

## Health Services Research Network

### Response to the Review of UK Health Research.

*We have restricted our response to the area of research which we know most about and which is our principal concern, namely health services research.*

1. What are the strengths and weaknesses of the MRC and NHS R&D programmes at present? How do each of these support the research and training needs of the NHS, social care, industry and academia? Does more need to be done?

*MRC strengths: support for methodological and biomedical research and research on long-term, enduring issues. Support for training fellowships. Provision of investigator-led (responsive) research proposals.*

*MRC weaknesses: too medically (doctor) oriented; lack of vision of the enduring issues that underlie some key health care policy challenges; too narrow in the type of research supported (biomedical paradigm still dominates).*

*NHS R&D strengths: supports research that is policy-relevant; research priorities influenced by policy-makers enhances likelihood of research output having some influence; broad interest in health care rather than limited to biomedical agenda; involvement of patients in commissioning and conducting research. Support for training fellowships.*

*NHS R&D weaknesses: over-optimistic view of the potential influence of research on practice and policy creates unrealistic expectations that could rarely be achieved; lack of support for the long-term enduring questions as too focused on short-term 'answers'; despite best attempts to enhance the influence of policy-makers and patients on the research agenda, there has only been limited success in altering professional and researcher control of the agenda.*

2. What do you believe are the key scientific and organisational challenges facing health research, and underpinning training, in the UK over the next decade? How might the UK Government best help address those challenges? What do you believe should be the Government's objectives for health research, and why?

*Scientific challenges: development of health services research methods; development of high quality health care databases; improvements in our ability to study organisational attributes.*

*Organisational challenges: facilitating access to high quality health care databases; reducing the 'unnecessary' obstacles to research whilst maintaining ethical and confidential conduct which are currently deterring excellent and needed research;*

*enhancing the capacity to conduct high quality research on the delivery and organisation of services.*

3. What should be the Government's priorities for health research? Is there anything it should stop doing or funding? What is it not doing or funding that it should do, and, in the absence of further sources of support, what can it lower in order to release the necessary funds?

*More research on the way health services are delivered and organised as this will increase the cost-effectiveness and the acceptability of new interventions as they are introduced; research on policies before and as they are introduced rather than relying largely on ideology. Inevitably this would require a reduction in biomedical research.*

4. How should decisions be taken on the balance between the long-term economic and social benefits of a high quality biomedical research base; and the needs for research to improve healthcare and other public services? What is the appropriate balance between public funding for investigator-led and priorities led research? How do we balance funding for basic science, translational science and applied science? Is this something that should vary over time? What mechanisms should be used to make judgements about this balance?

*There is no simple formula. A balanced portfolio is needed so decisions should be taken by groups which represent the breadth of research areas identified in the question. This is not currently the case. For example, although the UKCRC claims to be concerned with health services research issues, there are no representatives of health services researchers on the governing board. Similarly, the board of the NIHR has no one representing health services research.*

5. In your experience, how have the results of publicly-funded health research in the UK been used, both in the development of new treatments and to influence / change wider policy and healthcare practices? What lessons can usefully be learned to improve the uptake of advances in science and medicine?

*The impact of research has, inevitably, been variable. This is not unique to health research. Much health services research, particularly the assessment of specific health technologies (such as drugs, diagnostic tests and surgical operations) has had a direct influence on policies and guidance developed by bodies such as NICE. In the area of research on the organisation and delivery of services, research aims to influence decision-makers' and practitioners' thinking as much as directly altering services. The former can have a more profound and lasting impact than the latter but is difficult to 'measure' and to demonstrate a causal link. An example is recent research on networks which has been widely used by those implementing networks and found to be of great help.*

6. How might better links be forged between ‘basic’, translational and applied researchers, working across the whole field of health research, from the laboratory bench to the front line of the NHS? How might better links be forged across disciplines, e.g. with engineers, physicists, and social scientists?

*By bringing these disparate groups together. Two recent opportunities at the national level were the establishment of the UKCRC and the NIHR, both of which limited their vision (as judged by their membership) to basic and translational but stopped short of health services research. However, there is the danger that in focusing research on innovations, existing health care practices and policies are not subjected to the rigorous inquiry that is needed.*

*There also need to be opportunities at a local level. Financial management policies in universities need to do more to encourage inter-disciplinary research. And the RAE could do more; at present it tends to perpetuate the disciplinary silos that can obstruct links.*

7. How can the Government encourage translation, entrepreneurship and innovation in health research to improve public services in the UK?

*In some areas of health care, there is no need for any public sector involvement (eg pharmaceuticals) as translation is, if anything, too rapid and not sufficiently rigorous. In contrast there are many orphan areas (such as improved design of wheelchairs) where private entrepreneurship is clearly inadequate and the public sector needs to invest to improve services for the public.*

8. How can UK health research funding be most effectively used to provide the appropriate infrastructure for basic, translational and applied research, whether funded by the UK public sector or other sectors? How can UK health research funding be most effectively used to support the work of NICE, facilitate innovation and collaboration with industry, and address market failures in the application of healthcare?

*The second question is limited to research on technologies with no suggestion that funding might be effectively used to improve the way public services are organised and delivered, what policies are adopted, how staff are best deployed etc. This exemplifies the challenge we face: the need to think more widely as to how health research can benefit the public and not just the health care industry.*

9. What lessons should the UK learn from other countries in making the proposed changes to the institutional arrangements for the funding of health research?

*The main lesson is that there is a need both for policy-driven, commissioned research and for investigator-led, visionary research. Whether both can be managed by a single organisation is questionable. Each involves rather different mindsets which is why most countries have two funding bodies (eg USA, Canada).*

10. In implementing the single fund for health research, to what extent should the MRC and DH / NHS R&D be merged or brought together? And to whom should the single, ring-fenced fund be accountable? Please provide reasons and any supporting evidence for your response.

*Clearly liaison between the two bodies has had only limited success in aligning the two sets of priorities. We would welcome greater cooperation but would want to see both commissioned and investigator-led research continue to be supported. If that could be guaranteed within a single organisation, then the funds could largely be merged and be accountable to the Secretary of State for Health (as the principal customer for publicly-funded health research should be the health department, not the DTI).*

11. To what extent does the success of recent innovations in health research (e.g. Clinical Research Networks) and the proposed structures rely on the new *Connecting for Health* NHS IT system, and to what extent should it do so?

*It should avoid reliance on the NHS IT system until the planned systems have been proven to work! Meanwhile, alternative, tried and tested systems (such as specialised clinical databases) should be supported and maintained.*

12. Given that NHS R&D is currently devolved, but that the work of Research Councils is not, how can these functions work best together to maximise the health and economic benefits to the UK?

*Increasingly, health research of all types needs large studies requiring significant funding. Devolution of research funds has been detrimental, most of all to the three smaller nations which have relatively few funds but have to maintain a full research management infrastructure and have to rely on 'external' involvement to ensure probity. Attempts should be made to reverse this policy and return to a centralised UK health research fund.*