

Editorials

Academic health science centres in Australia: let's get competitive

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Joining university to clinical service, research to practice

The model of the academic health science centre (AHSC) arose decades ago in the United States,¹ and is now internationally well established, with 17 centres in Canada, eight in Holland, five in the United Kingdom, two in Singapore, but none in Australia. An AHSC is where a leading university joins with a major tertiary health care provider in a tripartite mission of excellence in clinical service, research and education. AHSCs drive a care continuum from innovation, to bedside, to the community, endeavouring to ensure that the latest advances and highest standards reach patients. They are so well established abroad that the debate has moved on to extending AHSCs into systems or networks to embrace primary health care and global responsibilities.²

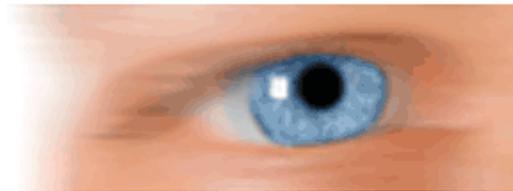
Curiously, Australia's National Health and Medical Research Council (NHMRC) makes no mention of AHSCs in its 2010–2012 strategic plan,³ despite its own external review (the Zerhouni Review) advocating creation of at least a few Australian centres of world-class excellence in translational and clinical research.⁴ Similarly, AHSCs did not attract serious discussion in the report of the Council of Australian Governments (COAG) National Health and Hospitals Network (NHHN) Agreement (April 2010), although the detail at least

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acknowledges that engagement with university clinical schools and research centres is critical to translating clinical research into practice, ongoing professional development and training the next generation of clinical leaders.⁵ Strong advocacy for AHSCs to be introduced in Australia has apparently been ignored,^{6,7} with Brooks warning that our nation is failing to capitalise on global developments in academic medicine.⁷

So what are the barriers? First, there is a culture clash between federally funded autonomous universities and state-funded hospitals managed as a separate conglomerate in each state and subject to local politics and regional priorities. Indeed, the emphasis in state health departments, it seems, is more on homogeneity than the excellence strived for in academia. This engenders turf wars between universities and hospitals over their diverse missions, priorities, operational frameworks and employment conditions, with process and contracts frustrating attempts to bridge the gap. Cost shifting replaces what should be cost sharing. The second barrier is that the three AHSC pillars — research, education and health care — are overseen by three separate federal government departments and thus three separate ministers. Third, there are additional players in the research sector — the independent medical research institutes — who, although affiliated with universities and tertiary hospitals, have at times eschewed translational links with clinical medicine in favour of basic science. Finally, Australian health care is delivered in a pluralistic mix of private and public funding. Yet none of these issues is unique to Australia or insurmountable, especially when one considers the complexities of the US health care environment where AHSCs began.

Cultural cringe may be a further hurdle for AHSC advocates. The NHMRC has foreshadowed the concept of “advanced health care centres”,⁸ seemingly in response to sensitivities among its political masters about use of the term “academic”. Surely, however, the Australian public are now mature enough to embrace excellence rather than mediocrity in health care, just as they do in sport? In fact, perceived anti-intellectualism is not uniquely Australian, as the case for retaining the term “academic” similarly needed pressing in the UK. Simply put, the best doctors treat patients, do research and train tomorrow’s health care providers. There is now an international association of academic health centres,⁹ whereas a web search for the “advanced” variant suggests instead a primary and community care focus.

The advent, in mid 2011, of Local Hospital Networks, a central plank of the COAG NHHN Agreement,⁵ offers a pivotal opportunity to introduce AHSCs. Indeed, the simultaneous introduction of Medicare Locals, organisations intended to integrate and coordinate primary care services, provides a serendipitous platform to extend AHSCs into primary care. Ring-fencing hospital leadership from state health bureaucracies will be essential, particularly given the watered-down version that survived COAG. We should not underestimate the challenges of change management, which will require both top-down and bottom-up approaches to unite hospitals and universities, primary care and medical research institutes in a single mission. The choice of governance method is perhaps best determined locally;^{10,11} an integrated model with a single organisational structure is the ideal, but affiliated models may be more achievable with multiple partners. The NHHN should foster economic support for AHSCs through the 60% federal funding proposed for research and training in public hospitals (100% in primary care),⁵ and it will be crucial that new monies be spent at the interface of training, service and research.

The real challenge will be winning the hearts and minds of federal and state politicians. As in Europe and North America, politicians will need convincing of the economic benefits of

linking research to health and embedding research and training as core business in our leading hospitals and primary care networks. Although our international competitiveness in biomedical science is an important pay-off in its own right, the things that swung the argument abroad were improved patient outcomes and cost efficiencies.

How many AHSCs does Australia need? With critical mass and existing academic strength as prerequisites, the number will depend on the extent to which AHSCs develop around universities or existing teaching hospitals, or amalgamate to form geographic clusters. Experience in the UK points to competitive national selection being a valid means of testing commitment and the strength of joined-up partnerships. We advocate a similar international review process here, say with four to six AHSCs designated in the first wave. The time is ripe for Australia's health systems to grasp this opportunity to move from good to great and establish world-class AHSCs in an Australian context.

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