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EVIDENCE BASED HEALTH POLICY

Introduction

Thank you for your welcome this morning.

I am delighted to be here as you begin a challenging and interesting day looking at the contributions of health policy research to the development and analysis of health care services.

This is an area where researchers, health care professionals and politicians need to work together more closely, and more effectively.

From the politicians' point of view, developing health policy is in some ways the easy bit – although getting it funded can be a different issue. The hard part is getting policy implemented in a way that will make a real difference to health outcomes.

You know the lines about the reception of a new health policy:

The allergists voted to scratch it
The gastroenterologists had a gut feeling about it
The ophthalmologists considered the idea shortsighted
The podiatrists thought it was a big step forward
And the radiologists could see right through it.

So the missing punch line is – what about the researchers?

I guess there are two options – none of them humorous enough to constitute a punch line. You can be involved from the beginning in the formulation of policy (and in how it is funded) and share in the brickbats and the accolades. Or you can sit on the sidelines and pontificate as the commentator with 20/20 hindsight.

Your conference today will help you decide where and how you can play a role in evidence-based health policy.

Public expectations for research

There is no doubt that public opinion is firmly of the view that health and medical research should be a priority for government funding.

Every year Research Australia conducts a public opinion poll on health and medical research, and every year the vast majority of Australians - between 80 and 90 percent - rate health and medical research as an important priority for the federal government.

Australians want to see significantly more resources poured into finding better treatments, preventions and cures for cancer and heart disease and the emerging issues such as obesity and diabetes that are associated with modern lifestyles. And they say they are prepared to sacrifice future tax cuts so such investments can be made.

Where and how do we expect to see the results of this research that we all support play out?

Of course we hope to see the pay-off for our research investments in a thriving biotechnology industry and exciting new products to treat and prevent disease.

But the reality is that we also need to take the next step. If we are to truly capture the full value of our investments in research and in the health care system, then we need to leverage health and medical research to influence health policy and practice.

Research is not just about the development of new medical treatments. It's also about how and when those treatments are best utilized and delivered and paid for in our health care system.

Why health services and policy research is needed

Health is one of Australia's major industries, with services used by every Australian, spending now at 9.8 percent of the gross national product, and a workforce of over half a million people.

So we should rightly expect that such an extensive and expensive enterprise is underpinned by a lively culture of research to inform health policy.

And never more so than at a time when health reform is on the agenda.

Well, it is on Labor's agenda at least. I regret that it is clearly not on the agenda of the Howard Government.

As Kim Beazley and I have regularly stated, a Beazley Labor Government will make it a priority to reform our health system to achieve sustainability, to remove financial barriers to care for those who face them, to address health inequalities, and to better focus on prevention and early intervention to improve health outcomes for the whole population.

An integral part of this reform must be research to assess the needs and inform the policies, evaluation to measure the outcomes and progress against the agreed targets, and effective communication of the results.

Failure to do this has led to recent policy decisions which have had wide-reaching and negative ramifications which were arguably quite predictable.

A classic example is the Medicare safety net. From the moment it was first proposed, policy experts said it was inflationary and inequitable, and so it has proven to be. Most of the benefits go to the well off, leaving those who can least afford it to bear the brunt of rapidly rising out-of-pocket costs.

Blow-outs in the cost of the safety net have seen the Health Minister backflip on his “*rock solid, cast iron guarantee*” given during the election campaign and we can surely predict more changes to come.

At the same time, a 21 percent increase in PBS co-payments, combined with increasing out-of-pocket costs as a consequence of Special Patient Contributions, brand premiums and therapeutic premiums, increases in the threshold of the PBS safety net, and the 20-day rule, has led to a decline in the number of PBS prescriptions.

We are quite concerned about this, because we do not think it is due to an outbreak of wellness or even a major impact of the Quality Use of Medicines program. We are especially concerned that the biggest decreases in prescriptions are in areas like cardiovascular disease and mental illness, where the ramifications of people not taking needed medications will inevitably show up in increased acute care services.

The Health Minister and his office have offered a range of explanations, including – believe it or not - the number of public holidays. But the plain fact is, they do not know what is happening, or why, and what the consequences will be elsewhere in the health care system.

Nevertheless, the Minister will persist with further cuts to the PBS budget, blundering through with policy initiatives that are uninformed by research or modelling.

The central role of the NHMRC in health research

The National Health and Medical Research Council plays a central role in the funding of health and medical research and in the development of the strategies which underpin that funding.

Importantly, the NHMRC must find the right balance in its funding support for research.

It must ensure that a focus on commercial outcomes does not diminish support for innovative basic research.

And that the drive for progress in understanding the molecular basis of a disease such as lung cancer does not subsume the funds that must be spent on behavioural research to get people to quit smoking.

The knowledge accrued through research will only have its full impact if it is then translated into practice. And so there must also be an investment in the development and promulgation of clinical practice guidelines AND ensuring that they are implemented AND regularly updated.

It's a big task that the NHMRC has been given, and so we must ensure that it is well equipped to deliver on that task.

The NHMRC was set up in 1936 when Billy Hughes was Minister for Health.

Now Billy Hughes is not someone who is usually quoted favourably in Labor circles.

But I want to draw your attention to his statement on the establishment of the NHMRC:

"...the new Council must have regard to a balanced policy in which the application of existing knowledge will be steadily mainstreamed, and at the same time all possible efforts towards the acquisition of new knowledge must be made. Research must be actively pursued and developed and as fast as new knowledge is acquired it must be applied."

In 1999, the *Health and Medical Research Strategic Review* (the Wills Review), acknowledged that there was a disproportionately small amount of NHMRC funding specifically allocated to health services research – the research which helps ensure that new knowledge is applied. The Review also made recommendations to address this problem.

But the poor relative status of this area of research, and its lack of champions, is demonstrated by the slow progress to implement the Wills recommendations and provide for increased and better integrated activity in this area.

So much so that several years ago, in an editorial of the *Medical Journal of Australia*, Martin Van Der Weyden called health policy research and development in Australia "a *virtual desert*" as he decried the fact that in 2003 less than three cents of every dollar the NHMRC invested in new research was earmarked for health policy research.

His lament was well founded. And he was supported by the findings of the Grant Review in December 2004, which recommended improved structures, processes and governance, and an increase in dedicated funding for what it called 'policy and practice-based research'.

Specifically the Grant Review called for funding of \$70 million over 5 years to build capacity and fund a research program that "*deeply involves not only researchers, but also research-literate policy makers and practitioners.*"

In fact, in early 2001, in order to address the gaps identified by Wills, then Health Minister Michael Wooldridge announced funding of \$50 million for the establishment of an NHMRC program that would support policy relevant research, develop a critical mass of researchers in the field of health services research, and encourage collaborative links between researchers and policy makers.

The program was initially called the Collaborative Streams Program, but it was later re-named the Health Services Research Grants Program. The bodies to administer this funding have been variously styled the Joint Health Services Research Committee, the Health Services Research Working Group, and the National Health Committee.

In my cynical moments I sometimes think that more attention has been paid to the names of the committees and programs in this area than to actually funding the research.

That money allocated in 2001 did not begin to go out until 2005, largely because of endless discussion over what research should be funded.

In response to questions at Senate Estimates about the delays, the Department of Health and Ageing admitted that there were “*barriers and difficulties in establishing and sustaining a priority-driven health services research program in Australia*” – but did not articulate what these were.

The Department did admit to significant disagreement about what actually constitutes health services research.

Now I’m a lawyer by training and a politician by profession, and I’m not averse to arguing over definitions. But I am somewhat perturbed when the argument goes on for some four years over something that was, or should have been, already in the NHMRC remit since it was first established – even if it was poorly funded.

I know that Australia is not the first country to be confronted by the contradictions and limitations in the definitions of health services research.

As far as I can tell we are still without a definition of health services research, but we do have some objectives, and we have a set of indicative questions for the consideration of those researchers who seek funding, and finally money is beginning to flow to these researchers.

Since January 2005, some \$21 million of that \$50 million first put on the table in 2001 has gone out to fund seven grants.

And since 2001, some additional funds have also gone to project grants. Just how much money seems to depend on where the information comes from.

According to the 2005 NMHRC Annual Report, in the five years to December 2005, \$55.9 million was provided for health services research.

The data provided to us through Senate Estimates shows that the funds for such research through to December 2008 will total \$34.3 million.

I guess it's a matter of definition!

The good news is that the funding has started to roll, and important work such as that of Professor Stephen Leeder, on optimising prevention and the management of care for people with chronic illness, is underway.

When this work is completed, or has delivered results, what next?

Using health services research in health care practice and policy making

Researchers mainly publish their findings in peer-reviewed journals. This gives them visibility in their research community and the numbers of publications and their citations are commonly used as indicators of research performance.

However this is not the most efficient way of getting information to health service practitioners and decision makers – certainly not those who are politicians!

There is now an established pathway for getting new knowledge out to health care professionals, although I do understand that getting knowledge out there and getting it used regularly are two different things.

The growing emphasis on evidence-based medicine, supported by clinical practice guidelines, the Cochrane Collaboration, and the decisions of the expert advisory groups such as the Pharmaceutical Benefits Advisory Committee and the Medicare Services Advisory Committee, does mean that there is an increasing likelihood that best current knowledge is applied to the treatment of an individual patient.

How is research to be used in policy making?

Is the evidence-based medicines model, which gives greater weight to particular kinds of research, an appropriate or a relevant model for policy making?

Certainly evidence-based medicine offers the vision of solving all health care funding problems by eliminating unnecessary and unproven health care.

We understand that stringent evidence is required if the public purse is to pay for new drugs, medical technologies or other interventions.

But scientific evidence has little to say about whether a policy can be implemented or is politically acceptable.

Other sorts of research – media reports, feedback from the public, advocacy by stakeholders, and polling – provide evidence about political acceptability and public priorities.

What weight should we give to this research in the mix?

And what about the complex scientific issues, such as cloning and global warming, where the research and the researchers rarely speak with a single clear voice about the correct or even the appropriate policy?

In just a few weeks the Parliament will consider legislation to implement the recommendations of the Lockhart Review. Because there will be a conscience vote, every parliamentarian must personally grapple with the scientific and ethical issues around assisted reproductive technologies, stem cell research and cloning.

We are listening to the evidence and opinions from the experts – and trying to tell the difference.

We are weighing up the hopes for medical breakthroughs, the need for Australia to remain on the cutting edge of biomedical research, the ethical ramifications, and the policy imperative that all such research in Australia is subject to uniform national laws and regulations.

It's a fascinating case study in how and why public policy is made, and the role of evidence in this process.

Conclusion

In the current environment, health services research struggles to gain its rightful place.

Jonathan Lomax has highlighted that whereas clinical research is often concerned with efficacy studies (“*will this work under ideal circumstances?*”), health services research is largely concerned with effectiveness questions (“*will this work under real-world circumstances?*”).

He then goes on to say that this lack of “*laboratory purity*” sometimes leads competitors for the available funds to accuse it of being second-rate.

I hope that this is not correct, but I suspect that there is some element of the truth here.

Perhaps most importantly, I believe that policy makers and politicians do not value health policy research as much as they should, indeed as much as the Australian public values health research that may lead to a miracle cure.

I would like to see policy makers fighting for support for health services research, health policy research, or policy and practice-based research.

The United States has a specific agency dedicated to health services research, the Agency for Healthcare Research and Quality. This agency operates separately from the National Institutes of Health, and has a budget of \$(US)300 million budget and almost 300 staff to support a broad array of basic and applied health services research projects, training and dissemination activities.

In Australia, I believe we should be considering and debating the potential advantages and disadvantages of this approach.

Would such an agency make a difference to health services research and ultimately the health system of this country?

I am genuinely interested in hearing your views on this policy question.

Good luck today with all of our deliberations and I look forward to hearing the results.

Thank you.