

## CITY UNIVERSITY, LONDON

### **Response to Cooksey Review of UK Health Research**

We welcome the opportunity to make an input into this review of UK health research funding. Health related activity makes up around one third of total activity at City University, while contributing through our research to the development of policy and practice within our areas of expertise forms an important part of the University's mission.

**The importance of public health interventions:** The speech delivered by the Prime Minister on 26 July 2006 stressed both the importance of public health to the future of the country and the importance of early public health interventions if we are to reduce inequalities and maintain the health of the population. As he said: "In the future, health care cannot be just about treating the sick but must be about helping us to live healthily." To achieve this, there is an urgent need for development of the range of public health research – biomedical through to sociological. Universities can play a critical role in this development and City University in particular is well placed to make a significant contribution. For example, staff from City University's Centre for Food Policy have contributed to the debate which has resulted in the work now taking place on limiting the advertising of junk food to children, referred to by the Prime Minister in his speech, as well as to those on obesity and school meals.

**Integrated Research:** The UK has one of the largest integrated health economies in the world; this provides an ideal test bed for carrying out research across the full range of concerns, from basic blue sky research through implementation to research to improve efficiencies and outcomes in the delivery of services. It is important that any new system of funding allocation should support this unique research opportunity offered in the UK.

More specifically, London itself provides tremendous scope for undertaking research across a wide range of areas within a relatively bounded geographic framework. Any new system should ensure that due account is taken of the opportunities for cross-cutting research provided by London.

**Big Science or Service Development:** The focus of the consultation document gives the impression of an assumption that innovations in practice come only from biomedical developments. However, the potential contribution of practice-based innovations such as new ways of delivering services and improving communication with patients should not be overlooked. Although developments in this area meet the policy priorities of the Department of Health, currently it is not usually possible to obtain funding for evaluation studies. Such studies need not be resource-intensive and are capable of delivering considerable value for money and gains in health outcome. Currently numerous health policies are implemented to tackle rising demand for health care which have an inadequate evidence base, for example expert patient programmes and community matrons. Alternatively, in some cases the impact of a policy on other parts of the system of health care or on patient behaviour is not adequately understood, for example the four hour waiting time target in A&E. Other areas such as Child and Adolescent Mental Health experience repeated policy directives (see Health Advisory Service (1995) *Together we stand. Thematic Review*. CAMH, HMSO; Department of Health and Department for Education and Skills (2004) *The national service framework for children, young people and maternity services*. London. HMSO) that are proving difficult to implement as the processes and practices required to implement them are not adequately researched and disseminated.

One perceived area of weakness in current arrangements is the absence of funding for implementation studies and post implementation reviews; for example such as the cultural

implications of introducing new IT systems or the effectiveness of new treatments arising from scientific research. There are limitations associated with clinical trial research and real benefit will only be achieved if end-user research (focusing on both practitioners and patients) is carried out in respect of new practices and innovations. In particular, it is important to understand the impact of changes on different communities, which are often small and hard to reach. As indicated above, London provides ideal opportunities for localised studies. For example the research challenges in improving the treatment of TB in marginalised communities are sociological, anthropological and organisational. Similar research questions are central to delivering better health care across virtually all domains: our concerns are that the infrastructure requirements of “big science” means that this type of research will be marginalised and continue to be inadequately funded.

The importance of developing this knowledge base in order to be able to provide an appropriate service delivery infrastructure to take advantage of big science and stay ahead in the provision of health care must be recognised if the UK is to remain an attractive country for future investment by the biotechnology industry. Cutting edge biomedical research cannot feasibly be carried out when services are struggling with demand; neither will high quality health technology companies want to invest in a system that is struggling to deliver basic care since this will confound outcomes. Under these circumstances recruitment to large trials will be difficult in the UK and investment from quality high tech companies will go elsewhere.

Systematic reviews have informed not only investment but also disinvestment. Work on the patient/citizen/user voice, considered peripheral only twenty years ago, is now central to the provision of health services, and informs not only service delivery and appropriateness, but in some cases, service content. Uptake and implementation require both good science to underpin decisions, and good networks and social relationships to ensure buy-in to evidence-based decisions as well as to inform the identification of the most important research questions. In this regard, recent collaborative work between City, the Universities of Lancaster, York and Glasgow and the Peninsula Medical School has been exploring narrative synthesis of different types of research evidence, particularly where meta-analysis is not appropriate, while other work done by City and Lancaster has looked at the extent to which individual studies making up a systematic review hold data on context and implementation which might be useful to others intending to adopt a particular intervention.

Given that NICE has taken on the functions of the former HDA, more and better work on cost effectiveness in public health will become increasingly important. City's Centre for Health Economics has undertaken pioneering research on the use of cost effectiveness thresholds in public decision-making, examining the consistency of NICE decisions in this regard and producing a conceptual model of public decision-making that allows quantification of issues such as the threshold used to judge value for money and what other factors are taken into account, using econometric techniques.

It is notable that much of the research in disciplines which underpin health services research (sociology of health, health economics, anthropology) has been very successful in universities which do not have a medical school. Medical schools are not inevitably the most effective location for multi- and interdisciplinary research: for example, work on understanding the importance of food and what informs poor feeding, understanding public health economics, patient choice, and complex engineering systems which support the delivery of health care, eg through the development of non-invasive techniques, is likely to be taking place in other arenas..

The UK requires both technology development and service development in health. The consultation document does not make reference to funding for policy-related research but the

Government should ensure that the future of this important area is preserved. The terms of reference of the new single fund should therefore ensure that both receive due attention. The establishment of two distinct streams of funding and decision-making may be a suitable approach, since appropriate peer review will demand rather different expertise in each case. Alternatively, an appropriate level of subsidiary ring-fencing for activity which focuses on the social sciences of medicine could serve the same purpose. Either way, it will be important to ensure that there is a suitable mix of input to funding decisions from appropriately qualified medical and non-medical health practitioners and social scientists who will ensure that Government priorities are addressed.

It is recognised that funding commitment to existing hard science infrastructures needs to be maintained, but it should equally be recognised that less equipment-dominated activity can make a major – and cost-effective - contribution to change and development in health.

**Priorities or Investigator Led:** The balance between priorities-led research and investigator-led research is also important. The UK has a good record of success in investigator-led research through its universities and history shows that, in the long run, such research frequently turns out to be more important for policy and/or practice than research driven by policy agendas. In this regard, maintaining the current capacity of the other Research Councils to provide an additional funding stream able to respond to blue-skies ideas which may sit outside identified Government priorities for health would serve to strengthen the national position. UK health research currently benefits from this variety of funding sources and the degree of flexibility thereby provided. This serves also to avoid over-domination by the hard sciences.

**Clinical Research Networks:** Clinical research networks have proved an effective mechanism for establishing links between researchers. An appropriate balance needs to be struck between local, regional and national networks, and good resources are required. Broadening clinical research networks out into public health networks (for example, to address health issues in schools) would build on benefits already achieved and provide a positive move forward.

Effective clinical research networks depend on ensuring informed patient and clinician choice. Health informatics is critical to the delivery of timely, up to date information to both patients and clinicians. Work undertaken by City's Centre for Health Informatics to evaluate aspects of home telecare, in collaboration with clinical partners from elsewhere in Europe and a UK technical partner, provides one such example. The project involves the use of hand-held computers in the home by patients with chronic diseases including chronic respiratory failure, bronchial asthma, chronic heart failure, hypertension and type 2 diabetes to collect clinical and quality of life data associated with the management of their disease. Socio-economic evaluation is being undertaken from the perspectives of the patient, the healthcare professional and the health manager to establish what is needed to achieve a successful telecare operation.

**Training:** Funding to meet training needs to assure the future of the research base should be considered – there appears in recent years to have been a shift towards greater concentration of resources at the expense of a broader base for basic research and a reduction in funding for PhD or post-doctoral positions. The Health Foundation programme, developed outside the NHS, is broadening the base of PhD research in the Allied Health Professions and Nursing and provides a good example of what can be achieved through collaboration towards this end.

**Population and Primary Care:** The UK health economy is fairly integrated and we have the ability to undertake primary health care research better than anywhere other than the Scandinavian countries. This has been important for both the pharmaceutical industry and healthcare technology and we should be building on this strength, which risks dissipation if any

new system is too centralised. One of the key advantages to UK health research is provided by the public health/primary care delivery end of the spectrum and our ability to get out into the community, for example by providing infrastructure support for GPs. This could be fostered further although practitioners will require a broader information base than they can currently access.

Population based studies are also critical to success, as evidenced by research on the effects of smoking – such achievements, which are of global value, could be lost in future if resources are focused too much on the biomedical (curative) end of the spectrum. The patient safety agenda and the Service Delivery Organisation Programme should also be ringfenced in some way. Prevention and the cost-effectiveness of action to improve health and reduce inequalities, as addressed by the Wanless Report 2004, should also be a priority for health research. The value of operational informatics in underpinning services should also be recognised – this is an area which struggles to attract funding currently.

The National Research and Development Centre for Welfare and Health in Finland provides a good example of the type of public health information resource being developed elsewhere that the UK should perhaps be seeking to emulate if we are not to fall behind in our ability to provide population based evidence which may become more important in evaluating future health technologies. See [www.stakes.fi](http://www.stakes.fi) (click on "in English" on the top line of the site). We need to develop skills in setting up and using this kind of evidence if we are not to fall far behind other countries and reduce future potential for investment in the UK.

**Basic Research vs Translation:** As regards the balance between basic research and translation, there may be lessons to be learned from industries such as engineering and pharmaceuticals, where the proportion of funding given to these two areas is approximately reversed by comparison with the health services. Furthermore, inadequate attention has been given historically to funding of proof of concept studies and supporting entrepreneurial activity – whether bringing a new product to market, introducing a change management programme, or providing pump priming resources to develop and evaluate the practice innovations and professional entrepreneurial activity which often result from our universal provision of higher education for all health care professionals.

**Research Bureaucracy:** Consideration should also be given to application processes once the new arrangements have been resolved. These should not be more complex than is necessary to support good quality decision-making. The health service currently suffers from excessively complicated and sometimes inconsistent systems, for example ethical approval requirements, which can take up disproportionate amounts of staff time by comparison with the value they provide.