Australian Government
National Health and Medical Research Council

NHMRC

2026 Review of NHMRC's Research Translation Centre Initiative

Review Report

Version 1.0

BUILDING
A HEALTHY
AUSTRALIA

Contents

1. Executive Summary

This report presents the findings of the 2025–26 review of NHMRC's Research Translation Centre (RTC) Initiative, which was undertaken to assess its strengths, challenges and opportunities for improvements.

The review draws on a mixed-methods approach, including a desktop analysis of Initiative documentation and performance data, an international environmental scan, and extensive stakeholder consultation comprising surveys, written submissions, and interviews across RTCs, health services, government agencies and international experts.

Overall, the review finds that the RTC Initiative has made a meaningful contribution to strengthening collaboration between health services and research institutions, building research translation capability, and supporting greater involvement of consumers and end-users in research. Stakeholders consistently identified workforce development, partnership formation and co-design approaches as key areas of achievement. There is evidence that these enabling activities are supporting research translation and influencing health service practice in some settings; however, outcomes are variable across Centres.

The review identifies that measurable improvements in health service delivery and patient outcomes are less consistently demonstrated. This reflects both the complexity of attribution within health systems and the relative maturity of the Initiative, as well as limitations in current reporting approaches and data availability. Greater clarity is required on how translation activities are expected to lead to system-level outcomes, and how these outcomes should be measured.

The accreditation model remains broadly fit for purpose as a mechanism to recognise high-performing collaborations and enable partnership development. The review reinforces that accreditation alone is insufficient to drive consistent and scalable impact, noting that system-wide translation was not an objective for the Initiative. Key challenges include a lack of clarity in the definition of research translation, variable alignment with health system priorities, and limitations in governance, reporting, and accountability arrangements. The administrative burden associated with accreditation was also identified as disproportionate to the level of support provided in some cases.

A major structural constraint identified throughout the review is the absence of sustained and predictable funding. Stakeholders consistently highlighted funding and resourcing limitations as the primary barrier to achieving the Initiative's objectives, affecting workforce capacity, partnership sustainability, and the ability to scale translation activities. These challenges are particularly acute for regional-, rural-, and remote-focused Centres.

The review also highlights challenges in engaging health system partners, particularly state and territory health departments, local health networks and primary care. Competing operational priorities, workforce pressures and limited incentives for participation constrain the integration of research into routine care. In addition, the Initiative faces issues of visibility and recognition, with stakeholders indicating that RTCs are not consistently understood or positioned as core health system infrastructure.

International comparisons reinforce the importance of sustained funding, balancing local health system needs with national priorities, having clarity about an initiative's role in the research translation system and being prepared to collaborate with others to achieve translation and scale-up and embedding community leadership to increase the success of translation efforts. No single

model provides a direct template for Australia; however, elements such as base funding combined with targeted competitive funding, mandated collaboration, and patient and community involvement in priority setting offer relevant insights.

Taken together, the findings indicate that the Initiative is achieving its aims in part but requires refinement to support more consistent impact. Key areas for improvement include:

- Clarifying the role and definition of research translation within the Initiative
- Aligning objectives, activities and reporting with health system and national priorities
- Strengthening health service leadership and integration
- Establishing sustainable and fit-for-purpose funding arrangements
- Improving impact measurement and reporting frameworks
- Enhancing coordination, collaboration and equity across Centres, including targeted support for regional, rural and remote contexts

In conclusion, future reforms to the initiative should focus on clarifying the role of RTCs in the research translation ecosystem and strengthening the enabling conditions for research translation rather than fundamentally redesigning the Initiative. In particular, a clearer focus on health service-led translation, supported by funding, system alignment, guidance on governance models and improved accountability, will be critical to ensuring that RTCs are recognised and capable of contributing to the translation of research into practice and delivers measurable benefits for patients and communities.

2. Introduction

2.1 Research Translation Landscape in Australia

Research translation is defined as the process of moving research findings into practical application in real-world settings and making research findings accessible and usable to practitioners, policymakers and the public to inform decision-making and improved health outcomes.[1] This approach situates research translation as a central function of the health and medical research system, focused not only on generating knowledge but on ensuring it leads to tangible improvements in policy, practice and population health.

Australia's health research, translation and impact ecosystem[2] encompasses a wide range of stakeholders including government, research institutes, health services, not-for-profit organisations, consumers and community, industry, business and international organisations. Together, these groups contribute to a complex, interconnected landscape in which research translation occurs through both individual organisations and formal and informal collaborations, supported by enabling strategies, funding programs, workforce education and training and data and digital infrastructure.

Within this ecosystem, the NHMRC Research Translation Strategy identifies key translation pathways and outcomes, including therapeutic products; medical devices and diagnostics; digital health solutions; clinician-delivered and procedural interventions; and public health and health system-level interventions. Research Translation Centres (RTCs) have a significant leadership role in this system. The Initiative positions RTCs as facilitators of collaboration, with a particular focus on embedding research within health services, drawing on and developing enabling infrastructure, and playing a substantial role in shaping policy, practice and guideline improvement.

When engaging with health services, RTCs operate across Commonwealth and state and territory functions of the health system. This includes state and territory health departments (policy and programs), Local Health Networks (LHNs) or districts (the service delivery part of the state and territory health departments, such as hospitals and other health services), and Primary Health Networks (PHNs), which include general practitioners, pharmacies, allied health professionals and aboriginal health services) In some cases, engagement also extends to private sector providers, including private hospitals and aged care services.

This review of the RTCs comes at an opportune time for NHMRC, aligning with the release of the NHMRC Research Translation Strategy 2026–2030 and the National Health and Medical Research Strategy 2026–2036. Both the National Strategy and NHMRC's Research Translation Strategy include actions to strengthen and support the RTC Initiative as one of the mechanisms to drive translation and implementation of research findings into real-world settings.

2.2 The Research Translation Centre Initiative

Since 2014, NHMRC has recognised leading centres of collaboration through the RTC Initiative that excel in the provision of research-based health care and training. Through accreditation, RTCs are

[1] National Health and Medical Research Strategy, p. 99

[2] Health research, translation and impact ecosystem | NHMRC viewed 3 June 2026

recognised for their leadership and excellence in research, translation, collaboration, and the training of health professionals and other end-users in an evidence-based environment.

NHMRC currently supports RTCs through accreditation of up to 5 years. Accreditation follows an application process and assessment by national and international peer reviewers against set criteria. There are currently 12 NHMRC-accredited RTCs across Australia. A further 2 centres, recognised as Emerging RTCs, are considered as having potential to achieve accreditation but needing time to develop. The 14 centres provide near national geographic coverage, with five RTCs having a regional, rural and remote (RRR) health focus (previously known as Centres for Innovation in Regional Health (CIRHs)). The RTCs collaborate nationally under the Australian Health Research Alliance (AHRA), established in 2017. The current list of RTCs, RTC(RRR) and emerging RTCs are shown in Table 1 and Table 2 below.

Table 1. Currently accredited Research Translation Centres

#	State	RTC Name	First Accredited	Last Accredited	Type
1	QLD	Health Translation Queensland (HTQ)	2015	2022	RTC
2	SA	Health Translation SA (HTSA)	2015	2022	RTC
3	NSW	Maridulu Budyari Gumal (SPHERE)	2017	2022	RTC
4	VIC	Melbourne Academic Centre for Health (MACH)	2015	2022	RTC
5	VIC	Monash Partners Academic Health Science Centre (Monash Partners)	2015	2022	RTC
6	NSW	Sydney Health Partners (SHP)	2017	2022	RTC
7	WA	Western Australian Health Translation Network (WAHTN)	2015	2022	RTC
8	NT	Central Australia Academic Health Science Network (CAAHSN)	2017	2022	RTC (RRR)
9	NSW	NSW Regional Health Partners (NSWRHP)	2017	2022	RTC (RRR)
10	NT	Top End Aboriginal Health Research Alliance (TEAHRA)	2022	2022	RTC (RRR)
11	QLD	Tropical Australian Academic Health Centre (TAAHC)	2019	2019	RTC (RRR)

#	State	RTC Name	First Accredited	Last Accredited	Type
12	VIC	Western Alliance Academic Health Science Centre (WAAHSC)	2024	2024	RTC (RRR)

Table 2. Currently Emerging Research Translation Centres

#	State	RTC Name	First Accredited	Last Accredited	Type
1	TAS	Tasmanian Collaboration for Health Improvement (TCHI)	2022	Retains emerging status (2024 review)	RTC (RRR)
2	WA	WA Rural Research and Innovation Alliance (WARRIA)	2022	Retains emerging status (2024 review)	RTC (RRR)

Currently, five of the 12 RTCs and two emerging RTCs are in the RRR category. The current four RTCs (RRR) at the time of the 2021 round were re-accredited and the Western Alliance Academic Health Science Centre in Victoria was accredited as a new RRR-RTC in 2024, after having been designated as an emerging centre in the 2021 round.

2.3 History and previous modifications of the Initiative

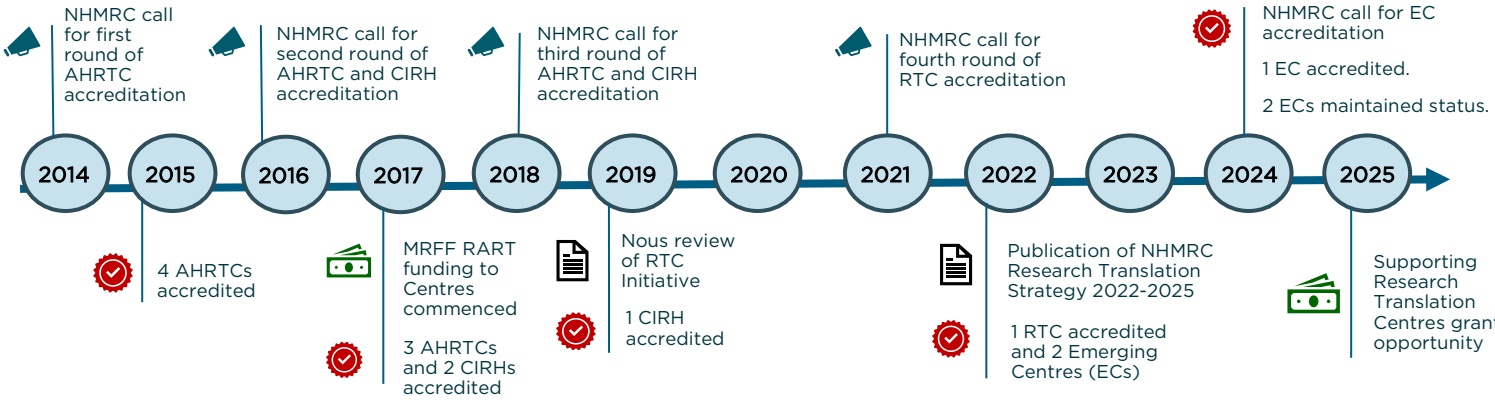
The RTC Initiative was established to support the integration of research and health care by recognising high-performing collaborations that embed research in clinical settings and translate evidence into practice. It draws on international models of Academic Health Science Centres (AHSC), which bring together research, health services and training to bridge the gap between research, clinical care and policy and accelerate improvements in health outcomes and system performance.

In the late 2000s, NHMRC undertook a series of reviews and consultations, including a 2008 international review and a 2010 discussion paper on advanced health research centres. This work aligned with broader system reform through the Strategic Review of Health and Medical Research (the McKeon Review), released in 2013, which recommended establishing Integrated Health Research Centres (IHRC) to embed research in health service delivery and improve translation into practice.

NHMRC established the Initiative in 2014 as a non-funded accreditation scheme to recognise collaborations between universities, research institutes and health services. The first call focused on Advanced Health Research Translation Centres (AHRTCs), with four centres accredited in 2015.

Subsequent accreditation rounds in 2016 and 2018 expanded the Initiative and strengthened its role as a national recognition mechanism. Figure 1 depicts a timeline for the duration of the Initiative showing the rounds and reviews undertaken.

Figure 1. Timeline of the RTC Initiative, 2014-2025



AHRTC: *Advanced Health Research Translation Centres*
MRFF RART*: Medical Research Future Fund Rapid Applied Research Translation Initiative*
CIRH: *Centre for Innovation in Regional Health*

Between 2014 and 2018, the objective evolved in line with successive calls for submissions. Early rounds (2014 and 2016) focused on identifying and recognising leading centres of collaboration. By 2018, the objective shifted towards encouraging leadership and collaboration and promoting the development of innovative and evidence-based models of care. These changes were incremental but reflect a shift in emphasis from recognising existing high-performing centres towards encouraging leadership and the development of research translation activity.

The structure of the Initiative also expanded. The initial 2014 round was limited to AHRTCs; however, applications from regional, rural and remote collaborations highlighted the need for a complementary model. In response, NHMRC introduced the CIRHs in the 2017 accreditation round. CIRHs shared the same overarching objective as AHRTCs but placed greater emphasis on health services research and translation in regional, rural and remote settings.

The accreditation criteria for AHRTCs and CIRHs were largely aligned, with limited differences to reflect context. These differences primarily related to the assessment of research excellence and service context, with CIRHs placing greater emphasis on addressing regional and remote health needs and building local capability.

AHRTCs and CIRHs were subsequently aligned under the broader concept of RTCs. Under the current model, NHMRC recognises two types of RTCs: RTCs and RTCs with a regional, rural and remote (RRR) focus. While the objectives are consistent, the criteria for RTCs with a RRR focus account for differences in scale, geography and capability, including the need to operate across dispersed settings and build research and translation capacity in health services.

In 2019, NHMRC commissioned an external review of the Initiative by the Nous Group to determine whether it could be modified or reformed to strengthen research-based health care and training to

improve the health and wellbeing of patients and communities, and the integration of research into multiple health services. Fourteen recommendations were presented to NHMRC which resulted in implementation of changes to the RTC Initiative in 2021.[3]

Some of the key recommendations implemented from the 2019 review of the initiative included:

- Continue to use an accreditation approach to recognise health translation collaborations.
- Update objective to emphasise improving the health and wellbeing of patients and communities through the translation of research.
- Although the review recommended discontinuation of the separate accreditation schemes (AHRTs and CIRHs), NHMRC continued accrediting two types of RTCs under revised criteria to better reflect the particular challenges and context of regional, rural and remote areas.
- Although national coverage was recommended as an ultimate goal, there were mixed responses from NHMRC's targeted consultations from 2020-21, hence, recognition of excellent collaboration in research and research translation continued to be the main aim of the initiative rather than national coverage. A number of process changes, including the 'Emerging' Centre (EC) status for strong submissions which did not reach all the required characteristics for accreditation, and a one-year provisional extension for centres applying to maintain their accreditation status if they did not meet all of the criteria.

2.4 Funding for RTCs

The RTC Initiative has not received funding through the Medical Research Endowment Account (MREA). Although the McKeon Review proposed a funded model, the Initiative was implemented as a non-funded accreditation scheme, placing emphasis on partnerships, governance and collaborative capacity. Accreditation has also been used to support access to external funding. NHMRC's policy position has been that the initiative would be supported by NHMRC accreditation as a recognition initiative and not a funding initiative. Through accreditation, NHMRC is recognising the value of leadership and excellence in research, translation, collaboration, and the training of health professionals in an evidence-based environment. By recognising these existing excellent collaborations, NHMRC also seeks to encourage the development of other high-quality collaborations across the country.

Some RTCs were able to receive targeted non-competitive funding through the Medical Research Future Fund (MRFF) Rapid Applied Research Translation (RART) scheme, with $10 million awarded between 9 RTCs under RART 2017 and $54.8 million between 9 RTCs under RART 2018. Since 2020, the RART grant opportunity has been managed as an open competitive grant opportunity.

In 2024, NHMRC offered the Collaborations in Health Services Research (CHSR) grant opportunity to support health service-led, collaborative research. While it was anticipated that RTCs would be competitive given their established partnerships, only around 16% of applications to the CHSR GO involved RTCs and evaluation findings showed they were not consistently successful, with only limited funding secured by RTCs or emerging RTCs as leads and mixed involvement as partners.

[3] https://www.nhmrc.gov.au/research-policy/research-translation/research-translation-centre-initiative

In 2025, NHMRC designed the 2025-26 Supporting RTCs grant opportunity scheme to provide bridging financial support to each NHMRC-accredited RTC for a two-year period ahead of the next call for accreditation. The intention of this targeted competitive grant opportunity was to accelerate the objectives of the RTC Initiative by supporting the RTCs to meet their strategic research aims and objectives through NHMRC funding and leveraging contributions from RTC partners, particularly those responsible for the provision of health care.

2.5 Purpose and aims of the Review

The purpose of this review was to examine the strengths and challenges of the current RTC initiative and identify opportunities for future improvements. The following 'Terms of Reference' (ToR) underpinned the review:

1. Assess whether the objective of the RTC Initiative is being achieved. The objective of the 2021 NHMRC RTC initiative was: *to improve the health and wellbeing of patients and communities through the translation of research into health care by:*
    - *promoting health service leadership in research and research translation that addresses priorities directly relevant to health services and the populations the centre serves.*
    - *strengthening collaboration between health services and research institutions.*
    - *delivering training and education and building research and research translation capacity and capability.*
2. Evaluate the appropriateness of the current accreditation model, including requirements, criteria and reporting.
3. Explore how the RTC Initiative could be modified to strengthen research-based health care and training to improve the health and well-being of patients and communities, and integration of research into multiple health services, including identifying whether alternative models, or elements thereof, should be considered.

3. Methodology

NHMRC conducted this review using the following methods:

1. Desktop review: The desktop review utilised existing data from the RTC Initiative (2014–June 2025), which included previous reviews, initiative guidelines and accreditation criteria, RTC success on historical competitive open and targeted grant opportunities, outcomes of previous initiative rounds and accreditation progress reports. This information provided background and context of the initiative and was used to inform the survey questions and interview guide.
2. International environmental scan: An environmental scan was undertaken, reviewing similar international initiatives utilised information available online, such as websites, reviews or evaluations of similar programs and relevant journal articles. It aimed to examine leading international models and identify lessons and opportunities to inform improvements to the RTC Initiative. This information also informed the interview guide.
3. Stakeholder consultations:

- Leadership groups, such as executive boards, and representatives of partner organisations from each RTC. Participants had the option of completing either a survey, written submission or semi-structured interview, either as an individual or a group.
- Interviews with representatives of state and territory government agencies that engage with the Initiative, including some chief health/medical officers, and the Commonwealth Department of Health, Disability and Ageing.
- Interviews with policy owners, organisation leaders and other experts of similar international initiatives and other experts from England, USA and Canada.
- Other stakeholders suggested by our key informants with knowledge of the Initiative.

Data was analysed using a mixed-methods approach, guided by the Terms of Reference and associated lines of enquiry. Qualitative and quantitative data from submissions, interviews, surveys and the desktop review underwent thematic analyses. This involved systematically coding responses/information, grouping codes into key themes, and testing these themes against the lines of enquiry to ensure alignment with the aims of the review.

Survey questions consisted of:

- Categorical ranking questions, where participants were asked to rate options on a 5-point scale. For example, participants ranked the accreditation process sections as either "Serious burden", "Burden", "Neutral", "Works well", or "Works very well".
- Ordinal ranking questions, where participants were asked to rank each option on a numerical scale from 1-10, with 1 being the highest priority and 10 being the lowest priority. Each option was then averaged across the respondents to determine the rankings.
- Open-ended questions which asked for text responses. These were also added to allow participants to further explain their quantitative survey responses to the above questions.

4. Outcomes of the Review

A total of 32 surveys and written submissions from key RTC stakeholder groups were received and 35 interviews were completed during the review, including:

- RTC representatives such as centre executives, health services executives and staff, academics, clinicians / medical staff and other stakeholders with knowledge about the initiative (12 interviews consisting of one-on-one meetings and group meetings). At least one response from each of the 12 accredited RTCs and 2 emerging RTCs were received.
- State and Australian government representatives, including State/Territory chief health officers (11 interviews).[4]
- Representatives of similar international initiatives (both the organisations and policy owners) and other experts from UK, USA and Canada (12 interviews).

[4] Representatives from the Tasmanian Collaboration for Health Improvement (Emerging RTC) also participated in the interview with the Tasmanian government representative (not counted in RTC number)

The review considered the aim, objective, scope and structure of the initiative and the outcomes are reported below under each of the Terms of Reference and having regard to the key lines of enquiry.

4.1 ToR 1: Assess whether the objective of the RTC Initiative is being achieved

Key lines of enquiry for ToR 1:

- Does the initiative objective reflect its overarching intent?
- What has the initiative delivered?
- What factors have facilitated or limited the achievement of intended outcomes?
- Did the initiative have any unintended consequences (positive/negative)?
- Does the current accreditation model support the Australian health system?

Alignment between the Initiative objective and the overall intent of the initiative

This component of the evaluation, mainly informed by the desktop review, highlighted that the RTC objective needs to be clearer. The desktop analysis found that the current objective broadly aligns with the overarching intentions of the initiative but does not fully capture its scope. The initiative intention is to 'encourage excellent health research and translation through collaboration between researchers, healthcare providers, and education and training to improve health and wellbeing for the populations they serve. However, the objective is primarily framed around enabling conditions, such as leadership, collaboration and capability building, rather than clearly articulating the outcomes expected from these enablers. There is limited clarity on how research translation should influence practice within health services, including integration into routine care and improvements in service delivery or patient outcomes for the populations served. This may contribute to variation in focus and achievements across RTCs and limits consistent assessment of performance. The objective also does not explicitly reflect the population focus, with limited reference to equity, inclusion and responsiveness to priority populations. Overall, the initiative objective would benefit from providing greater clarity on how enabling activities translate into measurable improvements in practice and outcomes at the service and community level.

Recommendation 1:

That NHMRC revise the RTC Initiative objective to provide greater clarity about the role of RTCs in the research translation ecosystem and NHMRC's expectation of RTCs on enablers and outcomes of research translation. The revised objective should ensure RTCs focus on the translation of existing evidence into practice over generation of new research, and define expectations, for example the integration of research into routine practice within participating health services, measurable improvements in service provision, and responsiveness to priority populations.

RTC achievements since accreditation

Overall, the Initiative has been most effective in supporting enabling activities such as encouraging or creating new collaborations, enhancing workforce capability and strengthening consumer and community involvement. There is evidence that these activities are contributing to research translation into health services, and changes in practice and service delivery in some settings, although this is not consistent across all centres. Evidence of measurable improvements in patient outcomes within the populations served remains limited. This reflects both the relative maturity of the Initiative, the time required for translated research to result in measurable improvements in patient outcomes, and the broader complexity of translating research into sustained local health service and community health impacts.

RTC reports on the outcomes achieved against the objective were mixed, with the majority of centres demonstrating success in research translation enabling activities rather than health outcomes. Findings from an assessment of RTC mid-accreditation reports, stakeholder interviews, survey responses and written submissions consistently show that the Initiative has delivered meaningful outcomes in capability building and collaboration. The major achievements reported by stakeholders through the survey are discussed below with supporting evidence from the interviews and desktop review.

Capability uplift through training/educating clinicians in research and translation methods

Stakeholders consistently highlighted training, education programs and clinician-researcher development as a clear strength of the Initiative. A majority of respondents reported a moderate to significant improvement in capability uplift through training and education. Qualitative responses reinforce this as a consistent strength, describing structured programs such as fellowships, mentoring, research education, and training for clinicians and the wider workforce to build research literacy and translation skills. Several respondents linked improvements to education initiatives embedded in health services (for example, protected time fellowships and health-service–embedded training approaches). RTC mid-term reports support this finding with all Centres reporting focussed training/education programs for clinician researchers.

End-user involvement in health and medical research

Almost all survey respondents reported moderate to significant improvement in end-user involvement. Stakeholders highlighted increasing RTC focus on consumer and end-user engagement with AHRA wide RTC involvement in establishing support materials for researchers, clinicians and their institutions. Stakeholders describe stronger consumer involvement and co-design activity in some Centres, including formal consumer advisory structures and training to lift consumer engagement capability. Respondents also noted variation in maturity and resourcing, with ongoing challenges in sustaining co-design when staff time and enabling support are limited.

Research translation that addresses health service and population priorities

Eighty-four per cent of survey respondents reported moderate or significant improvement in research translation that addresses health service and community needs. Respondents commonly described progress where Centres have introduced clearer priority-setting processes with health services, and where translation activity is co-designed with service leaders and aligned to operational needs. Several responses emphasised that progress depends on health service engagement and clarity about "who does it and who pays", and that priorities can be identified but are harder to progress without sustained commitment inside health services.

Health service leadership in research and research translation

The proportion of respondents that reported moderate to significant improvements in health service leadership was comparatively lower than for other areas of achievements, with 19% reporting 'no change.' Some respondents reported strong executive engagement and governance structures that enable priorities to be set and actioned, while others described limited or inconsistent engagement from local health network leadership and the challenge of maintaining health service involvement amid operational pressures. Several responses noted that where leadership is strong it supports faster decisions and clearer alignment, but where it is weak the Centre risks being perceived as part of the academic ecosystem rather than health service infrastructure.

Collaboration between health services and research institutions

Just over 74% of respondents had moderate to significant improvements in collaboration between health services and research institutions; 16% reporting no change. Respondents frequently described collaboration gains through cross-partner initiatives, including education and workforce development programs delivered jointly with government or health services. Some responses highlighted that collaboration is supported by forums, networks and 'brokering' functions that connect people and projects. Others noted persistent barriers where silos remain entrenched or where health service partners have limited capacity to engage, contributing to uneven collaboration across partners and jurisdictions.

Improvements in health service delivery

There was a mixed response by survey respondents to the health system delivery improvements. Of note, 16% did not respond to the question and 19% reported 'no change' and just over 52% reported moderate improvement. Qualitative responses suggest that improvements are more likely where Centres are well integrated with health services and where translation activity is explicitly aligned to service priorities (for example, co-designed projects, implementation support, and embedded translation roles). However, respondents also describe constraints that limit the

ability to consistently translate improvements across partners, including workforce pressure, competing operational priorities, and inconsistent engagement across health services.

Patient outcomes

Of all the achievements, the lowest proportion, 6%, of respondents reported significant improvement in patient outcomes and 19% reported 'no change.' Nineteen percent did not respond to the question. Qualitative comments reinforce that respondents often find it difficult to speak to patient outcomes at a Centre-wide level, and several explicitly note the absence of a clear basis for attributing patient outcomes to RTC activity. Respondents more commonly described awareness of positive impacts from individual projects, rather than being able to point to measurable, attributable patient outcomes for the Centre as a whole. Interviews with stakeholders highlighted measuring the impact of RTC activities on patient outcomes remains challenging. While stakeholders acknowledge the importance of measuring health outcomes, and it being a key aim of the Initiative, these outcomes reflect broader health system performance and are influenced by many factors beyond the control of individual Centres. Some stakeholders suggested responsibility for measuring these outcomes sits with the health system, with RTCs contributing through collaboration, capability building and research translation activities.

Despite overall positivity around achievements, progress varied across Centres and outcome measures. Stakeholders expressed that performance is shaped by local context, funding stability, leadership engagement and the maturity and strength of relationships between health services and research partners.

Analysis of stakeholder feedback identified several factors that support the achievement of outcomes. Centres reporting more advanced progress were typically characterised by active and sustained involvement of health service leadership, particularly where executives participated in setting priorities and supporting implementation. Stakeholders also highlighted the importance of a clear and shared purpose across partners, with strong alignment between organisational priorities enabling more effective collaboration and translation activity. Access to funding or other forms of resourcing was consistently identified as critical, enabling Centres to support coordination, undertake activities, and monitor and report on outcomes. Governance arrangements were also influential, with effective models providing clear accountability and decision-making while remaining adaptable to changing circumstances. In addition, stakeholders emphasised the value of strong consumer and community involvement, including Aboriginal and Torres Strait Islander leadership, where relevant, in improving the relevance and uptake of research.

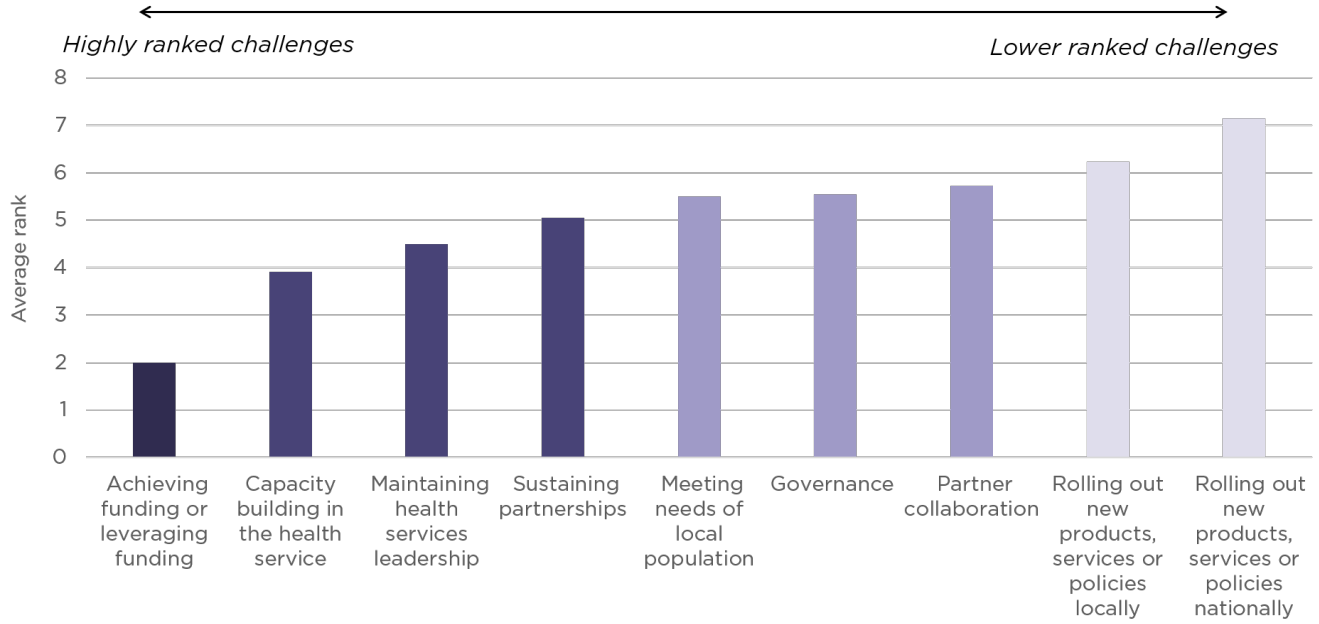
The findings indicate that while the RTC Initiative is contributing to improved health and wellbeing for patients and populations, particularly through Centres with sustained accreditation and mature programs, the level and impact varies considerably across RTCs. RTC impact case studies are published on the NHMRC website.[5] While some Centres have clearly demonstrated system-level impact, others are building capacity and infrastructure with promising initiatives yet to show measurable long-term outcomes. National collaboration through AHRA has further advanced equity, consumer involvement, and investment in translational research, supporting the Initiative's overarching goal.

[5] Impact and outcomes of Research Translation Centres | NHMRC, viewed 11 May 2026.

Barriers to achieving Initiative objective

RTCs and other stakeholder groups identified several barriers limiting the ability to achieve the Initiative's objective. Survey responses indicated that the top ranked challenge for RTCs is 'Achieving funding or leveraging funding' followed by 'Capacity building in the health service' and 'Maintaining health services leadership.' Challenges related to 'Rolling out new products, services or policies locally and nationally', were consistently ranked as less challenging than foundational enablers, indicating that Centres see capability, resourcing, governance and partner engagement as the more immediate determinants of progress.

Figure 2. Survey rankings for challenges faced by RTCs (lower values indicate higher perceived challenge).



Funding and resourcing

Consistent with the 2019 Review of the RTC Initiative,[6] this review has found that lack of funding available for RTCs is a key structural barrier to success. Consultations found that without funding support, RTCs are reliant on membership contributions, funding from other collaborators and success from competitive grant opportunities, to ensure sustainability of the Centres.

The funding and resourcing challenges also limit the involvement and impact of RRR centres, which operate with lean core teams, limiting coordination, planning, and delivery. Higher costs associated with geographic dispersion, travel, workforce shortages, and service readiness are not adequately accounted for in current funding settings. RRR centres face difficulty sustaining staff, embedding translation roles, and maintaining momentum without recurrent funding. Several interviewees noted that RRR-RTCs are forced to prioritise survival and basic coordination, rather than driving translation at scale. There were repeated calls for differentiated funding, weighted expectations, and base operational support to enable RRR-RTCs to fulfil their role.

According to stakeholders, the lack of funding has the following consequences:

[6] 2019 Review of the NHMRC Research Translation Centres Initiative (Nous Review) p.26

- RTC work is often undertaken as unpaid or in-kind effort through committees and working groups, which means it can be difficult to sustain when their 'day jobs' take priority.
- Uncertain and fragmented funding undermines continuity, quality and strategic planning.
- Difficulty sustaining core staffing and activities, slowing progress and limiting scale.
- Reliance on university partners to maintain the organisation can result in their having too much influence.
- Without funding, accreditation risks feeling symbolic, as centres struggle to meet expectations without the resources to deliver impact.

"Even relatively modest levels of core funding would dramatically increase capacity for coordination, workforce development, and sustaining translational programs over time." – RTC Leadership

Stakeholders reported that NHMRC's Supporting Research Translation Centres grant funding has been used for coordination roles across partners, joint initiatives and building translation workforce capacity, especially in implementation science and value-based care. Through the interviews with leads of international initiatives, there have also been some concerns raised about the potential negative impact of having core funding for the RTCs' entrepreneurship and that it may be used to replace partner contributions or the search for grants and other sources of funding.

Leveraging Funding

Accreditation of RTCs was intended to provide support to RTCs to leverage funding through other sources. RTCs have said that accreditation has assisted them to obtain funding through providing a 'stamp of approval'. However, the Centres have had mixed success in obtaining competitive grants and have indicated that this issue is not limited to MREA and MRFF grant opportunities. RTCs have attributed this to structural and governance constraints within the RTC model, including challenges in applying through administering institutions. For example, the administering institution may not prioritise the application led by the RTC and there might be misalignment between collaborative intent and funding arrangements, suggesting that while RTCs provide an important platform for collaboration, they are not yet consistently able to translate this into success in competitive grant opportunities. However, there is limited data to determine the extent of the problem because it is not possible to determine what MREA or MRFF grants RTCs have applied for, given that they must be submitted by administering institutions and applications do not necessarily indicate a link to RTCs (unless that is a specific requirement in the grant opportunity). Having this data in future would assist in developing appropriate responses.

Recommendation 2:

NHMRC to consider:

- competitive funding opportunities linked with accreditation that clearly outline achievements expected from the RTCs.
- other competitive funding opportunities in line with the priorities, actions and targets of NHMRC's Research Translation Strategy 2026-2030 and the National Strategy for Health and Medical Research 2026-2036.

Recommendation 3:

NHMRC to capture data through MREA and MRFF grant applications that indicate if the application is linked to an existing RTC.

Difficulties with building and sustaining research and translation capacity

Building and sustaining research and translation capability within health services and health services leadership was raised as a concern, largely linked to lack of funding and barriers to health service involvement. Interviews indicated RTCs face difficulties in sustaining partnerships and building effective relationships with state and territory government health departments and with health services. Some state and territory governments shared similar concerns such as RTCs needing a better understanding of, and responding to, health system priorities, and undertaking research translation activities that are relevant to the health services and have a high likelihood of being implemented.

Stakeholders reported that resource constraints, such as lack of funding, can limit the ability to build, maintain and sustain partnerships, support coordination, and deliver translation activity. Reliance on short-term or partner-based funding limits the ability to maintain core staff, deliver training and support long-term translation activity. These pressures are compounded by the fact that research and translation are often not core priorities for health services.

Other barriers include siloed working relationships, unclear value propositions, inconsistent engagement and trust across partners, complex governance arrangements, the absence of defined KPIs to support transparency, accountability and strategic alignment and misalignment between academic and health service priorities. Other issues constraining the development and retention of translation capability were limited protected research time, workforce shortages, and high staff turnover, particularly in regional, rural and remote settings.

"There remains entrenched silos between research, education, and clinical practice across the state, and whilst we are seeing a shift from competition to collaboration, the structures, particularly funding sources, continue to hamper progress." – State Government

Difficulties in engaging and sustaining partnerships

Consultation findings indicate that structural, financial, and cultural barriers continue to limit equitable participation and sustained engagement in RTC collaborations, including research organisations, health services and community-based partners. Several metropolitan RTCs require significant financial contributions by partners in order to participate in the collaboration. This type of structure can lead to inequities whereby only larger, heavily funded organisations such as tertiary academic institutions and major metropolitan hospitals can have meaningful roles within RTCs. This can exclude financially constrained, albeit important partners in research translation such as primary care clinics and other community-based organisations.

Despite the RTC accreditation being a non-funded Initiative, respondents reported that many partners expect clear, tangible benefits, often in the form of funding, before committing to collaboration. RTCs reported that important partners, such as major research organisations, have withdrawn when the value proposition was unclear or when funding was not forthcoming. Many RTCs felt that it has been challenging to sustain partnerships based on goodwill and trust of future returns alone. They stated partners may feel reluctant to collaborate due to past experiences that may have led them to be cautious, seeking guarantees before investing time or resources. Additionally, funding constraints mean that even enthusiastic partners may be unable to participate without support.

Stakeholders reported a lack of awareness and understanding of the function and benefits of RTCs has been a barrier to forming and maintaining partnerships, particularly those outside of the academic sector where they may have not heard of NHMRC accredited RTCs. RTCs continue to lack visibility or be seen to have a clearly defined role in the health system. This finding is supported by the 2019 Nous review that noted very few people within the health service are aware that the centres even exist, and that meaningful collaboration was not happening.[6]

A key objective of the current Initiative is to form strong collaborations between health services (including relevant government departments) and research institutions; however stakeholders have identified a range of barriers to achieving this (discussed further below). Some are structural issues that affect all types of relationships whereas others are related to specific relationships. The consultation highlighted competing operational demands, workforce pressures and lack of protected research time significantly limit health service participation in research translation. Administrative barriers and unclear accountability further restrict engagement from clinicians and executive level staff at hospitals and health services.

Recommendation 4:

NHMRC should encourage RTCs to engage a broad range of health service partners, including smaller and financially constrained health services, to support equitable participation in research translation activities.

Recommendation 5:

NHMRC to promote RTC activities and impact through publication of case studies, social media and Speaking of Science webinars and work with AHRA to communicate the role and value of RTCs.

State Health Departments

The consultation showed that some centres reported strong and established relationships, particularly those in large metropolitan regions, while others experience limited engagement or misalignment, resulting in uneven effectiveness across the Initiative.

Some RTCs considered state and territory health departments to often be only passively engaged with RTCs, leaving a gap between policy intent and practical support for research translation. State and territory bureaucracies were seen as difficult to navigate and to build relationships, especially with staff turnover requiring a continuing need to re-engage and explain the role of RTCs.

Representatives from state and territory health departments expressed that the Initiative is currently focused too heavily on academia and needs a stronger focus on research translation while being agile about the needs of the health system. They also noted the current fragmentation and called for structured, consistent partnership models between the RTCs and state government. Very few current state and territory health and medical research strategies refer to RTCs, although to varying degrees, they align with the aim and objective of the Initiative in integrating research into health services and fostering collaboration.

RTCs are currently not required to secure funding or formal partnerships with state or territory governments as part of accreditation and must only provide a letter of support. This likely contributes to the variation in the level of engagement and support across jurisdictions.

There was some support amongst RTCs for accreditation criteria to include a formal requirement for state and territory partnerships and/or funding. While there may be benefits in requiring a more substantive and formal commitment from state and territory departments, other RTCs suggest that state and territory governments will make a commitment where they see the benefit and value proposition. State governments had varied views on the need to formalise their involvement in RTCs; some sought to be included on boards, whereas others thought this as unnecessary and possibly detrimental to the RTCs' independence.

Despite the lack of formal collaboration requirements, there has been successful engagement between RTCs and state health departments. The engagement between Monash Partners, MACH and WAAHSC with the Victorian Department of Jobs, Skills, Industry and Regions (DJSIR) and Safer Care Victoria (SCV) through the Victorian Research Translation Centres Collaborative is an example of a strong partnership without the need for any formal arrangements. The regular formal and informal engagement at different levels ensures a shared understanding of priorities and plans between government and the RTCs. Future changes to accreditation could consider whether requiring formal partnerships or funding commitments may lead to stronger more consistent engagement.

Recommendation 6:

NHMRC to introduce an assessment criterion that:

a) requires applicants to demonstrate reciprocal planning between RTCs and state and territory governments that outlines processes for priority setting and working together to achieve outcomes.

As part of (a), demonstrate that they have consulted with the relevant state or territory departments to identify jurisdictional priorities that the RTC should factor into their plans.

Recommendation 7:

NHMRC to seek information on partnerships with state and territory governments as part of the RTC reporting requirements.

Local Health Networks

RTCs have reported inconsistent engagement with LHNs, despite having outlined a range of structures and processes that support LHN involvement in planning and participation in many successful projects. Most RTCs have struggled to involve local health leadership in research translation activities. LHNs were perceived to be focusing on immediate service delivery pressures as a priority, with little time to focus on research translation due to operational pressures.

"We have found it difficult to engage local health network leadership in the centre. Without this engagement, the purpose of the centre is not being met - translation of research and strengthening of health services." – RTC Partner

There can also be a lack of alignment with organisational priorities and funding cycles, making long term funding of activities by LHNs difficult. Thus, the consultations highlighted the need for greater effort by RTCs or support through the Initiative to engage LHN interest and participation, especially from regional, rural and remote partners, which often means the need for additional resources.

Recommendation 8:

NHMRC should highly encourage LHN participation as a minimum governance requirement (e.g., designated LHN executive seat(s), rural partner representation where relevant).

Primary Health

Given the important role of primary care in the health system, there was widespread recognition that RTCs need to engage with the primary health care sector for effective health research translation. However, RTCs indicated that they struggled to engage with primary health due to:

- Having difficulty identifying clinicians and other service providers that are willing to engage

- Payment systems which focus on remunerating for service provision by appointment time, which means making time available for research translation is not feasible.

Stakeholders indicated that there are a number of avenues to assist RTCs to engage with primary care, such as through:

- Schools of general practice, rural health or similar in universities where the academics often have dual roles as both researchers and clinicians.
- Primary Health Care Networks – there are 31 PHNs across Australia with the key goals of improving the efficiency and effectiveness of health services and improving the coordination of health services.[7]
- Practice-based research networks – there are 16 PBRNs listed by the RACGP, which are networks of primary care practitioners that collaborate to identify and explore research questions relevant to their work and the community they serve, with the aim of creating new knowledge that can be translated into practice.[8]

Recommendation 9:

NHMRC should require RTCs to outline plans for engaging with primary health care to both identify suitable projects and to participate in them.

Recommendation 10:

NHMRC should work with AHRA to develop information material to provide guidance to RTCs on engaging with primary care, including how to overcome structural barriers.

Unintended consequences of the RTC Initiative

Stakeholder consultations and the desktop review identified some positive unintended consequences of the initiative. Collaboration across RTCs through AHRA and VTRCC was reported as a positive secondary benefit which should be encouraged and built on to strengthen the RTC initiative and the research translation ecosystem more broadly. The establishment of AHRA and the AHRA RRR sub-committee was the most widely viewed positive unintended consequence., It is an advocate for the RTCs, a platform that provides support and to share learnings across RTCs.

Despite geographical coverage not being an explicit aim of the Initiative, the network of accredited and emerging RTCs now provides near-national coverage across Australia spanning metropolitan, regional, rural and remote settings.

[7] Primary Health Networks | Australian Government Department of Health, Disability and Ageing viewed 3 June 2026

[8] RACGP - Practice-Based Research Networks (PBRNs) viewed 3 June 2026

Recommendation 11:

NHMRC should seek to encourage cross-RTC collaborations, whether on the basis of jurisdiction or other shared interests to assist planning, pool knowledge and experience, and avoid duplication.

Recommendation 12:

NHMRC should continue to work closely with AHRA that will support the objectives of the RTC Initiative.

4.2 ToR 2: Evaluate the appropriateness of the current accreditation model, including requirements, criteria and reporting.

ToR lines of enquiry:

- What benefits do the RTCs receive from accreditation?
- Does the scope and structure of the accreditation model effectively support the RTC initiative's objective?
- Do the reporting arrangements allow for effective assessment of the outcomes?
- What inequities exist within the current RC accreditation model?

Benefits of accreditation

Participants were asked whether the accreditation model provided additional benefits to their collaborations. On average, responses showed that the accreditation's highest ranked benefit was 'Attracted, retained and strengthened partnerships and collaboration' followed by 'Leveraged funding.'

A second set of benefits reported by stakeholders related to RTC visibility and positioning. Respondents saw accreditation as a mechanism for creating awareness of the RTCs and their aims and objectives, indicating accreditation is perceived to improve recognition and understanding of the centre's role. The influence of accreditation on jurisdictional support was rated slightly lower, suggesting this benefit is more context-dependent and not consistently experienced across centres and jurisdictions.

Benefits that depend on broader system conditions or take longer to show results were ranked lower. This included the impact of the Initiative on improving RTC capacity and capability through attracting talent, influencing and increasing consumer involvement and fast-tracking outcomes. Taken together, the pattern suggests respondents primarily experience accreditation as a

mechanism that reinforces relationships, cohesion and visibility, with less consistent perceived impact on workforce attraction, consumer involvement, or accelerated outcomes.

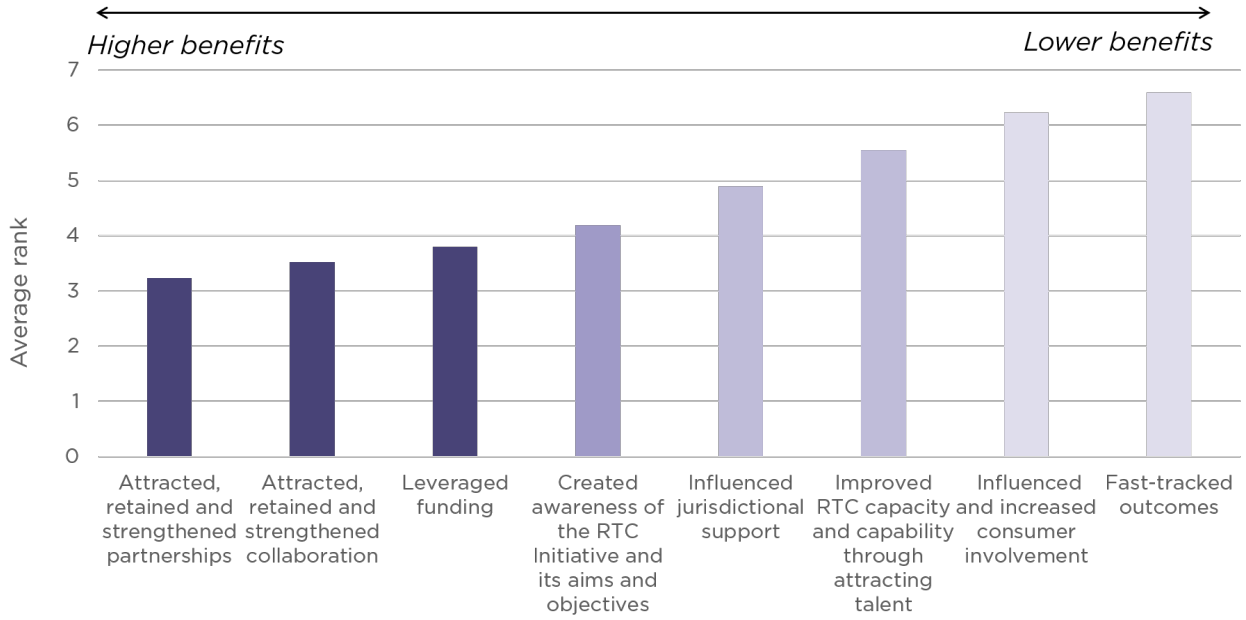
Improving capability and capacity and strengthening consumer and community involvement were identified as key benefits by some respondents. Respondents commonly described accreditation as providing credibility, legitimacy and a shared identity, which helps to maintain partner engagement and supports collaboration across institutions. Several noted that accreditation enables more structured, coordinated approaches to research translation, including clearer alignment of priorities and more deliberate partnership activity. There were also examples where accreditation supported workforce development, including attracting trainees or embedding research-translation roles within health services, and where it contributed to strengthened engagement with government or the broader health system.

"NHMRC accreditation gives a strong stamp of approval, increasing credibility and visibility, attracts partnerships and boosts competitiveness for grants, strengthens consumer & community involvement." – RTC Leadership

"Accreditation provides legitimacy and a clear identity, increases collaboration across RRR partners, improves capability and capacity, enhances ability to attract grants and helps shift culture so research is seen as core business."- RTC Leadership

However, respondents also highlighted that the value of accreditation is conditional and uneven. A recurring theme was that accreditation is most impactful when linked to funding or tangible support, with several respondents stating that benefits such as partnership retention and collaboration were strengthened when accreditation signalled access to resources or future investment. In contrast, where accreditation was perceived primarily as a "badge of status", some respondents questioned its practical value. These findings suggest that while accreditation plays a critical role in enabling collaboration and system visibility, its effectiveness is shaped by how it is implemented and supported within the broader funding and policy environment

Figure 3. Survey rankings for perceived benefits of accreditation (lower values indicate stronger perceived benefit).



Scope and structure of the accreditation Model

'Research Translation' remains insufficiently defined within the RTC initiative

Survey respondents consistently reported a lack of clarity around what constitutes research translation for the RTC initiative. Translation is interpreted differently across partners and jurisdictions, leading to inconsistent expectations, reporting and assessment. This ambiguity makes it difficult to evaluate success or compare performance.

"Different partners interpret translation differently, which creates inconsistency in expectations and reporting." – RTC Leadership

"The absence of a shared, operational definition of translation makes it difficult to assess success or compare performance across RTCs." – RTC Leadership

Re-accreditation submissions show inconsistent, and unclear descriptions of translation activities and the lack of shared definitions contributes to fragmentation across governance and pipelines.

Research Translation is not defined in the documentation for the RTC Initiative. As outlined under ToR 1, the objective is focussed on the enablers for translation, rather than clearly stating the expectations around research translation itself. While the RTCs have a role in the research translation ecosystem, the stakeholder consultations showed that the role needs to be clarified in the initiative's documentation to provide clear expectations for the RTCs.

Weak alignment with health service-led priority-setting and leadership

Currently, RTCs are not explicitly required to align their work programs with health service priorities. Additionally, there is no requirement for health services leadership in the governance of RTCs. This can feed into the issue of RTC priority-setting being primarily academic-driven rather than seeking to address health service priorities. The review found that the focus on health service priorities could be more clearly defined both in the Initiative's objectives and accreditation criteria.

State health department respondents expressed that RTCs should better serve the health system, shifting from an academic focus to health service-driven research, through more collaborative priority setting to achieve better alignment with jurisdictional priorities.

Distinction of RTCs in RRR settings has been successful and should be continued

There is strong support amongst stakeholders for the separate types of accreditation that distinguishes metropolitan-based RTCs and RRR-based RTCs. There was a recognition that RTCs in RRR regions faced more challenges in terms of geographical spread, workforce pressures, funding, and longer time frames required for activities compared to RTCs in metropolitan areas. RRR-RTCs were more likely to have an Aboriginal and Torres Strait Islander health focus, therefore, cultural and community engagement considerations can also take longer times to establish.

The consultations supported the above sentiment and stakeholders expressed that the accreditation process should be equitable, accounting for different health systems across Australia. Emerging RRR-RTC survey respondents stated that higher costs associated with geographical spread, travel and workforce limitations are not adequately reflected and balanced in

the current assessment criteria. As a result, RRR-RTCs face greater challenges in meeting accreditation requirements despite an imbalance in effort.

"The resources required to deliver NHMRC RTC goals are much higher in RTC RRRs than metropolitan RTCs. For example, travel is critical for RTC RRRs." – RTC Partner

"Funding inequities arise because accreditation expectations do not adequately account for the additional costs associated with geography and remoteness." – RTC Partner

The consultations show that the expectations RRR-RTCs to meet the same standard of 'research excellence' as metropolitan centres can create challenges. Current accreditation criteria assume a uniform model of partnerships, funding structures, and research translation approaches, which disadvantages RTCs in smaller jurisdictions or non-metropolitan areas where there are fewer partners, funding sources and research infrastructure.

Emerging RTC and RRR-RTC respondents felt that while the current distinction is good, the accreditation process and types of RTCs should be further revised to explicitly reflect the diversity of health systems across Australia. This could include differentiated expectations with more emphasis on capacity-building rather than health system outputs.

While maintaining accreditation standards, it is important that the accreditation criteria are focused in identifying the type of collaborations that will bring benefit to their communities and do not impose requirements which are unrealistic to the circumstances.

Recommendation 13:

NHMRC should maintain the two streams in the RTC Initiative and consider whether further distinctions in assessment and reporting would be appropriate to support equity and enable the RRR RTCs to become more sustainable and continue to deliver improvements to health services that are relevant to the communities.

The Emerging RTC Status should be better supported

In 2022, for the first time, NHMRC recognised three "Emerging RTCs." These were collaborations that did not meet the accreditation criteria but were considered to have the potential to do so. The emerging status was introduced as an outcome of the Nous review.

During our consultations, representatives from emerging RTCs reported that there are no clear or tangible benefits to being designated as an emerging RTC. They highlighted limited guidance provided by assessors, with little clarity on how applications could be improved in future rounds.

Stakeholders noted that Emerging RTCs were not eligible for funding support under the 2025-26 Supporting Research Translation Centres grant opportunity, nor has there been other assistance such as mentoring or an iterative process of feedback and review for these Centres. Stakeholders expressed this may impact success of these centres to reach full accreditation in subsequent rounds.

Recommendation 14:

If 'Emerging Centre' status is retained within the Initiative, it should be accompanied by strengthened support and clarity, such as providing more detailed, actionable feedback from assessor (including examples) and NHMRC, in collaboration with AHRA, should provide support to address identified gaps during the accreditation period to be able to be prepared for the next round.

Mixed opinions on whether the Initiative should aim for geographical coverage

Following the recommendations of the previous evaluation, the *initiative does not currently aim for total geographic coverage of Australia. While 14 centres now span metro and regional areas, this coverage emerged organically and is not strategically enforced.*

Interviews showed that stakeholders felt this *"flexible scope may leave gaps in underserved regions if not proactively addressed, however others felt that research excellence may be compromised if national coverage is set as a requirement of the Initiative. As the RTCs have naturally spread out over Australia, enforcing national coverage is unlikely to be an issue going forward as long as there is encouragement for collaboration between regions with similar local needs and between RRR and metro-based centres."*

Some RTCs are establishing links to organisations in areas not currently covered by RTCs, for example the Building Research and Quality Project, an initiative of the three Victorian RTCs, is being implemented statewide and some stakeholders raised the value of a hub and spoke model to reach smaller services

Further guidance and direction regarding governance arrangements should be provided while retaining some level of flexibility

The current accreditation requirements do not impose specific governance requirements on RTCs, allowing flexibility in how governance arrangements are designed and implemented.

RTCs report a wide range of governance structures, reflecting differences in local context, membership composition, and historical partnership arrangements. While almost all centres describe their governance as collaborative with shared decision-making, typically involving researchers, clinicians, health services, universities, consumers, and other partners, several respondents noted that this "equal say" model may function differently in practice. In the survey responses, governance ranked as one of the lowest perceived challenges experienced by RTCs.

Although the shared-governance model is generally viewed positively, respondents highlighted challenges related to role clarity, accountability, and the practical realities of coordinating diverse partners with different incentives and organisational priorities.

Out of 27 survey responses 20 (74%) answered 'yes' to all partners having influence on resource allocation. However, qualitative comments indicate that "influence" is often exercised through representation on boards or councils and that actual influence has sometimes varied due to board

structures or operating arrangements, with a respondent commenting "not sure if the consensus model is helping." A smaller group of respondents 7 (26%) reported that not all partners have influence, citing factors such as tiered funding arrangements, administering institution control over key financial processes, and limited discretionary resources.

Responses which report equal decision-making between stakeholder groups may not always match real-world influence, particularly where one partner (often the largest funder or employing organisation) provides the majority of operational resources or staffing. In some RTCs, governance arrangements have shifted towards university-led models, particularly where academic partners provide the majority of operational resources. This has led to a concern that there is a drift away from health service leadership to academic leadership. While this flexibility supports local adaptation, it may weaken integration with health systems and limit the influence of health service priorities in decision-making.

"Although two of our Partners are eligible to be administrating organisations of NHMRC funds, the default Partner Organisation is the Academic Partner. This creates an imbalance in Governance as the academic partner has an executive decision-making authority over the submission and management of grants." – RTC Leadership

Board or committee structures can be large and complex, especially with a large number of partners, making it difficult to maintain engagement, ensure consistent attendance, or progress decisions efficiently. Some RTCs have restructured their board size to be more responsive.

State and territory governments recognised the importance of inclusive boards, while noting that they should not be too big as this can result in difficulty making decisions. They supported the idea of independent chairs and suggested NHMRC provide guidance on governance, although there were different views on the level of specificity that was appropriate.

Notwithstanding concerns about imbalance, respondents expressed a preference for continued flexibility around governance in RTCs, given that each centre has different circumstances including the number of partners, funding, capacity and infrastructure. However, there were calls for more guidance to be provided, such as information about successful governance structures.

Recommendation 15:

NHMRC should strengthen wording in accreditation criteria to more clearly define expectations, effective governance models that ensure strong health service leadership in priority setting and decision making, with accountability across strategic, financial and operational functions, while maintaining considerable flexibility.

Administrative process should be commensurate with support

Consultations showed varying stakeholder views on the burden presented by the accreditation process, but even positive views are in the context of the requirements being commensurate with the level of funding support provided by NHMRC.

Survey respondents were mostly positive regarding the accreditation process with significantly more neutral and positive responses compared to negative. However, interviews highlighted that the accreditation process could be time-intensive and administratively onerous, particularly due to

the non-funding nature of the initiative and noted that this places pressure on already constrained clinical and management capacity.

"...the work required to be done to meet accreditation is burdensome and I am not sure it adds value to the process in the way possibly intended." – RTC Leadership

While accreditation was recognised as providing legitimacy and structure, several respondents questioned whether the level of effort required was proportionate to the value gained, noting that compliance activities can divert time and resources away from meaningful research translation and impact. This is exacerbated with the smaller RTCs and RTCs in RRR areas who often rely on partners being diverted from their work commitments to undertake these activities in-kind. There was feedback that the timing of the application process over the summer holiday period made the process more challenging.

Respondents suggested that, while there will be some burden attached to an accreditation process, it should be commensurate with the benefits that accreditation will provide.

Recommendations 16:

NHMRC should ensure assessment criteria are relevant and achievable and align with NHMRC's expectations for RTCs (and should be supported by more information so applicants understand the purpose of the criteria).

Recommendation 17:

NHMRC's reporting processes for the Initiative should only seek what is necessary and ensure requirements are clear and, if possible, align with other RTC reporting requirements.

Recommendation 18:

NHMRC should provide sufficient time for groups to prepare their accreditation applications and preferably avoid the summer holidays`

Reporting on the impact on health outcomes and health policy remains a challenge

RTCs are required to provide a mid-accreditation report which includes:

- Progress against the strategic plans
- Case studies to demonstrate impact of the Centre's research
- A summary of what has been achieved that would not have happened if the Centre had not existed (added value of the Centre)
- Financial information

RTCs are also expected to provide further information about their impact at the end of the accreditation period as part of the re-accreditation process.

Stakeholder interviews highlighted RTCs continue to find it difficult to report clear, attributable impacts on health services, outcomes and policy, even when research translation activity is

underway. While centres produce high-quality evidence, partnerships, and capacity-building initiatives, linking these efforts to measurable system-level change remains complex. Long timelines for health impact, limited access to integrated data, and the challenge of isolating the RTC's specific contribution in a multifaceted health environment were highlighted as all contributing to this difficulty.

"Current reporting focuses heavily on activity and process measures rather than measurable improvements in health outcomes or policy influence." – RTC Leadership

The challenges outlined above also make it difficult for NHMRC to be able to compare and measure the performance of each RTC and to develop an accurate assessment of the Initiative's outcomes. In England, Centres take a variety of approaches with some having a series of performance indicators, whereas others have decided that is more useful to report progress against the organisation's strategic plans. State and territory governments acknowledged the challenges in measuring outcomes but suggested a range of measures that would be better than the traditional academic measures, such as building capability in clinicians and systems, the number of patients supported (e.g. through clinical trials) as well as policy impact.

During consultations, RTCs asked for more guidance on how to report on the impact of their work. RTCs also note a growing recognition of the need for specialised implementation scientists, experts who bridge evidence and practice, to design, evaluate and measure translation pathways more effectively. They noted it can be difficult to access these skills when resources are limited. Stakeholders have advised that RTC responsibility for impact measurement should be commensurate with their role in research translation and should not encompass impact measured by the broader health system.

Recommendation 19:

NHMRC should consider the following that will simplify and structure the reporting requirements:

1. Revise impact reporting requirements to be commensurate with RTC's role in research translation and align with any revised objective.

2. Require RTCs to include impact measures in their strategies, providing a basis for internal reporting and for reporting to NHMRC.

3. Work with AHRA to:

a. support the adoption of a shared measurement approach, including common indicators, templates and logic models, to strengthen impact, reporting and enable meaningful comparison across RTCs

b. provide training or resources for assessors on expectations around impact measures.

4.3 ToR 3: Evaluate how the RTC Initiative could be modified to strengthen research-based health care and training to improve the health and well-being of patients and communities, and integration of research into multiple health services, including identifying whether alternative models, or elements thereof, should be considered.

- What alternative models or international practices could enhance the initiative's effectiveness and sustainability?
- What changes to the initiative are needed to ensure consistency with the NHMRC's Research Translation Strategy and wider government strategies and initiatives?
- What are the opportunities for future expansion?

Learnings from similar international models

A review of the international landscape assessed comparable initiatives in the United Kingdom, Canada, the United States of America, Singapore, the Netherlands and Sweden. It found that comparable initiatives have varying governance structures, funding mechanisms, partnership approaches and innovation pathways. This analysis informed a decision to interview policy owners, organisation leaders and other experts about the initiatives in England, Canada and USA as these were viewed as having the greatest relevance to NHMRC's RTC model.

The findings from the international landscape review and interviews indicated there are elements from international models that can be applied to the Australian context. No single model provides a blueprint for the future of the RTC initiative, although there are aspects, both positive and negative, that can inform improvements to it. Differences in government structures/health systems, economies, industry participation and population demographics limit the ability for Australian initiatives to achieve similar results or implement the same policies.
Appendix B includes a summary of the key learnings from the interviews undertaken with the leads of similar international initiatives, policy owners and other experts. Some of the key learnings that could be applied to the RTC initiative are discussed below.

Focus of the initiative - Arrangements for health research translation in England are complex with multiple, tiered research translation initiatives that focus on different parts of the research translation spectrum. The Nous review also found that "the English approach of different initiatives that span the translational research spectrum exists as a result of significant evolution over time. This allows each initiative to focus on one facet of translation." However, there is collaboration amongst organisations within an initiative as well as interaction between the organisations established under the different initiatives, which assists with knowledge exchange and joint activities (for example, the CEO of Health Innovation Oxford and Thames Valley (a HIN) is on the Board of Oxford Academic Health Partners (an AHSC) and representatives of the local ARC and Biomedical Research Centre attend Board meetings. There are also cross-cutting mechanisms

which bring together people from across the spectrum (for example Translational Research Collaborations).

In contrast to England's focus described above, in Australia the RTC Initiative attempts to cover a wide spectrum of research translation and implementation, which dilutes the focus. The focus of the RTC Initiative could be narrowed to more closely reflect the ARC model in England, which is designed to deliver applied health and care research focused on local population needs while enabling solutions to be scaled nationally. This includes addressing the gap between evidence and clinical practice (see discussion of the Initiative objective and the overall intent of the initiative at section 4.1).

Balancing local needs and national priorities – In England, Integrated Care Boards are the regional organisations that have responsibility for all of the health funding (including public health), and they have an explicit requirement to do research as part of their remit. To mirror this, ARCs are tasked with meeting the research needs of the ICBs, providing a two-way incentive to work together. At the same time, the National Institute for Health and Care Research (NIHR) has made some changes to encourage the ARCs to work on national priorities and to consider the potential wider impact of their projects (see below regarding funding). If applying for the national priorities funding, ARCs are required to involve at least three of the organisations to ensure national coverage. ARCs are also required to report on how many projects respond to national priorities. In discussing the focus on national priorities, one of the organisation leaders noted the importance of framing the national priorities in a way that they can be implemented locally in a meaningful way, otherwise there is a danger that the priorities are so vague as to lack meaning or they cannot be reconciled with local needs. In Australia, the National Health Reform Agreement between the Commonwealth, State and Territory governments includes specific funding for teaching, training and research. However, our federated system makes the two-way incentive approach of the NIHR to ensuring a close relationship between local health services and the ARCs more difficult to implement at the national level, but it is more appropriate at the jurisdictional level. address jurisdictional priorities through relevant assessment criteria and the availability of targeted competitive funding opportunities that also encourage cooperation between RTCs

Consumer and community involvement – Unlike the RTC initiative, in international models, consumer/community or patient and public involvement (PPI) is considered essential and is in some cases (Canada and England) mandatory, with involvement expected at all levels including boards and from the earliest stages of planning through the translation process. ARCs must appoint a dedicated lead responsible for community engagement, with resources allocated to support meaningful involvement throughout the research process. Recent PPI efforts in England have focused on ensuring the diversity of communities is properly represented and strengthening inclusion of minoritised and previously excluded communities. Canada's new Knowledge Mobilization Strategy and Action Plan recognises community-led research for action and indigenous-led solutions-focused health and wellness research as part of knowledge mobilization practice. While RTCs have played a significant role in developing community involvement in research and research translation, the revised Statement on Consumer and Community involvement in Health and Medical Research can provide a foundation for asking RTCs to identify ways to broaden and deepen these activities, in particular to provide for greater community leadership and to reach underserved communities.

Funding models influence behaviour and sustainability — While incentives-based funding strengthens collaboration, alignment, and entrepreneurial activity, there were differing views on

the appropriateness of base funding, with concerns expressed that it could lead to complacency and a loss of entrepreneurial focus. However, the ARCs, which are the closest to the RTCs in operation, are supported by base funding as well as having access to other competitive funding as it is seen as essential to develop collaborative projects. Base funding was seen as a better alternative than trying to get contributions from the local area health services, which were unable or unwilling to contribute. However, in the latest iteration of the scheme, funding has been rebalanced to provide more emphasis on funding for national priorities through a competitive process, with an expectation that ARCs will consider the applicability of a project for other populations and who they could work with to avoid duplication. As noted above, RTCs have indicated the importance of consistent funding to support their activities The USA's Clinical and Translation Science Awards (CTSA) model where funding continues subject to the recipients' meeting expectations, could be a way of avoiding potential complacency from receiving base funding.

Taken together, international models and consultation findings suggest that strengthening the RTC Initiative will depend on clarifying its role in the translation pathway, embedding it more firmly within health system structures, introducing sustainable and incentive-aligned funding models, strengthening coordination, and maintaining flexibility while increasing clarity and accountability.

Opportunities for future expansion of the RTC Initiative

Survey respondents ranked opportunities for future improvements to the RTC Initiative (*What can be done to improve the initiative's effectiveness and/or allow it to evolve to suit future needs?*). Overall, the findings indicate that improving effectiveness will depend less on structural redesign and more on investment, system integration, and enabling conditions that allow Centres to operate sustainably and collaboratively across diverse contexts.

Providing funding support was by far the highest-ranked priority in the survey and also supported by the qualitative responses, indicating near-universal agreement that sustained, predictable funding is critical to enable Centres to deliver on their objectives. Calls for funding are closely linked to enabling core functions such as coordination, workforce development and partnership management, with respondents noting that a formal, funded system would improve sustainability and allow RTCs to scale their impact.

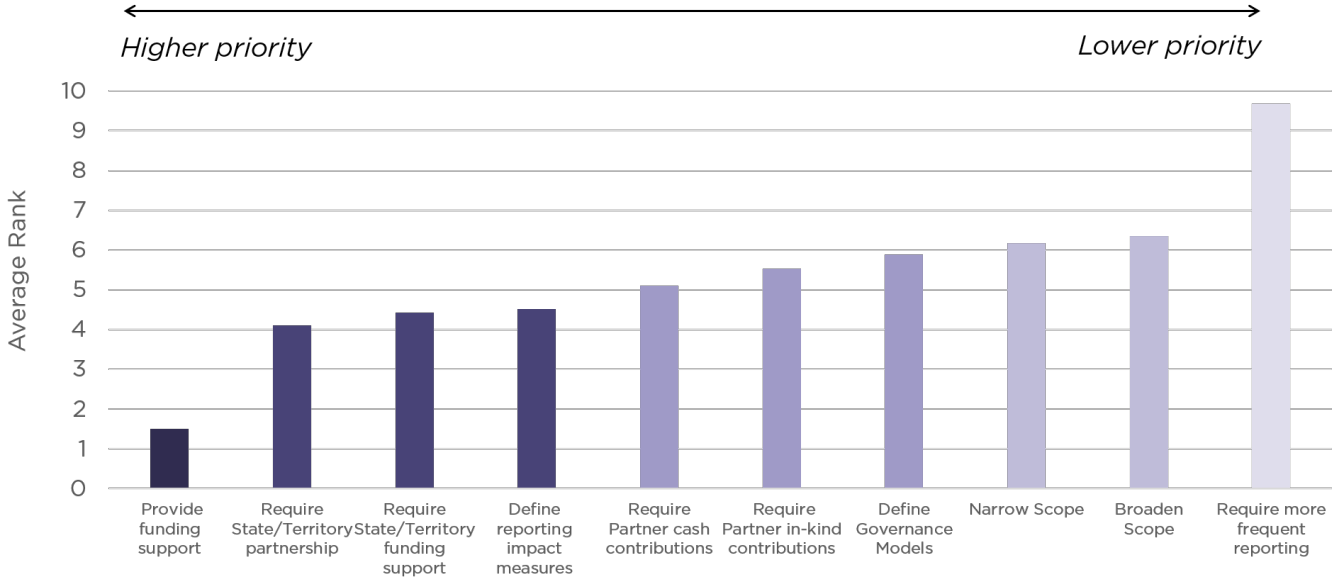
The next highest ranked potential improvements included requiring state and territory partnership and funding support and 'defining reporting impact measures.' Qualitative feedback suggests these elements are viewed as necessary to embed research translation more firmly within health systems, including through clearer accountability and alignment with health service priorities. Respondents also highlighted the importance of shared infrastructure, national coordination and integrated approaches, such as national research platforms, expanded cross-centre collaboration, and stronger integration with primary care and community settings. There were also calls for clearer definitions of translation and a stronger focus on measurable system impact, including embedding translational KPIs within health system performance.

Requirements relating to partner contributions (cash and in-kind) and defining governance models were rated as mid-range priorities. Respondents consistently emphasised the need for flexibility to reflect local context, particularly for regional, rural and remote Centres, and highlighted opportunities to strengthen equity through targeted funding, alternative delivery models (such as

hub-and-spoke approaches), and greater support for place-based research translation. Structural changes to the scope of the Initiative were ranked lower with broadening scope ranked lowest among improvement options.

Stakeholder interviews reinforced some of these themes to strengthen the RTC Initiative so that it is better positioned to deliver on its objectives and to respond to the evolving research translation environment in Australia. While the review provides supporting evidence that the Initiative has enabled important gains in collaboration, capability building and early translation outcomes, it also highlights variability in impact, sustainability and health system integration across centres. The opportunities highlighted by stakeholders below are focused on increasing health-service led research, clarity of purpose, strengthening alignment with national and jurisdictional priorities, addressing structural and funding constraints, and enhancing the Initiative's capacity to support meaningful, equitable and scalable research translation within health system

Figure 4. Survey rankings for opportunities to improve the Initiative (lower values indicate stronger perceived benefit).



Stakeholders' suggestions to improve the Initiative include:

- Strengthen the central role of health services in driving research and translation, moving from supporting collaboration to positioning health services as key leaders in setting priorities, commissioning research, and embedding evidence into practice. This responds to evidence that more explicit alignment with health system needs and leadership can improve the relevance and uptake of research.
- Ensure that research is more consistently aligned with local, real-world needs, system pressures, and population health priorities rather than being primarily researcher-initiated.
- Increase emphasis on localised excellence and encouraging collaboration for successful translation activities to be adopted consistently across health services and jurisdictions in Australia.

- Reinforce the priority to translate existing evidence into practice over generation of new research.
- Enhance coordination and alignment across the system, including stronger linkages with national and jurisdictional priorities to reduce fragmentation and duplication.
- Reinforce leadership, governance and shared responsibility, with a clearer articulation of roles for health services, research institutions and partners in jointly driving translation outcomes.
- Refine the approach to workforce capability, shifting from general capacity building to more targeted development of a workforce equipped with skills in implementation science and evaluation.

5. Strengths and limitations of the Review

This review draws on a mixed-methods approach, including national and international desktop reviews, survey responses, written submissions and interviews. While this enabled broad input across stakeholder groups and generated rich feedback on the perceived benefits, challenges and enablers of the Initiative, the review relies primarily on self-reported and perception-based evidence, which have their known limitations.

A key limitation to note is the extent and composition of stakeholder input outside of currently accredited RTCs. RTCs were asked to identify participants across their partnership groups, including those with longstanding involvement and those providing more recent perspectives. However, the participants of the stakeholder consultations within each RTC was determined by leads of the individual centres, which has the potential of introducing selection bias. Stakeholder input was supplemented through targeted engagement with state and territory government health departments and international stakeholders involved in comparable models. However, the number of participants that were not directly involved in an RTC was limited. While additional stakeholders were approached where gaps were identified, the review may not fully capture the breadth of perspectives from stakeholders who are not directly involved in one of the RTCs.

6. Conclusions

This review has assessed the RTC Initiative against the Terms of Reference, including progress against its aim and objective, the appropriateness of the accreditation model and options for future improvements. Overall, the findings show that the Initiative is achieving its aim and objective in part, particularly in strengthening collaboration, building research translation capability, and strengthening consumer and community involvement. However, outcomes related to translation into routine practice and measurable improvements in service delivery and patient outcomes remain less consistent. This reflects both the evolving maturity of the Initiative and the challenges of translating research in complex health system environments.

The review also finds that the accreditation model remains fit for purpose as a mechanism to recognise and enable collaboration, but does not on its own provide sufficient direction, alignment or support to drive more consistent and scalable impact. Refinement is needed to clarify

expectations, strengthen alignment with health system priorities, and better support the demonstration of outcomes. In considering future directions, the evidence indicates that improvements are more likely to be achieved through strengthening enabling conditions, particularly funding, system integration, capability and coordination, rather than through changes to the overall scope of the Initiative.

Taken together, the findings point to a need to evolve the Initiative to more clearly position its role in supporting health service-led research translation and to enable more consistent translation of evidence into practice across diverse settings. NHMRC will use the findings of this review, and the opportunities identified, to inform the future design of the RTC accreditation initiative.

Appendix A – Stakeholder consultations

List of organisations consulted

Research Translation Centres

- Melbourne Academic Centre for Health
- Monash Partners
- Sydney Health Partners
- Tropical Australian Academic Health Centre
- Western Alliance Academic Health Science Centre
- Health Translation SA
- Health Translation Queensland
- Maridulu Budyari Gumal, The Sydney Partnership for Health, Education, Research and Enterprise
- Western Australian Health Translation Network
- Central Australia Academic Health Science Network
- NSW Regional Health Partners
- Top End Aboriginal Health Research Alliance
- Tasmanian Collaboration for Health Improvement (Emerging)
- West Australian Rural Research and Innovation Alliance (Emerging)

Government

- WA Department of Health
- NSW Department of Health
- Tasmanian Department of Health
- SA Department of Health
- ACT Health
- Safer Care Victoria
- VIC Department of Jobs, Skills, Industry and Regions
- Department of Health, Disability and Ageing
- Queensland Health

International

- National Institute of Health Research (UK)
- Bristol Health Partners (UK)
- Liverpool University (UK)
- Academic Health Solutions (UK)
- Oxford Academic Health Partners (UK)
- Health Innovation Oxford and Thames Valley (England)
- The Health Innovation Network (UK)
- National Centre for Advancing Translational Sciences, NIH (USA)
- UC Davis Clinical and Translational Science Centre (USA)
- Ottawa Hospital Research Institute (Canada)
- Canadian Institutes of Health Research (Canada)

Appendix B – Features of international models

An international review of the health and medical research translation landscape assessed comparable initiatives in England, Canada, the United States of America. It found that comparable initiatives have varying governance structures, funding mechanisms, partnership approaches and innovation pathways. This analysis informed a decision to interview policy owners, organisation leaders and other experts about the initiatives in England, Canada and USA as these were viewed as having the greatest relevance to NHMRC's RTC model.

England

England has developed a comprehensive, multi-tiered system for health research translation that aligns Academic Health Science Centres (AHSCs), Applied Research Collaborations (ARCs) and Health Innovation Networks (HINs) with national priorities such as the NHS Long Term Plan. This interconnected structure supports specialisation and regional responsiveness while enabling innovations to be scaled nationally. Together, the three elements promote collaboration between academia and health services, reduce regional variation, and support continuous improvement through performance and impact reporting.

AHSCs are regionally based partnerships between universities and NHS organisations that were designated by NHS England and NIHR on the basis of excellence in health research, education and patient care. Eight AHSCs were designated in 2020 for five years[9], without associated funding, and continue to operate independently despite the cessation of formal designation. They are strongly academically focused, typically led by a single university, and work across the full research pipeline from discovery to implementation. As an excellence-based model, AHSCs are not designed for national coverage and are largely concentrated in southern England.

ARCs and HINs provide broader system coverage and implementation capacity. ARCs deliver applied health and care research focused on local population needs while enabling solutions to be scaled nationally, with a particular role in closing the "second translational gap" between evidence and clinical practice.[10] Funded by NIHR, there are ten ARCs (with an eleventh in development) covering all of England and supported by a national ARC Network to strengthen collaboration and alignment. HINs, funded by NHS England and the Office for Life Sciences, focus specifically on the rapid adoption and spread of innovation at pace and scale across the NHS. Fifteen HINs operate across distinct geographic regions, working closely with industry, academia and health services to support implementation, improve health outcomes and drive economic growth.[11]

Canada

Canada's knowledge translation arrangements have been evolving, with a new Knowledge Mobilization Strategy and Action Plan announced on 12 March 2026[12], including a commitment to advance health research impact through new and enhanced funding opportunities specifically focused on knowledge mobilization practice. One of these is the '**Partnering for Impact: Partnerships for Health, Systems and Community Improvements'** program to mobilise evidence-

[9] NHS Accelerated Access Collaborative » Academic Health Science Centres viewed 3 June 2026

[10] Applied Research Collaborations | NIHR viewed 3 June 2026

[11] The Health Innovation Network viewed 3 June 2026

[12] Launch of the Knowledge Mobilization (KM) Strategy and Action Plan: Message from the President - CIHR viewed 3 June 2026

informed solutions that respond to pressing healthcare, health system and health issues."[13] However, the details of how this program will operate have not yet been released.

The Strategy for Patient-Oriented Research (SPOR) Networks will continue. The Federally funded collaborations (through CIHR) focus on integrating patient perspectives into health research and improving outcomes.[14] SPOR Networks are pan-Canadian collaborative research networks involving patients, researchers, health care professionals, policy makers, academic health centres, health charities, and other stakeholders. They focus on specific health areas identified as priorities in multiple provinces and territories. The Networks address research priorities identified by patients and speed up the use of research findings into patient care and health care policy. There are seven SPOR networks – five focused on various chronic diseases and one focused on primary care.[15]

Academic Health Science Centers are university-hospital partnerships that appear to operate independently of the CIHR and have formed in response to local priorities and therefore have differing aims and structures.

USA

The United States has a large, decentralised health and medical research system centred on Academic Medical Centers (AMCs), which play a central role in biomedical innovation, clinical care and translational research. These university-affiliated institutions operate at the intersection of academia, healthcare delivery and public health, forming the backbone of the country's research and innovation capacity.

AMCs pursue a tripartite mission of research, clinical care and medical education and are typically linked to accredited medical schools and teaching hospitals. With more than 1,200 AMCs nationwide, they are concentrated in major academic hubs but are present in nearly all states. Their research activity spans disease-specific innovation, population and digital health, health equity, and major contributions to clinical trials, precision medicine and health system reform.

Federal support for translation is provided through the National Center for Advancing Translational Sciences, which funds the Clinical and Translational Science Awards (CTSA) program.[16] This program supports a national network of over 60 academic medical institutions to accelerate the movement of research discoveries into improved care. While CTSA hubs are generally metropolitan and university-based, they are encouraged to develop links to community and rural settings through partnerships and outreach programs.

[13] Knowledge Mobilization: Funding - CIHR viewed 3 June 2026

[14] Funding Research - CIHR viewed 3 June 2026

[15] SPOR Networks - CIHR viewed 3 June 2026

[16] Clinical and Translational Science Awards (CTSA) Program | National Center for Advancing Translational Sciences viewed 3 June 2026