Health services research in Australia

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The long-awaited Wills Implementation Committee Report (CoA 2000), which was completed by November last year, has now been released. Wills' earlier Report (CoA 1998) identified the need for the development of health services research capacity in Australia, and this new Report recommends how this should be done, through the establishment and support of several large multi-disciplinary centres. These should be based around health services, health policy, health economics, public health and clinical practice and these are required to give scientific leadership to Australia's efforts in priority-driven research. They are to be funded through NHMRC, with funds rising to $10m per annum.

Health services in Australia today account for 8.5% of GDP, or $50.3 billion in 1998-99 (the latest expenditure data available, AIHW 2000). Pressures to increase expenditure in the future will continue, driven by new technology, changing patterns of disease and disability, rising community expectations, population growth and demographic changes.

Whilst overall cost control can be achieved through blunt budgetary instruments, the challenge is to improve health service delivery in terms of accessibility, effectiveness and quality while containing costs - in short to deliver better value for money. Each country's health system is unique, an outcome of its history, culture, politics and economics. Therefore the extent to which health services research findings can be transferred across countries is limited. Biological systems behave similarly across international borders; health systems do not. As the Wills Review of Health and Medical Research in Australia (CoA 1998) concluded

"... we can participate in the international exchange of ideas about health care organisation at fundamental levels and can learn from overseas experiences, but ultimately we must develop and evaluate our own solutions."

Australia prides itself on its contribution to international medical research. Why is it so lacking in health services research capacity? The first concerted program of health services research was established by the Hospital and Health Services Commission in 1973, one of the Whitlam Government initiatives, to underpin its health planning and policy implementation (Shea 1984). Although the Commission itself was as short-lived as the Whitlam Labour Government, support for health services research continued through the Research and Development Grants Advisory Committee of the Commonwealth Department of Health. Although RADGAC remained an important avenue for investigator initiated health services research, its budget was small, compared to the funds available through NHMRC (less than $1.5m available to it, compared to $19m for MRC in 1980/81). More importantly, RADGAC's budget remained fixed in nominal terms while medical research funds stand out as a growth area, even during times of budget stringency (Crichton, 1990).

The Public Health Research and Development Committee was established in 1989, and became a Principal Committee of NHMRC the following year. Its terms of reference were to support and expand public health research, and to fund research in priority areas. It did little to encourage health services research, seeing that as outside its remit of public health. Although RADGAC has long disappeared from view as a source of health services research funding, it continued to exist until 1997, when it was formally absorbed by NHMRC. At that time, its continuing funds were $745,000 while medical research funds were $154m (NHMRC 1998).

The Wills Committee is not the first to recommend the building of strong health services research capacity. Kerr White (White 1986), in his review of public health some fifteen years ago, recommended a new National Centre for Technology and Health Services Assessment responsible for methodological and applied health services research, including economic evaluations, technology assessment and studies of utilisation. This was to stand alongside the (then) Australian Institute of Health, a National Centre for Health Statistics, and substantially more

funds for population-focused research. The 1993 review of the NHMRC (Bienenstock, 1993) repeated the recommendations of the previous three reviews that the NHMRC should take responsibility for funding health services research. The Wills Review found that very little had changed since Bienenstock observed that health services research was not well developed in this country, and repeated the recommendations of the earlier reports.

Why has health services research held so little sway? Health services research is a multi-disciplinary field and people become health services researchers through many different entry points, and work in many different settings under many different employment contracts. To date, there has not been an identified community of health services researchers as there has been of medical researchers. Medical research is identified with dramatic breakthroughs in the understanding and treatment of disease - wonder drugs, the breaking of the genetic code although in practice it relies on advances through slow and careful observation, - and these stories are among the most frequent type of news coverage (Chapman & Lupton, 1994). In contrast, health services research is related to broad health policy issues which are seen as worthy but complex and dull (Haas et al, 2001).

There is also a delicacy in the relationship between health services research and health policy that does not exist between biomedical research and policy. The results of health services research may challenge government policy, by identifying alternative approaches, highlighting ambiguities, or even showing how little evidence there is for a proposed course of action. I clearly remember one debate with a policymaker who was concerned that allowing any rigorous evaluation of policy impact would suggest the policy makers did not know what they were doing. This uneasy relationship may be responsible for a reluctance to fund health services research, other than in terms of narrowly specified and short-term commissioned research. Interestingly, the investment in health services research capacity is one way to diffuse this unease as strengthening capacity will promote more research, differing methodological approaches and support diverse opinions.

In spite of the neglect of the field by NHMRC and other research funding agencies, and the successive reductions in funding, there are now signs of a very active and committed cohort of health services researchers across Australia. The Health Services Research Conference, held in Sydney in 1999, attracted over 400 participants primarily from Australia and New Zealand. The breadth of the topics covered and the quality of the work presented attracted positive comments from many of the international speakers. The enthusiasm generated by the group has led to a second conference (to be held in Wellington, New Zealand, in December of this year) and plans for regular meetings; and the formation of the Health Services Research Association of Australia and New Zealand which will be launched at the Wellington conference. The conference aims to fill a commonly felt and as yet unmet need, for a forum where researchers can meet in an atmosphere of collegiality, and where researchers and policy makers/practitioners can exchange views and share perspectives.

There are a number of issues that must be addressed if Australia is to build a sustainable health services research capacity. These are frequently brought up by health services researchers, and echo the diagnosis found in the Wills Review. Perhaps the most widespread issue is that of vulnerability, of both individual researchers and of their organisational base. Most individual researchers are supported on short-term contracts. For example at the 1999 conference, a poll of active researchers showed that many had employment contracts of less than twelve months, most had contracts of less than two years, and only one person had any guarantee of being employed beyond five years.

This is not about the development of career paths, but simply about having a job and paying the mortgage. The vulnerability of individual prospects is set in the context of little or no institutional support. Although there are a number of groupings and centres, these also survive on short-term contract funding without long term, let alone tenured, academic positions. They have been built around the vision, energy and drive of one or two people, who then find more of that energy going into securing the funding to keep the group together than into research.

The lack of funding for investigator-initiated research is evident. Less obvious but equally important is the lack of funding for basic health services research, that is for the development of concepts, theories and methods. There are substantial funds committed by government agencies for commissioned research allocated through a competitive process. However, tenders are usually called on extremely short notice with the successful tenderer required to start work immediately. This may be followed by substantial delays in the awarding of the contract, thus adding to the uncertainties of funding and increasing the difficulty of responding to such applications unless the group has the luxury of spare capacity. There are concerns about the lack of peer review in these

competitions. The contract rarely includes support for publication of the results, thereby limiting the field's capacity to learn from experience.

Another issue, related to the predominance of commissioned research, is the link between research and policy. By its nature, much of the commissioned research is short-term, addressing immediate problems. There is a need for research that tackles longer-term strategic issues but it does not fit readily into policy priorities, six-month contracts, and specified 'deliverables'. There is a need for increased awareness in policy makers and practitioners of what research can deliver, and what it cannot, and in what time frames. Correspondingly, there is a need for researchers to appreciate better the policy and practice environment and the pressures on decision-makers.

Another issue is the lack of training courses and other avenues for professional development. This makes it difficult for would-be researchers as there is no clear entry point, and for researchers seeking to consolidate and enhance their own skills. It also makes it difficult for commissioners of research to judge the skills base of those seeking their support.

There are two key themes that emerge from discussions by researchers. One is quality, and many of their concerns as discussed above are about ensuring better quality of research. The second is strategic relevance, ensuring that the research that is undertaken that will have lasting importance.

Overall, the Wills "Virtual Cycle" recommendations can be seen as falling into three areas: more funding for medical research, a more strategic approach which would encourage priority driven research, and capacity building in health services research. Even prior to the release of the Wills Implementation Committee Report, there has been a commitment of more funding for NHMRC, and the development and implementation of mechanisms to support research in identified priority areas. However, what has been left out so far is the building of research capacity in health services research. The NHMRC response to the Wills Report (NHMRC 2000) has a chapter on priority driven research, but nothing on health services research capacity or leadership.

In the latest round of NHMRC research grants, the success rate for health services research applications was 5%. Thus health services researchers had one chance in twenty of being funded. Compared to this, public health researchers had almost three chances in twenty, and researchers in the basic and clinical sciences had over five chances in twenty.

What does this mean? Either there is a systematic problem in the assessment and review process for health services research, or there are major deficits in research capacity - though, of course, these two are not mutually exclusive. The ease with which Australian health services researchers find good positions in other countries suggests that it is not the lack of research talent. The resultant brain drain further challenges the maintenance of any critical mass, though, whether in centres or around specific topics.

The NHMRC response to this poor success rate has been to focus on public health and consider ways to bolster public health research. This comes at the end of long term commitment to public health practice and research from both Commonwealth and States, in the form of the Public Health Education and Research Program, National Health Priorities, the National Centre for Epidemiology and Population Health, the development of public health capacity in Commonwealth, State and Territory departments of health and the support of the Public Health Association. Where does health services research fit in this - at worst, it is excluded altogether while at best it is subsumed under public health. It is time that health services research was recognised as a field of endeavour in its own right and distinct from both public health research and clinical research.

The NHMRC response to recommendations on capacity building are so far explicit: the new funding will be directed to programs of priority driven research. This is in contrast to Wills recommendations which call for the establishment and ongoing support of large centres, thus implying long term funding within an institutional arrangement that confers some longevity rather than temporary liaisons. Wills describes the centres as taking scientific leadership, implying a focus on methodological research, training and professional development, underpinning priority driven research not necessarily doing it all. What is required is a multi-faceted strategy. At this stage, it does not seem that we are likely to see it.

References

AIHW 2000, *Health Expenditure Bulletin No 16, 2000*, Australian Institute of Health and Welfare, Health and Welfare Expenditure Series.

Bienenstock J 1993, *External Review of the National Health and Medical Research Council: Report to the Minister for Health*, Australian Government Publishing Service.

Chapman S, Lupton D 1994, 'Freaks, moral tales and medical marvels: health and medical stories on Australian television', *Media Information Australia*, vol 72, pp94-104.

CoA 2000, 'Health and Medical Research Strategic Review (Chair: Peter Wills): Enabling the Virtuous Cycle', *Implementation Committee Report*, Commonwealth of Australia, September 2000.

CoA 1998, '*Health and Medical Research Strategic Review (Chair Peter Wills): The Virtuous Cycle: Working together for health and medical research*', *Discussion Document*, Commonwealth of Australia, December 1998.

Crichton A 1990, '*Slowly Taking Control: Australian Governments and Healthcare Provision, 1788-1988*', Allen and Unwin.

Haas M, Chapman S, Viney R, Hall J & Ferguson A 2001, 'The news on health care funding: a study of reporting in the Australian print media for 1996', *Journal of Health Services Research & Policy* vol 6, no 2, pp78-84.

NHMRC 1998, '*1998 Grants Book*', National Health and Medical Research Council, Commonwealth of Australia.

NHMRC 2000, '*Health and Medical Research Strategic Review: National Health and Medical Research Council Implementation of the Government's Response, Final Report*', National Health & Medical Research Council, Canberra.

Shea B 1984, 'The future of health research in Australia', *Community Health Studies*, vol 8,no 1, pp101-109.

White K 1986, '*Australia's Bicentennial Health Initiative: Independent Review of Research and Educational Requirements for Public Health and Tropical Health in Australia*', Commonwealth Department of Health, Canberra.