Submission 166 — Paul Ekert

Medical Research is an intrinsic and essential component of the provision of the best standards of health care. The absence of research programs that accompany health service provision implies either that there is no further need to question current dogma or practice, no improvements or greater understanding that can be gained, or that there is no will to pursue such knowledge for the longer-term benefit of Australian patients. Such complacency can only harm clinical care. The downgrading of Australian teaching hospitals as centers of research excellence to centers only of service provision has been to the great detriment of health care.

It is commonly suggested that in the field of Health and Medical research, Australia “punches above it’s weight”. By such logic, research productivity will increase the less it is funded! Such self-congratulatory platitudes hide the truth and prevent clear thinking on the subject and should be avoided. We have outstanding researchers in Australia, across many fields. So do many other countries. Australia is not the world leader we consider ourselves to be, and Australia will continue the decline as it continues to spend less than comparable countries on health and medical research. That decline will inexorably be accompanied by a decline in health care standards. We will wait for other to do research. The implementation of new discoveries will be delayed, and the costs will be greater. The benefits of homegrown discoveries, financial and more rapid translation to patients, are lost. Australia’s reputation as a nation with a strong academic infrastructure and traditions will diminish, as will those who seek to train, study and work here. Opportunities for Australian students to participate in research will be lost.

I would submit to this review the following suggestions.

1. Research should be a core activity of our public health and particularly public hospital system. This needs to be a recognized part of hospital funding. When public hospitals are also centers of research excellence, then translation of research discoveries to clinical practice is enhanced rather than hindered. Currently, clinician-researchers are a rare and endangered breed. Their work in hospitals is valued only for the clinical component.

2. There is an urgent need for a complete revision of the NHMRC project grant process. Because the NHMRC is the main funding body for Health and Medical Research, no review of this area can be complete without a thorough examination of the role of the NHMRC. The major problems with the process as it stands are;

- The submission and review process is protracted and so time consuming, that a significant proportion of a researcher’s time is subsumed in this process and not in the conduct of research.

- There is excessive and unnecessary duplication of documentation generated by the grant submission process that directly hinders, rather than enhances, the efficient review of grants.

- The capacity of the NHMRC to fund worthy projects is steadily diminishing. The effect is to drive out good people from the sector and diminish the range of research done.

- The funding of research fellowships is abysmal and a deterrent to participation. The average age of researchers when they gain their first (SRFA) fellowship from the NHMRC is approximately 50 years and the success rate is less than 1 in 10.

- Research project grant funding does not cover the costs of research. Proper funding of research grants frees up other funding sources that can be put towards people support (for young and gifted researchers) and for higher risk projects.

- The NHMRC project grant budget must be quarantined from treasury cost-cutting exercises, and the value of research not be left to “bean counters” to judge.

3. Some consideration should be given to returning to the “block” funding schemes for institutes that show sustained and high levels of research excellence. In this system, those people at these institutes wit