

Office for Research

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SUBMISSION TO
STRATEGIC REVIEW OF HEALTH AND MEDICAL RESEARCH IN AUSTRALIA
ON BEHALF OF AUSTIN HEALTH

Austin Health is delighted to have the opportunity to make a brief submission to this important review. We make it predominantly from the perspective of the importance of research to the public hospital sector, but also make some observations about the sector as a whole.

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):

- (a) From the perspective of the end users – the Australian citizen who is ill or who wishes to be prevented from being ill – the most compelling reason is that health care (including preventative health) has been shown to be better and safer when health practitioners are actively engaged in research to improve health, or have at least been trained (in an environment that emphasises the nexus between research and training) to weigh research evidence as an integral part of delivering health care.

For instance a number of studies have shown that teaching and research hospitals have better patient outcomes than non-teaching hospitals. One example was a recent study from Spain, which has excellent integrated data on its national health outcomes, that showed a positive correlation between survival from cardiac causes of death and the publication citation rates for the clinicians in different hospitals.¹

The Australian Medical Council recognises the importance of this connection between a viable medical research sector and the quality of emerging medical graduates

¹ References can be provided on request

by specifying in its accreditation criteria for medical schools that they adequately address the nexus between research and training.

- (b) An internationally competitive health and medical research sector also provides economic benefits for Australia. We believe others will argue this with supporting data on start up companies, but point to the large amount of export income earned by Australia from educating foreign undergraduate and doctoral students – a substantial proportion of the latter engaged in biomedical research, attracted by Australia’s reputation and capability in this field. Australia also attracts substantial amounts of foreign funding for its biomedical research. A recent example from our own precinct has been the decision of the international Ludwig Institute for Cancer Research, as a result of a major reorganisation, to site one of its only three centres in Australia (the others will be condensed to Oxford and San Diego). The Austin site will be the single translational cancer research centre worldwide for the Institute.

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

The principal source of funding should logically remain the Australian Government, although the Victorian government makes a useful (but much smaller) contribution towards supporting infrastructure for the State’s medical research institutes.

The National Health & Medical Research Council is well placed (and supported by a great deal of pro bono work by numerous peer reviewers) to continue to manage the decisions about who and what should be supported for much of the more basic biomedical discovery in Australia, and to manage the accountability for those funds.

A lack at present is adequate processes for funding and supporting research at the level of health care institutions. We have already mentioned evidence showing hospitals that are actively engaged in research are safer places (for many reasons). However, despite research and training having been specified as a requirement in Medicare-agreement funding of State health services by the Commonwealth for some years, there is not accountability for funds to be spent in this way and most State health departments do not see it as a priority. Large projects (especially multi-site ones) may be supported by NH&MRC, pharmaceutical companies or some other bodies such as professional associations. However, there is scope for much more research into better health care methods and translation at local facility levels if some dedicated and protected funding for salaries and infrastructure were dispersed at that level.

Current impediments that would need to be addressed include (i) providing some protected time and creating a career path in part-time research for suitably trained hospital staff (doctors, nurses and allied health professionals) and (ii) providing some human and physical infrastructure to support this at a local or hospital network level. As an example of one

mismatch in funding research in Australia, infrastructure to support peer-reviewed major research grants is provided to universities and larger research institutes, but not to hospitals.

With regard to governance going forward, we see merit in developing an overarching research strategy that encompasses research at national and state level, with one body that oversees implementation and performance. It would be important though, if good translational research into practical issues at the delivery end of health care is to be best nurtured, for a significant amount of total research funding to be allocated directly to health care providers (especially teaching hospitals) for them to allocate at the local level according to local capabilities and needs. The project grant processes of NH&MRC are too cumbersome and 'high level' to be able to manage 'bread and butter' research at this local level.

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):*

To this we would respond briefly by saying there are advantages and disadvantages in trying too hard to predict 'winners'. The Panel will be well aware that some of the most valuable discoveries leading to better human health have come unexpectedly, even by serendipity, as researchers followed their curiosity to try to understand how something worked.

Nevertheless, NH&MRC does try to stimulate research in certain areas each year by specifying priority areas – and this can be valuable when areas perceived as important are being under-researched (e.g. aboriginal health). This is probably a mechanism that is worth continuing.

As a general principle, though, it is important to achieve a good balance between basic (discovery) research that aims to understand diseases and body (and social) functioning on the one hand, and more translational research to apply basic knowledge on the other.

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):*

We support the move toward providing a single ethical and scientific review of multi-centre clinical trials by committees certified by NHMRC. However the approval process would be further optimised by the harmonisation of specific State statutory and legislative requirements (eg Human Tissue Act 1982), which currently vary considerably between States.

Our main response to this question is to refer back to what we wrote about the importance of enhancing a well-supported research culture, infrastructure and personnel in the sites where translation occurs, especially in teaching hospitals ('Academic Centres'). The reasons to put the biggest focus on this sector are that it is currently under supported, has the strongest links with universities and research institutes (for sharing of staff and knowledge transfer), and not only manages most sicker patients for a part of their illness but also acts as

a knowledge transfer conduit to the community of general practitioners. The largest challenge to enhancing the translational research function of the public hospitals is likely to be the same one that causes its present difficulties – the division of responsibilities between federal and state governments, which leads to the latter focussing mainly on the day-to-day challenges of administering health care – often to the exclusion of providing for the future.

We do not mean to imply that research in primary care and in public health is not also important. Improving translation in primary care may be helped by providing a mechanisms for salary support, at a fractional level, for a number of research-trained practitioners in larger group practices or networks. Without this, the priorities of earning a living in a system that remunerates practitioners for each episode of care works against significant research in this sector, except by the small university academic units.