Australian government, such as the NHMRC, the Australian Research Council (ARC) or Department of Health
- Private sector investment by Australian private businesses, other not-for-profit organisations or other philanthropic donations, or
- Other international funding from foreign governments, businesses and/or philanthropic organisations.

The level of additionality is likely to vary by institute and over time. For example, in the event that an MRI may have otherwise collapsed but for the MRSP over the 2012–2025 period, all of the outcomes subsequent to that rescue could be additional to the counterfactual (base case). Of course, this is a special case, and would not be expected to be observed for all MRIs. It was expected that the MRSP enabled most MRIs to act more strategically and efficiently than would otherwise have been the case in the absence of MRSP support, leading to an uplift in grant revenue to NSW.

This additional research activity was expected to deliver in turn improvements in health outcomes and potentially also social, cultural and environmental benefits depending on the nature of the research.

Understanding (and quantifying) the proportion of outcomes attributable to the MRSP is a crucial part of the analysis; this has been ascertained through literature review and stakeholder interviews. The project method is discussed in more detail in subsequent sections.

Types of impacts, by stakeholder type, expected as a result of the MRSP

It would be expected that there would be multiple rounds of impact as a result of access to the MRSP. In economic parlance, these are referred to as ‘direct’ impacts to the MRIs and second round⁹¹, ‘indirect’ impacts to other stakeholders beyond the MRI, including the wider NSW workforce and innovation ecosystem, the NSW health system and the NSW economy.

Beyond NSW, there may also be benefits to patients and carers in Australia and globally as research is translated into clinical practice over time.

Potential direct impacts to MRIs

The direct impacts of the MRSP to the MRIs to be explored and quantified where possible are:

- Increase in grant awards from non-NSW funders arising from critical mass, excellence in research capabilities and increased funding predictability
- Increase in strategically significant research projects that may lead to second round investment, expenditure or industry growth
- Development of strategically significant infrastructure that attract future investment
- Avoided turnover of staff
- Increased operational efficiencies
- Increase in publications and citations, especially Tier 1 citations
- Increase in jobs and workforce development, especially for people from priority populations
- IP formation, including patents
- Revenues from IP generated by the MRI
- Change in environmental impact of MRI, either through the avoidance or increase in emissions, chemicals, water usage and/or plastics usage.

Potential second round, indirect impacts to the wider NSW research ecosystem

These direct impacts to the MRI would then be expected to create second round, spillover effects that positively impact other research organisations, industries and the NSW economy, but particularly within innovation and industry precincts or clusters⁹² where the MRIs are located. Potential second round, indirect impacts to the knowledge ecosystem could include:

- Knowledge spillovers and innovation precinct development
- Growth in wider precinct enabled by research and improved access to infrastructure
- Upskilling of the workforce.

⁹¹ Again, here, the use of ‘second round’ is economic parlance that refers to a sequence of economic impacts and is not referring to MRSP funding rounds.

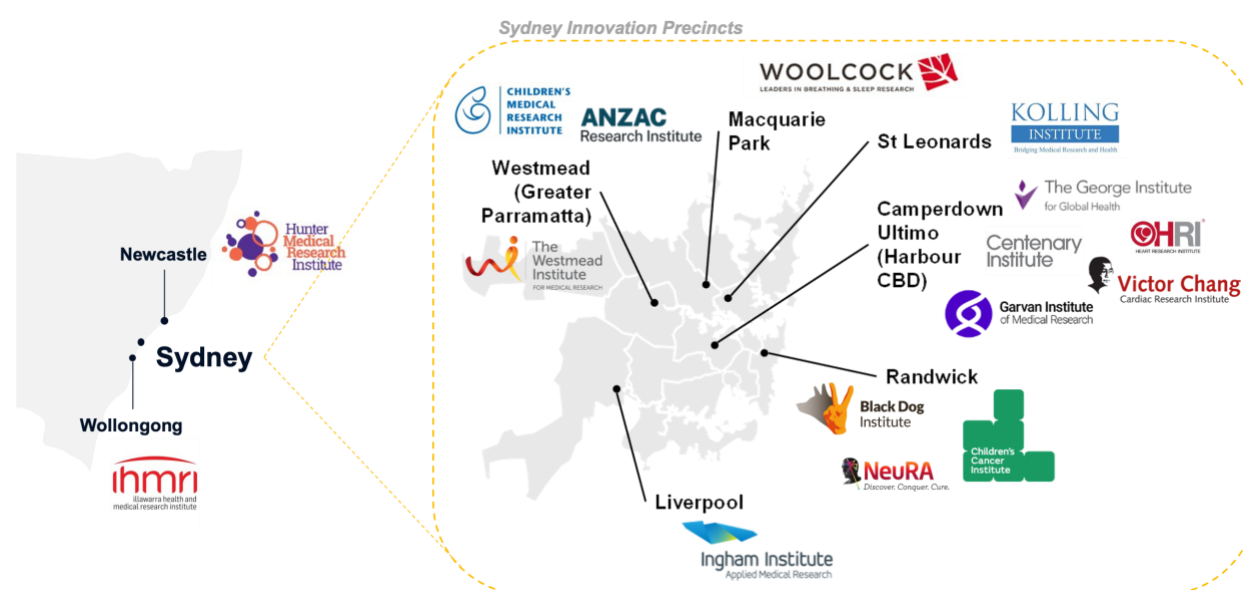
⁹² The term ‘innovation precinct’ is widely used in Australia, while ‘innovation district’, ‘hub’, or ‘cluster’ are more commonly used internationally, but the underlying concept and rationale is the same.

Knowledge spillovers and innovation precinct development

Beginning with Michael Porter's landmark work in cluster theory, decades of research has shown that clusters are essential to supporting the growth of an industry. Firms inside clusters tend to grow faster, innovate more, compete and build wealth globally at the national scale. For example, a review by Hall, et.al (2010) of 150 international studies found a median spillover R&D elasticity of 0.08; that is, a 1% increase in R&D expenditure by other firms or external sources leads to a 0.08% increase in a firm's productivity. A more recent Australian study by Palangkaraya and Webster (2015)⁹³ similarly demonstrated both intra-industry and inter-industry R&D spillovers have statistically significant, positive impacts on firm output, although the effects are smaller than those reported in international studies. This work showed R&D conducted by other firms within the same 2-, 3-, and 4-digit ANZSIC-coded industry and state all exhibit statistically significant, positive impacts on firm output, with elasticities of 0.0017, 0.0008, and 0.0003, respectively.

As shown in the map in Figure A2.1, many of the MRIs supported by the MRSP are located within state-significant innovation and industry precincts. These include the Camperdown Ultimo Health Precinct in the Harbour CBD, the Randwick Health Precinct, and the Westmead Health Precinct in Greater Parramatta. MRIs are also present in smaller but strategically important health precincts, such as those at Liverpool, St Leonards, Macquarie Park, and in the Newcastle-Hunter region⁹⁴.

Figure A2.1: Health and Innovation Precincts in New South Wales and Locations of the MRSP Grant Recipients 2012–2024



⁹³ Palangkaraya, A. and Webster, E. 2015. Measuring R&D spillovers from Australia industry: Uses and limitations of using the Extended Analytic Business Longitudinal Database (EABLD), accessed at: <https://www.swinburne.edu.au/media/swinburneeduau/research/research-centres/cti/reports/Measuring-RD-spillovers-from-Australia-industry-2015.pdf>

⁹⁴ NSW Innovation and Productivity Council. (2018). *NSW innovation precincts: Lessons from international experience*. Investment NSW. <https://www.investment.nsw.gov.au/assets/Uploads/files/IPC/Full-Report-IPC-NSW-Innovation-Precincts-2018.pdf>

This literature suggests that within these precincts, in addition to the direct impacts to the MRI, there may be second round, indirect impacts to other research institutes and/or firms in the precinct, including:

- Additional investment or expenditure by other private sector organisations in research or industrial activity
- Spin-offs of new companies and export market development by private companies based on licenced IP
- Wider research sector jobs creation
- Attraction of new clinical trials to NSW
- Knowledge spillovers to other organisations or companies co-located with the MRI in an innovation or industry precinct or cluster.

Additionally, where an MRI is an anchor tenant,⁹⁵ or has been supported to become an anchor tenant through time by the MRSP, the impacts would be expected to be higher. For example, Agrawal et al⁹⁶ researched the impact of anchor tenants on research productivity the presence of an anchor tenant significantly improved the research productivity of the cluster. For example, the marginal impact of one more paper on the expected number of patents is:

- 1.6 times larger in an industry cluster with an anchor tenant in the medical imaging sector
- 2.7 times larger in an industry cluster with an anchor tenant in neural networks
- 1.6 times larger in an industry cluster with an anchor tenant in signal processing.

Thus, recognising the role of ‘anchor tenants’ in a cluster to strengthen innovation and industry capability and support the growth of the wider ecosystem should also be considered.

This has similarly been recently recognised by NSW’s industry and innovation policy settings. For example, in 2022, the NSW Innovation and Productivity Council’s 2022 report *The role of anchors: lessons from international innovation precincts* identified at least two MRSP-recipient MRIs to be precinct anchor tenants: the Hunter Medical Research Institute within the John Hunter Health and Innovation Precinct and the Children’s Medical Research Institute within the Westmead Health and Innovation Precinct.

While there is no ‘hard and fast’ definition of an anchor tenant, in addition to these MRIs identified by the NSW Innovation and Productivity Council, it was expected that other MRIs that have received funding through the MRSP also meet the definition of an anchor tenant, with the following identified as key criteria:

- Large institute attracting significant funding from a diverse range of funders

⁹⁵ An anchor tenant in a knowledge precinct is a large, local, R&D-intensive firm and/or institute that significantly influences the local economy and innovation ecosystem. Anchor tenants create demand externalities for other businesses, stimulate local industrial R&D, and enhance the productivity of local innovation systems. They play a crucial role in creating and capturing externalities within local innovation systems, contributing to the regional innovation system and the absorption of local university research. See Agrawal (2002).

⁹⁶ Agrawal, A. and Cockburn, I.M. (2002), *University Research, Industrial R&D and the Anchor tenant Hypothesis*, NBER Working Paper Series, National Bureau of Economic Research, accessed at: https://www.nber.org/system/files/working_papers/w9212/w9212.pdf#:~:text=We%20develop%20and%20test%20the%20hypothesis%20that%20the,be%20an%20important%20channel%20for%20transmission%20of%20spillovers.

- Track record for high impact research (measured by journal metrics)
- Track record for research collaboration, including with industry.

In addition to the two above MRIs it was also assessed that the Black Dog Institute, the Children's Cancer Institute, the Garvan Institute, the George Institute for Global Health and Neuroscience Research Australia (NeuRA) met the criteria for an innovation precinct anchor tenant.

Wider precinct investment and activity enabled by the MRSP

Theoretically, the MRSP may have also catalysed further investment and economic activity in the precinct, including the development of other spinoff companies, which themselves raise capital and increase expenditure in the precinct. This could have been enabled through increased access to critical research infrastructure, such as novel animal models, biobanks, imaging capabilities or other leading infrastructure required for medical research, which other institutions and firms in the innovation precinct may have been unable to access but for the MRSP.

Upskilling NSW's medical research workforce

Funding for the MRSP was also expected to have contributed to the development of research excellence and sustainability both for the MRI and the wider NSW innovation ecosystem through the creation and retention of highly skilled jobs. By making funding more predictable, MRIs would have been able to both avoid turnover of key staff and to invest in the upskilling of key roles, including roles where skills shortages and/or specialised areas of need have been identified in NSW, such as biochemists, biochemical engineers, bioinformaticians, clinical haematologists, medical oncologists, nurses and other medical professionals.

Potential impacts to patients and the wider NSW health system

In addition to the economic impacts from research arising from increased attraction of grants and investment to NSW, the MRSP will have enabled improvements in health outcomes made possible by the additional research that was undertaken by the MRIs as a result of the MRSP.

Valuing these additional health outcomes and the MRIs' contribution to these improvements is a multi-step process (Box A2.2).

Box A2.2: Valuing the contribution of research to improved health outcomes

Valuing contributions of medical research to improve health outcomes is a complex and challenging exercise due to the ways in which research is conducted over time and around the world and the delays to the realisation of benefits.

The first thing to understand is that health and medical research is continuous, global in scale, and dependent on consistent investment across the innovation lifecycle, from 'basic' research improving the understanding of the fundamental biology and progression of disease, through to research that sees these new ideas translated into the clinic and to rigorous clinical trial programs aimed at quantifying the efficacy, effectiveness and cost effectiveness of new interventions.

Sustained investment in medical research can significantly improve survival, quality of life improvements and consumer experience in the health system, as well as improve the efficiency and environmental sustainability of health services delivery (see next section).

As a result, research enabled by funding support provided by the MRSP would be expected to deliver second round, indirect improvements in survival and quality of life over time across the range of research areas in which the MRIs work.

Given this, the impact analysis must follow a standard, multi-step approach to first identify improvements in health outcomes that have been observed, with a lag, as a result of the research within each research domain, and then to attribute the MRIs' contribution to this research. The key steps in this process are identified in turn:

- *Quantify the improvements in health outcomes by research domain* — First, it is necessary to estimate the change (improvement) in health outcomes that have been achieved over a particular period of time (or are expected in the future) as a result of research at the MRI enabled by the MRSP. The economic impact analysis employs a 'bottom up' case study approach based on interviews with the MRIs with regard to key changes in clinical practice, survival, quality of life and other outcomes over the past 13 years (2012–2025). These major changes will be applied to the relevant patient populations in NSW to estimate a high-level value of health and economic impact.

Importantly, the benefits of the research conducted by MRIs supported by the MRSP over the 2012 to 2025 period would be expected to be realised in the future. Generally speaking, investment in research is assumed to have a benefits realisation horizon of approximately 17 years,⁹⁷ which means that research activity conducted today will begin to yield benefits in 17 years' time from the year of award. In practice this would mean, for example, a research project conducted in 2015 would be expected to translate into improvements in survival outcomes for people diagnosed in 2032. The central assumption would be that benefits from the health gains realised through research will be expected to accrue for patients diagnosed between 2029 to 2042, due to the 17-year lag in benefits realisation. Where the additional research conducted by an MRI is predominantly health implementation science or perhaps involves a more accelerated program of research a shorter benefits realisation horizon of 7 years would be modelled.⁹⁸

- *Determine the proportion of health gains attributable to medical research* — Once the improvements to health outcomes have been identified, the contribution of medical research to these outcomes would be estimated. The NHMRC, in its successive evaluations of the value of NHMRC funded research, has estimated that on average 50% of the gains in health outcomes are attributable to medical research.⁹⁹ In the absence of better information, depending on the nature of the information from the MRIs, this would be the starting assumption for the economic impact analysis.
- *Determine the proportion of benefit attributable to NSW MRIs* — Once the proportion of observed health gains have been defined and attributed to research, then in light of the global nature of research it would be necessary to identify the NSW MRIs' specific contribution to the global research community. The generally accepted approach is to undertake citation analysis

⁹⁷ Morris ZS, Wooding S, Grant J. The answer is 17 years, what is the question: understanding time lags in translational research. *Journal of the Royal Society of Medicine*. 2011;104(12):510-520. doi:10.1258/jrsm.2011.110180

⁹⁸ Hanney, S.R., Wooding, S., Sussex, J. *et al*. From COVID-19 research to vaccine application: why might it take 17 months not 17 years and what are the wider lessons? *Health Res Policy Sys* **18**, 61 (2020). <https://doi.org/10.1186/s12961-020-00571-3>

⁹⁹ National Health and Medical Research Council, 2014, *Measuring Up 2013*, accessed at: *Measuring up 2013 | NHMRC*; National Health and Medical Research Council, 2019, *Measuring Up 2018*, accessed at: <https://www.nhmrc.gov.au/about-us/publications/measuring-2018>.

which can measure research impact by identifying citation rates in the top 1% and 10% journals using SciVal data. The MRI's share of citations in these top journals is used to estimate their contribution to the research outcome.

Additionally, there may be improvements in patient and carer experience that have been enabled by the MRIs' research. These impacts would be identified where possible in addition to the quantitative health impact analysis where available.

The MRSP may have also enabled improvements to the wider NSW health system through workforce development or research that enables services to be delivered more efficiently or safely. Building on the identification of improvements in health outcomes, improvements in outcomes for the NSW health system would also be identified including:

- Training of the NSW medical research workforce, tiered by career phase, gender and cultural background
- Improved efficiency or safety of NSW health services, measured by reduced length of stay, reduced risk of adverse events, improved cultural competence of the workforce or improved experience for NSW health workers
- More environmentally sustainable services, such as through the avoidance of carbon emissions, water usage, and/or plastics usage
- Conversely, there could be adverse environmental impacts from additional research in NSW that may need to be identified, such as an increase in carbon emissions, water usage, and/or plastics usage involved in changed health practice.

Putting it all together: potential net impacts to NSW

These bottom-up direct and indirect impacts will be aggregated to identify impacts by stakeholder and by key impact dimension including economic, health, social, cultural and environmental impacts. These benefits would be compared against the MRSP costs, including both the costs of administering the funds as well as the grant outlays, to determine the benefit-cost ratio and value for money.

Economic evaluation methods

Overview

To estimate the health, economic, social, cultural and environmental impacts of the MRSP, the following steps were undertaken:

- Literature and data review
- Data request and data acquisition to close information gaps
- Stakeholder consultations and case study development
- Trend analysis of NHMRC funding in NSW as a result of MRSP funding
- Economic impact modelling
- Quantitative impact analysis of social, cultural and environmental impacts.

These steps are discussed in turn.

Literature and data review

The first step of the economic impact analysis was the conduct of a literature and data review, which involved a review of:

- MRSP Annual Progress Report data
- Other MRSP reports and data not included in reporting requirements for the MRSP, including annual reports and data for the 2005–2012 period, other investment and expenditure in innovation and industry precincts or clusters where the MRI is co-located
- Citation analysis for each research domain
- Evaluations of similar programs in Australia and internationally
- National NHMRC, ARC, MRFF and other publicly reported data by research domain over the 2005–2025 period.

These data were reviewed to identify key data for impact assumptions development and to identify potential data gaps to be filled through stakeholder consultation, MRI surveys and MRI data requests.

For example, MRI financial and operational data was reviewed for the 2012–2025 period to identify:

- Grant revenues, by source
- Projects of strategic significance, either for their size or collaborative elements
- Estimates of additionality, where available
- Publication and citation impact data
- IP formation
- Revenues from IP
- Workforce and training expenditure, including for key career phases (early and mid-career researchers), career disruptions (women returning to work), in highly skilled areas (e.g., bioinformatics) or people from disadvantaged backgrounds or priority populations (First Nations people, disabled people, women, people from low socioeconomic status backgrounds, LGBTQIA+)
- Operational efficiencies, such as through avoided turnover or avoided overheads made possible through MRI mergers (e.g., the Schizophrenia Research Institute merging with NeuRA)
- Major improvements in health outcomes have been achieved in 2012–2025 period
- Major improvements in health outcomes expected from in next 15 years
- Major improvements in health services delivery have been achieved (cost/efficiency)
- Environmental initiatives.

Overall, the review found comprehensive summaries of grant revenues, by source, and operational data, but inconsistent and sometimes incomplete information with regards to the additionality effects of the MRSP through time, and more detail with respect to the strategic significance of selected projects, IP

formation, revenues from IP, social, cultural and environmental impacts of the MRIs' operations that may have been potentially enabled by the MRSP.

In addition to MRI reported data, other key data acquired to support the analysis included:

- NHMRC grants data 2005–2025
- MRFF grants data
- AIHW incidence, prevalence, mortality, survival data by condition
- AIHW Burden of Disease data
- WHO Global Burden of Disease disability weights
- National Hospital Cost Data Collection
- Academic and grey literature on spillover assumptions
- Scopus citation analysis
- Carbon prices as reported by World Bank Group.¹⁰⁰

Stakeholder consultations and case studies

MHC conducted consultations with every NSW MRI and worked in partnership with the MRI to develop a range of case studies to draw out, in a qualitative manner, the ways in which the MRSP enabled additional activity to occur and how this had impacts on the MRI, the wider research ecosystems and the state's health system.

Data requests and acquisition

Following this review of the MRSP and publicly available data, data was requested of the MRIs to close information gaps to allow for a complete understanding of the impact of the MRSP on MRI activities and outcomes for NSW. This included data requests for:

- Impact of the MRSP on risk of financial collapse through time
- Impact of the MRSP on strategically significant projects
- Impact of the MRSP on strategically significant infrastructure
- Tier 1 journals for their research domain
- IP formation and revenues
- Impact on the MRSP on grant success (additionality)
- Impact of the MRI on the precinct or cluster, including the impact on other investment, expenditure or industry growth in the precinct or cluster or research not represented in the reports that has been catalysed by their work
- Workforce by cohort

¹⁰⁰ World Bank Group. (2025). State and Trends of Carbon Pricing Dashboard, accessed at: <https://carbonpricingdashboard.worldbank.org/compliance/price>.

- Training expenditure by cohort
- Environmental initiatives.

Citation analysis from SciVal was used to identify the MRIs' share of citations in Tier 1 journals, including the top 1% and 10% of journals by research field.

Trend and Ordinary Least Squares (OLS) regression analysis

In addition to the review of the MRSP's outcomes, trends in other funding support for MRIs was also evaluated, including trends in NSW's share of NHMRC funding and other funding support from the Independent Research Institute Infrastructure Support Scheme (IRIIS) and Research Support Program.

Ordinary Least Squares (OLS) regression analysis was undertaken to estimate the impact of MRSP funding on NSW Commonwealth grant revenue (NHMRC and MRFF). The analysis used NSW gross state product (GSP), as well as other Government research support funding, to control for exogenous impacts to NSW grant revenue. Timeseries data of funding to NSW universities and MRIs through the Independent Research Institute Infrastructure Support Scheme (IRIIS) and Research Support Program (RSP) as part of higher education block grants were used to inform the estimate of other indirect research support funding in addition to the MRSP as enablers of grant funding (NHMRC and MRFF) outcomes.

Data from 2020 and 2021 were excluded from the analysis due to the outlier impact of the COVID-19 pandemic on research funding and GSP. Historic CPI was used to adjust all figures into \$2025, to ensure the impact of inflation is accounted for. Data were aggregated over four-year periods that align with MRSP funding rounds. The total period of analysis was 2004 to 2023 (20 years; five rounds), which includes eight years (two rounds) of data prior to the introduction of the MRSP in 2012, which allowed for the model to account for a meaningful change in government baseline funding when calculating the impact on total NHMRC grant funding.

The OLS model specified the total funding granted to NSW-based institutions by NHMRC and MRFF as a function of MRSP funding, with NSW GSP and other research funding serving as covariates. Multiple potential regression specifications were considered; ultimately, log-log regression was found to be the best fit for the data ($R^2 = 0.95$, which indicates a very strong fit).

Economic impact modelling

Once consultations were completed and the additional data requested was collected, the project team synthesised these data together with information gathered in the rapid literature and data review into summary of data and assumptions for the bottom-up economic impact modelling.

To cope with uncertainty, the economic impact modelling involved the development of three scenarios for impact: a 'central, expected case' as well as a low and high impact scenarios.

The economic impact evaluation complied with all key methodological requirements as set out in the NSW Treasury CBA guidelines (TPG23-08), including the use of a social discount rate of 5% with sensitivities of 3% and 7%, the development of cash flows in real value terms, and sensitivity analysis for key variables.

- Reporting basis
 - Financial years

- Pricing
 - Real terms (\$2025)
 - Wage uplift (real wage price growth in wages above CPI – WPI)
 - Health services – real price growth above CPI (AIHW)
- Social discount rate
 - 5% (Central case)
 - 3% (Low case)
 - 7% (High case)
- Sensitivity analysis
 - Additionality effects (expected (central) low, high scenarios to be MRI specific)
 - Timing of benefits realisation
 - Attribution of health gains to medical research / MRIs
- Value of QALY gained¹⁰¹

Qualitative impact analysis

Where key impacts could not be credibly quantified, case studies were developed to illustrate impact,:

- Impact of the MRSP for reducing turnover and supporting development of high-performance teams through retention of key roles
- Social impacts – Improved outcomes for priority populations
- Cultural impacts – Cultural competence in research or health services delivery
- Environmental impacts – Reducing footprint of research.

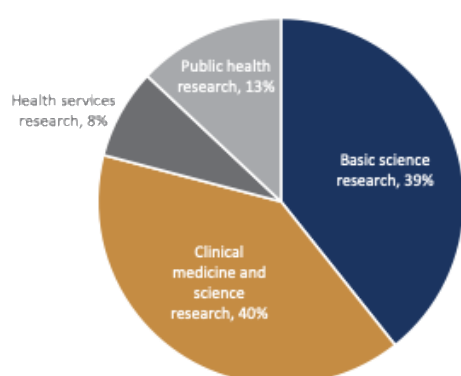
¹⁰¹ Taylor, C, 2017, Economic Evaluation <https://australianprescriber.tg.org.au/articles/economic-evaluation-of-medicines.html#r7>

Appendix 3. MRSP-funded MRIs

MRIs received funding throughout the evaluation period unless otherwise noted. For intermittently funded MRIs, the specific funding periods are detailed below. Information about these institutes can be found on their websites, linked below.

- [ANZAC Research Institute](#) (2012–2016; 2016–2020)
- [Black Dog Institute](#)
- [Centenary Institute](#)
- [Children’s Cancer Institute Australia](#)
- [Children’s Medical Research Institute](#)
- [Garvan Institute of Medical Research](#)
- [The George Institute for Global Health](#)
- [Heart Research Institute](#) (2016–2020; 2024–2028)
- [Hunter Medical Research Institute](#)
- Illawarra Health and Medical Research Institute¹⁰²
- [Ingham Institute for Applied Medical Research](#)
- [Neuroscience Research Australia](#)
- [Victor Chang Cardiac Research Institute](#)
- [Westmead Institute for Medical Research](#)
- [Woolcock Institute of Medical Research](#)

Across the 13 currently funded MRIs, the distribution of research activity is as follows:



Data source: Director-level survey of currently funded MRSP MRIs

¹⁰² The Illawarra Health and Medical Research Institute ceased operations in 2023. A website with information about the institute is not available.

Appendix 4a. Director-level survey instrument

Introduction

Thank you for taking part in this survey as part of the independent evaluation of the Medical Research Support Program (MRSP).

The Office for Health and Medical Research (OHMR) has engaged MH Consulting Group, in partnership with Insight Economics and Nexus Consulting, to undertake an independent evaluation of the MRSP, supporting transparency and evidence-based investment in medical research.

This survey is a key opportunity for you to provide insights into how the MRSP has been operating across the current and previous funding rounds, and to support an evidence-based assessment of its effectiveness and impact. The survey is designed to gather both strategic perspectives and detailed operational insights about how the MRSP is supporting medical research institutes (MRIs), and how it contributes to the broader research ecosystem in NSW.

This survey complements information you and others at your MRI have already provided to the MRSP evaluation team and information we have obtained from OHMR through applications and progress reports. Survey responses will provide new insights that go beyond routine progress reports and interview data. The information collected will help assess how well the MRSP is meeting its objectives and inform both the evaluation and the broader Review of the MRSP.

This is your opportunity to have your say on how the MRSP has contributed to the work done by your MRI and its contribution towards health and medical research in NSW.

Estimated time to complete: Approximately 20 minutes

Important Information:

- Privacy and confidentiality: Your responses are confidential and will not affect your MRI's current eligibility for grants or funding received by your institution. They will, however, play a key role in shaping the future of the MRSP.
- Submission deadline: Please submit your responses by **26 September 2025**.

Thank you for your time and contribution.

About you

About you

1. What is your position at your MRI?

(free text response)

2. How many years of experience do you have in your current role?

- <1 year
- 1–<2 years
- 2–<5 years
- 5–<10 years
- ≥10 years

3. How many years of experience do you have working at your MRI?

- <1 year
- 1–<2 years
- 2–<5 years
- 5–<10 years
- ≥10 years

About your MRI

4. Below are the Broad Research Area classifications used by NHMRC. Please roughly estimate the proportion of your MRI's research activity in each stage of research (total should add to 100%; proportions are intended to be indicative and not exact).

Note: Please omit the "%" sign and add numeric values only in the space provided.

Key Health Domain	Proportion of your MRI's work in this area
Basic science research: seeks to understand the biological processes that underpin health and disease at the molecular, cellular, organ system and whole body levels. It may be conducted in vitro, in vivo and/or in silico. It may use, but is not limited to, cells, tissues or other materials of human origin or from relevant animal models.	___%
Clinical medicine and science research: seeks to improve the diagnosis, treatment and prevention of human diseases and conditions. It may involve interaction with patients and/or the use of clinical diagnostic materials or patient data.	___%
Health services research: seeks to understand and improve the effectiveness, quality, safety, social and environmental dimensions of health care including access, distribution, timeliness and efficiency.	___%
Public health research: seeks to improve the health of a population through the prevention of disease, prolongation of life and promotion of health and wellbeing. It includes research to understand the social, behavioural, environmental and other determinants of health and disease.	___%

Your MRI's research collaborations

This section will ask you about research collaborations that your MRI is involved in with other research institutes or organisations.

We are interested in **meaningful, high-quality collaborations**, where there is clear evidence of:

- shared effort, resources and/or infrastructure to achieve research excellence,
- exchange of skills, knowledge and ideas to increase research capacity (e.g. research trainee placements or exchange program).

5. Thinking about your portfolio of collaborations, to what extent does your MRI have meaningful collaborations with the following types of organisations? (Select one option for each)

Type of collaboration	A lot	Somewhat	A little	Not at all
Universities	☐	☐	☐	☐
Other MRIs within NSW	☐	☐	☐	☐
Other MRIs in other states and/or internationally	☐	☐	☐	☐
Local health districts and the services they provide (including hospitals)	☐	☐	☐	☐
Other health service delivery organisations (including primary care)	☐	☐	☐	☐
Government agencies within NSW	☐	☐	☐	☐
Government agencies interstate and/or commonwealth	☐	☐	☐	☐
Pharmaceutical companies	☐	☐	☐	☐
Not-for-profit organisations	☐	☐	☐	☐
Other private sector organisations	☐	☐	☐	☐
Other	☐	☐	☐	☐

If you have said “other” above, please provide details on the type of other organisation(s) you collaborate with.

(free text response)

6. Thinking about your portfolio of collaborations, to what extent does your MRI engage in the following types of collaboration? (Select one option for each)

Type of collaboration	A lot	Somewhat	A little	Not at all
Shared infrastructure (e.g. equipment, facilities, platforms)	☐	☐	☐	☐
Shared data or datasets	☐	☐	☐	☐
Joint research projects or studies	☐	☐	☐	☐
Shared funding or co-investment in research projects and/or infrastructure	☐	☐	☐	☐
Training and capacity building	☐	☐	☐	☐
Joint governance or strategic planning	☐	☐	☐	☐
Shared central services, such as financial, legal or communications/media	☐	☐	☐	☐
Other	☐	☐	☐	☐

If you have said “other” above, please provide details on the type of collaboration.

(free text response)

10. Are the MRSP's objectives aligned with achieving a vibrant health research and innovation ecosystem in NSW? (select one option)

- Strongly aligned
- Somewhat aligned
- Somewhat conflicts
- Strongly conflicts

Perceptions of the terms and conditions of MRSP funding

Eligibility and allocation of MRSP funding

The **eligibility criteria** to receive MRSP funding are as follows:

- The MRI is located in NSW
- The primary purpose of the institute is to conduct health and medical research
- The MRI can demonstrate organisational independence (numerous criteria to demonstrate independence)
- The MRI conducts high-quality research at sufficient scale (demonstrated by average annual income from eligible competitive grants of $\geq \$3$ million over previous 3 years)
- The MRI is financially viable (demonstrated by liquidity ratio ≥ 1.0 , low level of debt and can provide audited financial accounts as evidence)

11. To what extent do you think the eligibility criteria are aligned with the three objectives of the MRSP (i.e. research excellence, critical mass and sustainability)? (select one option)

- Strongly aligned
- Somewhat aligned
- Somewhat conflicts
- Strongly conflicts

One of the criteria for **eligibility** for MRSP funding is the conduct of high-quality research at sufficient scale. This is determined by an average annual income from eligible competitive grants of at least \$3 million in the previous 3 years. Eligible grants include 4 nationally competitive grants:

- Australian Research Council (ARC)
- Cancer Australia (CA)
- Medical Research Future Fund (MRFF)
- National Health and Medical Research Council (NHMRC).

Institutes are categorised into tiers based on their average annual eligible grant income:

- Tier 1: ≥\$15 million
- Tier 2: ≥\$10 million
- Tier 3: ≥\$3 million

Allocation of MRSP funding amount is based on research income from NHMRC grants only.

MRIs in Tier 1 receive the highest proportional payment for funds they are awarded, while MRIs in tier 3 receive the lowest. For the 2024-2028 round, rates of MRSP support were in the range of 25 to 45 cents per NHMRC grant dollar.

12. Please indicate if you agree or disagree with the following statements (select one option for each):

	Strongly agree	Agree	Disagree	Strongly disagree
1. Eligibility for MRSP funding should be based on income from nationally competitive research grants (i.e. NHMRC, MRFF, ARC and CA)	☐	☐	☐	☐
2. The minimum threshold to be eligible to receive MRSP funding (i.e. \$3 million over the previous 3 years) is appropriate	☐	☐	☐	☐
3. A greater proportion of funding should be allocated to MRIs that have received more income from eligible research grants (i.e. the tier system should remain)	☐	☐	☐	☐
4. If the tier system is retained, the dollar amounts for the tier thresholds (i.e. Tier 1 ≥\$15 million; Tier 2 ≥\$10 million; Tier 3 ≥\$3 million) are appropriate	☐	☐	☐	☐
5. Allocating MRSP funding based on NHMRC grant income alone is appropriate	☐	☐	☐	☐

Expenses supported by the MRSP

The terms and conditions for MRSP funding specify that the funding may be used to cover the indirect costs of research – i.e. costs incurred by the recipient in its conduct of health and medical research funded by other sources and that are not covered by funding agreements for those projects.

Expenses that are not supported by MRSP funding include:

- Research projects
- Capital works
- Support activities where a statewide asset already exists (e.g. biobanking)
- Additional standard exclusions common to standard NSW government grant funding agreement

13. Please indicate if you agree or disagree with the following statements (select one option for each).

	Strongly agree	Agree	Disagree	Strongly disagree
1. Included expenses: The criteria on which expenses are supported by MRSP funding are <u>clear</u>	☐	☐	☐	☐
2. Included expenses: The criteria on which expenses are supported by MRSP funding are <u>appropriate</u>	☐	☐	☐	☐
3. Excluded expenses: The criteria on which expenses are NOT supported by MRSP funding are <u>clear</u>	☐	☐	☐	☐
4. Excluded expenses: The criteria on which expenses are NOT supported by MRSP funding are <u>appropriate</u>	☐	☐	☐	☐

Impact of the MRSP on research outcomes at your MRI

This section will ask you about your perceptions regarding the impact of the MRSP on various outcomes **at your MRI**.

14. What has been the incremental benefit of the MRSP towards achieving the following outcomes at your MRI, over and above other funding sources? (Select one option.)

Outcomes	Large effect	Some effect	No effect	Don't know
Research outputs				
1 The <u>quantity</u> of research conducted (Examples of impacts on research quantity may include: enabled more research projects to be completed, enabled a new program of work to be developed, enabled more research publications and scholarly outputs)	☐	☐	☐	☐
2 The <u>quality</u> of research conducted at your MRI (Examples of impacts on research quality may include: more research publications in top journals in your field, increase in number of research prizes awarded)	☐	☐	☐	☐
3 Development of innovations and discoveries	☐	☐	☐	☐
4 New products that received regulatory approval for market use	☐	☐	☐	☐
5 Research collaborations with other organisations	☐	☐	☐	☐
Research infrastructure				
6 Maintain existing research infrastructure at your MRI	☐	☐	☐	☐
7 Improve existing research infrastructure at your MRI	☐	☐	☐	☐
8 Establish new research infrastructure at your MRI	☐	☐	☐	☐
Workforce capacity and capability				
9 Attract and hire researcher talent to your MRI	☐	☐	☐	☐
10 Retain researcher talent at your MRI	☐	☐	☐	☐
11 Attract and hire non-research workers to your MRI	☐	☐	☐	☐
12 Retain non-research workers at your MRI	☐	☐	☐	☐
13 Attract and train research trainees to your MRI	☐	☐	☐	☐
14 Employment opportunities for research trainees who completed training at your MRI	☐	☐	☐	☐
15 Hire and retain priority groups at your MRI (priority groups include Aboriginal and Torres Strait Islander people, Culturally and linguistically diverse people, People with a disability, LGBTIQ+ people, and Refugees and asylum seekers)	☐	☐	☐	☐
16 Hire and retain people trained in shortage or specialised areas	☐	☐	☐	☐
17 Overall capacity of the workforce at your MRI	☐	☐	☐	☐
Financial stability and viability				
18 Your MRI's financial stability	☐	☐	☐	☐

Outcomes	Large effect	Some effect	No effect	Don't know
19 Your MRI's long term financial viability	☐	☐	☐	☐
20 Your MRI's ability to win nationally competitive research grants	☐	☐	☐	☐
21 Your MRI's ability to win other types of competitive research grants	☐	☐	☐	☐
22 Your MRI's ability to acquire other sources of funding	☐	☐	☐	☐

15. For the purposes of this evaluation, we'd like to assess a hypothetical scenario (the 'counterfactual', what would happen if the MRSP did not exist). Please indicate the likely impact on your MRI if MRSP funding ceased at the end of the current four-year cycle in 2028.

Outcomes	Large negative impact	Some negative impact	No impact	Some positive impact	Large positive impact
Research outputs					
1 The <u>quantity</u> of research conducted (Examples of impacts on research quantity may include: enabled more research projects to be completed, enabled a new program of work to be developed, enabled more research publications and scholarly outputs)	☐	☐	☐	☐	☐
2 The <u>quality</u> of research conducted at your MRI (Examples of impacts on research quality may include: more research publications in top journals in your field, increase in number of research prizes awarded)	☐	☐	☐	☐	☐
3 Development of innovations and discoveries	☐	☐	☐	☐	☐
4 New products that received regulatory approval for market use	☐	☐	☐	☐	☐
5 Research collaborations with other organisations	☐	☐	☐	☐	☐
Research infrastructure					
6 Maintain existing research infrastructure at your MRI	☐	☐	☐	☐	☐
7 Improve existing research infrastructure at your MRI	☐	☐	☐	☐	☐
8 Establish new research infrastructure at your MRI	☐	☐	☐	☐	☐
Workforce capacity and capability					
9 Attract and hire researcher talent to your MRI	☐	☐	☐	☐	☐
10 Retain researcher talent at your MRI	☐	☐	☐	☐	☐

Outcomes	Large negative impact	Some negative impact	No impact	Some positive impact	Large positive impact
11 Attract and hire non-research workers to your MRI	☐	☐	☐	☐	☐
12 Retain non-research workers at your MRI	☐	☐	☐	☐	☐
13 Attract and train research trainees to your MRI	☐	☐	☐	☐	☐
14 Employment opportunities for research trainees who completed training at your MRI	☐	☐	☐	☐	☐
15 Hire and retain priority groups at your MRI (priority groups include Aboriginal and Torres Strait Islander people, Culturally and linguistically diverse people, People with a disability, LGBTIQ+ people, and Refugees and asylum seekers)	☐	☐	☐	☐	☐
16 hire and retain people trained in shortage or specialised areas	☐	☐	☐	☐	☐
17 Overall capacity of the workforce at your MRI	☐	☐	☐	☐	☐
Financial stability and viability					
18 Your MRI's financial stability	☐	☐	☐	☐	☐
19 Your MRI's long term financial viability	☐	☐	☐	☐	☐
20 Your MRI's ability to win nationally competitive research grants	☐	☐	☐	☐	☐
21 Your MRI's ability to win other types of competitive research grants	☐	☐	☐	☐	☐
22 Your MRI's ability to acquire other sources of funding	☐	☐	☐	☐	☐

16. From the list of 22 outcomes, please select the five outcomes where MRSP funding has had the biggest impact on your MRI and rank them in order (1 = biggest impact; 5 = smallest impact of your top 5).

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____

17. Do you think the MRSP had any negative impacts on your MRI or its work?

- ☐ Yes
- ☐ No

If yes, please provide details below.

(free text response)

18. Please provide two brief (one sentence) examples of how you used your MRSP funding in a way that contributes to each of the MRSP's objectives.

The objectives of the MRSP are:

- **Excellence – Support excellence in health and medical research through the delivery of high-quality outputs**
- **Critical mass – Promote critical mass in health and medical research as part of the effective use of resources**
- **Sustainability – Monitor and help ensure the financial sustainability of participating institutes**

Excellence (example 1): (free text response)

Excellence (example 2): (free text response)

Critical mass (example 1): (free text response)

Critical mass (example 2): (free text response)

Sustainability (example 1): (free text response)

Sustainability (example 2): (free text response)

Impact of the MRSP on the NSW health and medical research ecosystem

This section will ask you about your perceptions regarding the impact of the MRSP on the NSW health and medical research ecosystem.

19. What has been the incremental benefit of the MRSP towards achieving the following outcomes for the NSW health and medical research ecosystem, over and above other funding sources? (Select one option for each.)

Outcome	Large impact	Some impact	No impact	Don't know
1 Scope and quantity of research conducted across the NSW health and medical research ecosystem	☐	☐	☐	☐
2 Quality of research conducted across the NSW health and medical research ecosystem	☐	☐	☐	☐
3 Health outcomes for individuals and/or population (e.g. disease prevention, survival and quality of life of patients in the health system)	☐	☐	☐	☐
4 Health services in NSW (e.g. efficiencies in health services, safety, workforce participation)	☐	☐	☐	☐
5 Research infrastructure	☐	☐	☐	☐
6 High-quality collaborative research	☐	☐	☐	☐
7 Research workforce capacity	☐	☐	☐	☐
8 Long-term viability of the NSW health and medical research ecosystem	☐	☐	☐	☐

20. For the purposes of this evaluation, we'd like to assess a hypothetical scenario (the 'counterfactual', what would happen if the MRSP did not exist). Please indicate the likely impact on the NSW health and medical research ecosystem if MRSP funding ceased at the end of the current four-year cycle in 2028. (Select one option for each.)

Outcome	Large negative impact	Some negative impact	No impact	Some positive impact	Large positive impact
1 Scope and quantity of research conducted across the NSW health and medical research ecosystem	☐	☐	☐	☐	☐
2 Quality of research conducted across the NSW health and medical research ecosystem	☐	☐	☐	☐	☐
3 Health outcomes for individuals and/or population (e.g. disease prevention, survival and quality of life of patients in the health system)	☐	☐	☐	☐	☐
4 Health services in NSW (e.g. efficiencies in health services, safety, workforce participation)	☐	☐	☐	☐	☐
5 Research infrastructure	☐	☐	☐	☐	☐
6 High-quality collaborative research	☐	☐	☐	☐	☐

Outcome	Large negative impact	Some negative impact	No impact	Some positive impact	Large positive impact
7 Research workforce capacity	☐	☐	☐	☐	☐
8 Long-term viability of the NSW health and medical research ecosystem	☐	☐	☐	☐	☐

21. From the list of 8 outcomes, select the five outcomes where MRSP funding has had the biggest impact on the NSW health and medical research ecosystem and rank them in order (1 = biggest impact; 5 = smallest impact of your top 5).

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____

22. Do you think the MRSP had any negative impacts on the NSW health and medical research ecosystem?

- Yes
- No

If yes, please provide details below.

(free text response)

Future directions for the MRSP and other comments

23. Considering the future direction of the MRSP, please rank how important it is for MRSP funding to contribute towards achieving the outcomes below (with a rank of 1 being the most important and 4 being the least important):

	Rank
• Strengthening NSW's reputation in national and international research	_____
• Enabling a vibrant and collaborative NSW health research ecosystem	_____
• Improving population health outcomes in NSW	_____
• Promoting a healthcare system in NSW that is equitable, high-quality, and sustainable	_____

24. What future strategic directions would you suggest for the MRSP?

(free text response)

25. Do you have any suggestions to improve any aspects of the MRSP's objectives, design and/or implementation?

(free text response)

26. Is there anything else that you would like to tell us about your experience with the MRSP and/or its impact on your MRI or the wider NSW health and medical research ecosystem? Please enter any comments below.

(free text response)

Appendix 4b. Grant administrator-level survey instrument

Introduction

Thank you for taking part in this survey as part of the independent evaluation of the Medical Research Support Program (MRSP).

The Office for Health and Medical Research (OHMR) has engaged MH Consulting Group, in partnership with Insight Economics and Nexus Consulting, to undertake an independent evaluation of the MRSP, supporting transparency and evidence-based investment in medical research.

This survey is a key opportunity for you to provide insights into how the MRSP has been operating across the current and previous funding rounds, and to support an evidence-based assessment of its effectiveness and impact. The survey is designed to gather both strategic perspectives and detailed operational insights about how the MRSP is supporting medical research institutes (MRIs), and how it contributes to the broader research ecosystem in NSW.

This survey complements information you and others at your MRI have already provided to the MRSP evaluation team and information we have obtained from OHMR through applications and progress reports. Survey responses will provide new insights that go beyond routine progress reports and interview data. The information collected will help assess how well the MRSP is meeting its objectives and inform both the evaluation and the broader Review of the MRSP.

This is your opportunity to have your say on how the MRSP has contributed to the work done by your MRI and its contribution towards health and medical research in NSW.

Estimated time to complete: Approximately 20 minutes

Important Information:

- **Privacy and confidentiality:** Your responses are confidential and will not affect your MRI's current eligibility for grants or funding received by your institution. They will, however, play a key role in shaping the future of the MRSP.
- **Submission deadline:** Please submit your responses by **26 September 2025**.

Thank you for your time and contribution.

About you

1. What is your position at your MRI?

(free text response)

2. How many years of experience do you have in your current role?

- <1 year
- 1–<2 years
- 2–<5 years
- 5–<10 years
- ≥10 years

3. How many years of experience do you have working at your MRI?

- <1 year
- 1–<2 years
- 2–<5 years
- 5–<10 years
- ≥10 years

4. How many years of experience do you have managing research grants in the health and medical research sector in NSW?

- <1 year
- 1–<2 years
- 2–<5 years
- 5–<10 years
- ≥10 years

5. How many rounds of the MRSP have you been involved in (either managing the grant application or reporting)? (Select all that apply)

- 2012–2016 round
- 2016–2020 round
- 2020–2024 round
- 2024–2028 round

About your MRI

This page will ask you about indirect costs and how they are covered at your MRI.

MRSP funds are intended to cover the indirect costs of research. In this survey, we are defining indirect costs as expenses incurred by your MRI to support research activities but are not directly attributable to a specific project. These include, but are not limited to, the infrastructure and administrative support needed for research to function, such as laboratory equipment and facilities, IT, data management, human research ethics committees, legal and compliance, fundraising and philanthropy, and grants management.

6. What sources of funding does your MRI use to cover the indirect costs of research? (select all that apply)

- Funds obtained through the Medical Research Support Program (MRSP)
- Competitive research grants
- Non-competitive research grants
- Income for indirect costs (from dedicated schemes)
- Fundraising and philanthropy
- Commercial income
- Capital income
- Investment income
- Other (e.g. Provision of research and clinical services) – please specify _____
(free text response)

7. Which other research infrastructure funding sources has your MRI received support from? (Select all that apply)

- NHMRC Independent Research Institutes Infrastructure Support Scheme (IRIIS)
- MRFF National Critical Research Infrastructure Initiative
- National Collaborative Research Infrastructure Strategy (NCRIS)
- NSW Health Research Attraction and Acceleration Program
- NSW Health Co-funding for National Collaborative Research Infrastructure Strategy
- Other, please specify: _____ (free text response)
- None of the above – My MRI has not received research infrastructure funding from any sources other than the MRSP

Your experience applying for the MRSP

The questions on the following pages pertain to your experience with the application for the 2024–2028 funding round of the MRSP.

Perceptions of the MRSP application process

8. Please provide your best estimate of the total elapsed time (i.e. from start to completion) required to complete the MRSP application.

- ≤1 day
- 2–3 days
- 4–6 days
- 1–2 weeks
- >2 weeks
- Other, please specify: _____ (free text response)

9. How many people were involved in completing the application for MRSP funding? Please tell us the number of individuals involved.

(free text response)

10. Please estimate the number of hours required across all staff involved in completing the application for MRSP funding.

(free text response)

11. Please specify the positions of the people involved in completing the application for MRSP funding. (select all that apply)

- Executive leadership (e.g. Director, CEO)
- Senior research leadership (e.g. Theme/Program Head, Research Director)
- Other researchers
- Research managers / Coordinators
- Grants manager / officer
- Finance manager / officer
- Information manager / officer
- Administrative staff (e.g. executive assistant, general administrator)
- Communications / Engagement staff
- Other, please specify: _____ (free text response)

12. Please indicate the extent to which you agree/disagree with the following statements.

	Strongly agree	Agree	Disagree	Strongly disagree
1. The documentation required to demonstrate eligibility is fair and appropriate	☐	☐	☐	☐
2. The resources (including time) required to complete the application was reasonable and proportionate to the funding received	☐	☐	☐	☐
3. The resources (including time) needed to complete the application was reasonable relative to my experience of applying for other similar grants	☐	☐	☐	☐
4. The application process was easy to navigate	☐	☐	☐	☐
5. The application assessment process is fair	☐	☐	☐	☐
6. The application assessment process is transparent	☐	☐	☐	☐

13. Do you think the application process can be improved?

- Yes
- No

If yes, please provide your suggestions.

(free text response)

Perceptions of communication with OHMR

This page will ask you about your experience of communicating with OHMR during the MRSP application and assessment process for the 2024–2028 round.

14. Did you seek any clarification from OHMR regarding the grant application process?

- Yes (go to Q15)
- No (go to Q16)

15. If yes, please indicate if you were satisfied with the assistance you received.

	Strongly agree	Agree	Disagree	Strongly disagree
1. OHMR provided me with the information I needed	☐	☐	☐	☐
2. I received information in a timely manner	☐	☐	☐	☐
3. Overall, I am satisfied with the assistance I received from OHMR	☐	☐	☐	☐

16. Please indicate the extent to which you agree/disagree with the following statements.

	Strongly agree	Agree	Disagree	Strongly disagree
1. The information received from OHMR prior to the application deadline was <u>satisfactory</u>	☐	☐	☐	☐
2. The communication from OHMR prior to the application deadline was <u>timely</u>	☐	☐	☐	☐
3. The information received from OHMR after the application deadline to notification of the grant outcome was <u>satisfactory</u>	☐	☐	☐	☐
4. The communication from OHMR after the application deadline to notification of the grant outcome was <u>timely</u>	☐	☐	☐	☐

17. Do you have any suggestions to improve communication from OHMR?

- Yes
- No

If yes, please provide your suggestions.

(free text response)

Your experiences with reporting for the MRSP

Resources required at your MRI

The questions on the following pages pertain to your most recent experience with reporting on annual progress for the MRSP.

18. Please provide your best estimate of the total elapsed time required to complete the annual progress report for the MRSP (i.e. from beginning the report until submitting it to OHMR). Please select the best estimate for each of the following reporting periods, referring to your most recent experience:

- ≤1 day
- 2–3 days
- 4–6 days
- 1–2 weeks
- >2 weeks
- Other (please specify, free text)

19. How many people are involved in completing the annual progress report for the MRSP? Please tell us the number of individuals involved, referring to your most experience of completing the annual report.

(free text response)

20. Please estimate the number of hours required across all staff involved to complete the annual reporting requirements for the MRSP. Please refer to your most recent experience of completing the annual report.

(free text response)

21. Please specify the positions of the individuals involved in completing the annual reporting requirements for the MRSP, referring to your most experience of completing the annual report.

- Executive leadership (e.g. Director, CEO)
- Senior research leadership (e.g. Theme/Program Head, Research Director)
- Other researchers
- Research managers / Coordinators
- Grants manager / officer
- Finance manager / officer
- Information manager / officer
- Administrative staff (e.g. executive assistant, general administrator)
- Communications / Engagement staff
- Other, please specify: _____ (free text response)

The questions on the following pages pertain to your most recent experience with reporting at the midterm assessment for the MRSP.

22. Please provide your best estimate of the total elapsed time required to complete the midterm report for the MRSP (i.e. from beginning the report until submitting it to OHMR). Please select the best estimate, referring to your most recent experience:

- ≤1 day
- 2–3 days
- 4–6 days
- 1–2 weeks
- >2 weeks
- Other, please specify: _____ (free text response)

23. How many people are involved in completing the midterm report for the MRSP? Please tell us the number of individuals involved, referring to your most experience of completing the midterm report.

(free text response)

24. Please estimate the number of hours required across all staff involved to complete the midterm report for the MRSP. Please refer to your most recent experience of completing the midterm report.

(free text response)

25. Please specify the positions of the individuals involved in completing the midterm report for the MRSP, referring to your most experience of completing the midterm report.

- Executive leadership (e.g. Director, CEO)
- Senior research leadership (e.g. Theme/Program Head, Research Director)
- Other researchers
- Research managers / Coordinators
- Grants manager / officer
- Finance manager / officer
- Information manager / officer
- Administrative staff (e.g. executive assistant, general administrator)
- Communications / Engagement staff
- Other, please specify: _____ (free text response)

The questions on this page pertain to your most recent experience with reporting for the MRSP.

26. Please indicate the extent to which you agree/disagree with the following statements.

	Strongly agree	Agree	Disagree	Strongly disagree
1. The information requested in reporting is appropriate.	☐	☐	☐	☐
2. The instructions to complete reporting are clear	☐	☐	☐	☐
3. The resources (including time) required to complete the reporting were reasonable and proportionate to the funding received	☐	☐	☐	☐
4. The resources (including time) needed to complete reporting were reasonable relative to my experience of applying for other similar grants	☐	☐	☐	☐

Information and metrics reported

27. Are there any metrics that are required for reporting that are challenging to report on?

- Yes
- No

If yes, please provide further information, including which metrics and why they are challenging to report.

(free text response)

28. Are there any metrics or other information that you believe would be valuable for OHMR to collect as part of the reporting process that are not currently being reported?

- Yes
- No

If yes, please provide further information, including what data you believe should be collected and why.

(free text response)

Suggestions for improvements

29. Do you think that reporting for the MRSP can be improved?

- Yes
- No

If yes, please specify. Please note, we are aware of feedback on reporting provided to OHMR as part of the reporting process, and will consider any comments provided here alongside those already provided.

(free text response)

Impact of MRSP on research grant income

These pages will ask you to estimate the impact of receiving MRSP funding on the amount of research grant income received by your MRI.

30. In the last round of MRSP funding (2020-2024), was there an increase in the amount of research grant income received by your MRI as a result of the MRSP (i.e. relative to what you might have received if you had not received the MRSP)? (Select one option)

- 0% - no change in research grant income
- Approximately 10% increase
- Approximately 20% increase
- Approximately 30% increase
- Approximately 40% increase
- Approximately 50% increase
- Approximately 60% increase
- Approximately 70% increase
- Approximately 80% increase
- Approximately 90% increase
- Approximately 100% increase
- Other, please specify: _____ (free text response)

31. Has this level of impact of the MRSP on research grant income received been the same across the entire duration of the MRSP (i.e. since 2012)? (Select one option)

- Yes, the impact has been roughly the same since 2012 (go to Q34)
- No, the impact has changed over time (go to Q32)

32. In the 2012-2016 MRSP funding round, what was the extent of the increase in the amount of research grant income received by your MRI as a result of the MRSP (i.e. relative to what you might have received if you had not received the MRSP)? (Select one option)

- 0% - no change in research grant income
- Approximately 10% increase
- Approximately 20% increase
- Approximately 30% increase
- Approximately 40% increase
- Approximately 50% increase
- Approximately 60% increase
- Approximately 70% increase
- Approximately 80% increase
- Approximately 90% increase

- Approximately 100% increase
- Other, please specify: _____ (free text response)

33. In the 2016-2020 MRSP funding round, what was the extent of the increase in the amount of research grant income received by your MRI as a result of the MRSP (i.e. relative to what you might have received if you had not received the MRSP)? (Select one option)

- 0% - no change in research grant income
- Approximately 10% increase
- Approximately 20% increase
- Approximately 30% increase
- Approximately 40% increase
- Approximately 50% increase
- Approximately 60% increase
- Approximately 70% increase
- Approximately 80% increase
- Approximately 90% increase
- Approximately 100% increase
- Other (please specify)

Other comments

34. Is there anything else that you would like to tell us about your experience with the MRSP? Please enter any comments below. (free text)

Appendix 5. Case studies

The case studies below were provided by MRSP-funded MRIs, along with those summarised in Section 5. These case studies provided insights on how the MRSP contributed to outcomes and impacts, informing our synthesis and overall assessment of the MRSP's achievements (see Section 7, Evaluation Synthesis).

Outcome: Contribution towards improving the financial position of MRIs and supporting the financial stability and resilience of MRIs

Evidence that the MRSP has contributed towards increasing revenues from other income streams

Case study 13. Infrastructure investments that leverage national and international grant funding to advance the development of tuberculosis and COVID-19 vaccines

MRI activity

The Centenary Institute uses MRSP funding to operate and maintain a Physical Containment Level 3 (PC3) facility, the only facility in NSW capable of conducting animal studies with high-risk human pathogens with pandemic potential such as *Mycobacterium tuberculosis* and SARS-CoV-2. This capability enabled the Institute to rapidly pivot during the COVID-19 pandemic and to sustain a long-standing tuberculosis research program. Through the PC3 facility, the Institute supported nationally and internationally funded research programs to advance the development of vaccines against COVID-19, tuberculosis and other high-threat respiratory pathogens. This work conducted included preclinical vaccine and therapeutic studies, establishing in vitro and in vivo infection models.

Impact

The PC3-enabled research enabled success in acquiring high value national and international grants for the development of tuberculosis and COVID-19 vaccines including:

- Advancement of a “variant-proof” COVID-19 vaccine, supported by a US\$19.3 million award from the Coalition for Epidemic Preparedness Innovations (CEPI), progressing toward first-in-human trials in 2026.
- Preclinical vaccines testing capability for novel recombinant BCG and protein vaccines funded by MRFF, which enabled the subsequent CEPI consortium award
- Development of a nasal COVID-19 vaccine designed to reduce infection and transmission, supported by a NSW Health Vaccine Accelerator grant, with the patented delivery technology applicable for vaccines against other respiratory pathogens.
- Development of next-generation tuberculosis vaccines, including a US\$13 million National Institutes of Health (NIH)-funded contract for head-to-head comparisons of various adjuvant-antigen combinations.
- Development of novel anti-tuberculosis drug candidates, supported through NHMRC funding including an NHMRC Ideas grant and NHMRC Centre of Research Excellence.

Contribution of the MRSP

MRSP funding is used to maintain the PC3 facility, contributing to the costs to operate the facility and salaries of professional services staff who support researchers. Without MRSP support, the facility could not operate, and the associated vaccine and therapeutic research programs, including major NHMRC, MRFF, CEPI and NIH-funded projects, would not have proceeded.

Data source: Case study provided by MRI

Outcome: Contribution towards building the research workforce and capacity

Evidence that the MRSP has contributed towards increasing and sustaining research workforce size and capacity

Case study 14. The MRSP contributes operational infrastructure that stabilises workforce and builds research capacity

MRI activity

MRSP funding provides the stable operating environment required for researchers, clinicians, and professional staff to work effectively across its 3 research streams: Neurodegeneration, Mental Health, and Translational Neuroscience. It supports NeuRA's research workforce by enabling the Institute to retain and progress early- and mid-career researchers (EMCRs), expand student supervision and mentorship capacity, and support gender equity and diversity initiatives, including parental leave top-ups and flexible appointments. This workforce stability allows EMCRs to build research programs, compete successfully for external funding, and contribute to sustained research activity across the Institute.

Impact

The stable workforce environment enabled by the MRSP has strengthened NeuRA's overall research capacity and productivity. By retaining skilled researchers and supervisors, the Institute has enhanced its ability to deliver high-quality scientific, translational, and clinical research, accelerate research translation, and maintain collaboration across the Randwick precinct.

This strengthened capacity has enabled research that contributed to earlier diagnosis, reduced adverse events, and improved quality of life for participants in clinical and translational programs. It has also supported more efficient models of care, reduced hospital utilisation, and strengthened clinical-research integration. At a system level, MRSP-enabled infrastructure has supported high-impact publications, new diagnostic and digital innovations, and sustained NSW's research capability by supporting researchers and students within secure, compliant research environments.

Contribution of the MRSP

Approximately 31% of NeuRA's total infrastructure activity was supported through MRSP funding. This included support for laboratories, equipment, data platforms, biobanks, and clinical research spaces, as well as critical enabling services such as IT, HR, finance, research governance, regulatory compliance, biosafety and administrative services. Without the MRSP, NeuRA would have faced significant operational, scientific, and compliance risks, and research outputs would have been smaller in scale, slower to deliver, and less competitive for national and international funding.

"Ultimately, it underpins every aspect of discovery, innovation, and impact delivered by the Institute."

Data source: Case study provided by MRI

Outcome: Contribution towards excellence in research

Evidence that MRIs used MRSP funding to invest in infrastructure to support research programs

Case study 15. For contribution towards clinical research: Attracting research talent and excellence with world-class facilities: the HMRI neuroimaging centre

MRI activity

The HMRI Neuroimaging Centre was established through a partnership between HMRI, the University of Newcastle, and Hunter New England Local Health District, with the latter 2 providing initial capital investment. The Centre delivered the first research-grade neuroimaging facility in regional NSW within the John Hunter Health and Innovation Precinct. The Centre houses a research-dedicated Siemens 3T Prisma MRI scanner, allowing the flexibility and methodological depth needed for cutting-edge research including advanced neuroimaging, diffusion imaging, fMRI, spectroscopy, cardiovascular imaging, AI-supported image reconstruction and emerging hybrid applications. It has enabled more than 70 research projects across neuroscience, cardiology, oncology, respiratory medicine, musculoskeletal health and mental health, and has involved collaborations across local, national and international partners. HMRI assumed full responsibility for running and supporting the Centre from 2023.

The MRI system at the Centre will undergo a major MRI upgrade in 2025–26, delivering one of Australia’s highest-performance research imaging platforms and incorporating a novel cooling approach to reduce the system’s carbon footprint.

Impact

MRSP support has enabled the Neuroimaging Centre to become a nationally significant regional research hub, with impacts including hundreds of peer-reviewed publications and successful competitive grant applications. It has also attracted leading world-class investigators to HMRI, and provided a unique regional training environment linking researchers, radiographers, engineers and data scientists across the Precinct, building capability across the Hunter region.

Contribution of the MRSP

MRSP funding has provided the long-term, stable resourcing required to expand, professionalise and modernise the Neuroimaging Centre. It has supported approximately 45–50% of the Neuroimaging Centre’s annual operational costs since 2012, including specialist staff such as MRI physicists, radiographers, image analysts, data scientists and quality-assurance specialists. It has also supported ongoing equipment servicing and upgrades, preventative maintenance, software licensing and quality-management systems. Without the MRSP, the Centre would not have been able to retain specialist expertise, maintain technical excellence, or achieve National Imaging Facility accreditation.

“MRSP funding has therefore been central to sustaining operations, enabling growth in research output and ensuring regional researchers can access facilities on par with Australia’s major metropolitan hubs.”

Data source: Case study provided by MRI

Case study 16. For contribution towards health services research: Driving improvements in clinical care: The Australia New Zealand Hip Fracture Registry

MRI activity

NeuRA provides in-kind support to the Australia and New Zealand Hip Fracture Registry (ANZHFR). In 2024, multidisciplinary teams from 106 hospitals (84 in Australia and 22 in New Zealand) contributed data to the registry. The Register provides a scalable data platform that supports multicentre research, guideline development, and innovation such as predictive analytics and digital decision-support tools.

Impact

The registry supports hospitals to compare performance, identify variation in care, and implement improvements. Over its first decade, ANZHFR has played a central role in the development and monitoring of the Hip Fracture Guideline and Clinical Care Standard.

Additional impacts arising from the Registry include:

- Increased use of nerve blocks for pre-operative pain management
- Higher rates of pre-operative cognitive and delirium assessment
- More patients being mobilised early after surgery
- Reduced unwarranted variation in care across hospitals
- More efficient orthopaedic and geriatric care pathways, including reduced length of stay and reduced variation in clinical care.

The Registry continues to identify areas for further development, such as timely surgery for all patients and improved discharge planning for bone protection and secondary fracture prevention.

Contribution of the MRSP

MRSP funding supported approximately 20-30% of ANZHFR activity. The infrastructure funding has supported professional and research support functions, including some IT systems, research governance, ethics, and financial management. The website (previously hosted by NeuRA) and data storage, hosted by an external provider, provides real-time clinical dashboards and produces annual national performance reports used by hospitals across Australia and New Zealand. Research projects undertaken at NeuRA are generated from this important registry data.

Without MRSP funding, the ANZHFR would have had significantly reduced capacity to support the ethical and contractual requirements of a binational clinical registry. Key improvements in pain management, earlier surgery, and better cognitive and delirium assessments would not have been achieved at the same scale or pace.

Data source: Case study provided by MRI

Case study 17. For contribution towards public health research: Reducing intentional self-harm

MRI activity

Suicide is an urgent public health challenge in NSW, with intentional self-harm being a leading cause of hospitalisations. The Black Dog Institute led a strategically significant program of work to develop and evaluate the LifeSpan model, a comprehensive, community-based suicide prevention approach aligned with WHO best-practice guidance. LifeSpan combined 9 evidence-based strategies delivered across education, community and health settings. Strategies included universal interventions (such as school-based programs), selective strategies for at-risk groups (e.g. gatekeeper training frontline workers and community members), and indicated approaches for individuals in crisis (e.g. aftercare services). A core feature of the model was the establishment of locally governed suicide prevention collaboratives to support coordinated implementation, community engagement and sustainability beyond the research period.

The model was evaluated using a stepped-wedge, cluster randomised controlled trial across 4 NSW regions with historically high suicide rates. The project brought together 152 organisations to collaborate for implementation and research purposes and more than 25,000 health professionals, educators, school students and community members in NSW were trained to recognise and respond to suicide risk or received support for suicidal distress.

Impact

The LifeSpan trial demonstrated measurable public health and system-level impacts, including a statistically significant 13.8% reduction in rates of hospital-presenting intentional self-harm across intervention sites (IRR 0.86; 95% CI 0.79–0.94; $p < 0.001$), with site-specific reductions ranging from 8.4% to 16.6%. No significant changes were observed in the rest of NSW. Post-trial, the suicide prevention collaboratives remain in place with activities coordinated via Primary Health Networks and/or Local Health Districts.

The LifeSpan trial in NSW led to a commitment from the Federal Government to pilot the approach in 12 of 31 Primary Health Networks (PHNs) across Australia, which now provides ongoing funding for suicide prevention coordinator roles for all 31 PHNs. It also led to:

- adoption of the LifeSpan model in NSW, ACT, and VIC suicide prevention frameworks
- the establishment of a national suicide prevention network to which every PHN belongs
- funding for workforce and regional network capacity building to support the model
- other investment in this approach to suicide prevention nationally (\$128m).

The LifeSpan framework is also being adapted as the national model in the Netherlands.

Contribution of the MRSP

MRSP funding supported the development of an integrated data platform linking coronial and health administrative datasets, enabling geospatial targeting, real-time monitoring and rigorous outcome analysis that would not have been feasible through fragmented systems. Without the MRSP, the model could not have integrated the advanced geospatial mapping needed to locate suicide and self-harm risk at the regional level and target local interventions effectively. The evaluation would have relied on fragmented, manual processes, limiting accuracy and scalability. The MRSP also supported the policy and advocacy team, facilitating translation of trial findings into state and national suicide prevention policy. Together, these contributions elevated the scale, credibility, influence and long-term impact of the research beyond the trial itself.

Data source: Case study provided by MRI

Evidence that the MRSP contributed towards research innovation and leadership

Case study 18. Strengthening pandemic preparedness for vaccine-preventable infectious diseases

MRI activity

WIMR established and leads the Vaccine, Infection and Immunology (VIIM) Collaborative Research Group, a statewide partnership generating human immunology evidence to inform vaccine development and pandemic preparedness. A flagship program within VIIM maps the earliest immune responses to HIV and herpes simplex virus (HSV) to guide mucosal vaccine design. This research is highly innovative in its use of freshly resected human tissues collected within minutes of surgery from more than 20 NSW hospitals, combined with advanced spatial proteomic and transcriptomic imaging. The approach enables direct observation of immune-pathogen interactions during the first hours of infection, providing physiologically relevant insights that are not achievable using animal models.

Impact

The program has attracted significant industry investment from Moderna, GSK and ViiV Healthcare, generated patent-ready antiviral discoveries, and strengthened NSW's capability in mucosal vaccine development and pandemic preparedness. The data and expertise from this body of work helped inform NSW policy on pandemic preparedness, making NSW a critical component of the federal response.

Contribution of the MRSP

MRSP funding supports specialised technical staff and high-cost PC3 laboratory operations. In addition, recent advances in this research were dependent upon access to spatial transcriptomic technology (Xenium 10X and Cytassist) supported by an MRFF National Critical Infrastructure Grant. This case study provides an example of the compounding of MRSP support from different projects, providing an economy of scale that underpins multiple projects, and attracts expertise and resources to NSW. VIIM and this internationally competitive work in mucosal vaccine development would not exist without the MRSP.

Data source: Case study provided by MRI

Outcome: Contribution towards increasing research collaboration

Evidence that MRSP-funded infrastructure led to national and international research collaboration

Case study 19. Integrating oral health research into policy and practice

MRI activity

The Australian Centre for Integration of Oral Health (ACIOH) at the Ingham Institute is Australia's first interprofessional oral health research centre, established to integrate oral health into broader health systems, policy and practice. Supported by MRSP-enabled infrastructure and overheads, ACIOH leads translational research programs spanning maternity care, chronic disease management, primary care and priority populations. The Centre works closely with national and international partners through the Australian Network for Integration of Oral Health. Exemplar projects include:

- The Midwifery Initiated Oral Health Program, which was initially developed as a multi-centre randomised controlled trial and has now been scaled up nationally and adopted internationally.
- The Diabetes and Oral Health Program, strengthening collaboration between oral health and diabetes providers including development of a tailored diabetes oral health training and a validated screening tool.
- The Pharmacy and Oral Health Program, which produced an integrated oral health training program for pharmacists that has been accredited by the Pharmaceutical Society of Australia.
- Grinnin' Up Mums & Bubs Program, a culturally safe antenatal oral health model of care codesigned with Aboriginal Health Workers in the South West Sydney LHD.
- Research Training for Oral Health Clinicians, a collaboration with SLD to develop a series of training videos to build capacity in undertaking research and quality improvement projects.
- The development, evaluation and scale-up of integrated models of care across midwifery, nursing, pharmacy and Aboriginal health settings, underpinned by rigorous research and workforce training.

Impact

ACIOH's work has delivered substantial health, policy and workforce impacts, including:

- National and international scale-up of the Midwifery-Initiated Oral Health (MIOH) program, with 472 midwives in Victoria trained, integration into undergraduate curricula at 6 Australian universities, adoption across multiple countries, and recognition by the World Health Organization as best practice.
- Development of evidence-based programs linking oral health with diabetes care, pharmacy practice and nursing education, now embedded in university curricula, professional CPD pathways and national microcredential platforms.
- Direct influence on national and international health policy across Australia, Europe, the UK and the US related to reproductive, maternal and child health; intellectual and learning disabilities; aged care; screening and prevention among adults; access to dental services, and subsidisation of dental care.
- Co-design and dissemination of culturally appropriate oral health resources across NSW, nationally and internationally, translated into multiple languages and endorsed by health authorities.

Contribution of the MRSP

MRSP funding contributes towards the overheads and operational infrastructure required to sustain ACIOH's core research team and activities. The MRSP constitutes 30% of the Institute's non-research income, contributing

to a 5-person philanthropy, communications and fundraising team (previously limited to 1 resource), costs of refitting research spaces, and operating costs of a new Centre of Excellence in Campbelltown.

Data source: Case study provided by MRI

Outcome: Contribution towards the health system and health benefits

Evidence supporting research translation to health policy and practice

Case study 20. A novel low dose, fixed dose combination for the treatment of hypertension

Activity

The George Institute, in partnership with its spin out company, George Medicines, has led the development of a once-daily triple antihypertensive single-pill combination that can help to address persistently poor blood-pressure control, a major contributor to cardiovascular disease globally. The pill comes in 3 doses, including 2 lower than those currently available in single pill combinations. Building on early trials that demonstrated improved control with low dose triple therapy compared with usual care, the Institute established a dedicated single-pill formulation programme to develop (GMRx2) designed to bring to market an affordable, scalable fixed-dose combination suitable for primary care in countries across the economic spectrum. In clinical trials, the drug showed good tolerability and the most common adverse event reported was symptomatic hypotension.

The phase 3 development program comprised a series of trials, including a placebo-controlled safety and efficacy study, with long-term extension assessing 12-month safety and durability, and comparisons with dual-combination therapy. It included a global trial, the VERONICA-Nigeria study, showing significant improvement in blood pressure where disease burden is high and treatment gaps wide. In the recently completed TRIDENT study, the largest ever trial conducted for secondary prevention in patients with intracerebral haemorrhage, risk was reduced by almost 40%. Together, this work progressed the triple-pill strategy from concept through late-stage clinical development and has helped inform international regulatory and guideline discussions.

Impact

The triple-pill program has generated clinical, system, economic and social benefits:

- Improved patient outcomes versus comparators: Across trials involving more than 4,000 participants, the triple combination achieved average systolic blood-pressure reductions of 5 to over 20 mmHg depending on starting levels.
- Health-system efficiencies: Simplifying treatment from multiple medicines to a single daily pill may streamline prescribing and dispensing and reduce supply-chain complexity.
- Research and policy impact: The program strengthened NSW's leadership in cardiovascular prevention research, influenced international guidelines and led to a marketed product with regulatory approval (USA FDA approval in 2025).
- Economic benefits: Commercial partnerships generated milestone payments and future royalty streams, with income supporting job creation and skilled employment.
- Social benefits: This program showed the potential to improve access to affordable cardiovascular treatment, particularly in underserved populations in Australia and globally.
- Environmental benefits: The development of this single pill may reduce the packaging, freight and waste associated with distributing multiple separate medicines.

Contribution of the MRSP

MRSP funding provided the stable, long-term infrastructure required to deliver this multi-phase international program. MRSP-supported capacity underpinned biostatistics, data management, GCP-compliant trial operations, health-economic modelling, implementation science capacity and international coordination. The Institute estimates that at least 20% of the total contribution enabling the program's impact, including late-stage development and regulatory progress, can be attributed to MRSP-supported capability. Without MRSP funding, the program would not have progressed at the same scale, speed or level of international impact.

Data source: Case study provided by MRI

Case study 21. Translating health service innovations into practice: the case of MediBus

Activity

The Diabetes Alliance Program Plus (DAP+) is a partnership between the Hunter Medical Research Institute (HMRI), the University of Newcastle, Hunter New England Local Health District, and the Hunter New England Central Coast Primary Health Network. The program was developed in response to high rates of avoidable emergency presentations for diabetes complications across the Hunter New England region, reflecting gaps in access to specialist care, particularly in regional, rural and Aboriginal communities.

DAP+ reverses the traditional model of care by bringing specialist diabetes expertise into primary care and community settings. Initially delivered through outreach case conferencing with GPs and practice nurses, the model has evolved into a large-scale, evaluated service supported by a purpose-built MediBus. The MediBus delivers comprehensive diabetes assessments and multidisciplinary care directly to communities, alongside GP-specialist joint clinics, case conferencing, workforce training and culturally safe engagement activities. HMRI staff and affiliates are embedded within clinical teams, integrating translational research, health economics and implementation science to support scale-up and sustainability.

Impact

Across the first 2 years of expansion, DAP+ demonstrated:

- Improved clinical outcomes, with sustained reductions in HbA1c (9.7% in Year 1), non-HDL cholesterol reductions (5–9%), albumin-creatinine ratio improvements (14–17%) and modest weight loss (1–1.3%), reducing long-term cardiovascular and microvascular complications.
- High-volume service delivery, including over 2,000 case conferences, more than 1,200 new patients (including 157 Aboriginal and Torres Strait Islander participants), 700+ specialist advice calls in Year 2, and completion rates ranging between 91% and 95%.
- Whole-of-community reach, demonstrated through culturally safe delivery in Aboriginal Medical Services, virtual case conferencing in remote towns, and strong community feedback across rural inland sites such as Moree, Tenterfield and Boggabilla.
- Workforce development, with DAP+ functioning as a training ground for emerging endocrinologists, GPs, nurses and allied health professionals and strengthening regional diabetes care.

In 2025, DAP+ was awarded the Primary Care Innovation Award at the 5th annual 2025 Hunter New England and Central Coast Primary Health Network (HNECC PHN) Primary Care Quality and Innovation Awards, and the People and Culture Award at the 2025 NSW Health Awards.

Contribution of the MRSP

MRSP funding enabled HMRI to build the research, evaluation and analytics capability that transformed DAP+ from a clinician-led innovation into an evidence-backed, scalable model of care. The MRSP supported data science systems, health-economic modelling, impact evaluation and implementation science and community engagement frameworks required to demonstrate clinical effectiveness, community reach and system value.

This MRSP-enabled evidence base directly underpinned HMRI securing a \$12 million philanthropic investment from the Colonial Foundation, supporting MediBus build and deployment, workforce expansion, digital infrastructure and program evaluation. This investment was followed by NSW Health's commitment to statewide scale-up of the DAP+ model. Without MRSP investment, the program would not have had the analytical depth, credibility or scale required to attract this level of philanthropic and government support.

Data source: Case study provided by MRI

Case study 22. Increasing productivity with workplace mental health programs

MRI activity

Mental illness is a leading cause of absenteeism and long-term work incapacity, with research demonstrating the contribution of workplace risk factors. The Black Dog Institute has led a program of research examining the relationship between work and mental health, with a focus on identifying modifiable workplace risk factors and testing effective prevention strategies. Through a series of seminal, world-first controlled trials of different types of workplace mental health interventions, the Institute developed and evaluated the world's first evidence-based online resilience training for frontline workers, a smartphone application that has been shown in a randomised controlled trial to be able to prevent depression in a range of workers, and a new type of skills-based mental health training for managers.

The RESPECT Manager Training Program was developed and evaluated in partnership with Fire and Rescue NSW through a cluster randomised controlled trial involving 128 managers and nearly 2,000 employees. This trial provided robust evidence that brief, targeted mental health training for managers could deliver measurable benefits for both employees and employers. This study demonstrated an 18% reduction in work-related sick leave among teams whose managers received training, compared with a 29% increase in the control group, equivalent to 6.45 fewer hours of absence per employee over 6 months. Managers reported greater confidence and were more likely to initiate early contact with staff experiencing mental health challenges. Furthermore, cost-benefit analysis revealed a return on investment of nearly 10:1, with every dollar spent on training saving approximately \$10 in reduced absenteeism costs.

Impact

This research resulted in the development of a new model for how different types of work factors can impact health. This framework has been cited 948 times and adopted internationally, informing policies of the OECD, WHO, NICE and the European Parliament. Within NSW, the manager mental health training has been integrated into the government's \$55m Mentally Healthy Workplaces Strategy. An independent evaluation found that by 2022 more than 90,000 business had modified their activity as a result of this policy change with 25,841 individual workers receiving evidence-based workplace mental health training. The estimated flow on health benefits to workers in NSW equated to a saving of more than \$72 million due to reduced sickness absence.

A smartphone application developed to prevent depression through this body of work has also been promoted by SafeWork NSW and implemented at scale. More than 33,000 workers had accessed this intervention, with the estimated health and social benefits valued at \$12 million.

Contribution of the MRSP

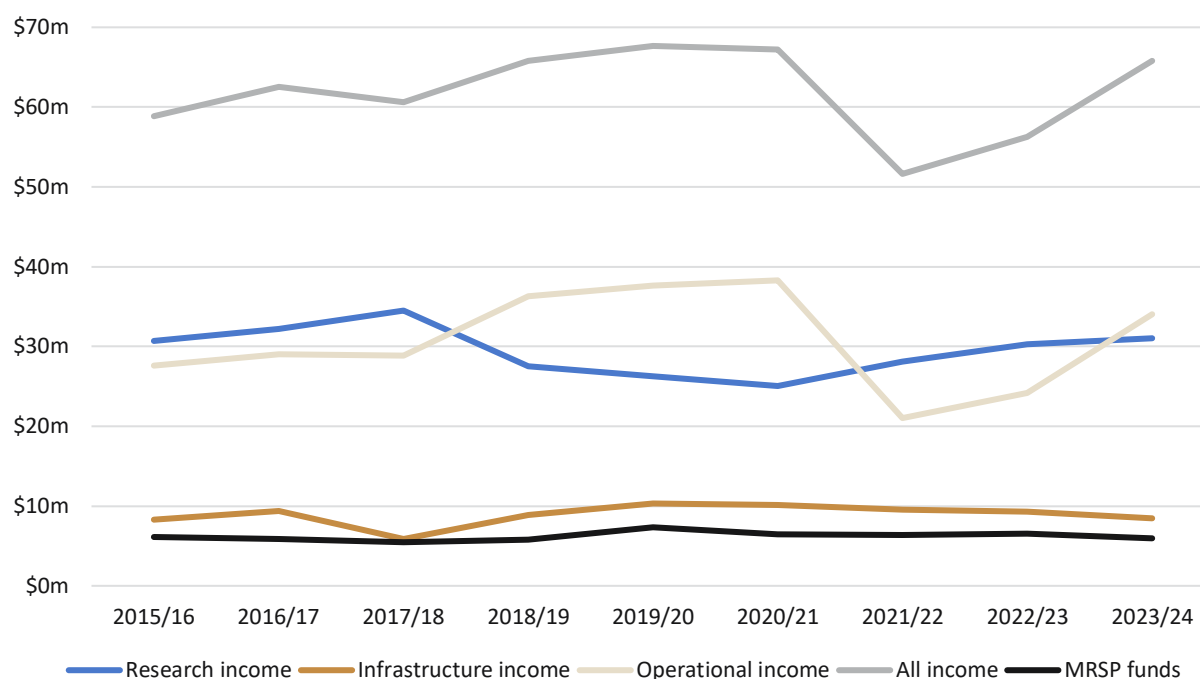
MRSP funding enabled the establishment of lived-experience capability, digital innovation, and dedicated research translation functions that transformed trial findings into scalable workplace programs. Without MRSP support, these activities would likely have remained discrete research outputs rather than informing policy, legislation and large-scale implementation across NSW, nationally and internationally.

Data source: Case study provided by MRI

Appendix 6. Additional graphs

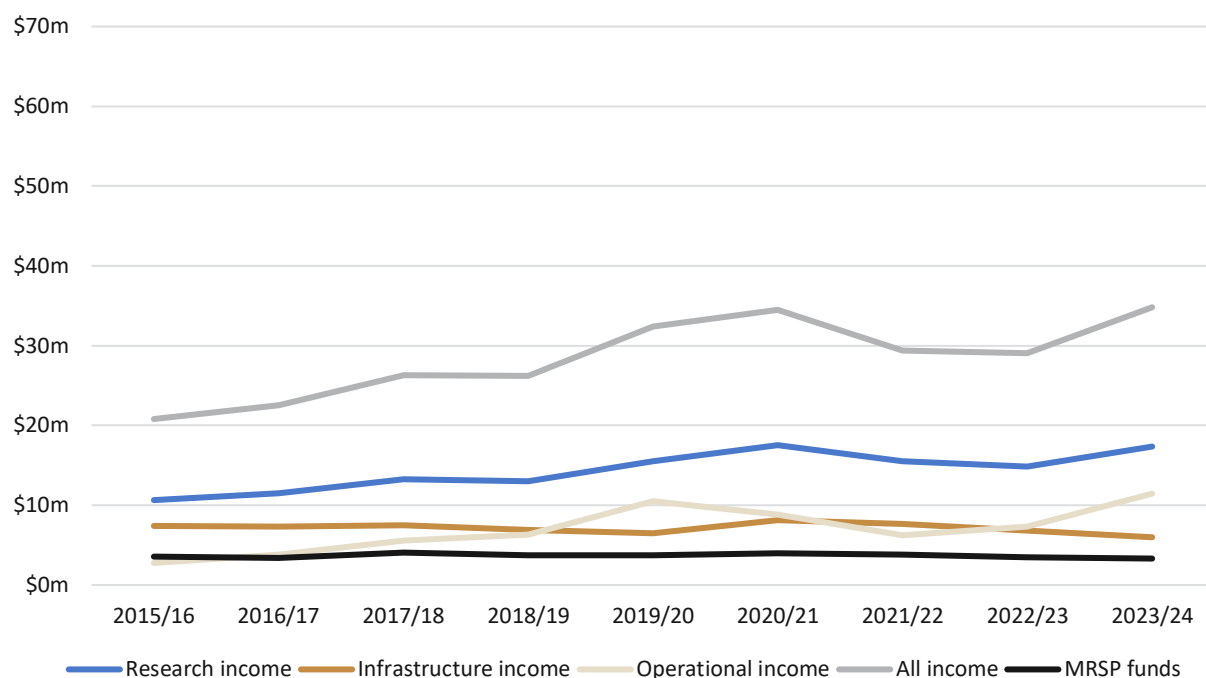
Data to support the MRSP's contribution towards improving the financial position of MRIs: Evidence C – MRIs leverage MRSP funding to varying extents

Figure A6.1. Mean MRI income for Tier 1 MRIs, by income type



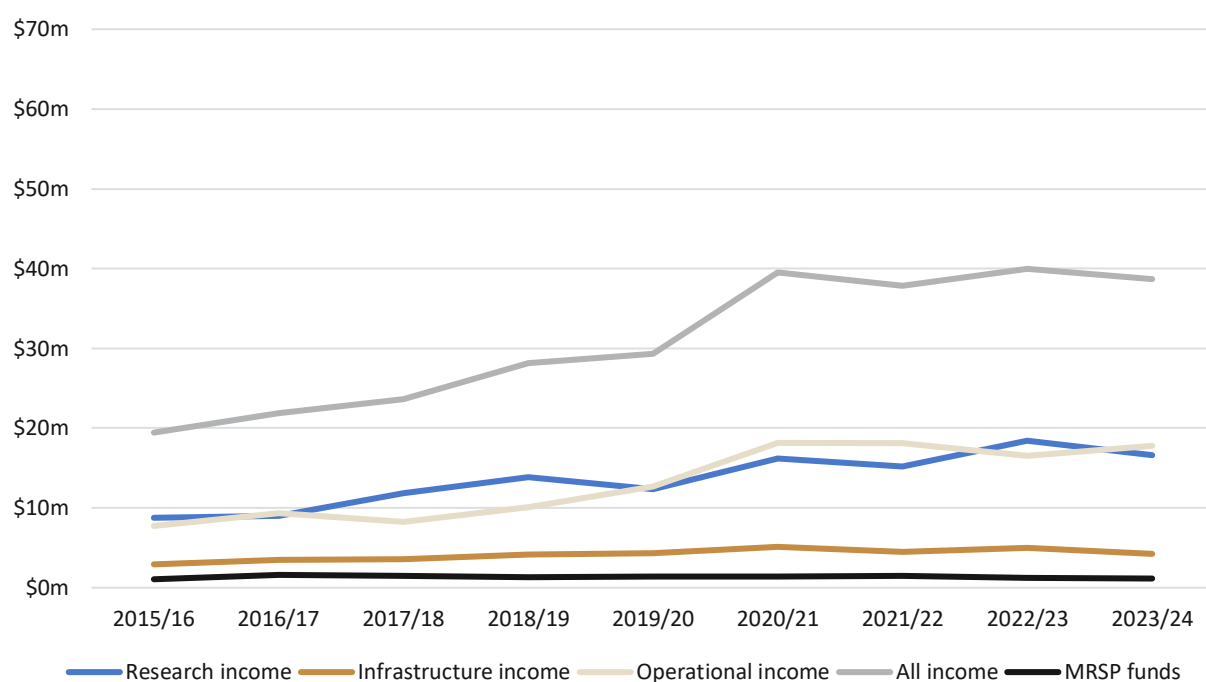
Data source: Annual financial reporting by MRIs to OHMR (as per the requirements for receiving MRSP funding)

Figure A6.2. Mean MRI income for Tier 2 MRIs, by income type



Data source: Annual financial reporting by MRIs to OHMR (as per the requirements for receiving MRSP funding)

Figure A6.1. Mean MRI income for Tier 3 MRIs, by income type



Data source: Annual financial reporting by MRIs to OHMR (as per the requirements for receiving MRSP funding)

Appendix 7. Summary of outcomes used in the economic evaluation, as reported by MRI

The following table shows the results as reported by impact type by MRI over the life of the MRSP (2012–2025) discounted to present value terms and reported in \$2025.

Table A7.1: Impacts as reported by MRIs over life of the MRSP (2012–2025) in present value terms (\$2025, '000s, NPV_{5%})

Costs and benefits		Tier 1				Tier 2				Tier 3				
(\$'000s)	Total	A	B	C	D	E	F	G	H	I	J	K	L	M
Direct MRI benefits (NPV_{5%})														
Grant and other revenue uplift	1,316,036	111,464	181,629	540,207	10,429	0	11,832	0	0	242,009	42,824	0	168,254	7,388
Infrastructure revenue	7,223	5,428	0	0	0	0	0	0	0	1,795	0	0	0	0
Commercialisation revenue	186,006	480	184,521	0	0	0	27	0	0	978	0	0	0	0
Avoided turnover of staff	200,759	8,497	67,233	0	0	0	0	0	0	116,110	8,454	0	0	465
Ecosystem benefits (NPV_{5%})														
Benefits from clinical trials	298,687	270,115	11,836	0	2,389	0	7,998	0	0	5,656	542	0	0	150
Benefits from knowledge spillovers	578	54	87	259	3	0	6	0	0	73	13	0	81	2

Appendix 8. Sensitivity and break-even analysis summary

Sensitivity and break-even analysis: low and high additionality scenarios

While MRIs are able to provide data to inform the revenue they receive, either through grants or commercialisation/infrastructure income, the proportion of these revenues attributable to MRSP funding is based on assumptions provided by MRIs themselves, and is a significant source of uncertainty.

The estimates of this impact provided by MRIs vary substantially; identifying and quantifying what has been additional has been challenging, in part, because previous evaluation rounds have not encouraged MRIs to consider economic impact in this way. The estimates of additionality provided by MRIs vary dramatically between institutes, from 0% (the MRSP has not led to any uplift in activity) to 100% (the MRSP has enabled all revenues received by the MRI or the MRI would cease operations but for the MRSP).

To address this, sensitivity analysis was conducted around this variable to assess how different specifications of additionality lead to different benefits (both in magnitude and sign).

Top-down additionality assumptions are applied to reported financial flows for each MRI. This sensitivity analysis considers four scenarios:

- A lower-than-estimated additionality effect (10%) scenario among MRIs that indicated the MRSP had some impact
- A higher-than-estimated additionality effect (30%) scenario among MRIs that indicated the MRSP had some impact.

This means that it was accepted that if an MRI had said the MRSP had had no impact on outcomes that this was unchanged (0% additionality values were not varied in either case).

Tables A8.1 and A8.2 (below) show the results for these scenarios.

Due to potential under-reporting of impacts in the early rounds of the program, the analysis estimates a negative NPV in the first round of the MRSP (BCR less than one) in the 'lower than estimated effect' scenario, but then turns positive thereafter. This suggests that even if the additionality effect were in the lower bound of estimated impact (10%) for only a subset of the MRIs, the MRSP has still delivered a positive economic benefit to NSW and value for money.

If the effect was higher, then the impact naturally also increases, with the BCR for the program expected to exceed 3.1 before any health impacts are considered.

Given the inherent uncertainty in estimating additionality, it is useful to also consider break-even analysis: what level of impact would have to be realised for the MRSP to have delivered benefits in excess of its cost.

If one considers only an uplift in grant funding, which was the most significant source of benefit, then from a break-even perspective, the MRSP must enabled at least a 6.7% uplift in grant revenue among all MRIs. If this limited only to MRIs who indicated that the MRSP had an impact on outcomes, 8.0% is the break-even hurdle.

When ecosystem-wide benefits are considered, the break-even point for additionality is substantially lower: 1.5% for all MRIs, and 1.8% for MRIs who did not directly indicate that the MRSP has no impact.

This implies that, even under the “low additionality” scenarios considered below, the project is estimated to produce a positive NPV.

Table A8.1: Benefits to MRIs (Lower than estimated additionality scenario (10%) among MRIs that indicated the MRSP had influenced outcomes) (\$2025, '000s, NPV_{5%})

Direct Benefits (\$ '000s)	2012–2016	2016–2020	2020–2024	2024–2028*	Life of MRSP (2012–2025)
MRSP costs (NPV_{5%})					
Total program costs	\$241,668	\$263,350	\$231,663	\$42,831	\$779,513
MRSP benefits (NPV_{5%})					
Grant uplift	\$112,792	\$217,385	\$123,731	\$30,699	\$484,607
Infrastructure revenue	\$2,617	\$2,286	\$1,364	\$957	\$7,223
Commercialisation revenue	\$750	\$289	\$76,417	\$108,550	\$186,006
Avoided turnover of staff	-	\$89,178	\$87,019	\$24,562	\$200,759
Ecosystem benefits (NPV_{5%})					
Benefits from clinical trials	\$7,998	-	\$133,451	\$157,238	\$298,687
Knowledge spillovers	\$129	\$257	\$156	\$36	\$577
Total benefits (NPV_{5%})	\$124,286	\$309,395	\$422,136	\$322,042	\$1,177,859
Net benefits (NPV_{5%})	-\$117,383	\$46,045	\$190,473	\$279,211	\$398,347
BCR	0.5	1.2	1.8	7.5	1.5

Source: Analysis of MRI-reported data. *Partial data to 2025 only.

Table A8.2: Benefits to MRIs (Higher than estimated additionality scenario (30%) among MRIs that indicated the MRSP had influenced outcomes) (\$2025, '000s, NPV_{5%})

Direct Benefits (\$ '000s)	2012–2016	2016–2020	2020–2024	2024–2028*	Life of MRSP (2012–2025)
MRSP costs (NPV_{5%})					
Total program costs	\$241,668	\$263,350	\$231,663	\$42,831	\$779,513
MRSP benefits (NPV_{5%})					
Grant uplift	\$338,376	\$652,156	\$371,192	\$92,097	\$1,453,822
Infrastructure revenue	\$2,617	\$2,286	\$1,364	\$957	\$7,223
Commercialisation revenue	\$750	\$289	\$76,417	\$108,550	\$186,006
Avoided turnover of staff	-	\$89,178	\$87,019	\$24,562	\$200,759
Ecosystem benefits (NPV_{5%})					
Benefits from clinical trials	\$7,998	-	\$133,451	\$157,238	\$298,687
Knowledge spillovers	\$129	\$257	\$156	\$36	\$577
Total benefits (NPV_{5%})	\$349,869	\$744,166	\$669,598	\$383,441	\$2,147,074
Net benefits (NPV_{5%})	\$108,201	\$480,816	\$437,934	\$340,609	\$1,367,561
BCR	1.4	2.8	2.9	9.0	2.8

Source: Analysis of MRI-reported data. *Partial data to 2025 only.

Sensitivity analysis: low and high discount scenarios

Another key point of sensitivity, particularly in the calculation of benefits over time, is the choice of social discount rate used to determine the present value of past transactions. The discount rate is the percentage rate at which financial transactions are appreciated to be comparable to costs and benefits realised now. In this retrospective analysis, a higher discount rate implies a higher relative value for past benefits and costs, as these transactions are compounded at a social discount rate of 5% (consistent with NSW Treasury guidelines).

While the impact on the project's BCR is minimal—the choice of discount rate scales past costs and benefits equally—these sensitivity analyses provide an alternative understanding of the size of past costs and benefits, and the magnitude of the project's NPV. Based on direct benefits, the project's NPV can be assessed at somewhere between \$1.02 billion (3% discount rate) and \$1.23 billion (7% discount rate) (see Tables A8.3 and A8.4, respectively).

Table A8.3: Benefits to MRIs (Low discount scenario – 3%) (\$2025, NPV_{3%})

Direct Benefits (\$ '000s)	2012–2016	2016–2020	2020–2024	2024–2028*	Life of MRSP (2012–2025)
MRSP costs (NPV_{3%})					
Total program costs	\$193,347	\$227,419	\$216,184	\$42,023	\$678,973
MRSP benefits (NPV_{3%})					
Grant uplift	\$245,428	\$496,545	\$326,187	\$82,065	\$1,150,225
Infrastructure revenue	\$2,098	\$1,978	\$1,283	\$941	\$6,299
Commercialisation revenue	\$605	\$250	\$71,823	\$106,501	\$179,178
Avoided turnover of staff	-	\$76,491	\$81,238	\$24,095	\$181,823
Ecosystem benefits (NPV_{5%})					
Benefits from clinical trials	\$6,452	\$0	\$127,251	\$155,544	\$289,246
Knowledge spillovers	\$103	\$222	\$145	\$35	\$505
Total benefits (NPV_{3%})	\$254,685	\$575,486	\$607,926	\$369,180	\$1,807,277
Net benefits (NPV_{3%})	\$61,338	\$348,067	\$391,742	\$327,158	\$1,128,304
BCR	1.3	2.5	2.8	8.8	2.7

Source: Analysis of MRI-reported data. *Partial data to 2025 only.

Table A8.4: Benefits to MRIs (high discount scenario – 7%) (\$2025, NPV_{7%})

Direct Benefits (\$ '000s)	2012–2016	2016–2020	2020–2024	2024–2028*	Life of MRSP (2012–2025)
MRSP costs (NPV_{7%})					
Total program costs	\$300,966	\$304,267	\$248,038	\$43,640	\$896,911
MRSP benefits (NPV_{7%})					
Grant uplift	\$385,590	\$663,497	\$374,113	\$85,252	\$1,508,451
Infrastructure revenue	\$3,251	\$2,638	\$1,449	\$973	\$8,310
Commercialisation revenue	\$926	\$332	\$81,246	\$110,599	\$1,508,451
Avoided turnover of staff	-	\$103,696	\$93,139	\$25,030	\$221,865
Ecosystem benefits (NPV_{5%})					
Benefits from clinical trials	\$9,880	\$0	\$139,849	\$158,933	\$308,662
Knowledge spillovers	\$161	\$296	\$166	\$37	\$661
Total benefits (NPV_{7%})	\$399,808	\$770,459	\$689,961	\$380,824	\$2,241,052
Net benefits (NPV_{7%})	\$98,843	\$466,192	\$441,923	\$337,184	\$1,344,141
BCR	1.3	2.5	2.8	8.7	2.5

Source: Analysis of MRI-reported data. *Partial data to 2025 only.

Table A8.5: BCRs sensitivity analysis

		2012–2016	2016–2020	2020–2024	2024–2028*	Life of the MRSP
Central assumptions						
· MRI reported additionality						
· 5% Discount rate						
	NPV	\$78,069	\$403,311	\$416,224	\$332,171	\$1,229,775
	BCR	1.3	2.5	2.8	8.8	2.6
Additionality sensitivity analysis						
Lower-than-estimated impact: 10% (non-zero MRIs)						
	NPV	-\$117,383	\$46,045	\$190,473	\$279,211	\$398,347
	BCR	0.5	1.2	1.8	7.5	1.5
Higher than estimated impact: 30% (non-zero MRIs)						
	NPV	\$108,201	\$480,816	\$437,934	\$340,609	\$1,367,561
	BCR	1.4	2.8	2.9	9.0	2.8
Discount rate sensitivity analysis						
3%						
	NPV	\$61,338	\$348,067	\$391,742	\$327,158	\$1,128,304
	BCR	1.3	2.5	2.8	8.8	2.7
7%						
	NPV	\$98,843	\$466,192	\$441,923	\$337,184	\$1,344,141
	BCR	1.3	2.5	2.8	8.7	2.5



MH Consulting Group (MHC)
0421 611 431
PO Box 158
Erskineville NSW 2043
www.mhcgroupp.com.au
ABN: 64633637144