

# STRATEGIC REVIEW OF HEALTH AND MEDICAL RESEARCH IN AUSTRALIA (McKeon Review)

## Submission by the Department of Health Western Australia

The key questions posed in the McKeon Review are:

- 1) Why is it in Australia's interest to have a viable, internationally competitive health and medical research sector?
- 2) How might H&MR be best managed and funded in Australia?
- 3) What are the H&MR strategic directions and priorities and how might we meet them?
- 4) How can we optimise translation of health and medical research into both commercial and social outcomes?

The WA Department of Health (WA Health) will specifically address Question 2 in respect to issues around infrastructure funding, and Questions 3 and 4 together in respect to a program of research that has both a strong policy focus around improving the sustainability of the health system and practitioner-driven research.

### ***Question 2: How might H&MR be best managed and funded in Australia? Infrastructure Funding support for health and medical research***

A recurring issue in regard to developing a viable health and medical research (HMR) sector relates to support for the required general infrastructure component of HMR, both in terms of the quantum of funds and its sourcing. Multiple funding pathways to support HMR infrastructure, arising from different Commonwealth and State Government sources and policy settings, creates potential inefficiencies, inequities (omissions) and a degree of opaqueness.

In respect to Commonwealth funding, university-based researchers obtaining grant funding attract infrastructure funding to their university through the higher education funding programs administered by the Department of Industry, Innovation Science, Research and Tertiary Education (DIISRTE), under the Research Infrastructure Block Grants (RIBG) and the Sustainable Research Excellence (SRE) schemes. Independent research institutes are not eligible for any of these funds but are eligible for the Independent Research Institutes Infrastructure Support Scheme (IRISS) from the NHMRC in proportion to their researchers' competitive grant income.

Various State Governments provide infrastructure funding support typically to research institutes, although Western Australia also supports researchers in public hospitals and universities (see table below). The rationale for such funding is generally that the mainstream Commonwealth funding for research is inadequate and thus the State schemes are seen as a top-up and complementary.

## Infrastructure Funding for Research by type of institution and source of funds

<b>Researcher Institution</b>	<b>Commonwealth Funding</b>	<b>State Funding</b>
<b>University</b>	DIISRTE - SRE RIBG	Some specific infrastructure funding
<b>Public (Teaching) Hospital</b>	None	Possible generic State support for health services, and/or specific infrastructure funding
<b>Research Institute</b>	NHMRC - IRISS	Various State schemes for infrastructure support

These different funding arrangements are not without their issues. Independent research institutes are often affiliated with one or more Universities which may be accompanied by various arrangements that underpin staffing and flows of funds including infrastructure support. While these may be of mutual benefit, the specific relationship between the amount of research funds attracted, the research being conducted and the infrastructure support provided, can become blurred. Further, claimant institutions may be able to utilise various administrative mechanisms to maximise advantage from the current funding schemes, which leads to the potential for cross- or double-funding of infrastructure from Commonwealth and State sources.

As far as the quantum of funds is concerned, in recent years there has been concerted attention given by the Commonwealth Government to increasing the level of infrastructure funds, with the aim of providing 50% of research funds through the Sustainable Research Excellence scheme. This has not flowed through to all HMR researchers and the State Government continues to be informed that support for infrastructure costs is insufficient and that State support should increase beyond the current rates of around 15-20 cents of the research dollar for research institutes.

It will also be apparent from the above description of infrastructure funds that there is no direct support for health service based researchers through any of the Commonwealth infrastructure funding support schemes, unless such researchers are linked to universities or research institutes. Even then, the infrastructure funding is directed to the institution that the researcher's grant is administered from, rather than directly for the research. The administering institution then allocates a proportion of the infrastructure funding to the research groups concerned based on its own internal priorities. The resultant amounts may not relate to the specific needs of the researcher nor the health service involved.

From the health service perspective, it is noted that Commonwealth-State health funding arrangements will alter as a part of the activity based funding national health reform program, which will also consider the teaching, training and research (TTR) component of hospital activity. The TTR aspects being developed in the health sector needs to interface well with the related Commonwealth funding schemes for

the university and research institute sectors for there to be a consistent approach to infrastructure funding.

The adoption of a unified system of infrastructure funding at the Commonwealth level linked directly to research grant income could rectify some of the current issues of eligibility and incentives, and will also lead to a more transparent system of national infrastructure funding. This will also assist State Governments in their consideration of such funding, and will be important in the future when the TTR component in the national pricing framework comes into effect.

**Questions 3 and 4:**

***What are the H&MR strategic directions and priorities and how might we meet them?***

***How can we optimise translation of health and medical research into both commercial and social outcomes?***

Over the past 5 years WA Health has gained evidence that suggests that the direct participation of clinicians/health practitioners in research that is based in their areas of work, and the subsequent translation of successful research outcomes into practice, can make a significant contribution to improving the quality, efficiency and cost effectiveness of healthcare delivery. An additional benefit of this is improving the engagement and morale of the health workforce.

The above benefits have been identified through the WA Health research funding initiative: the Research Translation Project (RTP) program. The focus of the RTP program is to support joint policy and practitioner-driven research in order to contribute to a more sustainable health system.

The context of the RTP program is based on the following issues:

- Rising health costs in the face of population increase, ageing, technological changes, and emerging new demands on health systems
- Ageing, and sometimes disaffected, health service workforce
- Lack of opportunity for clinicians to undertake research due to pressing clinical and service demands
- Disconnect between research, policy and practice in general, and lack of effective and proven research translation into clinical/health policy and practice

Under the RTP program, WA Health provides funding for short-term research undertaken within the policy setting of improving the evidence for a sustainable health system focussing on efficiencies and cost effectiveness, which can be translated into improved policy and practice. The research translation projects themselves are solution-driven and specifically directed at the end-users. They are investigator-initiated ('bottom up') and cover a wide range of areas relevant to WA Health. Projects are selected through a competitive peer review process.

Key benefits and findings of this program, which is now into its sixth annual round, that are relevant to contributing to a more sustainable health system include:

- Cost savings and efficiencies demonstrated on the basis of research derived evidence: overall, the program is cost neutral and includes a few projects that have up to 6:1 return on research investment;
- Wider engagement of researchers, practitioners, health administrators and policy makers in research and knowledge translation;
- Research capacities developed among people not traditionally involved in research;
- Improved morale and engagement among staff in public health services, who can feel empowered by the ability to address and resolve problems through appropriate research;
- Increased senior executive support for research, because of strong alignment with organisational and managerial performance indicators (cost and efficiency), and immediacy of research outcomes ('useable' results within two years).

WA Health's RTP Program provides, therefore, a unique approach to encouraging research translation across the health system in that it integrates four key elements:

- The relevance of research to issues facing WA health, which results in research-informed system improvement;
- A focus on achieving cost savings and/or efficiencies in a short time-frame, which contribute to the sustainability of the health system;
- Engagement of, and collaboration between, clinicians/health practitioners, researchers, health economists and policy/decision-makers;
- Capacity building and staff engagement/satisfaction.

Based on this experience, WA Health believes that the Research Translation Project program provides a useful model for addressing some important aspects of Questions 3 and 4 of the McKeon Review. A case study around one of the RTPs is attached as an illustrative example for information.

## **Research Translation Project**

### ***Criteria-Led Discharge for Cardiovascular Patients***

Increased pressure for hospital beds often results in elective cardiac procedures being delayed or cancelled. Improved patient flow in cardiovascular medicine wards in WA Health is now occurring through the use of criteria-led discharge (CLD) protocols that were developed and evaluated in a Research Translation Project.

CLD allows for patients to be discharged by registered nurses without the need for final medical review. Nurses use a strict set of medically approved criteria to assess if the patient is suitable for discharge, with any deviation from these resulting in the patient reverting back to a medically-led discharge.

The introduction of the CLD process on a cardiovascular ward resulted in an estimated savings of \$926,000 per year, based on patients with Acute Coronary Syndrome and Arrhythmia. The return on investment for this project was over 6:1, with the project also having a number of additional benefits:

#### **Patient Benefits:**

- Decreased discharge waiting time
- Enabling discharges outside of normal hours.

#### **Health Professional Benefits:**

- More appropriate use of medical and nursing staff time
- Enabling flexibility for discharge times.

#### **Organisational Benefits:**

- Reduction in patient length of stay
- Improved patient flow.
- Increased access to beds for admitted emergency patients.