

October 2012

**Submission to the Strategic Review of Health and Medical Research
Health Services Research Association of Australia and New Zealand**

1. About the HSRAANZ and HSR

The Health Services Research Association of Australia & New Zealand (HSRAANZ) was incorporated in Sydney in April 2001. It was set up in response to a growing need to promote health services research in both Australia and New Zealand. The purpose of the Association is to facilitate communication across researchers, and between researchers and policymakers, to promote education and training in health services research, and to ensure sustainable capacity in health services research in Australia and New Zealand. The Association has grown over the years and now has a strong membership base of both individual health service researchers and corporate health services research groups, government departments and agencies. It has a particular focus on early career and Indigenous health services researchers.

The objects of the Association are to encourage and promote the development and conduct of health services research, in order to promote improved health services delivery and improved health; and in particular to promote the development of sustainable capacity in the field of health services research, facilitate and promote communication and collegiality among researchers engaged in health services research, facilitate and promote the regular exchange of views across researchers and policymakers, managers, clinicians and other interested parties, promote the education and development of researchers and others working in health services research, encourage the development of strategically important research, promote excellence in health services research and advocate for appropriate levels of funding for health services research in Australia and New Zealand.

Resources for health care are scarce, and technological advances place greater pressure on government and consumer budgets, with new treatments being available that offer gains in quality of life and survival, but at a high cost (such that other treatments could generate greater gains in population health). Moreover, as the population gains knowledge about the potential of health services to deliver high quality, safe care, their expectations about the processes and outcomes of health care services increases. It is therefore essential that consideration of efficiency and equity, as well as availability and acceptability to patients and the general public are informed by analysis, and that such analysis and its results should be a fundamental part of health and medical research, translation, and practice.

Health Services Research (HSR) is a multi-disciplinary research activity with an implicit objective of improving the health services patients receive. Thus it is an area of applied rather than 'basic' research - it uses theories of human behaviour from contributing disciplines, along with evidence from the medical sciences, to generate and test hypotheses about the delivery of health care. Improvement of health services has many dimensions: better quality care (including care that is effective, timely and appropriate), more accessible care, more equal distribution of health gains from health services, safer care, and improved efficiency, both allocative and technical, in the provision of health care.

HSR differs from single-discipline research in that it seeks to understand these dimensions from multiple perspectives. It calls on knowledge from the contributing direct service disciplines of medicine, nursing, allied health, and psychology to understand dimensions of effectiveness, quality and safety of direct care in all its forms. It calls on the disciplines of psychology, sociology, political science, management science and health economics, to understand the social dimensions of care: access, distribution, timeliness, efficiency. While HSR shares a concern for improvement of health services with practitioners of 'big-P' health policy (health ministers, senior bureaucrats), it is distinguished by its emphasis on a research basis for policy, in contrast to big-P policy practitioners who must consider expedient policy solutions and electoral support. HSR is underpinned by a belief that systematic investigation of health services, and the systems in which they are provided, is helpful in improving health outcomes.

The focus on **services** is what distinguishes HSR from other multidisciplinary health research activities. Population health (and most of 'public health') rightly focuses on the antecedents to ill-health and explanations for the distribution of health and disease. 'Public health' is historically an amalgam of population-based measures (eg, sanitation) and individual health services (eg, immunisation), but public health research is usually not principally 'service' focussed. The audience for HSR extends across a broad spectrum, from innovators in bioscience to experts in indigenous health. Practitioners and researchers share an interest in understanding how health services contribute to their own domains and how they can be improved to increase the welfare of society more generally.

Health services research and training is significantly underfunded relative to its potential to improve population health at reasonable cost. There is a shortage of health services researchers relative to demand for our services yet this has not been effectively translated into additional research funding. The past 10 years has seen some growth in the number of dedicated health services research centres in Australia, partly funded through the NHMRC Health Services Research, Capacity Building Grants and CRE schemes; and partly through State government funding (most notably recently in Queensland, with the inauguration of Australian Institute for Health Services Innovation) which have enabled some fledgling domestically based Masters and PhD training programs to be implemented.

2. General response to consultation document

It's gratifying to see recognition of the need for greater investment in health systems research and health economics to meet the challenge of maintaining a sustainable health-care system. Although it is not new, the emphasis in this review is stronger than other recent reports. But it fails to grasp the breadth of research required in this area.

As well as informing delivery of services, research also needs to inform "big picture" health policy. While some aspects of health care provision, such as efficacy, quality and safety will benefit from research evidence produced at the level of service delivery, we also need evidence about how efficient, accessible and equitable the health system is.

3. Management and Leadership of HSR

Unlike many other Australian government policy areas, the [Department of Health and Ageing](#) doesn't have its own internal research capacity or funding; it relies on the [National](#)

[Health and Medical Research Council](#) (NHMRC) to fulfil this role. This may be appropriate for biomedical and clinical research, but it doesn't work for health services, health policy and health economics research.

We are disappointed that the report has recommended that the management and leadership of health services research be left with the NHMRC, given the organisation's poor track record in supporting this type of research. We believe that to truly achieve evidence-based policies, the review should recommend a similar approach to the United Kingdom, where the [Department of Health](#) has its own policy research program and the [National Health Service](#) (NHS) has the [National Institute of Health Research](#), in addition to the separate [Medical Research Council](#).

A new Australian institute of health systems research should be established which would be the recipient of quarantined funding for health systems and health services research. This would fall in line with the review's recommendation that at least 3% of Australian and state and territory government health expenditure (an additional A\$2bn to A\$3bn per year by mid-2023) be set aside to drive research activity within the health system as an embedded component of the Australian government's health reforms.

4. Priority setting for HSR

The second important task for such a new Australian institute would be to set priorities for health systems research. While the review supports priority setting for research with earmarked funds, many researchers have been less than satisfied with previous priority setting processes in this type of research.

Over the past 15 years, we have seen a diverse range of attempts at health system and services research, including ones based on national health priorities, national research priorities, a priority-based collaboration between the states and the commonwealth, partnership projects and now partnership centres.

While consultations were undertaken prior to each new scheme, no independent evaluation has assessed the success or otherwise of these schemes. And most have come and gone so fast that, in practice, the individual research projects they supported resembled poorly-funded commissioned projects.

5. Building research capacity

Implementing a new national institute would require research capacity. When a similar need to build research and research capacity was identified in primary care, the response was the [Primary Health Care Research Evaluation and Development Strategy](#) and the funding of an institute (ACPHCRI) to provide leadership, and support centres of research excellence alongside, not instead of, access to NHMRC funding.

While the review recognises the importance of building research capacity, it fails to understand that this requires more than providing training, funding and time for health-care professionals to undertake research. Health services researchers come from many non-clinical disciplines and need to be sustained along a career path. An Institute for health systems research would facilitate this (see also Point 7 below).

6. Access to data

Access to high-quality data is also an essential part of the infrastructure required for health services research. Clinical trials are only one, and an increasingly expensive, way to deliver evidence on what works. We also need to know what works when new treatments are made available to all patients. We need to know what works for so-called rare diseases, where the patient population is not large enough to enable powerful trials, but where the prevalence is increasing, and many people are living with ongoing severe conditions. There's an urgent need for support for better collections of observational data (such as registries and longitudinal data).

We need to have the means to link data from various sources. In particular, we need to be able to link data on inputs (health professionals, hospitals and GP practices, for instance) to outputs and outcomes (volume of services provided, performance indicators, and health outcomes).

So far, the data linkage process has focused on linking patients' data (linking individuals' in-patient and emergency data with data from cancer registries, for instance). While this is important, there's very little linkage of patients' data to data on the health-care providers who treated them. Hospital data don't indicate who referred patients, for instance, so there's no link to primary care services. This is a major omission in data linkage given the importance of primary care in reducing hospital expenditures.

There are currently significant barriers to accessing linked data because the extraction process is costly and time consuming. And one-off data extractions that a researcher must keep confidential runs contrary to others reproducing and testing results of a study.

7. Inform policy with evidence-based research

In order to inform policy and practice with research evidence there needs to be a mechanism for that evidence to be presented – the mechanism that is currently used is “health technology assessment” (HTA is the science of synthesising and communicating evidence to policy-makers¹⁻³, and it is a branch of health services research). Organisations that conduct “health technology assessment” currently provide this evidence-based policy advice to Government but in ad hoc ways, generally through Government directly commissioning advice or requesting an evaluation of proposed health interventions or services³. Currently, “health technology assessment” and methods for developing or producing health technology assessment are not given a high priority by the NHMRC because the research is applied, rather than investigator-initiated. Similarly, the investigators usually have strong applied research backgrounds and backgrounds in evidence synthesis and translation in to policy (secondary research), rather than in investigator-initiated research (primary research).

Policy makers often need to make quick decisions on the basis of the evidence that is available and HTA provides this through an unbiased synthesis of the available evidence, an assessment of current issues that may impact on local decision-making, and in some cases economic modelling concerning the likely value for money of the proposed health intervention². Evidence gaps that are identified within these HTAs can then be fed back to

primary research commissioning organisations, to inform decisions on the best allocation of resources to fund primary research to address any additional information needs that the policy-maker may have¹. Currently in Australia there is no mechanism for HTA producers to feed this information to research commissioning organisations such as the NHMRC.

Despite Australia having an internationally renowned HTA capability and a pre-eminent role in methods development for this young academic policy science, there is little support for this science through the formalised health and medical research funding and capacity building mechanisms in Australia. Research is conducted via competitive tender, rather than competitive grants, and there is no support for fellowships for people with an HTA practitioner type of background (as opposed to an investigator-initiated research or even clinical backgrounds). Government is keen that capacity building in this area is made a priority, which is why Adelaide Health Technology Assessment (AHTA) at the University of Adelaide has instituted a postgraduate short course in the subject; a new subject is also available at UTS (taught by the Centre for Health Economics Research and Evaluation (CHERE)). However, ongoing support for senior HTA practitioners is required, along with mentoring and internship programs to build capacity at the more junior level.

Should an "expanded NHMRC" or (a better solution) our proposed new Institute become responsible for a program of evidence procurement, and for facilitating the capacity and capability to inform policy and practice with research evidence (see point 5 above), then there would need to be a clearer understanding by the responsible body that the research profiles of health technology assessment practitioners and health service researchers are not the same as for those undertaking investigator-initiated research. For example, although HTA is a translational science by its very definition, practitioners would not currently qualify to be a member of the NHMRC Research Translational Faculty unless they also hold an investigator-initiated NHMRC research grant. Similarly, the applied research undertaken by HTA practitioners has enormous policy impact but often does not result in academic citations of the work.

Therefore, although recommendation 15 is very welcome, this would require the application of a different paradigm for research excellence when it comes to "applied" as opposed to investigator-initiated research. Furthermore, an advantage of a new Institute would be that in implementing Recommendation 15, it would be natural that a Steering Committee of government policy makers be closely involved in the selection and prioritisation of applied projects. The approach could, perhaps, be modelled on the UK's National Health Service Health Technology Assessment Programme (<http://www.hta.ac.uk/>) which is directly responsive to policy-makers' need for knowledge and includes provision for funding secondary research to identify the current evidence available to answer a policy question, as well as primary research to address the important informational gaps identified by the secondary research.

8. Promote research participation by health professionals (Recommendation 3)

The current NHMRC Practitioner Fellowship Scheme is dominated by medical graduates. There should be a mechanisms to support other health professionals including nursing,

public health, community health, allied health and health management and policy to participate in research.

9. **Conclusion**

The [World Health Organization](#) calls health systems research the “brains of the health system”, and [argues for increased investment](#) in this field of research. If the Australian health-care system is not to be left without brains, the final report of the McKeon review will need make health systems research a part of the future of the our system.

References

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