# The challenge for academic health partnerships

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## ABSTRACT

- The future of academic medicine in Australia has been identified as a significant issue, but received little mention in the interim report of the National Health and Hospitals Reform Commission.
- Australia is at particular risk of failing to capitalise on what is happening globally with academic medicine.
- New "partnerships" between health services, universities and health research institutes should be encouraged for stimulating research and learning across the health sector.
- Such partnerships can drive translational research, provide full costing of research, and establish national and international networks of researchers and research funding.
- There are many interactions between Australian state and federal jurisdictions and their hospitals and primary care organisations, but these are often loosely coordinated and with little understanding of how universities and research institutes can help to deliver better and more efficient health care.
- Academic health science centres, as recently designated by the National Health Service in the United Kingdom, provide a useful model for consideration in Australia.


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Over the past 12 months, the *MJA* has identified the future of academic medicine in Australia as a significant issue. The uncertain future of Australia's teaching hospitals has been highlighted,[1,2] and their role as drivers of medical research emphasised. Unfortunately, little of this concern has been echoed in the recent draft of the National Health and Hospitals Reform Commission (NHHRC) report,[3] and across the health system there seems to be only a tacit acknowledgement of the opportunities for real partnerships with clearly defined outcomes that engage all parts of the system. One of the problems in this debate is the term "academic medicine" — what does it really mean, and how do we ensure that all doctors (health workers) practise "academic" medicine (health) to some degree?

In the United Kingdom, the Royal College of Physicians of London has defined academic medicine as

> work that is undertaken by clinicians with responsibilities to both their university and their NHS [National Health Service] Hospital Trust. They usually combine service delivery with research, teaching and/or administration.[4]

In a review of academic medicine in 2008, the British Medical Association outlined the benefits that academic medicine might contribute to future health care in the UK.[4] These include:

- Questioning and critically appraising the established knowledge base;
- Delivering financial gains and contributing to economic growth;
- Providing new ideas, evidence and products that bring about improved patient care and reductions in the cost of health care;
- Bringing about direct benefits to patients (treated in the NHS);
- Maintaining and enhancing the knowledge, skills and attitudes of the medical profession;
- Generating income and expertise in the use of resources;
- Actively contributing to a culture of high-quality clinical services (in the NHS); and
- Contributing to international health care.

All of these principles could be adapted to the Australian environment — whether you are working for a state or federal health service, a university, a health research institute, or even in the private sector. Surely these principles are an essential part of what we as health practitioners are all about, and they are equally relevant to doctors, nurses, allied health practitioners and other workers within the health system. This indeed must be how we can improve the health of Australians and ensure we enhance the quality of the health service we deliver.

However, we are at particular risk in Australia of failing to capitalise on what is happening globally with academic medicine. Edward Byrne, former Head of the University College London Medical School, recently summarised the exciting changes that have occurred in the UK[5] with the recognition of the importance of "partnerships" in research — particularly in driving translational research, the provision of full costing of research (which was announced in the recent Australian federal budget but will not be fully implemented until 2014), and the importance of establishing national and international networks of researchers and research funding.

In a major initiative to stimulate this agenda, the NHS recently instituted a competitive process for groups to seek designation as "academic health science centres" (AHSCs) through creating partnerships between NHS hospitals and primary care trusts, universities (driven by, but not exclusive to, their health science faculties) and health research institutes. This idea grew out of the Darzi report,[6,7] *High quality care for all*, which charts the next phase of NHS reform focused on creating a locally led, patient-focused and clinically driven health service that will improve quality of care. The impact of this report is even more powerful because Lord Darzi is not only Parliamentary Under Secretary of State (for Health) but also continues to practise as a surgeon in a major London teaching hospital and understands the importance of clinician leadership in the health system.

Those applying for AHSC status had to demonstrate not only an international reputation in research, but also excellence in educational programs for health professionals that stress interprofessional learning and team care as well as focusing on all the traditional health worker disciplines. In addition, these partnerships had to show clear evidence of exemplary health care delivery in their hospitals and to the local community, as well as evidence of community engagement and sound financial management. Of paramount importance was how the partnerships were going to function — where the responsibilities for strategic direction and decision making lay, and what the governance structure was that would ensure the partnership really would deliver.

What was interesting was that no new money came with designation as an AHSC, but the organisations that made submis-

sions obviously saw the tremendous opportunities that this "partnership recognition" might provide. They also had significant combined budgets (often £1–3 billion) to assist in directing these changes. The organisations recently announced as receiving AHSC designation will no doubt set a benchmark in medicine in the UK for others to follow, as well as gaining extra funding from a variety of sources, including research organisations (both local and international), government agencies, and through commercialisation.[8]

Could such a system work in Australia? There are many interactions between state and federal jurisdictions and their hospitals and primary care organisations, but these are usually loosely coordinated. There is a tacit understanding that health departments and the research and education sectors have to work together, and they do this to varying degrees. However, there is still a deep suspicion (probably on all sides but particularly within government departments) about how universities and research institutes can really help to deliver better and more efficient health care. This does seem to be part of a broader gap between government departments and universities in this country, when the universities could (and should) be seen to be their natural research and development partners in these endeavours.

There is little doubt that the well established United States model of academic health centres[9] has been a very powerful force for research, and was, I suspect, part of the motivation for the recent NHS initiative. These centres have been an enormous stimulus to the bioinformatics/engineering and biotechnology sectors and have also stimulated important health services initiatives. The type of partnership adopted in the US and the UK might be very beneficial to Australia in our present circumstances, but would require a significant rethink of our system. A key factor is that the governance structure required to deliver these outcomes may be a single entity (a Board with a single chief executive officer [CEO]) to run the combined academic (universities and research institutes) and service delivery (hospitals and primary care organisations) entity. This model of governance is already working at Imperial College London, where the Dean is CEO of the medical school and the associated hospitals,[8] and has been effective in driving change. Other governance models (with some variations) will be adopted by the other AHSCs, and these might see the partners continuing to maintain separate finances and governance but establishing an oversight Board to coordinate the partnership and achieve the desired outcomes. Given Australia's diverse and multifaceted health system with its multiple players (both public and private), unique opportunities will no doubt arise if we can create a structure to deliver the outcome of enhanced translational research.

What an exciting opportunity for us to be part of this change — but it will require a brave government (at state and/or federal level) to initiate these discussions, as well as an appreciation that, as in any partnership, the important issue is what the individual partners will give up in order to make the partnership work — but also how much they might gain from the partnership in terms of taking the health system forward. With such wide debate in the community generated by the NHHRC interim report,[3] surely this is an opportunity that should be at least discussed, and then led, not by governments, but by the potential partners.

## Competing interests

None identified.

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