Why have a viable medical research sector?

There are all the obvious reasons for this: Australia has a well educated, innovative, proven medical research community, which punches above its weight in discoveries that have, and continue to, change practice and improve health.

What is often missed in addition is that the alert, questioning, knowledgeable research community forms the gatekeeper for the assessment of new technologies in health. Without it, we are not well equipped to evaluate new and existing drugs, devices or procedures- a huge negative for Australia.

Management and funding?

Assessment of grants by proper peer review, such as we have had in the recent past, but are rapidly losing, is essential. Too much attention to 'compliance issues' and too little to having review of the right people involved has been destructive of the process.

We also desperately need an overhaul of the NHMRC Fellowship scheme, which is in disarray and apparently receiving little attention. This is critical to the protection of the people who perform our excellent medical research. There are two problems currently: firstly, that NHMRC Fellowships are funded at a salary rate far below the EBA of each of the Universities; secondly that lack of management of the scheme and its demographics means that there is no secure career path for young biomedical scientists and there is no security for mid-career scientists. Resolution of this crisis is possible but it urgently requires a productive conversation between the NHMRC, the Universities and the Government.

Strategic directions?

These have been identified well in the National Health Priorities, which reflect disease burden in the Australian community. However the National Health Priorities often do not align with funding priorities. For example, pathologies of Bones and Joints represent a huge and growing disease burden, recognised globally in the Decade of Bones and Joints, but this is by no means reflected in relative research dollars for this field.

Better translation?

Clinical trials are the key here but these are becoming almost impossible to perform. To obtain ethics approval across institutes is sufficiently difficult to dissuade all but the most hardy. Recent efforts to address this have had the opposite effect. In anything like an ideal world, clinicians would be required (with appropriate funding and support) to demonstrate evidence base for the treatment of patients. Instead, for any clinical trial to take place, busy clinicians need to find time to write an application, with marginal chance of success. Success then dooms the successful (particularly in the case of multi-institutional clinical trials)

to a crushing burden of ethics requirements. I urge the committee to probe this morass by talking to ‘end-users’.