

HSRAANZ Response - Consultation on the Medical Research Future Fund 2018-2020 Priorities

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Which 2016–2018 MRFF Priorities Need Further Focus And How Can they be Extended Or Re-Emphasised In The 2018–2020 MRFF Priorities

Priority 1 – A National Institute Of Research

The HSRAANZ support the creation of a National Institute of Research, a key role of which would be to guide and support the conduct and use of health services research. The reference to a National Institute of Research was in the 2016-2018 MRFF Priorities was non-specific. It would be helpful to provide more detail on the intended objectives of such an Institute in the 2018-2020 MRFF priorities.

The HSRAANZ is supportive of the Health Systems Improvement and Sustainability initiative, which is being organised through the Australian Health Research Alliance (AHRA). The initiative has called for a National Institute, but it has also looked at a range of areas in which health services use and

production of research could be improved. The following four broad areas are those in which a National Institute could act as a hub for conduct and use of health services research:

Evidence synthesis to support decision-making

Local context is important, but there should be a common evidence-base for many of the health services issues addressed by health care organisations across the Australian health system. A National Institute could act as a co-ordinator and a repository for the synthesis of evidence. In England, the NHS has established 'Commissioning support units', which exist to provide relevant and timely evidence to health service institutions.

Local evaluation and decision-making

Local health services, and Primary Health Networks are examples of health care organisations that make funding decisions on a continuous basis, but there is little research on how such organisations currently make decisions, or on what models of local evaluation and decision-making best inform the allocation of scarce health resources. A National Institute could co-ordinate research to establish best practices, which will naturally overlap with efforts to support evidence synthesis.

Clinician-driven improvement

Clinicians are best placed to drive improvements in the provision of health services at the coalface. The challenge is to move from a system that relies on highly motivated individuals to undertake such improvement research, to one that supports the routine conduct of improvement research across the health system. A National Institute could provide a focal point for research to inform and support such system change

Health systems research

A National Institute could co-ordinate the funding of health systems research to inform health policy, including large-scale data linkage projects and community panels. In England, the Policy Research Programme commissions research to meet the needs of Ministers and national policymakers. An Institute could also co-ordinate the funding of methodological health services research, with a focus on establishing the applicability and validity of methods that are relevant to the conduct of health services research in Australia.

Priority 2 – Building Evidence In Primary Care

HSRAANZ support an extended MRFF focus on "building evidence in primary care". The MRFF has had a limited focus on supporting improvements in the delivery of primary care services. Primary health care is perhaps the most complex area of the health system, including services provided by 'general practitioners, practice and community nurses, nurse practitioners, allied health professionals, midwives, pharmacists, dentists and Aboriginal and Torres Strait Islander health practitioners either, in the home, general or other private practice, community health services and local or non-government services'.

Whilst complex, primary health care has the greatest potential to improve population health and provide the basis for a sustainable health system. Supporting the provision of accessible, affordable, high quality primary health care is a key policy priority. Since the discontinuation of the Primary Health Care Research Evaluation and Development strategy, there has been substantial decrease in primary care research, in research translation and in capacity building. Research in primary health

care is difficult. Innovative solutions may be required, which should be a key focus of a new primary health care research and development strategy. The development of a such a strategy should be an explicit MRFF Priority.

Priority 3 – Behavioural Economics Applications

HSRAANZ supports the extension of the Priority ‘behavioural economics application’. The 2016-2018 Priority emphasised the role of applied behavioural economics on early intervention in mental health, healthy eating and physical activity. In addition to structuring choices so that consumers are encouraged to choose better alternatives, there is also a significant potential for the use of ‘nudges’ to alter and improve the behaviours of all actors in the health system. This Priority should be extended to understanding incentives and motivations across all the individuals and organisations in the health system, whether as consumers, patients, providers, funders and health delivery organisations. It should also recognise that many health decisions are the result of the interaction of consumers and providers, subject to various constraints and policy settings, in the context of asymmetric information and a third party payer system.

What Unaddressed Gaps In Knowledge, Capacity And Effort Across The Healthcare System And Research Pipeline Need To Be Addressed In The 2018–2020 MRFF Priorities?

Gap 1 – Non-Clinical Health Services Research Fellowships

HSRAANZ acknowledges the importance of clinical research fellowships to support the development of clinicians to improve health services. Noting our earlier statement that we need to “move from a system that relies on highly motivated individuals to undertake such improvement research, to one that supports the routine conduct of improvement research across the health system”, there is a need to invest in non-clinical health services research fellowships to build capacity to support high quality routine improvement research.

There is a vibrant health services research community in Australia, which encompasses clinical and non-clinical health services researchers, but many non-clinical researchers move from fixed term contract to fixed term contract. The limited security of employment results in the loss of many high-quality researchers at the early career stage. This in itself is a waste of the resources, but the espoused MRFF focus on health services research will not be possible without an expansion of capacity in health services researchers.

Required specialist research skills include biostatistics, epidemiology, health economics, qualitative research, consumer and community engagement, evidence synthesis and implementation science. Clinical health services researchers require foundational knowledge in these areas, but most clinical researchers will continue to rely on support from non-clinical researchers with higher level training and experience in these research areas.

Specialist researchers with these skills need capacity and support to develop methodological and applied research programs. The NHMRC funds a limited number of health services research fellowships, but not enough to support an expanded focus on health services research. A priority to increase the availability of non-clinical health services researchers will provide the necessary infrastructure to maximise the potential impact of health services research across the Australian health system.

Gap 2 – Availability Of Research Project Funding To Conduct Health Services Research

A second gap relates to the availability of research project funds dedicated to the conduct of health services research. The NHMRC funds health services research, but whilst the proportion of the NHMRC's budget allocated to health services research has increased, at 6% in 2016 it remains very low. This may be partly explained by the lack of a specific Grant Review Panel for Health Services Research for NHMRC project grants.

The HSRAANZ supports the recent funding calls that are being organised through the Academic Health Research and Translation Centres (AHRTCs), including the Rapid Applied Research Translation for Health Impact Grants in South Australia. These programs aim to fund short-term projects that are directly related to improving clinical health systems, patient outcomes and/or population health services. We think the MRFF should monitor and evaluate these schemes in detail (e.g. in-depth analyses linking project outcomes to project applications) to inform the review and funding of proposed projects, and the value of such research, with a view to increase funding to a level at which all high-value projects are funded.

The regional nature of the funding through the AHRTCs for applied research has merit – it supports proportionality of funding and consideration of local contexts and priorities. A separate national MRFF funding stream for health services research projects would complement the local funding schemes. A national funding stream could focus on funding:

larger-scale or broader applied health services research relating to health systems, such as funding models, organisational structures and processes and workforce.

methodological health services research, such as the development and evaluation of pragmatic and health service-relevant methods for evidence synthesis and economic evaluation, methods for improving consumer engagement and in implementation science.

Gap 3 – Ensuring Health Services Research Leads To Improved Health Care Delivery Across The Whole Health System

The HSRAANZ supports the concept of AHRTCs, and in particular the Centres for Innovation in Regional Health (CIRHs) as vehicles to support the broad application of health services research across the Australian health system. The MRFF Priorities should emphasise the importance of ensuring health services research leads to improved health care delivered across the whole health system.

Successful small-scale translation or implementation projects should be disseminated beyond the geographical area(s) in which they are demonstrated to be successful. However, models of care that are effective and cost-effective in metropolitan areas may not have the same effects in regional and rural areas (and vice versa). The MRFF should prioritise resources to support the dissemination, potential adaptation and large-scale evaluation of successfully implemented models of care.

What specific priority or initiative can address the above gaps?

Gap 1 – Non-Clinical Health Services Research Fellowships

Extending capacity of non-clinical health services researchers with specialist research skills could be facilitated through the NHMRC, extending current people funding programs to target specified research skills. Workforce modelling methods, linked to a planned expansion of health services research, should be used to estimate the required capacity of different specialised skill sets, to inform the optimal size and configuration of an extended non-clinical fellowship program.

To support the development of researchers with high-level research skills relevant to the conduct of health services research, consideration should be given to the relative lack of options for post-graduate training in many of the posited disciplines within Australia. One area in which high-level training options are available is biostatistics. The Biostatistics Collaboration of Australia (BCA) is a consortium of biostatistical experts from around Australia with representatives from universities, government and the pharmaceutical industry who have combined to offer a program of postgraduate courses. Similar models should be explored for the provision of training in epidemiology, health economics, qualitative research, consumer and community engagement, evidence synthesis and implementation science.

The Health Research Board in Ireland funds the [SPHeRE](#) (Structured Population and Health-services Research Education) Programme. SPHeRE expands an established structured PhD Programme in Health Services Research as part of an objective to create a national network in Population Health and Health Services Research incorporating all higher education institutions in Ireland. Each year, up to 12 scholars join the programme, which includes [six online teaching modules](#) that cover policy perspectives and key methodological issues, an annual conference and an alumni-scholar coaching panel. The establishment of a similar program in Australia should be a priority for the MRFF.

Gap 2 – Availability Of Research Project Funding To Conduct Health Services Research

As noted in response to Question 8, the HSRAANZ calls for an expansion of funding for local health services research projects through the AHRTCs and CIRHs. The HSRAANZ supports efforts to link researchers and health services, such as the Rapid Applied Research Translation for Health Impact Grants requirement for letters of support from health service organisations. Other approaches should be investigated, such as methods to reward research participation by health service institutions.

The Association also calls for the establishment of a national funding stream for larger-scale or broader applied health services research and methodological health services research. Investigator-led projects could be funded through the NHMRC project grant program, using specialist health services research Grant Review Panels (currently the NHMRC does not have a separate health services research GRP).

We also call for further investigation of options for generating tenders for health services research projects, as a supplement to researcher-initiated research. The National Institute for Health research in England has developed thorough panel-based processes for the prioritisation and specification of tenders for health services research projects.

Another approach currently used in England is the establishment of ‘Commissioning support units’, which undertake rapid evidence reviews and analyses to inform funding decisions within the NHS. Similar entities could support evidence-informed policy and practice in the tertiary, hospital and primary care sectors.

Gap 3 – Ensuring Health Services Research Leads To Improved Health Care Delivery Across The Whole Health System

A separate funding stream would need to be created to support the dissemination, potential adaptation and large-scale evaluation of successfully implemented models of care. Implementation at scale should allow for the use of large simple trials for the evaluation component.

The AHRCs and CIRHs are well placed to support and monitor dissemination within their jurisdictions, acting as hubs, providing pro-active and re-active services and connections to promote the adoption of effective and cost-effective new models of care.

What Strategic Platforms (Identified In The MRFF Strategy Document) Would The Priority/ies You Identified Fall Under?

- Strategic and international horizons
- Data and infrastructure
- Health services and systems
- Capacity and collaboration Trials and translation Commercialisation

How Can Current Research Capacity, Production And Use Within The Health System Be Further Strengthened Through The MRFF?

There is significant variation in the extent to which health services research is currently being undertaken within the health system. 'Best practice' health service institutions could be used as exemplars to promote the use and production of research within the health system. Common features might include:

- research support teams providing access to statisticians, epidemiologists, health economists and qualitative researchers;
- an internal funding pool;
- a grant management team to identify and manage external funds;
- dedicated research space for clinicians to delineate their clinical / research roles.

Additional Comments On The Discussion Paper

The current low levels of funding for health services research may be partly explained by inadequate infrastructure to create the capacity and motivation to undertake high quality HSR, and to bring researchers, health professionals and managers and policymakers and consumers together to identify, prioritise, undertake and translate high value HSR.

The lack of infrastructure results in fragmented and reduced impact HSR, which perpetuates the lack of investment in HSR, but more importantly does not fulfil the potential of HSR to create a high quality, equitable, efficient and therefore sustainable health care system for the Australian population.

HSR is not like basic or clinical science or even public health research, where research can be conducted in isolation and then reported with an expectation that positive research findings will be implemented. Health care is delivered in an increasingly complex system and research to improve health services must involve ongoing engagement between all stakeholders in a continuous process of improvement. To maximise impact and equity, health services research needs to be undertaken across the health system, not just in the large and high-profile institutions. Widespread health services research requires appropriate structures, support and incentives.