SUBMISSION TO

STRATEGIC REVIEW OF HEALTH AND MEDICAL RESEARCH IN AUSTRALIA

From the perspective of research managers supporting the research endeavours within tertiary teaching hospitals. Ms Areti Gavrilidis, Dr Sianna Panagiotopoulos

1. Why is it in Australia's interest to have a viable, internationally competitive health and medical research sector? *(Terms of Reference 1 and 6)*

There are various reasons why it is in Australia's interest to have a viable internationally competitive health and medical research sector, such as:

- Improved quality health care and well being for our population
- Translation into new treatments/devices/methods with the potential for social and large economic benefits
- Productivity gains
- Attraction and retention of the best people
- Branding and recognition of Australia locally and globally

2. How might health and medical research be best managed and funded in Australia? (Terms of Reference 2, 3 and 7)

Structural changes and new models: New models in structures and funding eg Academic Health Science Centres/Systems/Networks.

These models of health care integrate research, teaching, training, and clinical services by bringing together healthcare institutions such as hospitals, universities and research institutes. This model has been successfully established in the US, Netherlands, Singapore and more recently the UK.

Academic Health Science Centres should be established with appropriate budgets for clinical and translational research with agreed KPIs and monitoring and reporting arrangements.

Greater investment for hospitals: The strategy of funding of medical research and health by different government departments and levels of government needs to be better coordinated. The current funding strategies reward fundamental discovery research but not health care outcomes research. This is not a situation unique to Australia.

Greater investment, by both levels of Government, is required in funding people and projects in health and medical, clinical and translational research. Research should be an explicit, funded component of teaching hospitals and other health services which host (or wish to host) a clinician and translational research program. There should be explicit agreements between funding agencies and health care services [or academic heath sciences] conducting research, in regard to research activity. Agreements would encompass provision of appropriate clinical research appointments, protected time, career paths for part-time clinical researchers (doctors, nurses and allied health professionals) and research infrastructure as well as research outputs.

Streamlining of processes: Processes associated with research ethics, research governance, grant applications and associated annual reporting requirements need to be streamlined to: firstly, allow for efficiency improvements, better workforce utilisation and researcher time and secondly, to remove barriers that can enable clinicians to undertake clinical research. The move toward harmonisation and a single ethical and scientific review of multi-centre clinical trials by certified NHMRC committees is an attempt at streamlining which is fully supported. However, variation in State statutory and legislative requirements needs to be addressed if the research ethical approval processes are to be truly optimised.

Options and strategies to streamline the research governance arrangements need to be reviewed with the potential of establishing master agreements for national and international collaborative projects. Collaborative arrangements are fundamental to successful and timely research.

Greater standardisation of grant application forms for funding from government and non-government funding agencies to remove unnecessary waste and duplication of effort by researchers and research administrative staff.

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

Investing in world class research with a balanced investment across the pipeline from basic to applied research with adequate infrastructure and administrative support. Priority should be given to identifying evidence base gaps with a focus in implementation of research discoveries and knowledge into clinical practice.

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

The greatest value of health and medical research is in improving the health outcomes of our population. Translational research requires involvement of people of many different backgrounds and skills. A united approach between governments, funding agencies, healthcare institutions, academic institutions and industry in developing a mutually agreed strategy to overcome the barriers and 'organisational silos' is needed. The model of Academic Health Sciences Centres/Systems/Networks addresses the mission delivering better health by excellence in research and teaching.

The translation of health and medical research into better health and wellbeing can be optimised by:

- addressing shortage of individuals suitably trained to perform and administer translational research
- funding of clinical research which has been traditionally supported by hospitals through variety of arrangements including income from clinical practice and clinical trials rather than by grants
- assisting clinician-researchers who have an interest in doing research to be able to meet the demands of the clinical responsibilities, to attract competitive funding and have protected time for clinical and translational research
- separate category of grants for human-oriented research to be evaluated on their own standards and merit
- developing mechanisms that allow translational research to compete effectively against basic research [dedicated funding and positions for Translational clinician research fellows]
- increasing the level of funding directed at clinical research aimed at clinical practice change and policy with relevant criteria [clinical work does not stack up well against laboratory models when the primary criterion is scientific rigor]
- allocating adequate funding in the later part of the translational pathway [type 2 to type 4 refer to Figure 1 below] with adequate investment in the hospitals, the clinicians and clinicians researchers for adoption and implementation into practice

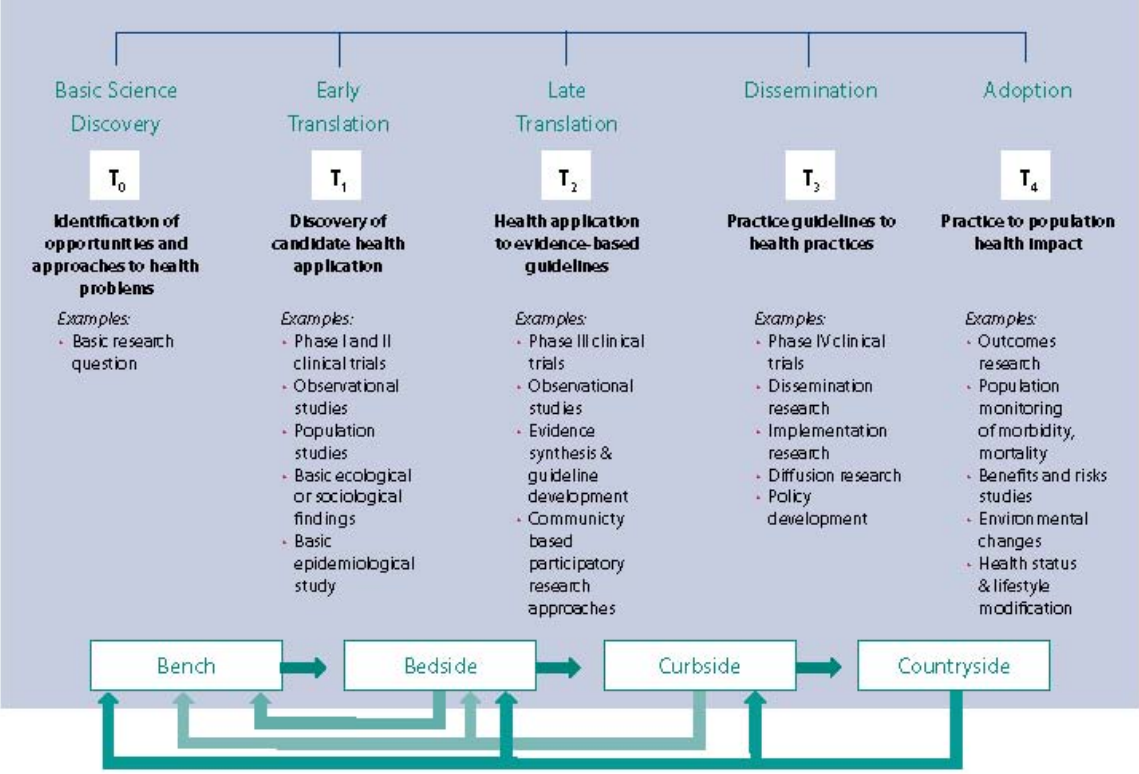

Figure 1: Models of the Translational Research Continuum
http://ahsc.arizona.edu/sites/ahsc.arizona.edu/files/Strategic%20Overview%20FINAL%2010.pdf

Infrastructure is required to maximize the capacity of clinicians to conduct core research activities. In the US the NIH Clinical and Translational Science Awards (CTSA) program was launched in 2006 to rapidly capture, translate and disseminate scientific advances. The CTSAs support the innovation and partnerships necessary to bridge the traditional divides. Some of the consortia have established successful public–private collaborations that span the full range of the translation pathway (from T1 through to T3 /T4 translation). More recently this has extended to funding the establishment of Clinical Research Centres within the CTSA program. In the UK recent investment has been made in NHS Clinical Research Facilities of about £100M on research nurses and technicians at 19 facilities [announced March 2012][1]. Such programs with new strategic models integrating health care, research and teaching have a greater chance to optimise the translation of research into preventive and improved health care outcomes with the associated economic returns.

[1] http://mediacentre.dh.gov.uk/2012/03/01/over-100m-to-support-groundbreaking-clinical-research/