



# TAKING GOOD CARE OF CLINICAL RESEARCH

BY PROF STEPHEN LEEDER

We would be missing a great opportunity to promote innovation, improve health outcomes and achieve efficiency gains if, as part of the current health reforms, we fail to provide for growth in research in its many varieties – ranging from the laboratory to bedside to community, and scientific scrutiny of the health system itself, in terms of both what it costs and what we gain from this investment.

Mr Rudd's renovation of the health system includes a concern for the scientific and research foundation. *Further Investments in Australia's Health*, published last month, reassures readers that the Commonwealth will assume full responsibility for the current multimillion-dollar investment in research in the publicly-funded health system. This is a welcome commitment but, as with much else, the details have yet to be revealed.

Developing a health care system that supports efficient and effective clinical service that can respond to change requires astute clinical observation, solid research, sound economic analyses, effective policy, and the people to make things happen.

Research in all of these fields is what underpins and sustains innovation, drives systemic improvements and wins efficiency gains for true clinical excellence.

At its best, research is competitive and sceptical: it takes risks, it seeks to advance and it takes a detailed critical interest in the claims of the past, of experience, of ritual, of rhetoric and fable.

It asks for figures when claims are made that one treatment, be it a new drug or a new investigation, is better than another. It asks about costs when a new diagnostic test is proposed to replace an older machine: what is the evidence that this new treatment is superior? Without this scepticism, standard practice remains exactly that and the competition among doctors and hospitals to provide superior quality of care languishes.

Why link research so tightly to patient care and to health care reform?

First, more research is necessary to provide a firmer scientific foundation for current clinical decisions, both in hospital and in the community. To improve health outcomes, we need research that takes us from bench to bedside – or indeed to the GP's office, pharmacy, or patient's home – and back.

We must support research in our health service to translate basic science discoveries into clinical applications but, equally important, we must use clinical observations to generate research foci for basic sciences.

Although research may proceed through lots of hard work peppered with brilliant leaps, without effective interactions between research workers, health professionals and policy makers, it can become a sterile end in itself.

To consider the sick patient, and then to ponder his or her dilemma with the mind of the scientist, can open new doorways for the invention of new therapies, the promotion of health, and the development and implementation of more effective health policies. Such reflection has led to the combination of treatments that have transformed survival from childhood leukaemia and made transplantation a practical possibility through selective suppression of patients' immune systems.

Second, we need to make every health dollar count. We have reached a 'flat of the curve' point in investment in health care, where we are spending more without achieving better health outcomes in relation to the amount invested.

This can be because we are prematurely applying new technologies and hanging on to old, ineffective interventions at great cost for reasons that have nothing to do with health gain. This is the least-developed area of science in the health system: the science of comparative effectiveness research. Mr Rudd would be well advised to look carefully to this branch of research in

assessing which of his strategies work best.

Third, in striving to develop a more responsive and agile health workforce for the future, we must provide for our students a learning and research experience that extends from our hospitals into the community. We also need to go much further in ensuring protected research time for clinicians.

As an example, chronic diseases account for more than 70% of Australia's overall disease burden due to death, disability and diminished quality of life. The system we use to manage these problems is obsolete. General practice and expanded primary care can play a central role in delivering improved health and economic outcomes in the community, but must be linked to a revision of the way in which we use hospitals for such people. Research into electronic data systems to support the continuing care of chronically ill patients is essential to achieving better care.

A move in this direction will strengthen the primary health care sector, stimulate more research into ways of providing effective care and encourage a shift to preventive health care.

Paying more critical attention to the intersection between clinical care, research and education of the health workforce will mean that that clinical decisions in the future will be even more firmly grounded on what research tells us than they are today. Given the illustrious history of the contribution of science and research to health care, that is an exciting and positive prospect. It is excellent that the Commonwealth has recognised the value in such an investment. ❁

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