McKeon Review of Health and Medical Research

Summary

Rural and remote communities have significantly worse health outcomes than metropolitan residents and research is needed to develop new approaches to improving rural and remote health.

Particular attention needs to be given to rural and remote context since poor rural and Indigenous health outcomes suggest that service models built on metropolitan assumptions are not effective.

Addressing the health of rural and remote populations requires the use of a wide range of methodologies drawn from the social sciences, public and population health, health services research, evaluation and implementation science and similar disciplines as well as more conventional evidence drawn from biomedical science. Funding arrangements should recognise this complexity and ensure appropriate peer review from researchers, policy makers, clinicians and community representatives.

Research to address rural health needs to be conducted by researchers who are resident in rural who understand the contextual factors which determine appropriateness, acceptability, effectiveness and sustainability of rural health interventions.

Considerable investment has been made in rural research capacity through the University Departments of Rural Health (UDRH) program, Rural Clinical Schools and regional Universities. It is important to build on this capacity and ensure sustained funding is available. Research groups in rural and remote communities cannot develop if funding is short term and intermittent and rural communities cannot rely on metropolitan research groups to address rural health disparities.

The costs of collaboration for rural research groups are considerable and while information and communications technology and the National Broadband Network may help, these costs of collaboration with other researchers and with policy makers need to be appropriately funded.

Much more attention is needed to building relationships between researchers, policy makers, service providers, clinicians and communities to facilitate the development of evidence based policies and programs, the evaluation of services and interventions and the best use of evidence by service providers in addressing poor health outcomes in rural and remote Australia.

Introduction

This response is written from the perspective of rural and remote populations and rural health researchers.

Thirty percent of Australia's population live in non-metropolitan settings and considerations of equity would suggest that their needs and role in the production of applied and relevant research should be addressed in a review of health and medical research.

Health has social determinants which relate to people and place. In Australia rural and remote residents, particularly Indigenous citizens, have the worst health outcomes, quality of life and life expectancy. Addressing these outcomes requires research addressing health, social determinants and health services which are poorly served by current arrangements.

It is critical to distinguish between health and medical research. Health is a broader concept than medicine and medical advances do not necessarily lead to improved population health. Chronic, lifestyle and continuing diseases place a heavy burden on rural residents and communities and are better prevented than treated.

Such research usually falls under the banners of population health and health services research and increasingly under the banner of rural health research.

Why is in Australia's interest to have a viable, internationally competitive health and medical research sector?

Having a viable and internationally competitive health and medical research sector means that Australians are engaged in setting the agenda for health and medical research which addresses issues of national and regional interest such as the impact of climate adversity on the (mental and physical) health of populations and individuals.

Research achievements are often the consequence of strong international collaboration between the best researchers. Rural Health researchers increasingly work with the best overseas researchers for the benefit of Australians and wider international populations.

A viable and internationally competitive health and medical research sector will enable us to recruit and importantly to retain the best international researchers and to build and develop research teams equipped to address the key health problems facing the Australian population foremost of which are rural remote and Indigenous health outcomes.

How might health and medical research be better managed and funded in the future?

A clearer understanding is needed of the differences between biomedical research, population health research and health services research. The challenges of implementing research evidence in policy, in services and in clinical practice must be addressed if the wide variations in practice and outcomes are to be overcome.

Particular attention needs to be given to context since poor rural and indigenous health outcomes suggest that policies and service models built on metropolitan assumptions are not delivering appropriate outcomes.

Addressing rural and remote health needs is a complex and potentially expensive exercise as evidenced by attempts to provide equitable workforce though incentives, training initiatives, fly-in fly-out, and other approaches. Policy often moves in incremental steps and the implications of such steps are seldom evaluated. Complex problems are likely to require sophisticated solutions and broad standardised "one size fits all" solutions may prove counterproductive. For example, the growth of fly-in fly-out specialist medical services may provide short term gains at high costs for rural communities weakening the resident skill base and increasing dependence on metropolitan services. Achieving behavioural change at individual, household and community levels to address the threats of chronic disease and obesity is challenging and will require new and innovative approaches within rigorous research and evaluation frameworks.

The funding of health and medical research funding and the allocation of research funds in Australia favour biomedical research over population and health services research which are more likely to impact on rural and remote health outcomes. Population health and health services research are applied rather than basic disciplines and employ a wide range of social scientific approaches such as qualitative and mixed method research, complex intervention studies and evaluations of new services.

Rural and remote populations are by definition different and small and in many cases research will have to address the problems of small numbers and use of innovatory approaches and research methods.

These arguments imply that alternative funding mechanisms are needed in which rural health research is assessed for quality, value and relevance by appropriately qualified panels of peers, policy makers, service providers and community representatives.

Evidence from the UDRH program suggests that building rurally embedded research capacity takes time - UDRHs are producing important research but it has taken 10 plus years for the capacity and capabilities to develop. This is no different from the development of metropolitan research capacity but rural researchers have started later. The APHCRI Centres of Research Excellence program is a promising start in this direction offering funding for 4 years to address questions of relevance to policy and practice.

Changes in the PHCRED strategy have meant that many researcher development programs have ceased in rural areas and this may have implications for the future of research and the supply of rural researchers to benefit some rural and remote communities.

What are the health and medical research strategic directions and priorities and how might we meet them?

Conducting high quality research requires extended application by teams and collaborations and this must go beyond a focus on single, short term project funding.

Effective primary health care has been shown to have the most cost effective impact on population health outcomes. Rural Australia relies on primary healthcare due to shortages of specialists and the weakness of market based health care to deliver specialist care. Research on how to best develop rural primary health care to address the key burdens of an ageing population, chronic and co-morbid disease and mental disorders are among the top priorities.

Progress has been made in developing a resident rural research workforce through the UDRH program and to some extent the rural clinical schools. Australia leads the world in rural health research and this is largely due to investments made since 1990. This capability needs to be consolidated and developed. Rural research groups face major difficulties in the recruitment and retention of skilled staff and are making major investments in "growing our own" through PhD and Post doctoral programs. Consistent investments need to be made in this workforce if we are to address the problems of rural and remote ill-health.

Building a research literate policy, management and clinical workforce requires action throughout the career cycle from initial training, through vocational training, and throughout the career path. Educational and training must be multi-professional, crossing research, policy, service and clinical boundaries.

Making research an explicit and funded component of the National UDRH program would be a helpful development in this regard. This might range from funding credible evaluations of the many innovative workforce developments to developing rurally based research programs to address obesity, chronic disease and mental health. Rural and remote UDRHs and Rural Clinical Schools face particular problems in recruitment of skilled research staff and cannot afford to lose staff when short terms funding cycles do not match long term community research needs.

How can we optimise translation of health and medical research into better health and wellbeing?

The separation of the production of research from the use of that research needs to be addressed. There are limits to the effectiveness of "producer push" strategies in which researchers complete research and try to sell it to policy makers, service providers and clinicians.

Research leading to better health and wellbeing is the result of extended partnerships between researchers, policy makers, clinicians and communities. Such collaboration has costs and while such costs must be carefully monitored, it is unlikely that effective research translation will take place without such collaboration.

Much more progress is needed in developing boundary crossing opportunities in which researchers, policymakers/managers, and clinicians work in each others' organisations and learn to cross organisational boundaries.

Research funders often baulk at the costs of such collaboration which frequently has significant travel costs. It is to be hoped that the development of the NBN will facilitate new forms of collaboration with more consistent and easily available IT mechanisms for collaborative working but it will not eradicate these costs of collaboration.

Requirements for the evaluation of policy and service developments and the routine publication of publically funded evaluation research would enable a more informed process of policy and service development and in the long term might enable better investments in rural and remote health and improved rural health outcomes.

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