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**Health Services Research Association of Australia and New Zealand – submission to:
NHMRC Public Consultation on the Draft NHMRC Principles of Peer Review**

The Health Services Research Association of Australia & New Zealand 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.

It is difficult to disagree with the document which states high level and widely accepted principles of fairness, independence, impartiality and balance. Yet, the experience of our members is that HSR suffers in terms of both peer review and grant success in spite of these principles, simply because in practice HSR is a small field with many cross connections (so conflict of interest); and that there are increasing problems in relying on the volunteerism required of reviewers – simply, people are so busy it is difficult to make time for this too; and it doesn't count in any performance metrics at Universities.

The real test of the NHMRC's peer review system is what happens to grant applications when it is not possible to ensure that the principles are being adhered to. For example, what happens when NHMRC has approached 5 or 6 reviewers who decline, time is running out, and they turn to someone in a peripheral area, or rely on fewer reviewers? There need to be mechanisms which can demonstrate that in such a situation these applications are not disadvantaged

Fairness

Fairness requires that reviewers have appropriate knowledge of the topic they are reviewing. HSR as a topic for or category of research is not well understood by many reviewers. The Association would therefore like to recommend that the NHMRC distribute the following definition of HSR for the benefit of reviewers and encourage them to consider this definition carefully when reviewing applications which have HSR as one of their keywords:

“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."

Selection Criteria, "each application is judged consistently and objectively on its own merits, against published selection criteria" (under 1. Fairness)

Firstly, there seems to be a continuing belief that efficacy has to be proven prior to effectiveness, but it seems inappropriate to apply this process to all areas of investigation. Most funded RCTs are non-pragmatic RCTs and little explicit consideration is given (within the selection criteria) to the extent to which the results of such trials will be generalisable to routine clinical practice. Efficacy trials have their place (e.g. drug trials, though even here trial design should be judged on the extent to which the trial population reflects the real world population), but for other forms of intervention, why waste time and resources conducting efficacy trials?

Secondly, HSR can contribute to a better understanding of the strengths and weaknesses of the use of existing technologies, and the design and evaluation of service improvements. A range of research methodologies are required, which may not be as internally valid as an efficacy trial, but may produce more externally valid results. This type of research should be highly valued as a form of translation research.

NHMRC needs to promote a greater recognition of external validity and the relative benefits of HSR methods.

The funding mechanism

The funding mechanism does not help either. All grants with a score of 6 or 7 get automatic funding; the rest of the available funding is (more or less) distributed evenly across the panels. HSR grants are less likely to get 6s and 7s because of the selection criteria –efficacy RCTs are generally straightforward and score highly on research methods (50% of score), because translation (as described above) is not high on the agenda. Significance is scored on the assumption that potential efficacy equals effectiveness and so scores highly (25% of total score). Because such efficacy RCTs are funded on a regular basis, the investigators are likely to have a strong track record, thus scoring highly on the remaining 25% of the total score.

With the more recent inclusion of HSR among a team of four other disciplines (health promotion, aging, nursing, and midwifery), it is now competing directly, as well as indirectly with more efficacy trials.

There is increasing evidence of the magnitude of the potential benefits from improving the use of existing technologies, which are likely to outweigh the generally incremental benefits derived from new technologies. This appears to be recognised by the NHMRC but the above issues need to be understood more clearly.