Response to the Horizon Europe Implementation Consultation

Research Australia Submission

September 2026

RESEARCH AUSTRALIA

Championing Australian health & medical research & innovation

Executive Summary

Research Australia, as the national health and medical research peak organisation, welcomes the opportunity to provide a submission to the Department of Industry, Science and Resources' Discussion Paper: Horizon Europe Implementation.

Research Australia strongly supports Australia's association to Horizon Europe and welcomes the opportunity to shape its implementation. Horizon Europe association gives Australian health and medical researchers, research institutions, hospitals, consumer advocacy groups and industry a long-sought pathway to funding under Pillar II. This proceeds after years in which Australian researchers have contributed to Horizon Europe projects without being able to receive its funding. Done well, implementation can extend the benefits of association well beyond a small number of research-intensive universities to the full breadth of Australia's health and medical research ecosystem – including the medical research institutes (MRIs), hospitals and local health districts, patient organisations, and industry that make up the Research Australia's membership.

Our key recommendations are summarised below and expanded in the body of this submission:

	Recommendation
1	**Establish a dedicated, hybrid Health NCP capability.** Create identifiable Health/Life Sciences expertise that reflects the scale of Australia's HMR&I sector, with health treated both as a standalone cluster and a cross-cutting contributor to digital, industry, climate, workforce and productivity priorities. Avoid a geographic NCP model and combine government, research-sector and specialist legal, financial, ethics and compliance expertise.
2	**Make Year One about capability, targeted participation and learning.** Map Australia's comparative advantages and European complementary strengths, target the most strategically relevant calls, and prioritise proposal-development support for new and less-resourced participants. Measure success through capability, partnerships, new entrants, participation and impact—not funding success rates alone.
3	**Align Horizon Europe with national priorities and productivity.** Use the National Health and Medical Research Strategy, MRFF Strategy and Priorities, SERD and National Research Infrastructure Roadmap to guide participation, while recognising HMR&I's broader contribution to productivity through innovation, commercialisation, workforce participation, better health and more efficient healthcare. This should include identifying areas where Australia can make distinctive international contributions, such as CDC-led pandemic preparedness.
4	**Build on existing infrastructure and international networks.** Leverage existing Australian and European research networks, science diplomacy, science attachés/ambassadors and organisations already operating in Europe rather than creating new infrastructure from scratch. Research Australia's proposed research/science ambassador program could contribute to this capability from Year One.
5	**Design for equitable, whole-of-sector participation.** Embed equity and RRRvR participation as core design principles and ensure Tier 2/3 support reaches MRIs, hospitals, consumer and patient organisations, SMEs and industry—not only research-

	intensive universities. Prioritise application-stage support and capability building to lower barriers for new and under-resourced participants.
6	**Give Research Australia a formal implementation, outreach and evaluation role.** Use Research Australia as a Tier 3—and potentially Tier 2—Health outreach and coordination partner, connecting DISR with the breadth of the HMR&I ecosystem, supporting capability building and helping develop participation, impact and evaluation measures from the outset.

Introduction

In November 2025, Research Australia made a submission to the Department of Industry, Science and Resources (DISR) on Australia's possible association to Horizon Europe, supporting association under Pillar II and setting out the opportunities and implementation considerations most relevant to the health and medical research and innovation sector. We welcome the Government's progress since that time towards formal association, and the release of this Discussion Paper on implementation. This submission responds directly to the questions raised in the Discussion Paper, brings forward the recommendations from our earlier submission where they remain relevant to implementation design, and adds the perspectives of our membership and comparative analysis of the positions of the university sector's peak bodies.

This submission also draws on Research Australia's submission to Strategic Examination of R&D, Productivity Commission Submissions, and the National Health and Medical Research Strategy. It also draws from our policy discussion paper, Advancing Health and Medical Research and Innovation Across Regional, Rural, Remote and Very Remote Communities in Australia, developed with the input of our membership. That paper found that although close to 30 per cent of Australians live in regional, rural, remote or very remote (RRRvR) communities, funding for health and medical research in those communities is not comparable to the funding available in metropolitan centres, notwithstanding real strengths in community connectivity, co-design and locally-led research priorities. Horizon Europe implementation is a live opportunity to apply that thinking, and we refer to it throughout this submission, particularly in our response to Question 17.

This submission also draws on Research Australia's contribution to the Horizon's Europe Implementation Roundtable held in Canberra, 9 September 2026.

National Contact Point (NCP) Network Structure and Functions

Research Australia supports the proposed three-tier NCP model. Our comments below draw on the practical experience of our membership — from research-intensive universities with existing Horizon Europe track records (such as RMIT, which currently leads the Horizon Europe-funded SMAR3TS consortium under the Marie Skłodowska-Curie Actions programme) through to medical research institutes, hospitals and charities with little or no experience of EU-style multi-partner, multi-country grant administration.

Question 1: What is the best way to structure the NCP network in Australia: by cluster, industry sector, geography, thematic or another approach?

We recommend a hybrid model anchored primarily in the six Pillar II clusters (so that Cluster 1: Health has a clearly identifiable, adequately resourced NCP line), overlaid with a thematic capability across all clusters for cross-cutting issues that recur constantly in health and medical research consortia — clinical trial regulation, human research ethics, data governance and privacy, and Indigenous health research governance. A purely geographic model risks fragmenting scarce clinical and health-research expertise across every state and territory; a purely sectoral model (e.g. organised around industry sectors such as space, critical technologies or clean energy) risks health being folded into a generic "life sciences" or "biotech" category that does not reflect the scale of the Cluster 1 program or the diversity of the health and medical research and innovation sector, which spans discovery science, clinical and public health research, digital health, and consumer and community involvement.

Question 2: Which of the NCP functions will be most important, and what is the best model for delivering them?

For the health and medical research sector, the most important functions are: (a) partner search and consortium formation support, given the scale of most Horizon Europe consortia and the historic difficulty Australian researchers have had finding and joining European-led bids; (b) legal, financial, ethics and compliance advice, given the complexity of EU funding rules, audit requirements and multi-jurisdictional human research ethics approval; and (c) proposal development support (training, mentoring, and access to successful exemplars), which is the single biggest barrier reported by smaller institutes and hospitals without dedicated grants offices. These are best delivered by a combination of a well-resourced central function (Tier 1/2) providing consistent, high-quality legal/financial/ethics advice once, nationally, and a distributed Tier 2/3 network providing local relationship-based support, consistent with the New Zealand model, which includes a dedicated Legal & Financial NCP.

Importantly, Year One should be approached as a capability-building and learning year. Australia needs to understand the Horizon Europe landscape, build relationships and capability, identify where Australia has comparative advantage and where European partners have complementary strengths, and help organisations focus effort on calls where they can make a meaningful contribution.

Question 3: What existing functions undertaken by government or sector organisations could support entities to participate in Horizon Europe?

Existing infrastructure that could be leveraged rather than duplicated includes: NHMRC's grant administration and peer review expertise; the Medical Research Future Fund's translational research networks; the Australian Health Research Alliance's clinical trial and translation networks; human research ethics committees and, in particular, accredited independent ethics review providers such as Bellberry, which already manage multi-site and multi-jurisdictional ethics review for the sector and could inform a streamlined approach to the ethics dimension of EU consortia; peak bodies such as Research Australia, , which has existing member communication channels reaching organisations that a new, unfamiliar government program would otherwise struggle to reach; and university research offices and EU liaison functions

such as those already operated by RMIT Europe and other institutions with a physical or contractual presence in Europe.

This should extend to Australia's existing science diplomacy infrastructure, science attachés/ambassadors and organisations with an established presence in Europe. Building a stronger Australian science capability in Europe could provide an immediately available platform for supporting partnerships and participation during Year One.

Longer term, consideration should be given to establishing a permanent EU Horizons mission or hub, based in Europe that can act as the relationship builder and liaison point on the ground rather than running it from Australia. This should be not aligned to any individual Australian institute.

Question 4: Would it be most effective to locate the Tier 2 NCPs within government, in the research sector, in industry organisations, peak bodies, or a hybrid?

A hybrid model. Government (Tier 1) should retain the central coordinating, priority-setting and quality-assurance role. Tier 2 delivery for the Health cluster should sit substantially within the research sector and relevant peak bodies (which hold the disciplinary expertise, trusted relationships and networks reaching MRIs, hospitals and universities), rather than within a single lead university or solely within government, which is unlikely to have the depth of clinical and translational research expertise required. Locating Tier 2 solely within research-intensive universities risks replicating the existing advantage of well-resourced institutions and disadvantaging MRIs, smaller universities, regional institutions, hospitals and charities that are Research Australia members but sit outside the university system.

Question 5: In addition to the expectations for NCPs outlined above, what expertise should every Tier 2 NCP possess?

Every Tier 2 NCP, regardless of cluster, should have working knowledge of: research security and foreign-interference obligations as they apply to international consortia; human research ethics and multi-jurisdictional approval pathways; Indigenous data sovereignty and culturally safe research governance; and basic contract, IP and data-protection literacy sufficient to make a first, informed referral to specialist legal/financial support. For the Health cluster specifically, NCPs should understand clinical trial and therapeutic goods regulatory settings, the National Health and Medical Research Strategy and MRFF priorities, and the practical realities facing smaller, community-facing organisations such as health charities and consumer groups.

Health should also be understood as an enabler of Australia's wider productivity agenda. HMR&I generates technologies, industries and commercial opportunities, while better health supports workforce participation, reduces disability and premature mortality and reduces pressure on the health system. Health therefore intersects with productivity priorities spanning economic resilience, digital transformation, workforce capability and more efficient care. For further information, see Research Australia's 2025 Submissions to the Productivity Commission.

Question 6: How should performance of Tier 2 NCPs be measured?

Beyond application numbers and success rates, performance measures should include: the diversity of applicant organisation types supported (MRIs, hospitals, charities and SMEs, not only universities); the proportion of new entrants (organisations applying to Horizon Europe for the first time) supported into a competitive application; participation by First Nations researchers and communities, and by regional, rural, remote and very remote organisations; and applicant-reported satisfaction and time-to-support metrics. Measuring only funding secured risks rewarding NCPs that work with already well-resourced, already internationally networked institutions, rather than building capability across the ecosystem.

Question 7: How should conflicts of interest be managed where NCPs are hosted by applicant organisations?

Where a Tier 2 NCP is hosted by an organisation that is itself an eligible applicant (for example, a university or MRI), a clear and published protocol should require: NCP staff to be functionally and, where possible, physically separated from that organisation's own grant-seeking teams; equal-treatment obligations requiring the NCP to provide the same standard of support to competitor institutions and to organisations outside its host's sector; and independent oversight or an appeals mechanism, administered by the Tier 1 central office, for organisations that consider they have received a lesser standard of support because of a real or perceived conflict.

Question 8: What organisations or industry sectors could most effectively deliver the NCP network and how could they be engaged to do so?

For the Health cluster, effective delivery partners include research-intensive universities with existing EU liaison capability, peak bodies such as Research Australia . Engagement is best achieved through an open, competitive but collaborative expression-of-interest process that explicitly rewards consortia bids (for example, a lead university partnering with a peak body and a regional network) over single-organisation bids, so that reach and reputation across the whole sector — not just within one institution — is built into the delivery model from the outset.

Question 9: What are the trade-offs and risks the government should be aware of with the NCP structures and establishment of the network?

Key risks include: concentration risk, where NCP functions default to the small number of institutions with existing Horizon Europe experience, entrenching rather than closing the participation gap; capacity risk, where volunteer or lightly-resourced Tier 2/3 functions cannot sustain the intensive, ongoing support multi-country consortium bids require; continuity risk, given Australia is joining for the final year of the current Framework Programme and NCP functions and relationships need to be sustained (or rapidly re-established) into FP10; and cost risk, where implementation funding is drawn from existing health and medical research appropriations (NHMRC, MRFF) rather than being genuinely additional, reducing net benefit to the sector.

There is also a Year One implementation risk if Australia focuses immediately on application volumes and funding returns without first developing the networks, intelligence and capability required for longer-term success.

Question 10: What level of activity could reasonably be delivered through a volunteer-based Tier 3 network?

A volunteer Tier 3 network can reasonably provide: awareness-raising and information dissemination within member organisations; a first point of contact and "warm referral" into Tier 2 specialist support; feedback to Tier 1/2 on emerging barriers and local coordination opportunities; and light-touch encouragement of consortium formation (for example, flagging relevant calls to member researchers). It should not be relied upon for legal, financial, ethics or contractual advice, or for sustained, hands-on proposal development support, which requires dedicated professional capacity and consistent availability that a volunteer model cannot guarantee. It is important to note however the limitations of organisations contributing to a volunteer Tier 3 network within existing limited funding available to peak organisations, and research institutions, including universities.

Question 11: What activities are appropriate for volunteers versus specialist NCPs?

As above: volunteers are well suited to awareness-raising, signposting and peer encouragement within their own networks (for example, a champion within a medical research charity flagging Horizon Europe opportunities relevant to rare disease research); specialist NCPs should retain all activities involving legal, financial, contractual, ethics, IP, research-security or compliance advice, and any activity where inconsistent or incorrect advice could jeopardise an application, a consortium relationship or Australia's standing as an associate country.

Question 12: Are there speciality skills/areas of focus that the NCP network could include, such as engaging First Nations communities, regional/rural access issues, administration and financial guidance, audit and compliance or others?

Yes. Research Australia recommends the network explicitly include: First Nations health research engagement, informed by existing NHMRC Indigenous health research guidelines and led by or developed in partnership with First Nations researchers and communities; regional, rural, remote and very remote outreach, recognising the distinct barriers facing organisations outside the major research hubs; rare disease research support, given the strong rationale for multinational cooperation where patient populations are small and dispersed within any single country (an area our member Rare Voices Australia, through its existing partnership with the European rare disease research alliance EURORDIS, is well placed to inform); and disability and gender-diverse inclusion, consistent with the equitable-access principles set out in our November 2025 submission.

This should be distinguished from the structure of the NCP itself, where participation does not require health expertise to be organised geographically.

Driving Alignment with National Priorities

Question 13: Can financial incentives drive success and alignment with national priorities? If so, what approach would be most effective?

Financial incentives can shape behaviour, but the evidence from comparable systems (and from our members' experience of NHMRC and MRFF funding) is that incentives targeted at the application stage (Model A: proposal development support) are more effective at broadening participation than incentives targeted at success (Model B), because Model B by definition only benefits organisations that already have the capability to win. Research Australia recommends Model A as the primary mechanism, with a modest, capped Model B top-up reserved for applications that align with an explicitly published set of national health priorities (for example, priorities drawn from the National Health and Medical Research Strategy) to avoid the perverse outcome of concentrating support on organisations that need it least.

The National Health and Medical Research Strategy and MRFF Strategy and Priorities provide logical guides for identifying areas of national health importance and potential alignment with Horizon Europe.

Question 14: What unintended consequences should government be aware of when thinking about incentivising alignment with national priorities?

A narrow or prescriptive priority list risks discouraging applications in areas where Australia has a demonstrated comparative advantage and strong success rates (for example, established global health and clinical trial networks) simply because they fall outside a predetermined list. It also risks disadvantaging investigator-driven, discovery research that cannot always be mapped neatly to a priority area in advance but which frequently underpins the priority-aligned translational research of the future. We recommend priorities be expressed as broad thematic areas (for example, aligned to the six National Science and Research Priorities and the National Health and Medical Research Strategy) rather than a narrow list of named topics, and be reviewed regularly as Horizon Europe work programmes and Australia's own priorities evolve.

There may also be value in identifying areas where Australia can make a distinctive international contribution—for example through the CDC and pandemic preparedness, including preparedness for future pandemic threats.

Question 15: What barriers do Australian SMEs and industry face in participating in Horizon Europe and how can they be overcome?

For health and medical technology SMEs specifically, the most significant barriers are: the cost and complexity of forming a compliant multi-country consortium without in-house EU grants expertise; unfamiliarity with EU intellectual property, data-protection and clinical-data-sharing rules, which differ materially from Australian settings; and the cash-flow burden of EU funding models, where reimbursement can lag project costs. These can be addressed through targeted proposal-development grants (Model A), a specialist Legal & Financial NCP function available to SMEs at no cost, and — learning from Medicines Australia and industry members' experience of international regulatory harmonisation — clear, centrally produced guidance comparing EU and Australian intellectual property, data and clinical trial settings.

Question 16: At what stage in the application process would support be most helpful?

Support is most valuable at two points: early, at the partner-search and consortium-formation stage, where Australian organisations without existing European networks are most likely to be excluded from a bid altogether; and mid-stage, during proposal drafting, where technical writing conventions, budgeting rules and compliance requirements differ from Australian grant applications. Given the Discussion Paper notes it "can take several months to develop suitable research proposals", we recommend NCP support be available and actively promoted well before a specific call closes, not only in the weeks immediately before a deadline.

For Year One, consideration should be given to targeted calls and proactive matching, helping Australian organisations focus limited resources on opportunities where their capability genuinely aligns with European needs rather than encouraging a high volume of speculative submissions.

Other Implementation Considerations

Question 17: How could we support participation from entities in regional and remote areas?

Research Australia's December 2025 policy discussion paper, Advancing Health and Medical Research and Innovation Across Regional, Rural, Remote and Very Remote Communities in Australia, is directly relevant here. It found that although close to 30 per cent of Australians live in RRRvR communities, funding for health and medical research in those communities is not comparable to metropolitan funding, despite genuine strengths — strong community connectivity, effective co-design practice, and research priorities that are led by local need and translate quickly into service delivery. The paper identified funding inequity, workforce gaps and research infrastructure deficits as the central, compounding barriers to RRRvR participation in any competitive research funding scheme, Horizon Europe included.

Applying that finding to Horizon Europe implementation, we recommend: a dedicated regional/rural/remote outreach function within the Tier 2/3 network, resourced to travel to and engage directly with regional universities, hospitals and health services rather than relying on organisations to seek out a Canberra- or capital-city-based NCP; partnership requirements or incentives that encourage metropolitan-led consortia to include a regional partner, so regional organisations are brought into consortia as genuine partners rather than token sites; targeted proposal-development funding (see Question 13) weighted toward RRRvR applicants, given they are least likely to have the spare workforce capacity or research infrastructure to self-fund a competitive bid; and recognition that many regional health services and hospitals conduct clinically important research (for example, in rural and remote health, and in conditions with higher regional prevalence) that may not be visible through conventional university-based research metrics. Regional universities are well placed to help design this outreach function: as the Regional Universities Network (RUN) has noted in its own advocacy on Horizon Europe (see Section 5), any new funding commitment must not be met by reallocating existing, already-stretched regional research funding — a principle Research Australia's RRRvR paper independently supports.

Question 18: Where are the gaps in the current implementation approach and how could they be addressed?

The Discussion Paper is, understandably, framed largely around a university- and industry-centred model of participation. The clearest gap for the health and medical research sector is the absence of explicit consideration of medical research institutes, teaching hospitals, health and medical research charities, and patient/consumer organisations as distinct participant types with distinct support needs — most have neither a university-style grants office nor an industry-style commercial development function. A second gap is funding transparency: the Discussion Paper does not address how the Horizon Europe membership/association fee itself is being funded, an issue Research Australia raised in its November 2025 submission and which directly affects whether implementation funding will be genuinely additional to the existing health and medical research funding envelope. A third gap is alignment: the paper does not reference how implementation will be sequenced with, or draw on, parallel processes including the National Health and Medical Research Strategy, the Strategic Examination of Research and Development, and the 2026 National Research Infrastructure Roadmap, all of which will shape national research priorities over the same period.

A further consideration is the need for an explicit Year One implementation strategy: mapping the landscape and Australia's comparative advantages; determining where Australia should lead, partner or develop capability; leveraging existing European and science-diplomacy infrastructure; targeting priority opportunities; and establishing baseline measures against which future performance can be assessed.

Question 19: In addition to the measures of success already identified, what additional measures should be used?

We recommend adding: the number and proportion of medical research institutes, hospitals, health charities and patient organisations (as distinct from universities and commercial industry) that apply to and are funded through Horizon Europe; the number of first-time Australian applicants to Horizon Europe supported into a successful or highly-rated application; measures of research translation and clinical/community impact arising from funded projects, not only publication or citation metrics; and qualitative feedback from smaller and first-time applicant organisations on the accessibility and usefulness of NCP support, to complement quantitative success-rate data.

For Year One, Government should establish a broader baseline encompassing capability developed, European partnerships and consortia established, new organisations engaged, breadth and equity of participation, targeted opportunities pursued and progress towards longer-term impact. Success measures can then mature over subsequent years towards funding outcomes, research translation, commercialisation and health, economic and societal impact.

Perspectives from Research Australia's Membership

Research Australia's diverse membership encompasses the full health and medical research and innovation ecosystem, providing valuable insights into the sector's needs and

opportunities. This submission draws on contributions from key members, including Bellberry, Rare Voices Australia, RMIT, The Kids Research Institute Australia, and the University of Adelaide, as well as broader sectoral perspectives. Universities, many of which are part of larger groups such as Universities Australia, the Group of Eight, or the Australian Technology Network, highlight the importance of dedicated capacity-building infrastructure, a New Zealand-style funding model, and the risk that institutions with existing European networks may disproportionately benefit without deliberate design. RMIT University exemplifies the opportunities available to well-prepared Australian institutions through active participation in Horizon Europe, emphasising the value of an in-region presence. The University of Queensland and Melbourne advocate for a facilitation hub and seed funding models to support broader engagement, while Macquarie University's dedicated EU funding service underscores ongoing institutional investment.

Medical Research Institutes (MRIs), including leading organisations like the Walter and Eliza Hall Institute and the Peter MacCallum Cancer Centre, share characteristics that make targeted Tier 2/3 support essential, given their global research activities and limited EU presence. Patient advocacy organisations, such as Rare Voices Australia, bring critical community and lived-experience insights at a local, national and international level but also reinforces the need for well-resourced support structures. Industry members, including multinational pharmaceutical companies and health technology firms, primarily focus on regulatory harmonisation and data-sharing issues, while research infrastructure organisations like Bellberry and the Australian Clinical Trials Alliance contribute expertise in ethics, compliance, and clinical trial networks. Finally, regional, rural, and remote communities emphasise the importance of deliberate inclusion, cautioning that without targeted efforts, disparities could widen, underscoring the necessity of integrating regional voices within the Horizon Europe implementation framework.

Conclusion

Research Australia is well placed to play a practical role in Horizon Europe implementation without duplicating government or university functions and advocating for a system that benefits all – and leveraging the expertise and needs across the ecosystem. Through our national network spanning universities, medical research institutes, hospitals, charities, patient organisations, industry and philanthropy, Research Australia could provide Tier 3 outreach and potentially Tier 2 support for the Health cluster, acting as a bridge between government and the broader HMR&I ecosystem. This could include disseminating opportunities, building capability and providing health-specific guidance, connecting organisations to specialist support, and ensuring smaller and non-university participants are effectively engaged. Research Australia could also support data and evaluation, helping measure participation, capability and impact beyond funding success rates, and provide a coordination point across Horizon Europe and parallel national reforms, including the National Health and Medical Research Strategy, SERD and National Research Infrastructure Roadmap. In this way, Research Australia can provide an existing, sector-wide mechanism to help ensure Horizon Europe delivers value across the full health and medical research and innovation ecosystem.

Research Australia congratulates the Government on progressing Australia's association to Horizon Europe and welcomes this early opportunity to help shape its implementation. The

design choices made now — how the NCP network is structured and resourced, whether financial incentives target application or success, and how success itself is measured — will determine whether the benefits of association are broadly shared across Australia's health and medical research and innovation ecosystem or concentrated among the small number of institutions already equipped to compete internationally. We urge government to design implementation around equitable reach into medical research institutes, hospitals, health and medical research charities, patient organisations and health SMEs, alongside universities and large industry, and to provide clarity and assurance that the funding required to do so is additional to Australia's existing investment in health and medical research.

Research Australia would welcome the opportunity to discuss this submission further and to contribute to any subsequent design or consultation process, including through our members with direct Horizon Europe and European research collaboration experience, and through the specific implementation roles set out in Section 6.

For further information regarding this submission please contact Dr Talia Avrahamzon, Head of Policy, Projects and Advocacy at talia.avrahamzon@researchaustralia.org or policy@researchaustralia.org

Warm regards,

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