Australasian Epidemiological Association
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26 March 2012

McKeon Review Secretariat
Strategic Review of Health & Medical Research
Commonwealth Government

Dear McKeon Review Panel,

We welcome the opportunity to submit comment to your review of health and medical research in Australia. The following comments are submitted on behalf of the Australasian Epidemiological Association (AEA). We are a professional association of approximately 700 members, involved in epidemiological and public health research, policy, and practice (http://www.aea.asn.au/). As such, our membership contributes in particular to improved primary and medical care through health services research, and to improved preventative health strategies through public health research.

We offer the following comments, focussing on how the Australian government can best support the health and medical research sector to bring about improvements in Australia's health and wellbeing.

***What are the health and medical research strategic directions and priorities and how might we meet them?*** **(Terms of Reference 5, 12 and 13)**

We would suggest that research on the determinants of good health and health behaviour could be improved so as to provide better evidence to support preventive health priority setting and intervention strategies. This should include prioritising study of disadvantaged populations. We praise the NHMRC's substantial efforts to expand research in indigenous health over recent years so as to contribute to the closing of the gap in life expectancy between indigenous and non-indigenous Australians. We would suggest that the NHMRC undertake a review to identify priority population groups who have poor health and/or health behavioural profiles to identify the determinants of these profiles, and to develop targeted intervention strategies to improve the health of such groups. This could be rationalised on the basis of ethical (e.g. to reduce health inequalities and to promote health equity), economic (to the extent that such groups might account for disproportionate healthcare spending or decreased cost-effectiveness), or policy development considerations (e.g., Preventive Health social marketing campaigns are likely to be least effective amongst those groups with the worst health behavioural profiles). Such groups might include low socio-economic status Australians, specific CALD or migrant groups, people with disabilities, racial and ethnic minorities, etc. An audit of previous or current NHMRC research in these areas could then guide strategically targeted research aiming to reduce health inequalities and promote health equity.

***How can we optimise translation of health and medical research into better health and wellbeing?*** **(Terms of Reference 4, 8, 9, 10 and 11)**

We see as a major area for expanded efforts at the NHMRC, as translation is clearly occurring at less than its potential, and much health policy and practice is inadequately evidence-informed. Meeting this challenge will require research on why translation does not happen as often or as quickly as it might, and it will require multi-disciplinary approaches including the social and political sciences. The inter-disciplinarity challenge may require some joint and coordinated research initiatives with the ARC, or some other means of raising the profile of and need for non-biomedical sciences to further understanding of and potential solutions for complex social and health problems.

The lack of methods for systematically and fairly assessing the contribution of research to policy and practice is a significant barrier to researcher participation in research translation. This problem is particularly challenging for non-clinical researchers (much of our Association's membership), whose work can inform non-health as well as health policy (e.g., in areas of education, housing, employment, etc.). We acknowledge that efforts have been made in this area that have not yet developed into usable metrics, and that the challenges are many. Nevertheless, we would urge the NHMRC to prioritise this area for further attention. Because researchers are not able to adequately represent and gain credit for such work in their track records (over and above the "Translation to Policy & Practice" entries in researcher RGMS CV's), this constitutes a disincentive to community-engagement and translation-oriented research in public health. Fellowship mechanisms might also be strengthened to encourage and support public health and health services researchers to allocate more effort to translation. The NHMRC Practitioner Fellowships are a valuable mechanism for bringing public health and health services practitioners into research (as are the TRIP Fellowships in the same regard for early career medical practitioners), but there is not a similar mechanism for encouraging researchers to develop their translation skills and efforts. We would suggest that NHMRC explore ways to achieve this, perhaps through offering a designated number of NHMRC Research Fellowships with substantial translation elements. Other approaches might include aligning some strategic NHMRC Research Fellowships with emerging policy (e.g., Commonwealth Male Health Policy, Commonwealth Preventive Health agenda, WHO Social Determinants of Health policy, etc.).

Thank you for the opportunity to submit to this important review. We look forward to the Panel's report.

Sincerely,

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