New Zealanders for HEALTH RESEARCH

Ngā Tāngata o Aotearoa mō te Rangahau Hauora

"New Zealand's peak body representing the entire health and medical research pipeline"

Submission to the Health Research Council on the proposed prioritisation vehicle for New Zealand health research

Introduction

New Zealanders for Health Research (NZHR) was established in November 2015 to bring about increased investment in health research from government, industry and philanthropy; this provides the overarching context for our response to the proposed prioritisation vehicle.

In developing this submission we have consulted with our partners and members as set out at the end of this document (from whom we derive 100% of our funding). Additionally, we have sought to represent the views of both health and disability service consumers and the wider community as reflected in our annual Roy Morgan Research NZHR public opinion polls. We also wish to thank the Health Research Council (HRC) for the opportunity to comment on the September 2018 proposals through participating in NZHR's health and disability services consumer forum.

Although the March 2019 consultation document is a significant advancement on the September 2018 proposals NZHR has a number of comments which we hope will be considered for incorporation into the HRC's final prioritisation document.

NZHR submission framework

NZHR's submission addresses the following two questions:

1. Do the HRC's prioritisation proposals optimally address Action 1 of the New Zealand Health Research Strategy (HRS), ie to "prioritise investments through an inclusive priority setting process"?

2. Do the proposals promote increased investment in health research?

Optimally prioritising investments through an inclusive priority setting process

NZHR assumes that the proposed prioritisation vehicle is intended to ensure that investments in health research are appropriately prioritised in ways that would, could or may not be achieved by simply applying the ten criteria listed under Action 1 of the HRS to health research funders and funding applications, and/or by continuing with existing practices and arrangements. Based on this assumption NZHR submits that the prioritisation vehicle should, and be seen by health research stakeholders and consumers to, clearly articulate:

1. the problem, issue and/or area of risk the vehicle (and the intent of the HRS's Action 1) purports to address (what's the "why" over and above a requirement to elaborate on the HRS's Action 1)

2. the impact and difference that is expected to result from the vehicle's implementation (what will stop, what will start, and what will continue?)

3. how its effectiveness will be measured (i.e. how and when will health research stakeholders and consumers know it has been successful?)

NZHR also submits that the proposal document itself could be enhanced as follows:

1. Provision of further clarity about how assessment of impact will be used to inform health research investment decisions. Health services consumers and health research stakeholders may commonly assume that the greatest impact from health research would result from addressing areas associated with, or with a significant risk of, high morbidity and mortality, and with the so called economic and personal burden of disease on individuals, family and whanau, communities and society, and government and government agencies. However, this assumption may not necessarily be correct (e.g. in respect of research into personalised medicine), and it may be helpful for the prioritisation vehicle to provide additional clarity on this point.

2. The section on health services research (page 8) should include a reference to research on service effectiveness in the second sentence.

3. The section on translational research (page 8), should include a reference to the importance of research into overcoming personal, professional and systemic barriers to translating research into practice. It should include a reference to the importance of research which, if translated into policy and practice, would challenge existing service delivery structures, including how they operate and how well they are resourced.

4. The section on supporting clinical trial infrastructure (page 8) would be enhanced if the last sentence was amended to read "….improve clinical trial networks and support infrastructure…."

5. The section capacity and capability (page 8) would be improved if the first sentence were to include a reference to the importance of the health research workforce receiving continuous internationally recognised professional development opportunities, modelled, for example, on the work of the internationally recognised Harvard MRCT.

6. The section on equity (page 13) sets a potentially unattainable bar which may be inhibit innovative or experimental research which results in some sections of the population receiving successful novel services or interventions, while others not involved in the research do not. If this were to constitute an exacerbation of a health inequity then, according to this section, the research would not be funded in the absence of a clear mitigation plan. We believe that this requirement would not be able to be fulfilled in many cases, especially in advance of any results becoming available, and we ask therefore that it be softened or modified.

7. The section on capacity and capability (page 15) would be improved if the first sentence were to read "…..with particular emphasis on building the Maori, Pacific ***and disability*** health research workforce."

8. The proposed governance arrangements (page 17) should include provisions for consumer representation. NZHR proposes a formally constituted consumer advisory group with which the cross governance committee (CGC) would be required to engage through representation on the CGC.

Promoting increased investment in health research

1. Promotion of health equity (p7) should reference not only the importance of achieving health equity within New Zealand (which implies equitable distribution or redistribution of existing health research resources), but also achieving health equity in respect of best health outcomes internationally (which could imply the need for an increase in health service resources and health research investment)

2. NZHR agrees with the section on knowledge mobilisation within the health sector (page 9). However, we note that if the proportion of health research investment which informs policy and practice is to increase the proportion allocated to other priority areas, and therefore the absolute amounts, will decrease in the absence of any real increase in the total government health research investment. We acknowledge that directly advocating for an increased investment is not appropriate for inclusion in the prioritisation document, but it would be useful if there was a general statement in the document that best endeavours will be used to ensure that any changes in investment proportionalities do not result in any investment reductions in real or absolute terms.

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