

STRUCTURE OF THE REPORT

The *2000 Annual Report of the National Health and Medical Research Council* (NHMRC) provides the reader with up-to-date information on NHMRC's functions, structure and strategic directions, as well as an examination of its performance in 2000.

'Highlights of 2000' provides a quick guide to the year's major milestones while in '2000 in review' the Chairperson provides his overview of the NHMRC's activities.

The NHMRC is structured around its four Principal Committees, and this is reflected in the four committee sections of this annual report. Each contains the Committee

Chairperson's report and three profile pieces which illustrate an aspect of the Committee's work.

The appendixes provide statutory reporting information, including the composition and functions of the Council, its Executive Committee and Principal Committees and information on internal and external scrutiny and financial and human resource arrangements. Listings of publications and media statements released during 2000 are included to provide the reader with a fuller view of the work of NHMRC, and the final appendix lists the acronyms and abbreviations used in the report.

HIGHLIGHTS OF 2000

- In May 2000, the Federal Minister for Health and Aged Care announced appointments to the five Chair positions of the National Health and Medical Research Council (NHMRC) for the 2000–2003 triennium, and in June 2000 he appointed a further 22 members to Council for three-year terms. The final member of Council was appointed in July 2000.
 - NHMRC developed a broad and ambitious Strategic Plan for the 2000–2003 triennium to address current health issues of national significance.
 - Each of the four Principal Committees of the NHMRC identified its priorities for 2001, based on NHMRC's overarching goals of enhancing effective health and medical research, promoting research findings, supporting research within an ethical framework, and developing health advice based on the best available evidence.
 - Cabinet appointed Professor Alan Pettigrew, formerly Deputy Vice Chancellor of the University of NSW, as the inaugural Chief Executive Officer of the NHMRC. Professor Pettigrew will commence his appointment in January 2001.
 - The Federal Minister for Health and Aged Care announced the results of the NHMRC 2000 funding round: 459 new Project Grants, three new Program Grants, 16 new fellowship appointments, 10 new R D Wright Fellowships, six inaugural Practitioner Fellowships, and eight inaugural Industry Postdoctoral Fellowships were announced.
 - NHMRC awarded 27 New Investigator Grants in 2000 to foster the development of new talent and encourage medical research as a career choice.
- The Research Committee (RC):
- introduced Practitioner Fellowships to strengthen research in clinical and public health and the first of these have been awarded to commence in 2001;
 - established an Industry Subcommittee to provide advice on ensuring optimal linkage between research, industry and commercial outcomes;
 - undertook wide-reaching and targeted consultation on the draft guidelines for intellectual property (IP) management; and
 - with the Strategic Research Development Committee (SRDC), established Health Research Partnership grants to encourage a multidisciplinary approach to high-priority health issues.
- The Strategic Research Development Committee (SRDC):
- developed a strategic framework based on identifying research priority areas, research gaps, and approaches to developing strategic research;
 - made preparations for, and/or undertook evaluations on, the Centres of Clinical Excellence in Hospital-based Research Program, the Hepatitis C Program, and the Evidence-based Clinical Practice Research Program;
 - awarded two projects to examine possible biological effects of exposure to Radio-Frequency Electromagnetic Energy on human health;

- awarded three projects under the SRDC's Health and Economics Program, which focuses on larger systemic issues affecting health, such as allocative efficiency, cost-effectiveness, and the impact of new treatments on system costs;
- awarded four Translational Grants relating to injury, one of which relates to injury in Indigenous communities;
- awarded 17 projects under the National Illicit Drug Strategy Research Program, at a cost of just over \$2 million (a second grant round was advertised in April 2000, with four projects awarded in late 2000); and
- in late March 2000, awarded five projects with a total value of \$870,000 under the Evidence-based Youth Suicide Research Program.

The Health Advisory Committee (HAC):

- identified six priority health areas in which it would initiate work early in the new triennium: Indigenous health, mental health, biotechnology, health inequalities, safety and quality, and preventive health;
- developed evidence-based advice on priority health issues, including colorectal cancer, nutrition in Aboriginal and Torres Strait Islander peoples, postnatal depression, the use of vitamin K for newborn babies, and providing information, support and counselling to women with breast cancer; and

- hosted an open forum in Sydney to launch guidelines relating to breast cancer, melanoma and diet for older Australians.

The Australian Health Ethics Committee (AHEC):

- developed a three-year strategy to increase support to the more than 200 human research ethics committees (HRECs) registered with the NHMRC;
- undertook extensive consultations with HREC members in four capital cities;
- established a working party with the Research Committee to produce guidelines on ethical and scientific aspects of xenotransplantation;
- established a working party with the Health Advisory Committee and began work on guidelines about the diagnosis and continuing care of persons with persistent vegetative states;
- began revising the *Guidelines on Ethical Matters in Aboriginal and Torres Strait Islander Health Research* by initiating consultations with people involved in Indigenous health and health research; and
- commenced work with the Australian Law Reform Commission on a joint inquiry on human genetic information and related privacy and discrimination issues.

2000 IN REVIEW

Statement by the Chairperson



Professor Nick Saunders

The year 2000 heralded the beginning of a new triennium and new membership of the National Health and Medical Research Council. The previous Council, led by Professor Richard Larkins, achieved a great deal throughout the 1997–99 triennium and I thank him and the previous Council for their significant achievements. During this period, the government introduced a major increase in funding for health and medical research. In response Council began the important task of reshaping its approach to funding health and medical research in Australia and establishing a framework for increasing the emphasis placed on strategic research. Important contributions

were also made to the area of health ethics with the release of the revised *National Statement on Ethical Conduct in Research Involving Humans* and through Council's promotion of awareness, understanding and debate in the field of gene technology. Council's ability to provide health advice was strengthened by adhering to an evidence-based approach and through close engagement with the myriad stakeholders who contribute to the Australian health system.

The transition from the last triennium has been successful. The previous Council left the NHMRC in good shape and has passed on valuable work-in-progress for the new Council to complete over the next three years. The new Council is fortunate to have significant continuity in membership, including the Chairs of the Research Committee and the Strategic Research Development Committee, who are both staying for a second term. This will enable strategic development and implementation of Council activities to progress smoothly.

In its review of the 1997–2000 Strategic Plan, the outgoing Council identified a number of future challenges for the NHMRC, including new and emerging diseases, internationalisation, interaction with industry, the transfer of research into policy and practice and strategic research. The incoming Council agrees that these are current health issues of national significance. The new Council has identified an additional range of major national health and health system issues that are likely to arise throughout this triennium. Health issues identified include: the health of Indigenous Australians, biotechnology and antibiotic-resistant bacteria. Health system issues to be taken into account include cultural

diversity in Australia, the ageing population and changes in societal structures and values. The NHMRC is committed to remaining in a position to respond to and address the diverse and complex range of issues present in the health and medical research environment.

Looking ahead, each of the four Principal Committees of the NHMRC has identified its priorities for 2001, and these are listed below.

- The Research Committee will implement the new Program Grant Scheme, commence the funding transition for block-funded institutes and commence the new Fellowship Scheme.
- The Strategic Research Development Committee will commence programs in aged care, mental health, Indigenous health, oral health, and systems of care for people with chronic diseases.
- The Health Advisory Committee will complete projects carried over from last triennium (a major task), give attention to urgently referred matters from government, for example, use of blood and blood products, and commence work to develop preventive guidelines.
- The Australian Health Ethics Committee will continue and improve its support for human research ethics committees around Australia, and provide advice on issues such as xenotransplantation and gene technology.

The recommendations of the Health and Medical Research Strategic Review¹ provide a basis for much of the strategic positioning of the NHMRC in the coming years. In 2001 Council will expend considerable effort to lift communication with our stakeholders,

including state and federal governments and departments, the scientific community, health professionals, industry, international organisations, consumers and the general community. Improvements in communication and interaction within the NHMRC are also a focus for Council. Another area of importance will be to monitor our performance and evaluate outcomes. Council will concentrate on ensuring that effective methods of monitoring and evaluating are in place and applied to all of its activities.

The forthcoming appointment of Professor Alan Pettigrew as our first full-time Chief Executive Officer is awaited eagerly. The NHMRC has established a challenging program of work to progress and complete over the next three years. I feel confident that all members share my enthusiasm for the tasks before us and look forward to an exciting triennium ahead.

I wish to thank all members of Council, staff of the NHMRC, volunteers and our many partners for their dedication and hard work. Australia has much to be proud of in their efforts and achievements to date.

PROFESSOR NICHOLAS SAUNDERS

*Chairperson,
National Health and Medical Research Council*

1 In March 1998 the Federal Government commissioned a wide-ranging review of health and medical research arrangements in Australia, known as the Health and Medical Research Strategic Review. The Review Committee was chaired by Mr Peter Wills AM. The *Final Report of the Health and Medical Strategic Review Committee* was presented to the Minister for Health and Aged Care in 1999.

I. Corporate overview

CORPORATE OVERVIEW

The *National Health and Medical Research Council Act 1992* established the National Health and Medical Research Council (NHMRC) as a statutory body, 56 years after its formation in 1936.

The Act strengthened the independence and autonomy of the NHMRC, thus facilitating Council's ability to provide independent, strong advice on all aspects of health and health care delivery in Australia.

The appointment to the NHMRC of its first Chief Executive Officer will further enhance Council's independent status and its capacity to implement a new strategic agenda over the triennium.

The NHMRC in brief

The NHMRC unites within one national organisation the three distinct but complementary functions of funding health and medical research, providing ethical guidance on health and medical research issues and producing health advice. A significant benefit of this unified approach is that the NHMRC is able to bring together and draw upon the resources of all components of the Australian health system. These include governments, medical practitioners, nurses, allied health professionals, researchers, teaching and research institutions, public and private program managers, service administrators, community health organisations, social health researchers and consumers.

The NHMRC Act sets out the following statutory obligations:

- to raise the standard of individual and public health throughout Australia;
- to foster the development of consistent health standards across the various states and territories;
- to foster medical research and training and public health research and training throughout Australia; and
- to foster consideration of ethical issues relating to health.

To meet these obligations the NHMRC is structured around three major programs, namely research, advice and ethics. A strategic plan is developed for each triennium to guide each program area and to provide overall direction to capitalise on the unique breadth of NHMRC responsibilities. These responsibilities range from basic medical research to applied research and to providing comprehensive and timely advice on the most complex and important matters affecting the health of the Australian population.

The NHMRC comprises nominees of Commonwealth, State and Territory health authorities, health professionals, unions, universities, the business community, consumer groups, welfare organisations, conservation groups and the Aboriginal and Torres Strait Islander Commission.

The NHMRC can meet up to four times per year to consider and make decisions on issues relating to public health, health and medical research and ethics in research, and health. Reports on these issues are considered by the NHMRC and, where appropriate, released in the form of guidelines, information papers and pamphlets. The NHMRC publishing program is responsible for ensuring that all information is made widely available throughout the medical

and general communities. The NHMRC Internet site provides up-to-date and easily accessible information to our Australian and international audiences.

The NHMRC's structure and composition are set out in more detail in Appendix I.

Changes to NHMRC legislation

In March 2000, the *National Health and Medical Research Council Act 1992* was amended to enhance operations and respond to some of the recommendations of the Health and Medical Research Strategic Review, conducted by Mr Peter Wills in 1998–99. The amendments are as follows:

1. Streamline the process of public consultation

Sections 12 to 14 of the Act have been amended to require the National Health and Medical Research Council to conduct consultations as follows:

- two stages of consultation whenever it makes a regulatory recommendation or engages in a prescribed activity; and
- one stage of consultation whenever it seeks to issue guidelines.

2. NHMRC to approve guidelines developed by other bodies

This new provision enables NHMRC to approve guidelines developed by other bodies, provided NHMRC is satisfied that the development process included public consultation identical to that required when NHMRC develops and issues guidelines.

3. Change in committee name and operations

The name of the Medical Research Committee is formally changed to the Research Committee. There has also been an amendment to the functions of the Research Committee, which are

now described as 'health and medical research' in recognition of the Committee's broader role.

4. Delegations

Delegation of Council powers has been extended to include the Chairperson of NHMRC.

5. Appointment of Deputy Chairperson

A formal mechanism has been included to allow Principal Committees to appoint a Deputy Chairperson.

6. Appointment of working committees

Council now has the power to appoint working committees.

7. Chief Executive Officer

The position of Secretary to the Council has been abolished and replaced with that of Chief Executive Officer. Staff supporting the NHMRC now report to the Chief Executive Officer.

8. Strategic Plan

The Council's strategic plan, and any variations to a strategic plan, must be submitted to the Minister for approval prior to tabling in parliament.

9. Grant processing procedures

Council will publish information each year detailing the procedures and timetables for grant applications. In addition, the Chief Executive Officer must adhere to the dates in the timetable for notifying applicants of the outcome of their application.

Strategic directions

The year 2000 marked the beginning of a new triennium for the NHMRC. The *NHMRC Strategic Plan 2000–2003* was approved by Council, and subsequently by the Minister for Health and Aged Care, in the second half

of 2000. The plan will provide direction for Council and its activities over the next three years.

The strategies contained in the plan are designed to enable Council to achieve its goal of providing leadership and working with other organisations to improve the health of all Australians. They include encouraging and supporting a high-quality research base; providing evidence-based advice; translating research into practice and outcomes; and promoting debate on health and medical research, ethics and policy. The strategies represent an integrated approach across the three programs of the NHMRC.

The key themes underpinning these strategies are communication and collaboration. Effective communication of research and health advice to the Australian and international communities is a high priority. Increased collaboration among NHMRC's Principal Committees and with external organisations will strengthen Council's ability to respond to and communicate with the variety of stakeholders who look to the NHMRC for advice.

Improved performance reporting

A key feature of the strategic plan is its emphasis on developing the organisation's mechanisms for reporting its performance. As a result of the changes in the NHMRC Act outlined above, the NHMRC will operate more independently of the Department of Health and Aged Care. Also, in the 1999–2000 budget the Government increased its investment in health and medical research with a significant increase in research funding. These initiatives bring with them the need for strengthened performance reporting arrangements.

In 2000 the NHMRC made significant progress in laying the foundations for a comprehensive reporting system that will enable more detailed performance reporting in future years. For the NHMRC's research function, the strategic plan proposes measuring performance using

a reporting system known as the Research Outcomes Evaluation Model. Performance measures for the health advisory and health ethics functions are being developed.

In late 2000, the NHMRC contracted Carron Consulting to conduct a feasibility study of 'performance indicators for the research function of the National Health and Medical Research Council'. This consultancy will provide further analysis of the Research Outcomes Evaluation Model and identify the availability of data and information needed to satisfy the performance indicators established by NHMRC.

This model for performance reporting will not apply to a full reporting year until 2001. However, in keeping with this approach, NHMRC's progress and achievements in 2000 are briefly described below under the priority areas listed in the strategic plan.

Strengthening and modernising the research funding system

The NHMRC has significantly reshaped its research funding system to make it simpler and more flexible and to provide for better peer review. This reshaping included:

- implementing review by discipline-based panels;
- introducing more flexible support as Project Grants in 2001; and
- finalising an agreement in July 2000 to incorporate block-funded institutes into the main grants schemes.

World-class research capacity

The NHMRC recognises the importance of attracting, funding, supporting and retaining a world-class medical research work force. Towards this outcome the NHMRC has:

- introduced Practitioner Fellowships (whereby practising health professionals can

incorporate an element of research into their careers) and awarded the first, to commence in 2001; and

- awarded 27 New Investigator Grants in 2000, to foster the development of new talent and encourage medical research as a career choice.

In addition, in order to provide support for up-to-date facilities to conduct research in genomics, NHMRC has:

- established a program in medical genomics, to support high-technology research and provide researchers with access to national facilities such as the Australian Genome Research Facility; and
- subscribed to the databases set up by Celera Genomics, providing Australian researchers in publicly funded institutions with access to invaluable human and mouse genome data.

Translation of knowledge for the benefit of the Australian community

The NHMRC is adopting strategies to ensure that health and medical research is translated into policy and practice. Collaboration is a central theme of these strategies. Towards this outcome the NHMRC has undertaken several initiatives, outlined below.

- Health Research Partnership grants have been established as a joint initiative of the Research Committee and the Strategic Research Development Committee to encourage a multidisciplinary approach to high-priority health issues. The first partnership grants were awarded in 2000 to commence in 2001.
- Funding commenced in 2000 for the first clinical trials/large scale recruitment studies. Co-funding between NHMRC and other organisations will be used to fund these expensive projects.
- International links are being forged to encourage collaborative research using

various international agencies. NHMRC has raised awareness of international researcher exchange programs offered through the Department of Industry, Science and Resources and the Australian Academy of Science.

- As mentioned above, Practitioner Fellowships have been initiated to provide an opportunity for practising health professionals to incorporate an element of research into their careers, bridging the gap between research and practice.
- Legislative changes have been passed to increase the speed and efficiency of guideline development in order to facilitate the review and endorsement of externally developed guidelines.

To facilitate collaboration with industry and progress commercial development of health and medical research, to date the NHMRC has:

- progressed development of guidelines for intellectual property management (wide-reaching and targeted consultation on the draft guidelines took place from 24 July to 25 September 2000)
- enhanced the Development Grants to support research commercialisation at the early 'proof of concept' development stage, and
- introduced Industry Fellowships.

The type, value and success rates of NHMRC grants are set out in the tables following.

Meetings, public consultations and public forums held by the NHMRC and its Principal Committees in 2000 are listed in Appendix XI.

The following grants and fellowships were first offered and awarded in 2000, funding commencing in 2001:

- Partnership Grants
- Practitioner Fellowships
- Postdoctoral Fellowships in Industry, and
- Development (industry) Grants.

Value, type and success rates¹ of NHMRC grants in 2000

Project Grants			Clinical Trials and Large Patient Recruitment Studies Grants		
Number	=	442	Number	=	8
Cost	=	\$39.3m	Cost	=	\$1.79m
Success Rate	=	25.4%	Success Rate	=	38.1%
Program Grants			Training Awards		
Number	=	5	Number	=	151
Cost	=	\$5.0m	Cost	=	\$5.1m
Success Rate	=	70%	Success Rate	=	33%
Capital Funding/Infrastructure Support Grants			Research Fellowships		
Number	=	8	Number	=	32
Cost	=	\$20.0m	Cost	=	\$6.1m
Success Rate	=	26%	Success Rate	=	23.5%
Note: the NHMRC administers these grants on behalf of the Department.					
New Investigator Grants			Strategic Research Grants		
Number	=	29	Number	=	28
Cost	=	\$1.9m	Cost	=	\$2.867m
Success Rate	=	16%	Success Rate	=	n/a

1 In this report the category of 'success rates' represents, as a percentage, the number of applications that received NHMRC funding out of the total number of applications received for a particular grant type in the calendar year. This information is included as an indicator of the performance of the overall Australian health and medical research system, of which the NHMRC is a part. These figures measure the effect of increased government funding of health and medical research generally, and should not be seen as a measure of the NHMRC's performance per se.

New grants awarded in 2000

There were 823 new grants awarded in 2000 for funding in 2001.

Fellowships	236
Project Grants	459
Programs	3
Scholarships	115
SRDC tied	3
SRDC untied	7
TOTAL	823

Development of guidelines and information papers

The Health Advisory Committee and the Australian Health Ethics Committee establish and manage a variety of working parties to develop guidelines for publication by the NHMRC. These guidelines and information papers are designed to inform the medical and general communities of the latest information gleaned from health and medical research. The Research and Strategic Research Development Committees also produce reports where appropriate. Publications are usually available in hard copy and all are accessible from the NHMRC web site. A complete list of guidelines and information papers produced in 2000 is set out in Appendix XII.

The Principal Committees

NHMRC's strategies are developed and managed by its four Principal Committees:

- the Research Committee (RC);
- the Strategic Research Development Committee (SRDC);
- the Health Advisory Committee (HAC); and
- the Australian Health Ethics Committee (AHEC).

Each Principal Committee has developed a work plan designed to complement the overall strategies of Council and to identify ways of achieving goals specific to each program area.

Research Committee

The primary role of the Research Committee is to build and support an effective Australian research sector. The research sector is built on high-impact research, a quality work force and infrastructure. The research funded by NHMRC aims to provide first-class knowledge that will increase the health of the Australian population and ensure, wherever possible, that the wealth generated from that research remains with Australians. In determining funding support, the Research Committee increased its focus on performance, outputs and outcomes of research in an international context. The committee facilitated the development of a highly skilled research work force by expanding training schemes and fellowships. The Committee supports the development of knowledge-based industries by providing incentives to bridge the gap between research and industry and foster an environment that values industry achievements.

The Research Committee provides research support through a variety of mechanisms, including support for individual research projects, broad programs of research, training awards and fellowships and special research units. Grants that were recommended to the

Federal Minister for Health and Aged Care by the Research Committee in 2000 (to commence on 1 January 2001) are detailed in the accompanying volume to this annual report, *NHMRC Grants Book 2001*.

A more detailed description and assessment of the Research Committee's activities is provided in Section 2.

Strategic Research Development Committee

The primary role of the Strategic Research Development Committee is to promote research in strategic areas where current research has been identified as lacking and does not correspond to the weight of the issue for health and health care in Australia. SRDC fulfils its role by identifying gaps in research knowledge; developing and implementing priority-driven research in identified areas; refining and advancing the priority setting process to maintain relevance and effectiveness; and monitoring the output of SRDC-supported research and its translation into improved clinical practice.

SRDC also assists in the development and dissemination of strategic research findings.

In 2000, the Strategic Research Development Committee contributed to Australia's research capacity by developing a new strategic framework that takes into account identification of health priority areas, the role of health service and system issues and increasing work force capacity. SRDC also continued to address existing areas of priority, including its evidence-based clinical practice research program, research programs in translating injury research into practice, and injury research partnerships.

A more detailed description and assessment of the Strategic Research Development Committee's activities is provided in Section 3.

Health Advisory Committee

The primary role of the Health Advisory Committee is to translate research findings into policy and practice, and to advise the community on health issues. Working within an ethical framework, HAC develops and supports others in developing health advice and implementation strategies, based on the best available evidence. HAC works to ensure that the advice is easily accessible to and meets the differing needs of government, health practitioners and the Australian community. HAC continues to contribute to the health and medical research agenda in Australia by identifying gaps in knowledge in priority areas. Overarching strategies in leadership and collaboration with other organisations are the foundation for improving the health of all Australians through the provision of evidence-based advice and the application of research findings to health issues.

In 2000, the Health Advisory Committee developed evidence-based advice on priority health issues. The advice includes psychosocial guidelines for providing information, support and counselling to women with breast cancer; guidelines for consumers and general practitioners on colorectal cancer; an information paper on nutrition in Aboriginal and Torres Strait Islander peoples; a systematic literature review on postnatal depression; and a revised statement and information pamphlet on the use of vitamin K for newborn babies.

A more detailed description and assessment of the Health Advisory Committee's activities is provided in Section 4.

Australian Health Ethics Committee

The primary role of the Australian Health Ethics Committee is to provide high-quality ethical advice with respect to health research and health care. AHEC contributes to the growth of excellent health and medical research in Australia by developing and supporting an ethical framework of a high standard.

AHEC provides leadership in raising community awareness and facilitating debate on ethical issues in health and medical research, particularly with regard to major national health issues such as biotechnology and assisted reproductive technology. AHEC is providing improved support for and liaison with human research ethics committees (HRECs) by increasing formal and informal communication with them and by collaborating with other organisations to support them. AHEC also continues to collaborate with other organisations to produce guidelines on specific issues and to strengthen collaboration with international organisations.

In 2000, AHEC developed strategies to provide increased support to HRECs around Australia and established working parties to examine issues such as xenotransplantation and the revision of guidelines on ethical matters in Aboriginal and Torres Strait Islander health.

A more detailed description and assessment of the Australian Health Ethics Committee's activities is provided in Section 5.

Staff of the NHMRC

NHMRC's staff support and facilitate the NHMRC's activities.

Changes to the *National Health and Medical Research Council Act 1992* in 1999 and 2000 created the position of Chief Executive Officer (CEO). Professor Alan Pettigrew was appointed as the inaugural CEO in 2000 and will join the NHMRC early in 2001. Under the CEO, the NHMRC will operate more independently from the Department of Health and Aged Care and will establish resources and structures that facilitate the operations of the Council.

Staff spent considerable effort during the second half of 2000 to develop the *Office of the National Health and Medical Research*

Council Business and People Management Plan 2000–2001. The plan has been developed to meet accountability requirements for the NHMRC and its Office outlined in the Departmental Portfolio Budget Statements,

and the performance indicators detailed in the *NHMRC Strategic Plan 2000–2003*, the Department's Corporate Plan and the 2000–2002 Certified Agreement.

2. Research Committee

Maintaining research in Australia

CHAIRPERSON'S REPORT



Professor Warwick Anderson

Each year the NHMRC Research Committee oversees the annual round of applications for research support. The Research Committee also develops and refines research funding policy to ensure that NHMRC research support mechanisms are fair and equitable, encourages the highest quality research, and provides support for research training of a new generation of health researchers.

On 20 November 2000, the Federal Minister for Health and Aged Care announced the results of the NHMRC 2000 funding round at

a launch held at the Walter and Eliza Hall Institute of Medical Research. A total of 459 new Project Grants, three new Program Grants, 16 new fellowship appointments, 10 new R D Wright Fellowships, six inaugural Practitioner Fellowships, and eight inaugural Industry Postdoctoral Fellowships were announced. On 23 November 2000, the Minister also announced two awards under the new Partnership Grant Scheme addressing the national health priority area of injury and injury prevention. For full details of NHMRC research support allocated in 2000 to be provided in 2001, refer to *NHMRC Grants Book 2001*, a supplementary volume accompanying this annual report.

Since 1998, the Research Committee has been reviewing its research support schemes to make them more contemporary, to remove unnecessary restrictions, to increase competition and to improve peer review. These changes were intended to strengthen and modernise Australian health and medical research. The reshaping of NHMRC's research support mechanisms is now well advanced. The first few months of this triennium have involved a consolidation of previous activities in the areas listed below.

- **New Program Grants:** These will be introduced from the 2001 grant application round. Their award is intended to focus on the track record of a team of researchers and is in accordance with the increased scale, scope and duration of grants recommended by the Health and Medical Research Strategic Review;
- **Project Grant support:** Development of Project Grant support into a more flexible one-line grant continues. For the 2000

application round, budgets were determined on the basis of support of research staff (Personnel Support Packages). In addition, the direct costs of research have been provided in multiples of \$5000, but reporting will be against a one-line sum;

- Block funding of institutes: Block funding has been a valuable mechanism during the growth of medical research in Australia through to the last decade. However, it had become increasingly recognised that the mechanism had outlived its usefulness. In 1999 the Research Committee established a working group to discuss options for change and by July 2000 had reached an agreed position for change with all block-funded institutes. An Administrative Review Panel, chaired by Professor David de Kretser, visited each of the institutes and the panel's reports provided the basis for the Research Committee to progress the transition of institutes into the NHMRC's wider funding scheme. The John Curtin School of Medical Research at the Australian National University will join the NHMRC scheme through similar mechanisms, with the final details to be determined;
- Practitioner Fellowships and Industry Postdoctoral Fellowships: The Research Committee has introduced Practitioner Fellowships and Industry Postdoctoral Fellowships and the first of these have been awarded to commence in 2001. Practitioner Fellowships are intended to strengthen research in clinical and public health by providing an opportunity for clinical and public health practitioners to combine an element of research with their professional careers, facilitate translation of research outcomes into practice, and contribute to evidence-based policy development in Australian health systems;
- NHMRC Research Fellowships scheme: Following widespread consultation, major changes will occur to the NHMRC Research Fellowships scheme from 2001. From this time, all applicants will apply for their Fellowship without having to apply for separate NHMRC funding to support their research project;
- Health Research Partnership Grants: Under the Council's strategic aim of working with other organisations, the Research Committee, in conjunction with the Strategic Research Development Committee, has developed the concept of Partnership Grants. Costs are shared between the partners and the NHMRC. Two Partnership Grants were awarded in the National Health Priority Area of injury and injury prevention, to commence in 2001. The next Partnership Grant (after injury) will focus on type 2 diabetes;
- Juvenile Diabetes Research Foundation International (JDRF): As part of the internationalisation of health research, NHMRC extended its collaboration with the JDRF. This collaboration will support a second round of Special Program Grants in type 1 diabetes commencing in 2001;
- Program in Medical Genomics: This program will support high-technology research within the Australian Genome Research Facility. Applications were ranked with the assistance of the United States National Institutes of Health;
- Subscriptions to genome databases: The NHMRC has an arrangement with Celera Genomics in the United States that allows all Australian public sector researchers the opportunity to access Celera's genome databases. Interest so far has been encouraging. The aim is to provide Australian researchers with access to invaluable human genomic databases compiled from both human and animal subjects used in and for research;

- **Aboriginal and Torres Strait Islander health:** The Research Committee has endeavoured to refine its consideration of project grant research proposals in Aboriginal and Torres Strait Islander health as part of the Discipline Panels approach. All relevant applicants were considered by both a special advisory panel and the appropriate Discipline Panel before ranking;
- **Biotechnology:** The Research Committee has established an Industry Subcommittee to provide advice on ensuring a healthy Australian biotechnology industry. A major project is to develop guidelines for management of intellectual property; and
- **Training:** The Research Committee is entering discussions with professional bodies with a view to increasing research training opportunities for young researchers in many health care areas.

The work already undertaken by the Research Committee in these areas of change is in line with many of the recommendations put forward in the Health and Medical Research Strategic Review (1999) chaired by Peter Wills AM. In progressing all of these changes, the Research Committee has also been mindful of its responsibility to meet the Government's response to that report. The Research Committee is now addressing three further major areas of change: public health research, clinical research and national research capacity.

Public health research

The Research Committee is committed to further building Australia's research capacity in public health. Health research at the level of the population and in particular communities is essential to develop effective ways of improving the health of the nation. The Health and Medical Research Strategic Review pointed to the importance of this research area and

the need to strengthen it. Australia is lucky to have many excellent public health and health services researchers, although the critical mass of such people is well below that for biomedical and clinical research. There has not been an opportunity in the past for substantial research grants in this area from the NHMRC.

The Research Committee has been considering how best to develop population health research in Australia. We recognise that, until the merger of the previous Medical Research Committee and Public Health Research & Development Committee in the last triennium, there were few funding vehicles available to help public health groups achieve critical mass. While the Research Committee has introduced some specific schemes to foster public health research (for example, the Partnership Grants and Sidney Sax Fellowships), there is a need to do more in this important area.

A discussion paper on a proposed program in population health research will be released during 2001.

Clinical research

The Research Committee has decided to undertake a comprehensive review of clinical research in Australia. Many professional groups have approached the NHMRC with their concerns about the relatively low percentage of graduates in the profession entering research. This is a phenomenon noticed in other countries too, including the United Kingdom and the United States. The United States National Institutes of Health has a range of initiatives to encourage medical graduates into research. We expect to announce the terms of reference for this group early in 2001.

National research capacity

During the remainder of this triennium, the Research Committee will be focusing on how to ensure that the national research capacity is enhanced; that Australia's links with international research are strengthened; that the next generation of bright and motivated young people are encouraged to enter health research careers; and that we capitalise on opportunities to develop research findings into national wealth.

Conclusion

The Research Committee is proud to work with the other NHMRC committees to ensure that Australia continues to be provided with the highest quality health care. As Chairman of the Research Committee, I would like to formally thank the thousands of Australian researchers who gave their time, expertise and commitment to the 2000 grant round by providing assessments and/or participating in peer-review panels. Such commitment allows the NHMRC to provide peer review of funding applications to ensure that scientific excellence is the basis of NHMRC support for research across the broad spectrum of human health problems at all levels — from genes to health care delivery.

PROFESSOR WARWICK P ANDERSON

*Chairperson,
Research Committee*



Professor D'Arcy Holman

PUBLIC HEALTH RESEARCH

Using research skills to serve the community

What makes public health researchers different is their strong links to the community and thus to government policy, according to Professor D'Arcy Holman, Director of the Centre for Health Services Research and Foundation Chair in Public Health at the University of Western Australia (UWA).

Professor Holman said that their commitment to working in this way does not preclude public health researchers from doing world-class science. 'In fact, it helps ensure that what they do is acutely relevant to health problems in the population', he said.

NHMRC recently awarded Professor Holman a five-year grant to develop five themes under the WA Record Linkage Project. The project draws on the unique WA Linked Database, linking all inpatient hospital episodes, births,

deaths, mental health service contacts and cancer registrations in WA since 1980.

Professor Holman committed himself to a career in public health as a teenager, inspired by his father, a flying surgeon in the Kimberley who moved into public health after realising that preventable social factors caused most of the region's health problems. He set up the state's system of Aboriginal health workers and community health services.

'I sometimes accompanied him during his work with remote communities and disadvantaged groups', Professor Holman explained. 'As a result, I entered UWA medical school with my heart set on a career in public health.'

The student D'Arcy Holman worked every vacation in a public health residenceship scheme for medical students. This brought him into contact with Professor Bruce Armstrong.

'He showed me how to do research, how to get it published in the world's best journals, and how to use research results for socially useful purposes', Professor Holman said.

'More than anyone else, I owe my early career success to him. Under his tutelage, I graduated in 1979 about to be published in an international journal and set on a path to becoming a career public health researcher. Moving straight to a PhD in epidemiology and preventive medicine was an easy decision.'

D'Arcy Holman was successful in attracting an NHMRC Medical Postgraduate Research Scholarship and, in 1984, became the first doctoral graduate from the NHMRC Research Unit in Epidemiology and Preventive Medicine. More recently, the NHMRC has been crucial in supporting research projects using the WA linked health data.

Record linkage in WA goes back to the 1970s, when Associate Professor Mike Hobbs saw the potential for developing something similar to the Oxford Record Linkage Study. He helped

ensure key data collections, including the state's hospital separation data and midwives' notifications of births, were set up with full patient identifiers to enable linkages to occur.

In the 1980s, Professor Fiona Stanley and her group drew together all the child-related collections into a linked maternal and child health research database, and the Roadwatch Road Accident Prevention Research Unit showed the value of linking hospital and police data in the study of road crashes.

However, the vision of a comprehensive system of linked health records on the entire population remained elusive until Professor Holman took up his post as UWA's Foundation Professor of Public Health in 1994.

'It became clear to me that the most useful thing I could do immediately was to work towards a comprehensive record linkage system', Professor Holman said.

'The time was right. Computing power and software had become more affordable; I had excellent knowledge of the data collections and good connections with the state Health Department; we had the necessary expertise. We sold the idea to the WA Lotteries Commission and obtained the \$1 million needed to build the system. By 1997, with the good work of system designer Dr John Bass, it was up and running.'

Today the WA Record Linkage Project contains links between some 13.5 million health records pertaining to 3.6 million people going back to 1980 and in some cases back to the 1960s and 1970s.

'The system is not research per se, but infrastructure that has enabled us to embark on a program of health services research on a scale and at a level of sophistication that would otherwise be impossible', Professor Holman said. 'It is highly cost-effective, significantly reducing the costs of large cohort studies.'

Professor Holman outlined two NHMRC-funded projects based on the linked data. The Quality of Surgical Care Project was established in 1996 to evaluate surgical outcomes for Western Australia. Using the record linkage system, it focuses on common procedures and procedures using new technology. It is coordinated by Professor Holman's deputy, Dr James Semmens.

In the program's next phase, individual surgeons will be invited to use data as a basis for self-review and peer review. A Quality of Surgical Care Association is to be created and given legal protection under the state's *Quality Improvement Act*. An early objective is to establish a system of 30-day surgical mortality audit.

'These unprecedented developments would never have occurred without the record linkage system and support from NHMRC for research to evaluate the outcomes of surgical care at the population level', Professor Holman said.

Practice is also changing as the result of NHMRC-supported research into the physical health problems of the approximately 7.5 per cent of the population who use mental health services.

The research, undertaken by PhD scholar David Lawrence and supervised by Professor Holman and research psychiatrist Professor Assen Jablensky, showed that the poor physical health status of mental health service users is comparable to that of the Indigenous population — their life expectancy is in the late 50s.

'The appalling physical health problems of this vulnerable group could never have been identified without the record linkage system', Professor Holman said. 'The results point to the urgent need to improve the access of people with mental illness to primary medical care for their physical health problems. An appropriate

intervention is now being worked up for trial by General Practice Divisions of WA.'

What's next? Professor Holman outlined three main strategic directions for the record linkage infrastructure. The first is to increase the levels of consumer and community participation in the WA Record Linkage Project. The second direction is to achieve the inclusion of links to Commonwealth health data.

'We hope to trial our proposed procedures during 2001', he explained. 'This is to fill a gap in the WA Record Linkage Project caused by the relative lack of data on health services delivered to patients in non-institutional settings.'

The third direction is to explore how the system can evolve to support population-based human genome research by including genealogical information (family links) and links created under very strict ethical guidelines to DNA repositories.

Professor Holman said it takes time to bring together all the skills, insights and resources

required to be a successful public health researcher.

'You need specific technical skills in one or more research discipline such as epidemiology, behavioural science and health economics', he said. 'Then you need to acquire an understanding of disciplines other than your primary one so you can work effectively in multidisciplinary teams.'

'It takes time to develop networks and connections with the community and the health system. Later, a significant challenge is to develop the leadership skills that distinguish the most effective researchers from those who are merely good at their technical work — learning to dream visions and to take prudent risks, to communicate to different groups and to serve social interests ahead of personal interests.'

'I tell my students that if they are successful 100 per cent of the time, they are playing too safe and not working on the cutting edge. I'm much happier with 70 per cent success, where the successes are highly meaningful, than uneventful success on pedestrian research.'



Dr Ingrid Scheffer and patient at the paediatric monitoring suite at the Austin and Repatriation Medical Centre

NEW PRACTITIONER FELLOW PURSUES EPILEPSY GENES

Dr Ingrid Scheffer is a child neurologist and epilepsy specialist with an outstanding track record as a clinical researcher. Her work has been at the forefront of epilepsy genetics, paving the way to a new understanding of what causes epileptic seizures and the development of new treatments. It has led to the identification of the first gene for epilepsy, with subsequent national and international collaborations resulting in identification of further epilepsy genes.

In 2000, Dr Scheffer was awarded one of NHMRC's six inaugural Practitioner Fellowships, effective from 2001.

'This Fellowship was designed for people like me', she said. 'I was already dividing my time equally between research and clinical work, but the Fellowship provides a secure, long-term (five-year) research framework, which is very hard to achieve in clinical medicine.'

'Clinicians cannot compete for regular research fellowships against scientists who spend 80 per cent of their time or more on research — we cannot match their level of productivity. On the other hand, you cannot do the sort of research I'm doing without having a significant clinical commitment — the science and clinical work are inextricably linked.'

Epilepsy is a host of conditions. Although some forms are recognised to have a genetic basis, many have genetic components. Progress in finding epilepsy genes has been relatively slow because most forms of the disease follow complex inheritance; that is, a number of genes act together with or without environmental factors.

At the moment there are seven genes known for epilepsy. Dr Scheffer's group has been involved in five, and is leading the work in the area.

'The competition is getting exciting because many other groups are modelling what we've done, which is to look at single-gene epilepsies by characterising the different types of epilepsy running through large families', Dr Scheffer said.

She says that exposure at the clinical coalface is the fundamental fuel for developing original clinical research concepts that are modified and reinterpreted in view of continuing contact with patients, families and colleagues.

'Identifying patients and families for study largely emanates from my recognition of their "special" features, and potential to provide new insights in poorly understood areas', she said.

She developed an interest in neurogenetic research at The Great Ormond Street Hospital for Sick Children, London, UK in 1989–90.

In 1991, she returned to Australia on an Epilepsy Fellowship at the Austin and Repatriation Medical Centre, where she still

works in the Department of Medicine, Neurology, the University of Melbourne. Dr Scheffer completed her PhD in the genetics of epilepsy under the supervision of Professor Sam Berkovic.

By studying families with seizures, Dr Scheffer has described four new inherited epilepsy syndromes that are being recognised around the world. She carefully characterises the epilepsy phenotypes in all family members, combining validated seizure questionnaires, general medical history, neurological examination and EEG studies.

'I also obtain previous medical records, including results of investigations, and review past EEG recordings where possible', Dr Scheffer said. 'I construct extensive pedigrees and explore the family history as widely as possible by speaking with all accessible distant family relatives, frequently ascertaining previously unknown affected family members. I classify each affected individual according to epilepsy phenotype and delineate the genetic epilepsy syndrome seen in each family.'

In some kinds of epilepsy, one form will run throughout a family. In other forms, there can be very different types of epilepsy within a family, ranging from mild febrile convulsions to a very severe epilepsy involving intellectual disability and many seizures a day. It can all be related to one and probably more genes.

'Once we see epilepsy in a clinical genetic setting, put the family history together, and develop a hypothesis about how it all works in one family, we hand over the blood samples of the family, with our pedigree and the types of seizures, to our molecular genetic colleagues', Dr Scheffer explained.

These colleagues are Professor Grant Sutherland and Associate Professor John Mulley of the Women's and Children's Hospital in Adelaide.

'They look for the genes in these conditions, but they can only do it with our data', Dr Scheffer continued. 'In one case, for example, after analysing the data critically, we said that of the family we studied in which 42 people had seizures, when we went into the detail of the types of seizure disorder, we thought that only 26 of those 42 were linked to the one gene. That information means the geneticists focused on those 26 samples and found a mutation in a sodium channel sub-unit. We published this finding in 1998.'

That particular example was to be the commonest of the conditions Dr Scheffer has described, Generalised Epilepsy with Febrile Seizures Plus.

'We have found three other families with mutations of that gene and a group from America found mutations in another related gene last year', Dr Scheffer said.

The evolution of the research makes an exciting story. In the past five years, the discovery of epilepsy genes has resulted in a crucial change in thinking about the neurobiology of the epilepsies. The challenge for the next five years is to take the research from the single-gene epilepsies into the common arena where many epilepsies follow complex inheritance.

'The epilepsies can now be considered as disorders of ion channels, drawing corollaries with other disorders such as paroxysmal muscle and cardiac diseases', Dr Scheffer explained. 'This insight lends itself to the development of new models regarding the interaction of multiple genes in the complex inheritance patterns underlying common epilepsy syndromes, and paves the way for future research.'

'We have many different ways in which we are going to look at the different genes that might be acting together. It will be a very difficult next step — it's also hard in other common diseases, such as asthma and hypertension.'

Dr Scheffer says that, although she had envisioned that finding epilepsy genes would take many years to influence clinical practice, this has not been the case.

‘Enormous insights are gained by understanding the molecular basis of a disease and they are already starting to modify how we think about a disorder and maybe how we treat it’, she said. ‘Although only seven genes have been found to date, epilepsy genetics has revolutionised the way we look at the disease because all the genes have been for disorders of ion channels. That knowledge opens up new possibilities, even with current treatments, because you can target the drugs that work on those channels.’

‘When we described a new form of epilepsy called Autosomal Dominant Nocturnal Frontal

Lobe Epilepsy, a number of these patients had been diagnosed as having hysteria. I saw a large family in South and Western Australia with this condition. We described it, then our group in Adelaide found a mutation in the acetylcholine receptor sub-unit in that family. The worst affected member of the family was very severely disabled by his seizures. We tried this 17-year-old adolescent on a drug that works on this receptor but is used for muscle diseases, and it has had an impressive effect. He now leads a far more normal life.

‘Although this is anecdotal at present, it may pave the way for formal trials in the future. In any event, critical awareness of research findings is increasingly likely to impact on daily practice and result in better care for patients and their families.’



Dr Deborah Marsh

INVESTIGATING THE GENETICS OF THYROID CANCER

R Douglas Wright (RDW) Fellowships are designed to provide outstanding researchers at an early stage in their career with an opportunity for independent research.

Dr Deborah Marsh, of the Cancer Genetics Unit at Sydney University's Kolling Institute of Medical Research, is the recipient of one of the 10 RDW Fellowships awarded in 2000. The Kolling Institute, based at Royal North Shore Hospital, is directed by Professor Robert Baxter. Professor Bruce Robinson heads the Cancer Genetics Unit.

Dr Marsh's research career has followed the theme of human cancer genetics, exploring

a number of inherited cancer syndromes and related sporadic tumours at the molecular level.

She has recently returned to the Kolling Institute and to a position of lecturer at Sydney University after three years of postdoctoral study at the Dana Farber Cancer Institute, a teaching hospital of Harvard University in Boston, USA.

As an RDW Fellow, Dr Marsh will build on the experience and skills gained in her PhD and postdoctoral studies to continue exploring the genetic steps in the initiation, development and metastasis of thyroid cancer.

'To date, I have been a member of teams that have worked on two cancer genes', Dr Marsh said. 'In my PhD at the Kolling Institute I worked on a disease called multiple endocrine neoplasia type 2 (MEN 2). A large component of this familial condition is thyroid cancer.'

For her postdoctoral studies, Dr Marsh was invited to the Dana Farber Cancer Institute, where she studied the genetics of a group of tumour syndromes characterised by developmentally disorganised cellular growth.

'We were part of a collaboration that identified the novel tumour suppressor gene PTEN as the gene for the breast and thyroid cancer syndrome known as Cowden Syndrome, as well as the gene for the related syndrome, Bannayan-Riley-Ruvalcaba', Dr Marsh said. 'PTEN has subsequently been shown to have a role in the development of a broad range of human malignancies, including brain tumours, prostate cancer, endometrial cancer, bladder cancer, melanoma and, to a lesser extent, breast and colon cancer. It was gratifying to be part of a team that discovered that the cause of certain cancers was linked to errors in this gene.'

Both MEN 2 and Cowden Syndrome are familial conditions.

'The gene associated with MEN 2 is RET and with Cowden Syndrome it is PTEN, but it's

quite clear that RET and PTEN don't account for all the events taking place in the initiation and development of different types of thyroid cancer', Dr Marsh explained. 'Clearly there is a need to investigate thyroid cancer further.'

When Dr Marsh returned to Australia and the Kolling Institute, a grant from the Leo and Jenny Leukemia and Cancer Foundation funded her ability to start building a small team. She appointed a research assistant and was able to purchase vital equipment.

'This grant allowed me to generate the preliminary results that I believe were critical to the success of my applications to the NHMRC, and to further understand the genetics of thyroid cancer', Dr Marsh said.

Her goal with the new NHMRC funding is to identify new genes involved in thyroid cancer, knowing that these findings could possibly have application to other types of cancer as well.

'While a small number of genes have been implicated in thyroid tumourigenesis, none has been shown to be an adequate marker for predicting patient survival or the risk of metastasis', Dr Marsh explained.

The Kolling Institute has access to a large thyroid tumour bank that is constantly expanding. Dr Marsh's starting point has been tumour samples collected from both individuals with a familial thyroid cancer condition and people whose thyroid cancer has occurred sporadically, as happens in the majority of thyroid cancers.

'Comparative Genomic Hybridisation is the first tool we are using to help guide us to regions of the genome that may play a key role in the development of these tumours. Then we plan to refine these regions using new technologies, including microarray analyses', she said.

Her overall goal is to isolate a novel gene identified in thyroid tumourigenesis and,

potentially, to provide a useful clinical marker for prognosis. Such a gene may also show potential as a target for gene therapy.

While this work is not going to provide therapies, Dr Marsh said that identifying the genes that play the major role in a disease is the first step in developing therapies.

All this seems a considerable distance from the love of nature that originally inspired Dr Marsh to study agriculture as a way to understand plants and animals at a deeper level.

'I chose the animal stream of the agricultural course, which shared some courses with the veterinary faculty', she said. 'We did a lot of prac sessions on the farms, working with farmers and seeing the land through their eyes, which I enjoyed. In my third year we did genetics and I really loved that as well. From the prac work on the farms it was clear to me that as a city girl I had some credibility problems and, while they were not insurmountable, in genetics I found something I loved enough to rechannel my energies.

'The basics of genetics that I learnt in the animal husbandry application were directly translatable to human genetics. The tools you use in human and animal genetics to investigate molecular genetic problems are the same. In human cancer genetics I could see more of a niche for me to make a contribution than if I opted to stay on the rural side.'

Dr Marsh says receiving the RDW Fellowship has already been extremely important 'because it's a message to me that a senior group of scientists has judged my work and potential to be worthy of recognition'.

'It's a great honour to have the Fellowship and I will be working hard to ensure that I do it justice.'

Dr Marsh hopes she will be able to establish her research career in Australia.

'It's quite nerve-racking to think about a future that relies on grant support when it's so highly

competitive', she said. 'I've been given the chance now, with this Fellowship, because I'm relatively fresh from my postdoctoral work in America where I was lucky to be quite productive. However, I'm fully aware that I have to be as good in Australia and that's quite a challenge, because this is a different scientific environment. We've heard a lot in the media lately that there will be more support

for science in Australia, but that's yet to filter its way down to scientists at my level. I see scientists for whom I have a great deal of respect missing out on grants. That makes you painfully aware that science is a tough career choice.

'To be a scientist you have to have a passion for it. Without it you are not going to survive.'

3. Strategic Research Development Committee

Responding strategically to
emerging problems

CHAIRPERSON'S REPORT



Dr John Best

In the first year of the new NHMRC triennium, the Strategic Research Development Committee (SRDC) is concluding its work on some programs from the last triennium and passing them to others who are better placed to continue working on them. To take the place of these programs, new priority areas for strategic research have been identified for the Committee's consideration during the triennium. Further details on these are provided later in this report.

SRDC's core business is overseeing the development and implementation of strategic research in areas, both ongoing and new to SRDC, where the research effort is not commensurate with the importance of that

research topic to health care in Australia. Now in its second triennium, SRDC faces a particular challenge — to build on the lessons of the past and move forward into new areas. The Committee has therefore developed a strategic framework for its activities that responds both to appraisal of its first triennium activities and the findings of the priority-setting process established in 1999.

Half of the membership of the SRDC is comprised of new members, and half of ongoing members from the last triennium. This gives the Committee a stable base, while also introducing new ideas and perspectives. Professor Janet Greeley has been formally appointed as Deputy Chairperson and a very active SRDC Executive Committee includes four members additional to the Chair and Deputy Chair: Professor Don Cameron, Dr Syd Allen, Ms Genevieve Cantwell and Mr John Delaney.

A strategic framework

The framework for the Committee's work is organised in three tiers: research priority areas, research gaps, and approaches to developing strategic research.

Tier one — research priority areas

The research priority areas were developed through the SRDC's consultation process, which was established in 1999. The new priority areas for this triennium are:

- Ageing;
- Mental Health;
- Systems of Care for Chronic Diseases;
- Oral Health; and
- Aboriginal and Torres Strait Islander Health.

In addition, work is continuing or concluding in the following priority areas from the last triennium:

- Radiofrequency Electromagnetic Energy;
- Evidence-based Clinical Practice;
- Injury;
- Hepatitis C;
- the National Illicit Drug Strategy;
- Evidence-based Youth Suicide Research Agenda;
- Health and Economics; and
- Centres of Clinical Excellence in Hospital-based Research.

The achievements of these continuing program areas are described later in this report.

Tier two — research gaps

The second tier of the Committee's new strategic framework is relevant to both the continuing programs and the new priority areas. At this level, the Committee considers in greater detail the research gaps in its priority areas as they relate to health services research, socioeconomic determinants, rural health and palliative care. This process is used to refine and define our focus in a way that responds to the advice about research needs received through the consultation process mentioned earlier.

In the last triennium, the Evidence-based Clinical Practice Research Program concluded that health services or systems issues were major factors in the uptake and use of evidence-based guidelines in clinical practice. A forthcoming forum will provide an opportunity for the lessons learned from this program to be passed on to other relevant organisations and individuals addressing the challenges of this area.

Tier three — three approaches to developing strategic research

Following a review of outcomes from the first triennium, the Committee looked more closely at where its work had helped fill knowledge gaps, and where these gaps might still exist. Of course, the Committee realised that knowledge gaps would continue to exist if there were no researchers with the 'capacity' to undertake research in the areas in question. For example, the SRDC report, *Paradigm Shift — Injury: from problem to solution — New research directions* informed both the translational and joint research partnerships work being done in the Injury Program area by identifying that a lack of available researchers in injury would limit the ability to generate knowledge through research in this area.

The Committee has therefore defined three different approaches by which it can deal with this issue and develop strategic research: scoping, capacity building and research.

Scoping is the process by which the Committee will clarify the particular niche into which its work might fall. For the Committee's purposes, it refers to an assessment of the research and knowledge that exists — we determine what we do not know from an appraisal of what we do know.

Capacity building is about facilitating researchers' capacity to undertake the necessary research. Strategies to achieve this may vary. For example, they might include supporting training awards, or simply placing less emphasis on the 'track record' of researchers should the scientific merit of a research proposal be otherwise exemplary. The Committee continues to consider how new researchers can be brought into the research field. Similarly, throughout the triennium, the

Committee will be looking at how to attract interested researchers whose current work is outside the health field.

Research as a means to increase knowledge is, perhaps, the more traditional domain of the NHMRC. From a strategic approach, increasing knowledge through research might be achieved by investigator-initiated, commissioned, partnership or translational research mechanisms. Investigator-initiated research relies on the imagination of investigators to determine the research focus, whereas commissioned research enables the Committee to target specific issues in need of focused research effort.

Partnership approaches to research are important in fostering strategic linkages between relevant players — such as researchers, clinicians, policy makers, administrators and industry — in a way that permits comprehensive and informative coverage of the issues, with sustainable outcomes. The Committee sees translational research as a multidisciplinary and innovative approach that fosters the translation of research outcomes into policy and evidence-based practice.

Applying the strategic framework

SRDC has refined its operational principles in the initial part of the new triennium and has begun to apply them to the research priority areas. The diagram below shows how the SRDC strategic framework is applied to the priority area of ageing.

As part of its approach to work in the area of ageing, the Committee will examine, for example, health services issues related to ageing and what evidence there is to support approaches used in residential care settings. Furthermore, the Committee has determined that, before researchers examine ‘healthy ageing’ in detail, they need more fundamental information about how cells age.

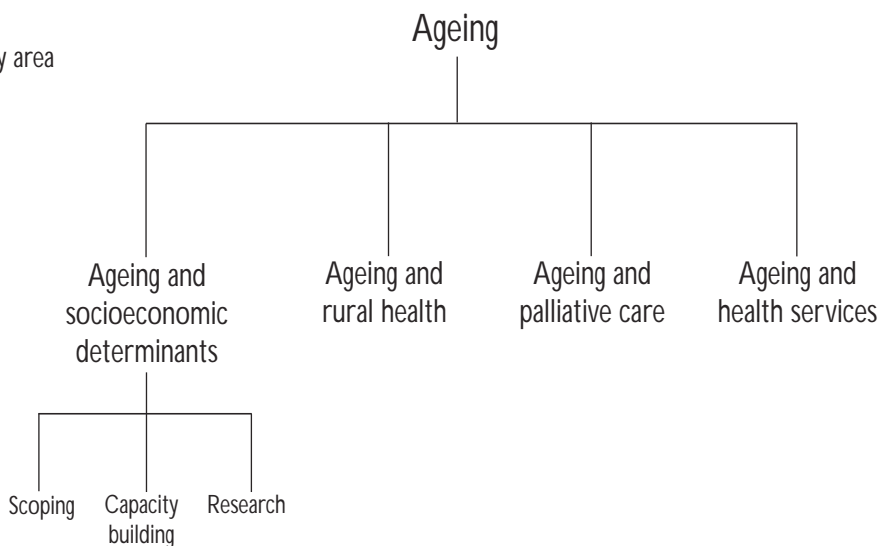
Evaluation

Evaluating the research programs that had been completed or were nearing completion at the end of the last triennium against objective criteria will allow the Committee to assess how well its aims were achieved. An iterative approach to evaluation also

Tier 1:
Research priority area

Tier 2:
Research gaps

Tier 3:
Approaches



permits the Committee to mould its new and ongoing programs in ways that will have the potential to improve the health and wellbeing of Australians. Evaluations are currently concluding on the Centres of Clinical Excellence in Hospital-based Research Program, and in the Hepatitis C Program. The Evidence-based Clinical Practice Research Program was evaluated in 2000, and feedback developed from this evaluation will be passed on to relevant agencies and individuals at a forum to be held early in 2001.

In addition, the SRDC is eagerly awaiting the findings of the research projects that commenced in 2000. For example, in 2000, the SRDC's Electromagnetic Energy Expert Working Committee called for expressions of interest to conduct research on the possible biological effects of exposure to radiofrequency electromagnetic energy that may be relevant to human health. Two projects were approved for funding:

- Effects of Radiofrequency Electromagnetic Radiation from Long-Term Mobile Phone Use on Vision and Hearing (\$309,005); and
- Human Physiological Responses to Exposure to Mobile Phone-type Radiation (\$213,570).

Three projects were approved for funding under the SRDC's Health and Economics Program in 2000. The priority area's focus was on larger systemic issues affecting health, such as allocative efficiency, cost-effectiveness, and the impact of new treatments on system costs. Funded projects were:

- Improving Technical and Allocative Efficiency of Hospital Care through Use (and Development) of Casemix Measures (\$84,954);
- Impact of Alternative Funding Methods on the Efficiency and Equity of Hospital Care in Australia (\$180,500); and
- Improving the Cost-effectiveness of Health Services for the Prevention and Treatment of Coronary Heart Disease (\$206,383).

In September 2000, three Translational Grants were awarded under the Injury Program. Since that time, a further grant relating to injury in Indigenous communities has been awarded. The four funded projects embrace a diverse range of topics, as follows:

- Development, Implementation and Evaluation of an Intervention to Prevent Work-related Musculoskeletal Injuries (\$106,377);
- The Role of Regulation in Preventing Sports Injuries (\$121,906);
- Development and Implementation of a Tractor Safety Evaluation and Rating System (\$48,453); and
- Injury Prevention through Community Development Initiatives in Central Australia (\$199,984).

During 2000, seventeen projects were funded under the National Illicit Drug Strategy Research Program, at a cost of just over \$2 million. A second grant round was advertised in April 2000, with four projects funded in late 2000. Funded projects include:

- A Pharmacogenetic Approach to the Treatment of Opioid Dependence Using the D₂ Dopamine Receptor Gene (\$140,373);
- Evaluation of a Methadone Maintenance Program for Heroin-dependent Young Female Offenders (\$172,940);
- An Analysis of the Needs of Indigenous Illegal Drug Users in the ACT and Region for Treatment and Other Services (\$240,905); and
- Barriers to Accessing Mainstream Drug and Alcohol Services by Kooris Who Use Injected Drugs (\$126,456).

Also, in late 2000, a grant was awarded to the Australian Institute of Family Studies to prepare a literature review on the role of families in the development, identification, prevention and treatment of illicit drug problems.

Under the Evidence-based Youth Suicide Research Agenda Program, five applications were approved for funding in late March 2000. The total funding for these projects is nearly \$870,000 and includes the following projects:

- Resourceful Adolescent Program: Universal Controlled Trial for Reducing Risk and Increasing Protective Factors in Adolescent Depression and Suicide (\$300,000);
- Increasing Resilience and Reducing Risk of Depression in Adolescents (\$300,000);
- Help Seeking and the Responses of Young Men to Intervention Services (\$99,415);
- Scoping Study for an Australian Longitudinal Prospective Adolescent Cohort Study (\$110,118); and
- Possible Role of the Wolfram Syndrome Gene in Suicide (\$57,130).

Conclusion

I am sure all the SRDC members share my excitement in seeing our tiered approach mature, with our outcomes and outputs clearly showing an improved capacity to respond to the health research needs in Australia. I would like to take this opportunity to thank the members of the SRDC for their considerable contributions already this triennium, and I look forward to reporting our progress in our next annual report.

DR JOHN BEST

*Chairperson,
Strategic Research Development Committee*



Professor Mohamed Khadra

STATE-OF-THE-ART CLINICAL SCHOOL TEACHES COMPASSION

‘One day in the UK I saw an advertisement for someone to head a new clinical school in Wagga Wagga. My wife and I fell over laughing — what a ridiculous place to have a clinical school! But the more we read and thought about it the more we realised that it wasn’t ridiculous. It is just that it hadn’t been done before. A clinical school in a purely rural area would be quite a challenge, one that I knew I would enjoy enormously and one that would use a lot of my qualifications and experiences in curricula design, research and computing.’

The speaker is Professor Mohamed Khadra, Professor in Surgery at the University of New South Wales and foundation Director of the Greater Murray Clinical School (GMCS) since January 2000. He is also a member of SRDC.

Professor Khadra is well travelled in every sense. Born in Ghana of Lebanese parents, for his first ten years he lived in a country town environment in which people valued education highly. Then, in 1970, the Khadras migrated to Australia and settled in Sydney. On completing his secondary education and just missing out on entry to medicine, Professor Khadra enrolled in dentistry. When he topped third year, he transferred to medicine at the University of Newcastle, New South Wales.

As a general surgery registrar at Royal North Shore Hospital, Professor Khadra found that the shortage of people with computer qualifications irritated him: ‘Every time you wanted something done you had to find a computer technician’. In 1991 he obtained a graduate diploma in computing by distance education.

Professor Khadra’s initial interest in urology was sparked by a term with an inspirational urologist, and consolidated when he was awarded the two-year Gordon Craig Fellowship, which included urology training and a year dedicated to research. His research on the sympathetic nervous system and its role in controlling continence was to form part of the PhD awarded him in 1999. During this year he also completed a masters degree in education. His thesis, an evaluation of an interactive CD-ROM he had written, using notes and images collected while studying for his urology exams, was ‘a great way to cut my teeth in computer-assisted learning and apply the theory I had learnt while working for the degree’.

In 1996, Professor Khadra was appointed a senior lecturer at the University of Sydney and a urology consultant at both Royal Prince Alfred and Concord hospitals. Then life took an abrupt turn. In 1997, a lump in his thyroid was diagnosed as a carcinoma. Treatment involved sessions of radio iodine therapy and several operations.

'This episode focused my thoughts on what we teach doctors and on my experiences as a surgeon', he said. 'I wrote an article in the *Medical Journal of Australia* [‘What price, compassion?’, MJA 169 (1998): 42–43] that criticised clinical medicine and nursing and what we emphasise in hospitals. It was written as a patient who had been a surgeon in the same hospital.

'I was making the point that the health system sends a clear and very negative message to junior staff, including interns, that patient contact is the lowest form of labour. As you progress and gain more money and kudos, you lessen patient contact and increase administrative work.'

After his illness Professor Khadra worked at the Freeman Hospital at Newcastle-Upon-Tyne in the north of England, one of the leading urology research centres in the UK. At Sydney University he had been involved in developing a new undergraduate medical curriculum. In Newcastle-Upon-Tyne he was exposed to a new approach to research and a very different curriculum. He describes it as an invigorating time, 'and all the while, the thoughts about compassion came into my mind'.

It was in England that Professor Khadra saw the advertisement that was to bring him to Wagga Wagga where, as head of the new clinical school, he began putting his ideas into action.

'I wanted to create a curriculum that reflected my beliefs about compassion and how we train medical students', Professor Khadra said. 'We also wanted a curriculum that did not require an enormous commitment in time from local doctors, because we have far fewer doctors per head of population than the national average. This also meant that the model of traditional clinical medical education that occurs in major hospitals around the world was not going to work for us. In any case, it did not address the fundamental issues about care, compassion

and respect for other health professionals that were lacking.

'I developed an idea that we have to be patient-centred in our curriculum. Instead of attaching medical students to doctors, we attach them to patients. Rather than seeing 20 or 30 patients in one day, as is the traditional model, our students will see a few patients consecutively, accompanying them wherever they go in the health system and developing a relationship that lasts throughout their course. At every point the student is learning fundamental things about patients, but most importantly, they are gaining insight into the human condition — the living conditions, thoughts, feelings and desires of that patient.

'In 2000, the first year the curriculum has been applied, we have had around 190 students rotating through the school. But I am also convinced that we can't achieve what we wanted in a six-week block: we need to immerse our students in the rural environment. So, from February 2001, we will have 12 students who have commenced with us in fourth year and who, it is planned, will stay for the fifth and sixth years of their clinical course.

'The key is that the students follow their patients, but once a week we bring them in and integrate their learning. It's a constantly questioning, challenging course where the student is in the driver's seat and patients' needs are paramount. I'm convinced this is the way to teach medicine. It's the way to teach compassion in our course and the way to anchor knowledge.'

The GMCS also benefits the region's health professionals, offering upgraded IT and library resources, and a postgraduate education program featuring prominent speakers from around Australia. This monthly series is attended by at least 100 doctors in three different locations, all linked by video.

Research is an important theme and the GMCS will focus on four research streams. 'First and foremost is educational research: evaluating the course as well as the IT and video conferencing that we use to reach our students, who are placed throughout the region', Professor Khadra said.

The second stream is clinical research. An offer to support research projects that local specialists and general practitioners in the area might be considering has resulted in more than 20 projects, 'at least half of which will end up in good solid publications'.

The third stream is biomedical research, based on links being formed with Charles Sturt University with a view to developing collaborative research. The fourth stream will be health services and population research.

'The idea is to launch projects in each category that will eventually attract competitive grants', Professor Khadra explained. 'We need to create a centre of academic excellence in a rural setting that can compete with anything in Sydney or Melbourne. Not only do we need doctors here, we need the health professionals, laboratory workers and researchers who go with them.'

Professor Khadra believes that, for too long, urban Australia has won most of the available research money, with very little coming to rural areas. His major intention as a member of SRDC is to draw attention to the need for capacity building.

'Capacity building in a discipline is a responsibility we should hold dear in our hearts', he said. 'We don't have mechanisms to develop a fledgling research unit with small training grants designed to help it progress to the stage where it can compete for the substantial NHMRC grants. Rural Australia is a classic example of where we need to develop the capacity to do research, but there are also fledgling subdisciplines, such as urology and palliative care.'

'That was my intention in working with SRDC's palliative care project. Palliative care is still a very young discipline, so SRDC is organising a workshop to work with young researchers who have a project, but not the wherewithal to take it to the next step. The idea is to team them with expert researchers who can share experience. I hope this will become a new model.'



Dr Sarah Robertson with Seymour College student Kate Hawker

Photograph reprinted from the *Age*, 6 May 2001

YOUNG TALL POPPY APPOINTED TO SRDC

As a child, Sarah Robertson was fascinated by the natural world. She always wanted to study science, but without her father's advice, could well have missed her calling. Dr Robertson is a NHMRC Research Fellow in the Department of Obstetrics and Gynaecology and Reproductive Medicine Unit at Adelaide University, and was appointed to SRDC this triennium.

Her principal research interest is the female immune response to semen, and its implications for embryo implantation and the development of the placenta. This research is vital for managing implantation failure, a major cause of infertility and miscarriage in humans, and a significant constraint in livestock breeding.

'I was lucky in that my father encouraged me to take a broad-based university degree that kept my options open', Dr Robertson said. 'That was why I opted for science, rather

than a more applied course such as physiotherapy or medical technology.'

On graduating, and uncertain about doing a PhD, she opted to work as an NHMRC-funded research assistant in the Department of Immunology at Adelaide University. The project on which she worked studied the gut's immune responses to the parasite *Giardia*.

After five years she was invited to work in the Department of Obstetrics and Gynaecology

on a new project to develop reproductive immunology. The project was based on emerging information that suggested that understanding how pregnancy works, and the basis of many pathologies of pregnancy in particular, required better understanding of the mother's immune response to the conceptus — the developing foetus and its enclosing membrane.

'I immediately saw parallels between the conceptus in the mucosal tissue of the female reproductive tract and the parasites I'd been working on in the gut', Dr Robertson said. 'That fresh angle has been instrumental in the way my work has developed ever since.'

It was at this point that Dr Robertson decided that she wanted a PhD, with a view to becoming an independent researcher. She has realised these ambitions, finishing her PhD in 1993 and running her own independent research program in the department since then. NHMRC funding has been essential to her capacity to operate as a researcher.

In 2000, Dr Robertson was made a Young Tall Poppy in recognition of her work and for promoting science careers to young Australians. The citation reads in part: 'Sarah's internationally recognised research on immune

problems in early pregnancy is also likely to reduce public health costs, since problems with placental development, which can compromise foetal growth, are associated with disease susceptibility in later life’.

A major current research focus is the pre-implantation embryo as a challenge to the mother’s immune system and understanding how the processes of immunological tolerance are established. ‘To achieve the most successful pregnancy outcome, the placenta needs to grow and develop optimally in the mother’s uterus’, Dr Robertson explained. ‘For this to occur, the woman’s immune system needs to adapt to tolerate the genetically foreign foetal and placental tissue.

‘I’m interested in understanding how the mother’s immunological tolerance is initiated, because what happens during its induction phase is the key determinant of the quality and strength of the immune response.

‘It seems to me that this response has to be in place when the embryo begins to implant. So we are interested in the function of semen and the process of insemination in driving the response. We’ve discovered that exposure to paternal antigens associated with sperm and the seminal fluid is the priming stimulus for initiating maternal tolerance. This is a very important finding, because if we can understand the mechanisms involved, we can generate new therapies for women with fertility problems.’

Many pathologies of pregnancy in conditions such as recurrent pregnancy loss, implantation failure, and pre-eclampsia, where foetal growth is compromised and babies are often born with low weights for their gestational age, can be traced back to imbalances in the mother’s immune system.

‘Understanding how to manipulate the mother’s immune response will have major potential for new therapies to help people who have

problems in becoming pregnant, as well as those who have less than optimal pregnancy outcomes’, Dr Robertson said.

‘That, in turn, has major implications for public health, because it’s clear that many diseases, including diabetes and cardiac disease, are associated with a poor in-utero environment. Improving that environment across the community would have potentially major benefits in the public health sense.’

The research is also being applied in livestock industries, where small improvements in the number and quality of progeny can translate into major economic benefits for the industry. ‘The agricultural sector is recognising that early pregnancy is the major opportunity for improving reproductive outcomes’, Dr Robertson said. ‘We are working with the Pig Research and Development Corporation to devise a surrogate seminal plasma for use in artificial insemination to improve implantation rates and the quality and size of offspring later in gestation.

‘This is a great opportunity for involving industry in our research. And if we can increase the number and variety of our animal models, we will learn more about biological mechanisms and that will improve our capacity to deliver to the human market.’

Dr Robertson’s group now has two patents relating to the intellectual property it has generated over the past six to eight years. ‘We are negotiating with commercial partners to exploit and develop that intellectual property, particularly in relation to therapies for treating human infertility’, she said.

Given the amount of work involved in doing this, Dr Robertson has been relieved to learn that the NHMRC intends to give greater recognition to partnerships with the commercial sector, and the generation and protection of intellectual property.

In her role as a member of SRDC, Dr Robertson believes she has a particular contribution to make as one of the two basic scientists on the committee. ‘Committees like SRDC need to understand that targeted research isn’t the conventional way scientists are motivated’, she explained. ‘Curiosity-driven research has always been the most efficacious way of coming up with new knowledge. For SRDC’s objectives to succeed, we must devise ways of encouraging researchers to understand the importance of targeted research and feel rewarded for doing it.’

Dr Robertson has been on a fast learning curve since SRDC made her responsible for the strategic research area of oral health. ‘Oral health is a major problem in the Australian community, particularly in certain age groups and sectors’, she said. ‘It is also a growing problem, despite the amount of money and effort that has gone into attempts to improve standards of oral health care. My portfolio is about trying to identify why that investment hasn’t worked and how we need to alter our approach.’

Dr Robertson has discovered intriguing parallels between her own work and the association between people with poor oral

health and conditions such as diabetes, heart and lung disease, and stroke.

‘All the diseases that are risk factors for compromised oral health are the diseases that seem to stem from less than optimal foetal life’, she said. ‘This suggests there might be immune system or metabolic set points established very early in life, based on the quality of the in-utero environment, that manifest in adults in each of these different tissue systems, including the mouth. If we can better understand how body systems are integrated, opportunities to prevent disease are going to be improved.’

Dr Robertson is working with the South Australian Department of Human Services and dental schools across Australia on her oral health portfolio. An early initiative is a workshop to identify new opportunities for research and to achieve a better understanding of the problems and possible solutions. Another initiative will be to start building bridges between dentistry and medicine and improving communication between the professions.

‘Oral health is always considered a separate discipline to the rest of medicine’, Dr Robertson said. ‘Bringing dentistry back to mainstream systemic health is vital and eminently achievable.’



Professor Philip Boyce

REDUCING THE BURDEN OF MENTAL ILLNESS

While there is an enormous burden of disease associated with mental disorders, many mental disorders go undetected and untreated, according to Professor Philip Boyce. Professor Boyce is head of the Department of Psychological Medicine at the University of Sydney, and a member of SRDC, where he has special responsibility for the strategic research area of mental health.

According to the Australian Institute of Health and Welfare, the impact of mental illness within the Australian population has become increasingly apparent. The 1997 National Survey of Mental Health and Wellbeing by the Australian Bureau of Statistics found that 18 per cent of adults in the community had a mental disorder in the months before the survey. The recent study entitled Burden of Disease and Injury in Australia indicated that mental disorders are the leading cause of

disability burden in Australia, accounting for an estimated 27 per cent of the total years lost due to disability.

‘We have very effective and very good treatments for the majority of disorders’, Professor Boyce said. ‘The problem is that people aren’t accessing the appropriate help and getting the services that they require. That is a very big challenge for us.’

The World Bank and the World Health Organization have predicted that, by the year 2020, the health burden attributable to neuropsychiatric disorders could increase by about 50 per cent, from 10.5 per cent of the total burden in 1990 to almost 15 per cent in 2020. Projections to the year 2020 indicate that depression will contribute the largest share to the burden of disease in the developing world, and the second largest worldwide.

‘This is of great concern, particularly in the case of depression, which can be effectively treated if it is recognised, and patients receive appropriate services’, Professor Boyce said. ‘However, there is a lot of stigma associated with depression, so people often won’t seek help, although they actually have a very treatable disorder.’

One cause for optimism is that, while there are still problems in obtaining accurate diagnoses at the points at which many people first access health services, that picture is changing. ‘We have put considerable effort into improving the skills of general practitioners and primary care workers in identifying mental disorders’, Professor Boyce said. ‘We are getting much better and smarter at working with them. But even then, because there is still stigma attached to mental illness, people don’t want to be referred to mental health services. This is a particular concern among younger people.’

SRDC recently allocated \$200,000 per annum to fund a research program to evaluate the effectiveness of early psychosis teams in the management of young people suffering

from first-episode psychosis, and to determine whether adherence to the clinical practice guidelines for first-episode psychosis improves the teams' effectiveness.

'We are talking about schizophrenia and bipolar disorders that, if untreated, can lead to marked functional impairment, and the project is to demonstrate that, if we diagnose them early, and provide intervention and treatment in their very early stages, we may prevent this deterioration', Professor Boyce explained. 'That is the big challenge — making sure we identify and treat these disorders early so that people don't have years of misery and become more difficult to treat.'

Professor Boyce identified several other important issues that need to be addressed. 'One is that we need better resources for mental health services', he said. 'A lot of resources are going to the high-tech work that happens in health systems. Mental health gets left behind. I'm not singling out any particular service but, for example, many resources will go into areas such as IVF programs, rather than providing services for people with psychiatric illness. Mental health services are not faring as well as they should.'

'The maldistribution of resources is another concern. We have very limited resources in rural communities, which makes it extremely difficult for the people there to access mental health services. There may be a much greater depth of hidden morbidity in the rural sector compared to urban settings. Another concern is the maldistribution of resources between the private and public sectors. In many ways, psychiatrists prefer to work in the private sector, so the public sector is stretched — we don't have enough highly skilled staff working there.'

SRDC has been forming its approach to mental illness in the light of these multiple concerns. Last triennium it focused on youth suicide and looked at ways to develop better research in the field. This work continues.

'In this triennium, our first strategy has been to look at the effectiveness of early intervention and, at the same time, to try to build the capacity within services so they can evaluate which services are effective', Professor Boyce said. 'We also need to identify barriers existing within the various systems to offering proven, effective interventions to people with mental disorders. For example, I'm involved with the Royal Australian and New Zealand College of Psychiatrists in developing clinical practice guidelines. The problem with guidelines is that the evidence is not being translated into routine clinical practice — we face a real challenge in getting all the people providing services to translate effective interventions into practice.'

Professor Boyce is pleased that psychiatry or mental health now has a voice on the NHMRC. As a member of SRDC, he hopes to raise the profile of mental health, as well as awareness about mental health problems in general, and work on having an evidence-based ethos accepted and applied across the mental health system. 'As I run a mental health service, I am interested in systems and in health service research in general', he said. 'We have a paucity of health services research and I would like to see more of it conducted in mental health. We certainly need a lot more.'

'The other issue is that the accomplished researchers constantly get the money. We are not really reaching people who may have good ideas and but haven't really developed the research skills. We need to develop those skills.'

'Despite all I've said, Australian psychiatric research is highly respected, although we still have a long way to go. Australia does exceptionally well in psychiatric research, producing something like 5 per cent of the publications worldwide. Given our population, that's extraordinary. We have some real centres of excellence, which are delivering excellent research that is well recognised around the world. Some of our researchers are world leaders, and we should be proud of them.'

4. Health Advisory Committee

Providing evidence-based health advice

CHAIRPERSON'S REPORT



Professor Adele Green

The year 2000 has seen a smooth transition from the Health Advisory Committee (HAC) of the 1997–99 triennium, ably chaired by Professor Stephen Leeder, to a new committee that I am honoured to chair. We are fortunate that three members of the previous committee — Professor Henderson-Smart, Professor Rubin and Professor Silagy — are serving again, with Professor Silagy now Deputy Chairperson.

Finalising the work of the 1997–1999 triennium

In the first two months of 2000, before its term of office expired, the previous Committee maintained its record of achievement by hosting an open forum in Sydney to showcase three sets of guidelines. They were:

- *Clinical Practice Guidelines for the Management of Cutaneous Melanoma;*
- *Psychosocial Clinical Practice Guidelines: providing information, support and counselling to women with breast cancer;* and
- *Dietary Guidelines for Older Australians.*

Following the open forum, in mid-February 2000, the previous Committee held its final meeting for the triennium, and was able to finalise six reports that were considered and endorsed by Council later that month.

Goals and priorities for the 2000–2003 triennium

The Health Advisory Committee for the 2000–2003 triennium was appointed with effect from 1 August 2000, and held a planning day, two full meetings and one executive committee meeting before the end of 2000.

The planning day was devoted to the development of a strategic plan to guide the work of the Committee throughout the

triennium. The goals established by the Committee are as listed below.

- Working within an ethical framework, HAC will identify areas where informed policy advice is lacking and will develop, and will support others in developing, health advice, including advice on implementation strategies, based on the best available evidence, and ensuring that the advice meets the differing needs and values of, and

is easily accessible to, government, health practitioners and the whole community.

- HAC will contribute to the health and medical research agenda in Australia by identifying gaps in knowledge in priority areas.

The Committee also identified priority health areas in which it will initiate work early in the new triennium (see the table below).

Priority health areas

Priority area	Focus of proposed work by HAC
Rural and remote health	Violence in Indigenous communities, and its implications for health
Mental health	Co-morbidity: HAC proposes to undertake work that will complement that already done under the auspices of the Department of Health and Aged Care on co-morbidity, in the context of the National Drug Strategic Framework and the National Mental Health Strategy.
Biotechnology	HAC members are pursuing various strategies to raise the level of their knowledge and awareness in the field of biotechnology, in order to enhance HAC's ability to provide timely and authoritative advice in this area.
Health inequalities	The year 2001 is the International Year of Volunteers. HAC recognises the important contribution made by volunteers in the health sector, especially in rural and remote areas. HAC will gather information about the role of volunteers in health care and will work towards producing resource materials appropriate for the use of volunteers.
Safety and quality	HAC proposes a collaboration with the Australian Council on Safety and Quality in Health Care to report specifically on strategies that have been shown to lead to improvements in this area.
Preventive health	HAC convened a national meeting in December 2000, bringing together people and organisations with an interest in preventive guidelines, with a view to mapping a nationally coordinated approach to the development and dissemination of such guidelines.

Partnerships

The present Committee strongly endorses the view of its predecessor that it can best accomplish its goals by working closely with partners to maximise the availability and impact of evidence-based health advice that will bring about better health outcomes for all Australians.

Changes to the *National Health and Medical Research Council Act 1992* that came into effect in March 2000 clarify the processes by which Council can approve guidelines developed by external organisations in accordance with NHMRC standards. Our Committee has prepared a procedural guide that explains how such external organisations should go about seeking Council approval of guidelines they have developed. It includes a clear statement of the criteria used to decide whether it is appropriate and feasible, within resource limitations, for Council to consider such guidelines. This document will be widely distributed to potential partners early in 2001.

The Commonwealth Department of Health and Aged Care is one major partner with which HAC has traditionally worked closely. During 2000, the Committee accepted new commissions from the department to develop guidelines in two important areas detailed below.

- The appropriate use of blood and blood products in clinical settings — draft guidelines were developed jointly with the Australasian Society for Blood Transfusion on the use of red blood cells in clinical

settings. The draft guidelines were produced in a very short time frame, to coincide with the introduction of the deferral of blood donors who lived in the UK during the height of the outbreak of the bovine spongiform encephalitis outbreak. These guidelines are expected to be finalised early in 2001, following extensive consultation. Further guidelines dealing with the use of blood products will be developed in the first half of 2001.

- Dietary guidelines — in 1999, the NHMRC completed and launched *Dietary Guidelines for Older Australians*, the final in a comprehensive series of guidelines that aims to promote the benefits of healthy eating and appropriate physical activity to improve health and wellbeing for all Australians. During 2000, work began to update the earlier dietary guidelines in the series, *Dietary guidelines for Australians* (1991), *Dietary guidelines for children and adolescents* (1995) and the *Infant feeding guidelines for health workers* (1996). This work will be completed by 2002.

Other partners with which HAC plans to work closely during the 2000–2003 triennium include the Health Inequalities Research Collaboration, the National Institute of Clinical Studies, the Australian Council on Safety and Quality in Health Care and the National Public Health Partnership.

PROFESSOR ADELE GREEN

*Chairperson,
Health Advisory Committee*



Ms Barbara Flick
Photography by Rob Little

BETTER HEALTH AND NUTRITION FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

While the importance of good nutrition to health has long been recognised, Aboriginal and Torres Strait Islander peoples continue to suffer a much greater burden of nutritionally related ill health than other Australians.

In February 2000, the NHMRC endorsed an information paper entitled *Nutrition in Aboriginal and Torres Strait Islander Peoples* and a companion Guide for Health Workers.

The paper is intended as a resource for health professionals working with Aboriginal and Torres Strait Islander peoples. Section 1 summarises the current situation in Aboriginal

and Torres Strait Islander health and nutrition. Section 2 outlines the importance of proper nutrition in pregnancy, infancy and childhood and discusses assessment of childhood growth and iron deficiency anaemia. Section 3 addresses those nutrition-related diseases of particular relevance to the Aboriginal and Torres Strait Islander population.

The guide was developed as a summary of the main paper in a format useful to community health workers.

The information in both documents is evidence based and well supported by research findings. Issues addressed cover traditional attitudes and practices relating to food choices, the health consequences of good nutrition through the life cycle, and interventions to improve Aboriginal and Torres Strait Islander nutritional status.

Ms Barbara Flick, a former member of the Health Advisory Committee, chaired the expert panel that developed the final published version of the information paper. An Aboriginal health worker since 1970, Ms Flick works for the Maari Ma Aboriginal Health Corporation in Broken Hill.

‘We wanted more than a textbook about diseases and which are the good foods to eat’, Ms Flick said. ‘We wanted to bring the historical factors into the classroom and into the hands of health workers, including doctors and nurses, to give them an understanding of why people are in the situation they’re in now. It’s not just about eating good food; it’s where you live, how you live, and how government regulation affects that.’

Ms Flick said that the health problems of Indigenous peoples vary from place to place in rural and remote areas. ‘There are some outstanding differences’, she said. ‘For example, in the Pitjantjatjara lands in the extreme north-west corner of South Australia, the rates of respiratory disease among young children are probably the highest in the world.’

'In the Torres Strait we found very high rates of type 2 diabetes, much higher than for Aborigines. That relates to a dramatic change to a much more sedentary lifestyle. People now use power boats instead of rowing around the islands to do their fishing. Religion and culture also influence nutrition in the community and, whenever that is the case, it's difficult even to talk about changing lifestyles. For example, eating pigs and dugongs for religious and cultural ceremonies contributes to the high rate of diabetes.'

Ms Flick said that the shift away from a traditional diet had had serious consequences for Aboriginal health. 'You can see how events around the country have affected Aboriginal people's lives and lifestyles', she said. 'The dislocation and dispossession of lands led people to be rounded up and put into reserves. The government controlled people's movements, so they couldn't leave the missions to hunt for food and fish the way they used to. Instead, they were fed a diet of milk, tea, sugar and white flour. I think that contributed a lot to the development of chronic diseases.'

'Government laws have also affected our nutrition and our access to traditional foods that were better for us, by restricting people's ability to kill bush tucker. That still happens. I think people need to be able to access the kind of nutrition that we have always had, though some Australians might see inequality in that. But part of what makes us Indigenous is the foods we eat. It's an important part of our lives, and we celebrate it.'

Socioeconomic status is another contributing factor to poor nutrition and health among Indigenous people. 'This has had a huge impact on the kind of foods we eat', Ms Flick said. 'We know that people who live in impoverished circumstances are more likely to suffer from poor health. In our communities, people are buying cheaper processed foods — lots of white flour, tea and sugar, scones and damper with butter and syrup — to try to make

food and money go further.'

Access to fresh fruit and vegetables is another problem, especially in remote areas. 'The report discusses geographical isolation, how expensive it is to get good food, especially fresh food and vegetables, into the bush and how much more expensive it is to buy food in the bush', Ms Flick said. 'During the wet season the roads are cut, so you are paying for food to be flown in.'

'We need political negotiations about subsidising the cost of freighting good food to remote areas, for example, by providing transport to bring fruit to a community. And there are many other issues for local and state governments about roads, communications and fuel costs that all impact on the nutritional status and wellbeing of people in isolated areas.'

Ms Flick said that housing and access to clean water are two major environmental factors that affect nutrition and infectious diseases. 'Sooner or later governments will have to address them', she added. 'It's not so much that we have overcrowding in our houses; the fact is there aren't enough houses for people to live in. It's a challenge to government to provide adequate housing.'

'There are many studies about the importance of access to clean water, the removal of human waste and the water supply to the house — people's ability to have a shower, wash dishes, access to hot and cold water, and how that can affect their health.'

Ms Flick has seen some positive changes over the years. 'When I first worked in a health area in 1970, the food triangle poster was everywhere', she said. 'I kept seeing this poster in remote Australia and thinking why display that kind of information knowing that people could not act on it. They weren't able to get fresh vegetables every day, or milk and cheese, and they eat completely different foods.'

'More recently, we have been looking at what people are eating already, analysing the nutrition in their daily intake, working out what is lacking, how we might understand why those elements aren't there, and how we could start talking to government about what was missing.

'Just as vegetarians and other groups have worked out how they can have their daily nutritional intake without eating meat, if people are not getting all of the five main food groups, you can still eat substitute foods that give you a wholesome diet. That's been the challenge for Aboriginal health and nutrition.'

On the positive side, Ms Flick says that the health of children and Torres Strait Islander babies has improved greatly over the past 30–40 years. She also sees better understanding by health professionals, who have taken themselves 'out of the square of traditional Western medicine and are getting to understand how land and our culture, ceremony and traditions, as well as nutrition, affect the health of Indigenous Australians'.



Associate Professor Sherryl Pope

Photograph by Peter Northcott

WOMEN AT RISK OF POSTNATAL DEPRESSION

Childbearing puts woman at particular risk of becoming depressed, according to Associate Professor Sherryl Pope of the School of Psychology at Edith Cowan University in Western Australia.

Associate Professor Pope, assisted by a team of researchers from the Women and Infants Research Foundation at Perth's King Edward Memorial Hospital, is the author of *Postnatal Depression: A systematic review of published scientific literature to 1999 — An Information Paper*. The National Health and Medical Research Council endorsed the information paper and accompanying consumer guide, *Postnatal Depression: Not Just the Baby Blues*, in July 2000.

Postnatal depression is the most common mood disorder associated with childbirth, affecting up to 15 per cent of childbearing women. This can have long-term consequences for women and their partners, babies and other children.

'We want to disseminate information in the community to change the way people view postnatal depression and reduce the stigma associated with it', Associate Professor Pope said.

The information paper is the first step in documenting current multidisciplinary research results on the prevalence, clinical presentation, course, assessment, treatment and prevention of postnatal depression. Feedback from people in the field is that it has already filled a gap by helping them keep up to date with an avalanche of literature.

'The review is designed to help health professionals and researchers to better recognise and treat the disorder', Associate Professor Pope explained. 'The consumer guide is to provide information that women and their partners and families need to be able to say, "Yes, this is what's happening to me and I need to do something about it".'

The review also makes recommendations about the types of research needed and the areas in which research needs to be carried out and funded over the next five to 10 years. Two such areas are treatment and prevention. 'We know quite a lot about the combination of biological, psychological and social factors that predispose people to postnatal depression', Associate Professor Pope said.

'While the combination varies in strength and intensity for different people, there seems little doubt that these factors interplay in childbearing women who become depressed. What we don't know very well is how to decrease the likelihood that people will become depressed, or which are the best forms of treatment. We have adopted various

treatments, gleaned mainly from literature and practices for general depression, but we don't have good research evidence to show they are the best way to go.'

In the huge amount of literature surveyed by Associate Professor Pope and her team, there were clearly areas where little research had been done, particularly in issues relating to men. These include the effect of having a depressed partner, men's depression that develops after childbirth, and the effect on men of the transition to parenting.

'Similarly, we know too little about the effect of childbirth on couples', Associate Professor Pope said. 'We know from research that the marital relationship seems to deteriorate during the first post-partum year, but we haven't looked at ways of halting that process. We also know that there's an increased rate of divorce and separation during that year, but we haven't devised treatment or prevention programs to address that. Yet the number of people who are separating makes this a big issue with major financial implications for government.'

Her training as a midwife more than 25 years ago also gives Associate Professor Pope a rare perspective into the problems facing some women and their partners and families.

'It means I tend to understand obstetric details and experiences more than most other psychologists', she explained. 'The blend of midwifery and psychology has been a real bonus. I think it has helped me gain the confidence of many of the obstetricians I work with. It also helps me understand the range of experiences women have both before and after childbirth, and how some of their physiological experiences might interact with psychological processes.'

'This is a very important aspect of the way I view the process of childbearing, which is as a holistic experience encompassing physiological, psychological and relationship changes and adjustments.'

Between 1989 and 1998, Associate Professor Pope was the Chief Clinical Psychologist at the King Edward Memorial Hospital. 'I quickly became involved in research, looking at postnatal depression and at issues in couples to see if there were ways to either prevent the onset of, or decrease, the symptoms that women developed', she said.

In 1995, Associate Professor Pope received National Mental Health Project funding for a three-year project on childbirth stress and depression. The project involved consultations with both consumer groups and health professional groups around the state to identify their wants and needs. It also developed strategies to meet those needs.

'I spent the next few years putting the strategies into place', Associate Professor Pope said. 'It was on the basis of that experience, plus our research and clinical work, that we were asked to tender for the NHMRC project. The initial project was to develop clinical practice guidelines, but we were concerned there would be insufficient high-quality information available to do that. And indeed, that's what we found.'

An early challenge in the project was the sheer number of articles identified in the first searches. A later challenge was in editing the draft report into a manageable document.

'We finished up with a massive tome because of the amount of literature that we had researched and because there are so many aligned publications we had also reviewed in some detail', Associate Professor Pope explained. 'A lot of people have a co-morbidity of issues, including antenatal and postnatal anxiety disorders, maternity blues and puerperal psychosis. We ended up with an enormous state-of-the-art document that could never have been published. So drawing boundaries around where the area started and finished were major challenges.'

As a result of the clinical and research work she has done, Associate Professor Pope is convinced that the community needs more information about childbirth stress and depression.

‘What we learned from the statewide community consultations for the childbirth stress and depression project has propelled me for the past five or six years’, she said. ‘Two key themes emerged repeatedly. Women didn’t know what was happening to them. When they were depressed, they didn’t recognise it as depression. And they didn’t know what to do about it. So they tended not to get help, they felt ashamed and embarrassed, and they thought it meant that there was something terribly wrong about them, that they were bad mothers and just couldn’t cope.’

Many women reject the ‘depression’ label. ‘Women were much more inclined to say “I’ve got the postnatal” or “I’ve had the postnatal”, dropping the depression part and assuming you understood what they meant’, Associate Professor Pope said.

‘It has made me evangelical about wanting to disseminate the message in the community that this is not something that people have brought upon themselves; it’s not some failing in them as individuals. It is a well-recognised phenomenon that occurs particularly after childbirth. It can be detected and treated properly and in some cases, need never return again. That is the most important thing. I see these two NHMRC publications serving that need.’



Professor David Henderson-Smart
Photograph reproduced from *Centre for Perinatal Health Services Research Annual Report 1998*

NEW GUIDELINES ON VITAMIN K FOR NEWBORN BABIES

For many years, most Australian babies have received an injection of vitamin K soon after birth. This is to protect them from vitamin K deficiency bleeding (VKDB), a rare disorder that can cause bleeding into the brain, which may result in brain damage or even death. VKDB can be avoided by giving babies extra vitamin K until they build up their own supply at approximately six months of age.

In 2000, following the manufacturer's decision to change the vitamin K preparation, the NHMRC invoked its rarely used 'urgency' provisions, under Section 14 of the NHMRC Act, to implement interim guidelines on using the new preparation. Two months later, in October 2000, Council confirmed its endorsement of the new guidelines.

According to Professor David Henderson-Smart, Professor of Perinatal Medicine at the University

of Sydney, a member of the Health Advisory Committee (HAC) executive, and Chairperson of HAC's Working Party on the Administration of Vitamin K to Newborns, NHMRC was responding to a public health concern.

'It's an issue that involves every baby that's born, many parents, and a whole range of clinicians', he said. 'Our aim was to be the guardians of the community and to provide reliable health advice.'

Why the urgency?

The explanation goes back to 1992, when the *British Medical Journal* published a paper that suggested there was a link between giving intramuscular vitamin K to newborn babies and childhood cancer. The media seized on the story and it caused huge alarm, particularly among parents and health professionals. As a result, NHMRC was asked to make a statement about the validity of the story and what should be done about treatment.

'Clinicians and parents, indirectly, rely on NHMRC to say what they should do', Professor Henderson-Smart said. NHMRC convened a multidisciplinary working party, chaired by Professor Henderson-Smart and, in 1994, issued recommendations for practice to provide clinicians with interim guidelines about treatment.

'The issue then was whether it would be better to give vitamin K orally, because there was no evidence of a link between that and childhood cancer', Professor Henderson-Smart explained. 'In fact, the evidence for the link between cancer and intramuscular vitamin K was based on one study that had some problems with it', he continued. 'Subsequent studies have shown that it is either not true or, at minimum, it must be very rare if there is a true association. Statistically and epidemiologically, we can now reassure people that it is a very small risk, if there is any risk at all.'

The 1994 recommendations for practice were that all infants should receive vitamin K, preferably by injection, as this was a more reliable means of administration.

In 1999 the manufacturer altered the vitamin K preparation to a new formulation, which it intended for use in adults and newborn babies. While the changes were minor, they required the NHMRC to immediately implement guidelines for the application of the new treatment before supplies of the old treatment ran out. In addition, in January 2000, the Australian Drug Evaluation Committee asked NHMRC to comment on the implementation and clinical use of the new preparation in newborn babies.

The change raised several questions. Was the new preparation effective? What were its side effects? What recommendations should NHMRC make about giving it, particularly as it was a preparation that could be also given by mouth, whereas the previous one was not licensed for oral use?

The multidisciplinary group formed to assess the new preparation included members representing obstetricians, paediatricians, midwives, nurses, public health workers and consumers. 'We had to both review the drug and its effectiveness, and address the practical issues of what could we sensibly say and do that would work in practice', Professor Henderson-Smart said.

'The question was whether every newborn should have the oral preparation, or could they still have an intramuscular injection. The difficulty is that the oral preparation requires three doses in the first four weeks of life, and someone needs to make sure that happens, whereas, with a single injection at birth, health-care providers can ensure that the baby has had the full treatment.

'We ended up saying that there are two choices of treatment. The injection is more reliable in that you know you have given all of it. Parents who don't wish their child to have an injection can elect to have vitamin K given orally. The problem then is making sure that parents can be supported in obtaining the preparation in time for the next scheduled dose.'

Normally, when NHMRC considers these kinds of recommendations, the proposed recommendations would already have gone out for consultation and, if necessary, been amended. 'In this situation, we used Section 14 of the Act, which allowed us to do all our work and go out to consultation *after* NHMRC issued the interim guidelines, but only when the document came back from consultation were the guidelines finalised', Professor Henderson-Smart said.

'We were anxious to act in a timely way and to avoid any panic in the ranks. What happened the first time, with the publication of that article and the media response to it was that, when people had no information, they froze. They didn't do anything. They stopped giving vitamin K. This time we were keen to have a smooth transition, even though we had fairly short notice about the change actually occurring.'

Having doctors and health-care workers implement the new guidelines and use the accompanying information for parents has not been difficult.

'People were anxious and waiting for the information', Professor Henderson-Smart said. 'As a coordinator of the Australia New Zealand Neonatal Network, I was able to keep members well informed about what the Working Party was doing, so they were waiting to receive the guidelines. It wasn't a case of having to beat people over the head to try to get them to act on the guidelines; this was something they wanted and needed.'

With the new guidelines now in use, Professor Henderson-Smart can turn his attention to other issues on the HAC agenda. He says his main role during his second term on HAC concerns 'pregnancy and the care of the newborn person'.

'Being a member of HAC is interesting because you normally tend to work in your own

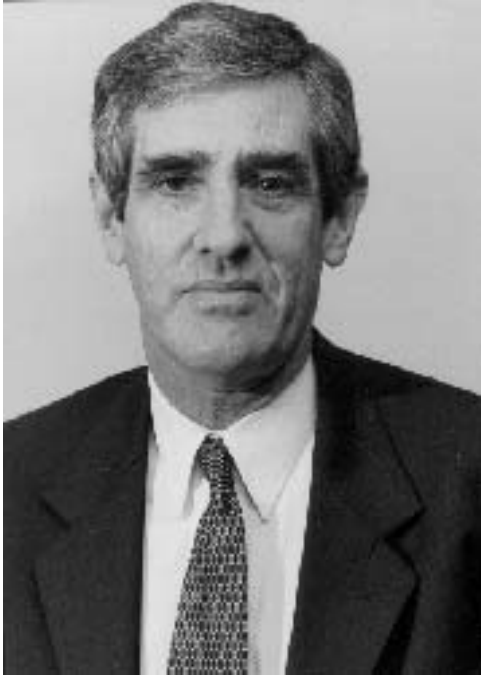
speciality and have blinkers on', he said.

'My main clinical work has been in neonatal intensive care and it's easy to think that the world revolves around what you do. Being on the committee is stimulating because it opens your mind and takes you outside medicine to social issues, such as poverty, and the availability of basic things that you would think everybody had, like clean drinking water.'

5. Australian Health Ethics Committee

Ensuring the ethical conduct
of research

CHAIRPERSON'S REPORT



Dr Kerry Breen

The year 2000 has seen the Australian Health Ethics Committee (AHEC) commence a new phase of activity to better support the work of the over 200 human research ethics committees (HRECs) registered with the NHMRC. This new phase is a natural evolution from the very important work completed in the 1997–99 triennium. In that period, Professor Don Chalmers very ably led AHEC through lengthy but rewarding consultations that culminated in the release, in August 1999, of the new *National Statement on Ethical Conduct in Research Involving Humans*. This National Statement has been endorsed by a number of peak bodies responsible for research involving

humans for purposes beyond just health. The National Statement has been welcomed by HRECs and acknowledged internationally as being an excellent, detailed, but concise guide to ethical review and ethical conduct in research.

In taking over from Professor Don Chalmers, who gave his time unstintingly to AHEC for six years as Chairperson, I am fortunate that I served under his leadership for the previous triennium. This, together with the reappointment of five other members, including Associate Professor Colin Thomson, who has been appointed as Deputy Chairperson, has resulted in a seamless transition that allows AHEC to build on the opportunities provided by the new National Statement. Our new members, who come from many different backgrounds, have enthusiastically embraced the challenging work.

Support for human research ethics committees (HRECs)

The 1999 *National Statement on Ethical Conduct in Research Involving Humans* is more comprehensive than its predecessor. It also provides opportunities for HRECs to be more efficient and to cooperate to the mutual benefit of members and the research community. In recognition of these opportunities and in response to requests from HRECs for assistance, in its first months of operation AHEC has focused on developing a three-year strategy to better support human research ethics committees. To ensure the planned support is appropriately targeted, AHEC has undertaken extensive consultations with HREC members, so far in four capital cities.

The three-year strategic plan to support human research ethics committees includes:

- completing a handbook in 2001 to aid in interpreting and applying the National Statement;
- maintaining the telephone advisory service for human research ethics committee inquiries;
- producing a regular bulletin directed towards human research ethics committees; and
- conducting regional training and topic workshops for human research ethics committee members.

Community expectations of the protection afforded by ethical review of research proposals involving human participants are rising and, at the same time, pressure is increasing on researchers to be more productive and competitive on a global scale. These competing pressures carry the risk of producing an adversarial environment between researchers and human research ethics committees. The Australian Health Ethics Committee plans to work with the other Principal Committees of the NHMRC (especially the Research and the Strategic Research Development Committees) to develop the concept of 'mutual obligation' between researchers and human research ethics committees. For this and other reasons, the Committee has welcomed participation in its meetings by two Council members.

Work has commenced on three other important issues identified in the NHMRC's Strategic Plan and on a newly referred matter. Jointly with the Research Committee, AHEC has established a working party to produce guidelines on ethical and scientific aspects of xenotransplantation.

With the Health Advisory Committee, a joint working party has begun work on guidelines about the diagnosis and continuing care of people in persistent vegetative states. Preliminary work has also begun on the revision of the *Guidelines on Ethical Matters in Aboriginal and Torres Strait Islander Health Research*, commencing with consultation with a range of people involved in Indigenous health and health research.

In late 2000, the Minister for Health and Aged Care and the Attorney-General announced that AHEC and the Australian Law Reform Commission would conduct a joint inquiry on human genetic information and related privacy and discrimination issues. Planning is well advanced so that this work may begin early in 2001.

One of AHEC's terms of reference is to promote community debate on health ethics issues. AHEC has developed its own communication strategy to complement the strategy being developed by Council. One means of achieving awareness and encouraging debate about ethical issues in research and health that will be trialled during this triennium is holding public consultation, which includes advertising for written submissions when ethical guidelines are being developed.

The previous Committee should be acknowledged for its work in creating the new National Statement to guide researchers and human research ethics committees. This Committee wishes to be recognised for its work in providing appropriate support to human research ethics committees, many of which carry difficult and increasing workloads.

DR KERRY BREEN

*Chairperson,
Australian Health Ethics Committee*



Professor Bryan Campbell

AUSTRALIAN RESEARCHERS INDEBTED TO HRECS

Australian health research owes a lot to human research ethics committees, according to Professor Bryan Campbell, Chief Health Officer (CHO) for Queensland Health.

As CHO, Professor Campbell is responsible for advising government on research, ethics, tertiary professional education, and quality in clinical care in both the private and public sector. He is also the Queensland representative on the NHMRC.

Professor Campbell believes the contribution of HRECs is under-recognised. 'I would like Queensland's HRECs to feel that we acknowledge their very important voluntary role and the amount of work they do. I also

want to give them increasing opportunity to discuss their problems', he said.

Since taking up his appointment in March 2000, Professor Campbell has concentrated on three major areas. One is ethics; the others are to develop a research framework for Queensland Health, and the quality of private health facilities.

'Our Queensland Health Ethics Advisory Committee is essentially a bioethics committee that considers the ethics of health care and health-care delivery', Professor Campbell said. 'At the same time, it needs a role very similar to that of the Australian Health Ethics Committee to support HRECs in hospitals and universities throughout Queensland. So we have been restructuring the committee and refocusing it with two major areas of interest. One is to consider important issues in health-care delivery; the other is to support the HRECs.'

Professor Campbell is keen to set up a network for Queensland's forty or so HRECs. To start breaking down the barriers of isolation, Queensland Health has organised a one-day workshop for February 2001 for all the state's HRECs, including universities, private health facilities and hospitals.

'Our primary aims are to build communications between HRECs and Queensland Health and to gain a clearer understanding of how we can better help ethics committees', Professor Campbell said. 'I would like to give more support to HRECs as a whole, and to develop a network for them.'

The three-part workshop has been organised in association with AHEC. Both AHEC Chairperson, Dr Kerry Breen, and Deputy Chairperson, Associate Professor Colin Thomson will participate. The Director-General of Queensland Health, Dr Rob Stable, is to open the workshop officially. Also included will be contributions from chairs of HRECs, as well as from other expert speakers, including Ms Francine Kelly and Mr Michael Staley.

In 1997, Ms Kelly was appointed to a new position designed to bring ethics committees in the New South Wales public health system together as a coordinated network. More recently, she has been involved in the development of a uniform research application form for HRECs.

Mr Staley, Manager, Scientific Services, Queensland Institute of Medical Research, will demonstrate software developed at the institute that allows both research officers and HRECs to track research applications through the approval process. 'This management tool will help ensure that nothing is overlooked in the consideration of research applications', Professor Campbell explained. 'It is freely available to HRECs.'

Professor Campbell says that, since the early 1980s, the work of HRECs has become increasingly complex and time consuming, and that the isolation of individual committees is a problem. 'It becomes apparent when you consider just one protocol before one committee', he explained. 'Each member has different ideas, and the real value comes with the discussion that occurs after the individuals have had a chance to read the application and think about it. Frequently, if you put the same project to two or three committees, each will debate different points and attitudes, enriching the discussion and understanding of the issues and problems.'

'It's part of the interest of ethics, but it's also one of the difficult areas. Usually there is no clear-cut right and wrong. These days, researchers are very aware of what's wrong. They are usually extremely careful and well informed. They put up the real problems, not proposals that make ethics committees throw up their arms in horror. So you need the wisdom of Solomon at times.'

'There are two considerations in of all this for committee members. They bring their own expertise and opinions, but they must

have very open minds to accept debate and discussion. And that's why they are such interesting people to work with.'

Professor Campbell's career path has given him direct experience of health and research ethics, in Australia and overseas, from the perspectives of medical practitioner, academic, researcher and administrator. A graduate of the University of Queensland, Professor Campbell trained as a physician and gastroenterologist at Royal Brisbane Hospital and the Royal Postgraduate Medical School in London. Subsequently, he worked as a full-time and visiting consultant, mainly at Royal Brisbane Hospital.

In 1975, he accepted an academic position with the University of Otago based in Christchurch, New Zealand. He returned to Royal Brisbane Hospital in 1979, where he spent 10 years as medical superintendent before being appointed Regional Director, Brisbane North Regional Health Authority. In 1995, he returned to academia and clinical practice at Royal Brisbane Hospital, before being appointed as the first head of the Graduate School of Medicine, University of Queensland.

Professor Campbell's 'hands-on' experience of ethics committees began in earnest when he returned to Brisbane in 1979 to a changing scene. NHMRC was starting to accredit and recognise research ethics committees and define their membership.

'When I became Medical Superintendent at Royal Brisbane Hospital, the membership of the ethics committee didn't satisfy the requirements of NHMRC guidelines', Professor Campbell said. 'So we strengthened and consolidated that committee, set up a scientific subcommittee and a protocol for researchers to follow in their applications to the committee, all adhering to NHMRC guidelines.'

'My interest in broader health ethics arose out of my role at the Royal Brisbane Hospital and grew in my role back at the university, where

we were introducing a new medical course with four major domains of learning. One of these was ethics and, as head of school, I took a particular interest in strengthening and developing this domain. At the same time, I was appointed to the state Medical Board, which obviously has a major role in monitoring the ethics of medical practice.'

As a relatively new member of NHMRC, Professor Campbell has been impressed by the amount of work undertaken by the four Principal Committees, and in particular the amount of work that is not directly involved in research protocols.

'Before becoming a Council member, you tend to think that Council is there to approve the research applications', he said. 'Then you quickly begin to appreciate that Council is there to ensure there is greater communication between the four Principal Committees and the community, that the research findings are applied to our health services, and that the research is used to improve the quality of health delivery throughout Australia. The role of the state representatives is important because it helps create links between the expertise of researchers and the expertise of the health service delivery arm. In effect, Council is a strategic umbrella that acts as a communication bridge between research and service delivery.'



Father Bill Uren, SJ

HOSPITAL ETHICIST A MEMBER OF AHEC

Father Bill Uren is one of a handful of hospital ethicists in Australia. He was also appointed to AHEC this triennium as ‘a person with knowledge of the ethics of medical research’, and is a member of AHEC’s Executive Committee.

Father Uren’s basic interest in health ethics and the ethics of medical research is philosophical, reflecting the theoretical point of view he developed during his academic training at Melbourne, Sydney and Oxford universities.

However, his work as hospital ethicist at Brisbane’s Mater Hospital since November 2000 is giving him a new perspective. ‘On the whole, my experience until this appointment had been theoretical — teaching health-care ethics and sitting on research ethics committees of one sort or another’, he said. ‘Hospital ethics brings you to the clinical side, the coalface.’

Father Uren first became involved in the ‘hands-on’ of health-care ethics when he was Rector of St Thomas More College at the University of Western Australia. The first test-tube baby had just been born and the state government was forming an ethics committee to investigate the whole question of artificial reproduction and in-vitro fertilisation ethics. The committee was to include a representative of the Catholic Church.

‘I’m a Jesuit priest, and the study for the priesthood involves quite a bit on medical ethics — a broad background training. I also knew a little about in-vitro fertilisation’, Father Uren said. ‘In the eyes of the archbishop, this made me the best qualified person in the diocese to represent the church on the committee.’ The committee met for three years before producing its final report in 1986.

In 1987, Father Uren moved to Melbourne, again as rector of a university college — Newman College at the University of Melbourne. He also taught in the university’s philosophy department, and soon became course supervisor and principal lecturer in a new course, Issues in Biomedical Ethics.

‘That’s when I got into a broader range of issues in health-care ethics’, Father Uren explained. ‘I also became involved in ethics committees at the Royal Melbourne Hospital, the Australian Catholic University, and the St Vincent Institute of Medical Research.’

In 1998 he moved to Brisbane, once again as rector of a university college, and pursued similar academic interests. He became a member of the ethics committees of Griffith University and the Holy Spirit Hospital, and the Ethics Advisory Council at the Mater Hospital. When the position of hospital ethicist at the Mater Hospital became available, he applied and was appointed.

The Mater Hospital comprises six hospitals and a research institute, and has some 4000

employees. It has had a hospital ethicist for about 10 years and the position is well integrated into hospital life.

Father Uren believes hospital ethicists are more common in Catholic hospitals because ‘in a sense, it’s about maintaining the specifically Catholic ethical point of view in those hospitals’. Even so, because hospital ethicists are rare in Australia, their role is not widely understood.

Father Uren outlined four areas of activity involved in his position at the Mater Hospital. First, he is a member of the Mater’s four research ethics committees.

Second, he is involved in consultation on difficult cases, often in the neonatal intensive care unit, or relating to foetal dysmorphism. These consultations include the doctor concerned, the executive director of the hospital, a nurse, a social worker, sometimes a patient representative — often a relative or a friend, and sometimes the patient themselves — and the hospital ethicist. Together they discuss the ethics of possible lines of treatment until they reach a consensus. ‘I feed in both secular ethical considerations and, particularly in a Catholic hospital, a specifically Catholic ethical point of view, if there is one’, Father Uren explained.

Third, he is involved in research in a variety of areas. ‘I’ve always been interested in the euthanasia question, the new embryonic stem cell research, and in the sorts of questions that are the subject of the joint inquiry by AHEC and the Australian Law Reform Commission on human genetic information and related privacy and discrimination issues’, Father Uren said.

Father Uren’s weekly ward rounds comprise the fourth sphere of activity involved in his position, and these take in the neonatal intensive care unit (ICU) at the Children’s Hospital, the paediatric ICU, the general ICU, and sometimes areas such as palliative care

and the oncology units. These rounds give Father Uren first-hand experience of the kinds of problems that arise and their ethical dimensions, and provide a good opportunity to make contact with the staff.

Overall, he believes that ethicists are a valuable resource in hospitals as ‘people who come from a specifically ethical background to suggest the guidelines, parameters and terms in which the discussion takes place’.

Over the years in which he has been engaged in ethics work, and on health and research ethics in particular, Father Uren has seen major changes in the nature of research being done, in medical knowledge, and in the kinds of ethical issues that result. ‘People often say that ethics has gone to the dogs, that once we had an agreed ethic in our community that was applied and accepted and there was very little deviation from it’, he said.

‘Since about 1960, and especially since the whole IVF debate in the 1980s, which was central, at least in Australia, the idea of ethical review has become much more of a commonplace and the community is probably much more conscious of ethics than it has ever been.

‘Issues surrounding business ethics, such as other events in Western Australia during the 1980s, also made people much more ethically sensitive. There isn’t an agreed ethic; I doubt whether there ever was. But very often people in positions of influence just applied the ethic they thought was appropriate.’

Father Uren believes we should welcome community involvement in ethical review. ‘In a sense the community has become a watchdog on ethics committees’, he continued. ‘This is a good thing. Perhaps we are a much more secularised society than we once were, but I think we are coming to recognise, sometimes through sad experience, that you cannot just descend into relativism and say one person’s

ethics are as good as another's. There should be some agreed community standards.

'That's been a healthy development in the way our community approaches a lot of these scientific developments. It is claimed that 96 per cent of all the scientific and medical research done since the beginning of time has been done since the beginning of the Second World War — we've had an explosion of scientific development. But in the past 20–25 years, in particular, we've also had an

explosion in the recognition of the need for ethical review.'

Father Uren said that it is now accepted that, to qualify for NHMRC funding, researchers have to submit their proposals to ethical review, and meet the guidelines for review. 'NHMRC and AHEC have complementary roles in protecting participants in research and promoting research', he concluded. 'AHEC is one part of the review spectrum, with the research ethics committees playing a very important role at the institutional level.'



Ms Jill Hambling
Photograph by Mark Chew

DEVELOPING A COMMON APPLICATION FORM

Victoria has developed a common application kit for use by researchers submitting proposals to the state's HRECs.

Ms Jill Hambling is one of a handful of people who have been involved throughout the intensive three-year process. As an administrative officer at St Vincent's Hospital in Melbourne, one of Ms Hambling's many research-related roles is as Executive Secretary to the St Vincent's HREC. This encompasses the independent research institutes on the St Vincent's Hospital Campus, as well as a HREC service for nearby groups that are linked to St Vincent's but do not operate their own HRECs.

Ms Hambling, a former nurse with a masters degree in health administration, was appointed

to her position at the end of 1996. 'In 1997, I began contacting people with similar jobs in other large teaching hospitals, and we formed an informal network to compare notes and benchmark our working procedures', she said. 'We soon realised that a common application kit would be a great asset.'

The idea fell on fertile ground and, in October 1997, the Local Network Research Ethics Committee appointed a working group to draft the kit. Ms Hambling was one of its four members, all of whom were drawn from her informal hospital-based network. By mid-1998, the group realised the kit would benefit a much wider variety of people than was first envisaged. At about the same time, the first consultation draft of the *National Statement on Ethical Conduct in Research Involving Humans* was being circulated for comment.

'A driver for developing a common kit was that we were all using a variety of guidelines', Ms Hambling said. 'We weren't all using all the guidelines available, and we were in a wilderness because the guidelines were out of date. The new National Statement demonstrated how much things had changed and we saw it was going to provide a very useful framework for questions in a human research ethics application.'

Meanwhile, word had spread about the development of the kit. Members of the working group were inundated with phone calls from people wanting to use it to inform the development or revision of their own kits.

February 1999 saw a welcome breakthrough, just as the working group was flagging. Members made contact with the Victorian Department of Human Services (DHS), which was restructuring its own HREC and wanted to redevelop its application form as an electronic kit that reflected best practice, was completely up to date, and would suit all researchers.

The department convened a meeting inviting the chairs of the major hospital and university HRECs to discuss how to advance a common application kit, and to gauge support for the project. As a result, a new, larger and high-powered working party was established to review what had been done and to align that work with the newly released National Statement.

‘We wanted an electronic kit that would guide researchers through the review process. Rather than just completing a form, we wanted to introduce users to the National Statement, the ideas behind the guidelines, the community views reflected in the statement, and to any changes in legislation’, Ms Hambling said.

‘The kit was to be suitable for all researchers involved in health research. We also wanted to improve the quality of review, not just by improving the standard of the kit and getting better information from researchers, but by making sure all the questions that the National Statement requires us to consider were included and that the necessary information was provided.’

July 1999 saw another breakthrough, when AHEC advised the working group that the Australian Pharmaceutical Manufacturers’ Association (APMA) had started a project to develop a standard application for clinical trials, and that the project had AHEC’s in-principle support.

‘By that stage we had drafted a modular application kit using the common kit developed in Victoria in combination with a similar one developed for area health services in New South Wales, and we had linked all our questions to the National Statement’, Ms Hambling said. ‘The second module in our kit was designed for clinical trials. We involved APMA and their feedback on our draft ensured that the kit would meet the requirements of pharmaceutical companies.’

In a third welcome breakthrough in November 1999, the insurers of Victoria’s public hospitals reviewed the kit’s model plain-language statement and consent form — a critical part of the application — and endorsed both, as well as the development of such a kit.

In April 2000, the working party decided to pursue the ideal of a national common application kit. At the subsequent meeting between representatives of the New South Wales and Victorian common application kit working groups, it was agreed to work towards a national form. The two working groups are contacting the other states and territories to gauge support for the notion.

Finally, in September 2000, the Department of Human Services launched the Victorian common application kit at St Vincent’s Hospital, in the presence of more than 200 people from hospitals, universities, institutes and HRECs across Victoria.

The kit, which is available on the DHS Ethics Committee web site (<http://www.dhs.vic.gov.au/phd/ethics>), consists of the following five modules plus the Requirements of Other Institutions:

- Module 1 Core Application;
- Module 2 Projects Involving Drugs and Therapeutic Devices;
- Module 3 Human Tissues;
- Module 4 Genetics; and
- Module 5 Ionising Radiation.

All applicants must complete Module 1 and the Requirements of Other Institutions. Applicants undertaking specific types of research must also complete any additional modules relevant to their research. Each module includes guidelines for answering the questions.

As each hospital or university decides to adopt the kit, a hyperlink or email address is created

to link the DHS web site to the institution and its site-specific requirements. For example, St Vincent's Hospital's standard indemnity is the only one the hospital will accept. A hyperlink alerts applicants to this requirement, as well as providing information such as meeting dates, application deadlines, and committee membership.

One obstacle yet to be overcome is the lack of a module for social science research involving humans, a source of negative comment on various drafts of the kit. 'We are still seeking someone to develop a generic module for people doing human rather than health research', Ms Hambling said. 'It will happen, but we had to make a decision to proceed with what we had, rather than to hold everything up because we lacked that module.'

Ms Hambling said that a welcome bonus of the new kit is that HREC secretariats are fielding far fewer questions than before, because of all the information on the web site. Another advantage is that it will be easy to revise the common

kit to reflect any changed or new legislation or guidelines. And, as a 'living document', it will be regularly revised and refined to reflect user feedback. A third benefit of the new kit is that it overcomes the need for researchers to complete multiple application forms when submitting a study to multiple sites.

In November 2000, AHEC approved a detailed three-year strategic plan to provide support for HRECs. It covers four themes: support, information, training, and participation in other developments. The last includes AHEC's intention to work with groups who have developed common application forms to foster a single national application form.

Ms Hambling welcomes this development. 'AHEC's new focus will help unite HRECs by helping us compare what we do and deal with our common problems. I am immensely relieved about the promise of that new direction and support', she said. 'It is another AHEC initiative that is to be applauded.'

Appendixes

APPENDIX I — COUNCIL

Role of Council

Appointees to Council hold positions for a period of up to three years. Consequently the work of Council is planned and reviewed on a triennial basis. All Council members, apart from the Chief Executive Officer, are part-time appointees. Members may be reappointed.

The Council meets in full session up to four times each year and publishes a report of the proceedings of each session. It undertakes its work through a network of Principal Committees, working committees and expert panels. The members of the network are part-time and give much of their time and expertise without remuneration.

In 2000, priorities were pursued through the following Council programs:

- health and medical research;
- health advice; and
- ethics.

The Council emphasises the need for and the assistance of appropriate consultation in the undertaking of its functions. Committees, working parties and expert panels are constituted to ensure that relevant professional and community interests are represented. In formulating guidelines, standards and advice, the Council consults as widely as practicable and appropriate.

Members of Council and its Executive Committee are listed below.

It is important that the advice of Council is widely disseminated, so significant effort is devoted to a publications program. The

publications released during 2000 are listed in Appendix XII. Media releases issued during the year are also listed in Appendix XIII.

Functions

1. To inquire into, issue guidelines on, and advise the community on matters relating to:
 - (i) the improvement of health;
 - (ii) the prevention, diagnosis and treatment of disease;
 - (iii) the provision of health care;
 - (iv) public health research and medical research; and
 - (v) ethical issues relating to health.
2. To advise, and make recommendations to, the Commonwealth, the states and territories on the matters referred to in paragraph 1.
3. To make recommendations to the Commonwealth on expenditure:
 - (i) on public health research and training, and
 - (ii) on medical research and training, including recommendations on the application of the Medical Research Endowment Fund.
4. Any functions incidental to any of the foregoing.

Composition and membership of Council

The composition of Council is determined by Section 20 of the *National Health and Medical Research Council Act 1992*.

Membership in 2000 was as follows:

Professor N (Nicholas) Saunders
Chairperson

Professor W (Warwick) Anderson
Chairperson, Research Committee (Principal Committee)

Dr J (John) Best
Chairperson, Strategic Research Development Committee (Principal Committee)

Dr K (Kerry) Breen
Chairperson, Australian Health Ethics Committee (Principal Committee)

Professor A (Adele) Green
Chairperson, Health Advisory Committee (Principal Committee)

Dr A (Andrew) Wilson
Nominee from New South Wales

Professor J (John) Catford
Nominee from Victoria

Professor CB (Bryan) Campbell
Nominee from Queensland

Professor B (Brendon) Kearney
Nominee from South Australia

Ms P (Prudence) Ford
Nominee from Western Australia

Dr J (John) Sparrow
Nominee from Tasmania

Dr S (Steven) Guthridge
Nominee from Northern Territory

Dr S (Shirley) Bowen
Nominee from Australian Capital Territory

Professor R (Richard) Smallwood
Officer of the Commonwealth Department of Health and Aged Care, as nominated by the Federal Minister for Health and Aged Care

Mr J (John) Delaney
A person nominated by the Aboriginal and Torres Strait Islander Commission, and having knowledge of the health needs of Aboriginal persons and Torres Strait Islanders

Professor K (Ken) Bowman
A person with expertise in health-care training

Dr J (Jennifer) Thomson
A person with knowledge of professional medical standards and expertise in postgraduate medical training

Dr M (Michael) Bollen
A person with background in, and knowledge of, the medical profession

Professor L (Lesley) Barclay
A person with a background in, and knowledge of, the nursing profession

Professor J (John) Young
An eminent scientist who has knowledge of public health research and medical research issues, and who has no current connection with Council

Professor G (Geoffrey) Duggin
A person with a background in, and knowledge of, the trade union movement

Dr G (Geoffrey) Brooke
A person with a background in, and knowledge of, business

Ms M (Michele) Kosky
A person with a background in, and knowledge of, consumer needs

Professor T (Trang) Thomas
A person with a knowledge of the needs of users of social welfare services

Professor C (Christine) Ewan
A person with a knowledge of environmental issues

Professor K (Kerin) O'Dea
A person with a background in, and knowledge of, public health issues

Dr B (Bronwyn) Kingwell

Dr C (Celia) Kemp
No more than two other persons with expertise relevant to the functions of Council

Gender breakdown

17 males
11 females

Mrs C (Cathy) Clutton
Executive Secretary

Executive Committee of Council

Functions

- To act on behalf of the Council as its executive organ.
- To keep under regular consideration the work of the Council and its Principal Committees and to ensure implementation of their decisions.
- To advise the Council on the organisation of the work of the Council and its Principal Committees.
- To decide to refer a matter, falling within the functions of the Council, to a Principal Committee or Committees for inquiry and for the development of guidelines, regulatory recommendations or advice, where the Executive Committee forms the opinion that, due to reasons of urgency or for a matter to be dealt with in a timely manner, the decision needs to be taken before the next session of Council.
- To approve the issuing of guidelines, the making of regulatory recommendations and the publishing of advice, where the Executive Committee forms the opinion that, due to reasons of urgency, it is necessary for those approvals to be granted before the next session of the Council.

6. To report on its activities at each session of Council.

7. To perform any other functions that the Council may, from time to time, determine.

Composition and membership in 2000

Professor N Saunders
Chairperson of Council

Dr K Breen
Chairperson of the Australian Health Ethics Committee

Professor W Anderson
Chairperson of the Research Committee

Dr J Best
Chairperson of the Strategic Research Development Committee

Professor A Green
Chairperson of the Health Advisory Committee

Ms P Ford
Professor CB Campbell
Professor J Catford
Three members representing States/Territories

Professor R Smallwood
One member representing the Commonwealth

Professor K Bowman
One other member of Council

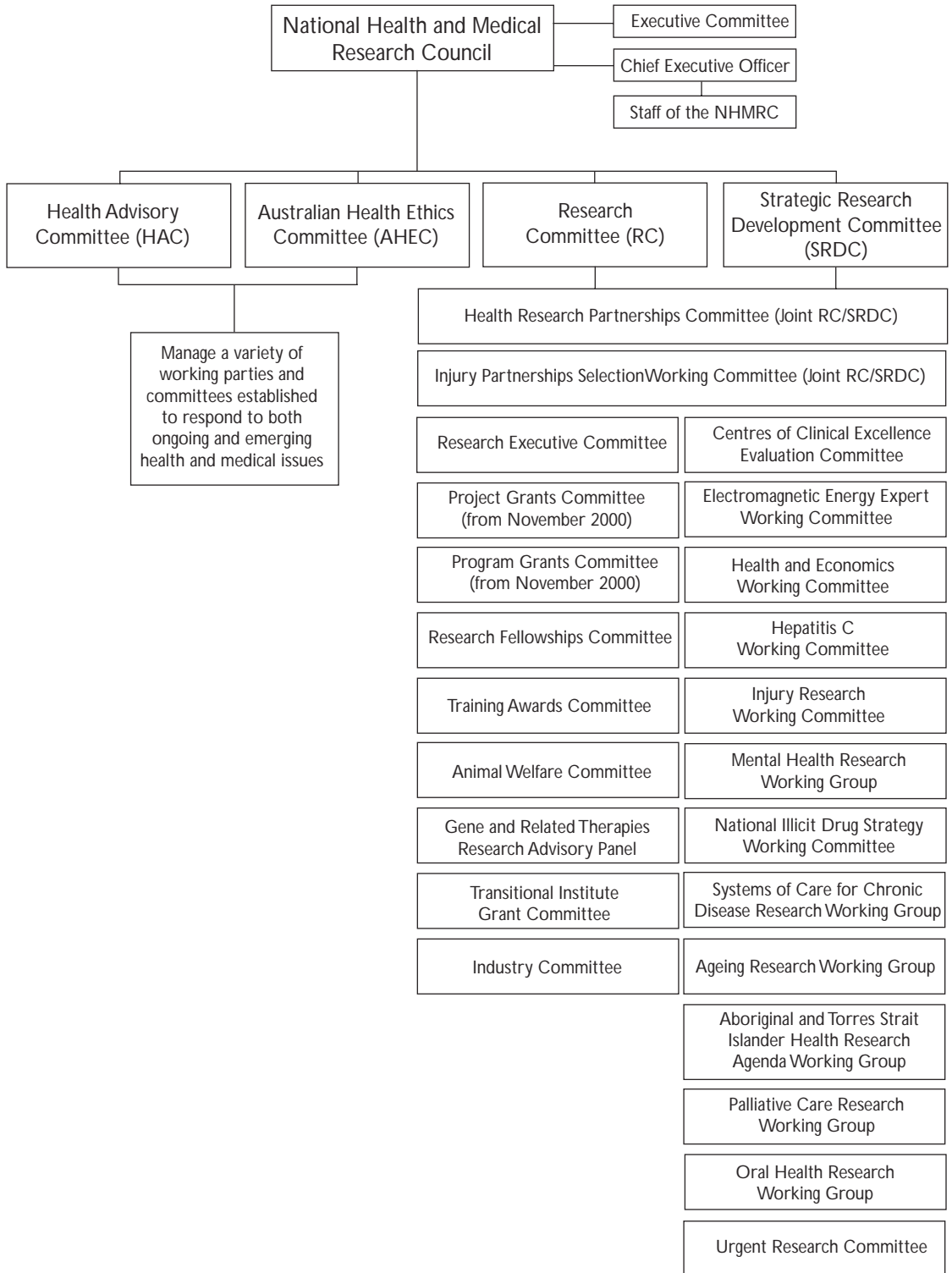
Ms M Kosky
One member representing consumer interests

Gender breakdown

9 males
2 females

Mrs J Campbell
Executive Secretary

Figure 1: Structure of the NHMRC



APPENDIX II — RESEARCH COMMITTEE (RC)

The Research Committee functions are set out in the NHMRC Act with additional functions that were determined by the Minister. Its functions and composition were gazetted in February 1997 as below.

Functions

1. To advise and make recommendations to the Council on the application of the Medical Research Endowment Account (MREA) (formerly known as the Medical Research Endowment Fund).
2. To monitor the use of assistance provided from that Account.
3. To advise the Council on matters relating to medical research, including the quality and scope of such research in Australia.
4. Such other functions as the Minister from time to time determines:
 - 4.1 to monitor the outputs and outcomes of research provided from the Account;
 - 4.2 to work with the Strategic Research Development Committee, to absorb successful research initiatives into the mainstream health research effort.

Delegations

On 2 June 1993 the NHMRC delegated to the Research Committee its power under S45 of the NHMRC Act to provide advice to the Minister on the assistance to be provided from the Medical Research Endowment Account, including the conditions under which assistance is provided. This delegation was confirmed by the current Council at its first meeting on 31 July 2000 as a delegation to the Research Committee.

Composition and membership in 2000

The RC composition, as gazetted, is required to reflect its mandate to cover the entire spectrum of health, medical and public health research. Members of the Committee are to have expertise in specific aspects of health research relevant to the operation of the Committee, from the molecular level, through cell biology, physiology, pathology etc, to clinical, epidemiological, social, behavioural, population and health services research, as well as knowledge and experience of research granting systems.

In addition, the Act requires that the Australian Health Ethics Committee has a member who is also a member of the RC.

Professor W Anderson
Chairperson, biomedical research

Professor S Redman
Deputy Chairperson, public health research

Professor D Alcorn
Biomedical research

Professor R Baxter
Biomedical/clinical research

Professor T Dwyer
Public health research

Associate Professor P Fuller
Biomedical research

Dr D Gearing
Intellectual property management and commercialisation

Professor A Kelso
Biomedical research

Associate Professor P Leedman
Clinical research

Professor J Mattick
Member AHEC, biomedical research

Professor N Nicola
Intellectual property management and commercialisation

Professor T Nolan
Public health research

Professor L Read
Intellectual property management and commercialisation

Professor T Sorrell
Clinical research

Professor R Trent
Biomedical/clinical research

Professor B Wainwright
Biomedical research

Associate Professor J Ward
Public health research

Gender breakdown

11 males

6 females

Ms E Hoole
Executive Secretary

WORKING COMMITTEES OF RC

The RC has established a number of Committees for the duration of the triennium (2000–2003):

- Research Committee Executive;
- Grants Committee (split into Program Grants Committee and Project Grants Committee, November 2000);
- Research Fellowships Committee;
- Training Awards Committee;
- Animal Welfare Committee;
- Gene and Related Therapies Research Advisory Panel;

- Transitional Institute Grant Committee;
- Industry Committee; and
- Health Research Partnerships Committee (joint RC/SRDC).

Details of the functions, membership and subcommittees/working parties for most of these committees are recorded below. The membership information relates to the year 2000, and some changes are scheduled to be implemented in 2001.

Research Committee Executive

Functions

1. To act as the executive organ of the Research Committee.
2. To advise the Research Committee on the priorities and organisation of the work of the Research Committee and its committees.
3. To take action on behalf of the Research Committee in situations where urgent advice is required on matters within the competence of the committee, or in situations where the normal processes of the committee are inappropriate.
4. To keep under regular review the functions, work and composition of the Research Committee and its committees.

Delegations

Delegation from RC to approve:

- changes to conditions of award of Project Grants, career awards and training awards in individual cases; and
- assistance to be provided from the MREA for activities which are consistent with Ministerial approval already given in general terms.

The Research Committee Executive also undertakes the task of determining eligibility of individual applicants to apply for NHMRC research awards, in accordance with its Access Policy.

Composition and membership

Professor W Anderson
Chairperson of RC

Professor S Redman
Deputy Chairperson of RC

Professor N Nicola
Associate Professor P Fuller
Professor D Alcorn
Professor B Wainwright

Other members of the RC to be co-opted as required.

Gender breakdown

4 males
2 females

Grants Committee

Functions

- To make recommendations to RC on policies for, and the award and administration of Projects, Programs, Units and Equipment grants; and
- To recommend to RC membership of Peer Review Groups and Advisory Panels.

Delegations

The RC has delegated the following authority to the Grants Committee:

1. approval of requests to vary expenditure against components or between years within a grant budget;
2. changes in Chief Investigators; and
3. transfers of grants between administering institutions.

Composition and membership

Professor B Wainwright
Chairperson

Professor R Kefford
Dr G Chenevix-Trench
Dr A Dart
Dr D Hilton

Professor J Kaldor
Professor P Klinken
Professor C Mitchell
Professor M Onslow
Professor A Plant
Associate Professor J Rostas

Gender breakdown

8 males
3 females

On 21 November 2000, the Research Committee agreed to split the functions of the existing Grants Committee into two separate committees, the Program Grants Committee and the Project Grants Committee.

The appointment of members to both the Program and Project Grants committees will occur early in 2001.

The functions of the Program Grants Committee are set out on page 96 of this report. The functions of the Project Grants Committee are the same as those of the Grants Committee, but with reference to Project Grants only.

Subcommittees and working parties of Grants Committee

Discipline Panels

In 2000, the role of the Discipline Panels was expanded from their 1999 role of nominating appropriate assessors and culling uncompetitive applications. In 2000, Discipline Panels undertook the full review of grant applications.

Each application was allocated to one of 20 Discipline Panels according to the field of research the applicant nominated as appropriate for that application. Some reallocations to other appropriate panels were made to allow for conflict of interest and better matches to panel expertise.

In place of the interviews conducted in earlier years, applicants responded to written comments from assessors and from the Discipline Panel considering the application. Each Panel reviewed its assigned applications, the assessments and applicants' responses and then ranked the fundable applications.

The continued development of the role of Discipline Panels followed their introduction in 1999 and they are widely seen as successful in overcoming problems with the previous regional system. The quality and timeliness of assessments has also been improved.

Discipline Panel 01 — Immunology

Fields of research

Cellular immunology
 Immunology not elsewhere classified
 Autoimmunity
 Transplantation immunology
 Humoral immunology and immunochemistry
 Genetic immunology
 Immunogenetics
 Cardiology (including cardiovascular diseases)
 Medical virology
 Therapies and therapeutic technology
 Biotechnology not elsewhere classified
 Cell metabolism
 Cell physiology
 Dentistry not elsewhere classified
 Infectious diseases
 Medical parasitology
 Oncology and carcinogenesis

Membership

Professor Anne Kelso
Chairperson

Dr Janette Allison
 Associate Professor Barbara Fazekas de St Groth
 Dr Steve Gerondakis
 Professor Charles MacKay
 Associate Professor Graham Mayrhofer
 Professor Chris Parish
 Professor Mauro Sandrin
 Associate Professor William Sewell
 Associate Professor Mark Smyth
 Associate Professor Keryn Williams

Gender breakdown

7 males
 4 females

Discipline Panel 02 — Pathology/ inflammation

Fields of research

Rheumatology and arthritis
 Haematology
 Allergy
 Pathology
 Dermatology
 Medical bacteriology
 Infectious diseases
 Protein targeting and signal transduction
 Respiratory diseases
 Gene expression
 Cellular immunology
 Diagnostic applications
 Genetic immunology
 Immunology not elsewhere classified
 Medical genetics
 Medical parasitology
 Molecular evolution
 Nephrology and urology
 Neurology and neuromuscular diseases

Quantitative genetics
Sensory systems
Transgenesis
Transplantation immunology

Membership

Professor Peter Smith
Chairperson

Dr Gary Anderson
Associate Professor Leslie Cleland
Dr Prue Hart
Dr Denise Jackson
Associate Professor Andrew Lloyd
Associate Professor Glenn Marshall
Dr Eric Morand
Professor Robyn O'Hehir
Dr Lorraine Robb
Professor Wayne Thomas

Gender breakdown

6 males
5 females

Discipline Panel 03 — Biochemistry

Fields of research

Biochemistry and cell biology not elsewhere classified
Enzymes
Medical biochemistry: proteins and peptides
Medical biochemistry: other
Cell metabolism
Medical biochemistry: lipids
Protein targeting and signal transduction
Medical biotechnology
Analytical biochemistry
Cell physiology
Cellular interactions (including adhesion, matrix, cell wall)
Endocrinology
Medical biochemistry: phospholipids
Cardiology (including cardiovascular diseases)
Diagnostic applications
Human biophysics

Immunology not elsewhere classified
Infectious diseases
Medical bacteriology
Medical biochemistry: carbohydrates
Medical biochemistry: nucleic acids
Medical mycology
Membrane biology
Nutrition and dietetics
Therapies and therapeutic technology

Membership

Dr Michael Berndt
Chairperson

Professor Paul Alewood
Dr Phillip Bird
Professor John de Jersey
Associate Professor Philip Hogg
Dr Wendy Jessup
Professor Peter Klinken
Professor Angel Lopez
Professor Christina Mitchell
Associate Professor Michael Parker
Dr Kerry Rye

Gender breakdown

7 males
4 females

Discipline Panel 04 — Cell biology

Fields of research

Protein targeting and signal transduction
Cell development (including cell division and apoptosis)
Biochemistry and cell biology not elsewhere classified
Cellular interactions (including adhesion, matrix, cell wall)
Cell metabolism
Cell physiology
Membrane biology
Reproduction
Dermatology
Diagnostic applications
Endocrinology

Gastroenterology
Gene expression
Haematology
Medical physiology not elsewhere classified
Neurology and neuromuscular diseases
Rheumatology and arthritis

Membership

Professor Julie Campbell

Chairperson

Professor Jerry Adams

Professor John Bateman

Dr Alex Bobik

Professor Carolyn Geczy

Professor Mary-Jane Gething

Associate Professor Thomas Gonda

Dr Douglas Hilton

Professor Martin Lavin

Professor Robert Parton

Dr Frances Shannon

Gender breakdown

7 males

4 females

Discipline Panel 05 — Microbiology

Fields of research

Medical bacteriology

Medical virology

Infectious diseases

Medical parasitology

Medical infection agents (including prions)

Medical microbiology not elsewhere classified

Medical mycology

Epidemiology

Molecular evolution

Population and ecological genetics

Respiratory diseases

Membership

Dr Alan Cowman

Chairperson

Professor Warwick Britton

Professor Christopher Burrell

Professor Suzanne Crowe

Professor Anthony Cunningham

Professor David Kemp

Associate Professor Marshall Lightowlers

Professor Denis Moss

Emeritus Professor Jim Pittard

Professor Julian Rood

Professor Tania Sorrell

Gender breakdown

9 males

2 females

**Discipline Panel 06 — Oncology/
nuclear medicine**

Fields of research

Oncology and carcinogenesis

Tumour immunology

Cellular interactions (including adhesion, matrix, cell wall)

Protein targeting and signal transduction

Respiratory diseases

Biochemistry and cell biology not elsewhere classified

Cell development (including cell division and apoptosis)

Endocrinology

Gastroenterology

Gene expression

Medical virology

Radiotherapy and nuclear medicine

Cell metabolism

Gene therapy

Genome structure

Nephrology and urology

Therapies and therapeutic technology

Membership

Professor Rick Kefford

Chairperson

Dr Toni Antalis

Professor Glenn Begley

Professor Andrew Boyd

Professor Ashley Dunn

Professor Ian Frazer
 Associate Professor Wally Langdon
 Associate Professor Michael McKay
 Dr Roger Reddel
 Professor Wayne Tilley
 Associate Professor Joseph Trapani

Gender breakdown

10 males
 1 female

Discipline Panel 07 — Pharmacology

Fields of research

Basic pharmacology
 Clinical pharmacology and therapeutics
 Pharmacology not elsewhere classified
 Toxicology (including clinical toxicology)
 Pharmaceutical sciences and pharmacy
 Anaesthesiology
 Complementary/alternative medicine not elsewhere classified
 Biochemistry and cell biology not elsewhere classified
 Cardiology (including cardiovascular diseases)
 Medical and health sciences not elsewhere classified
 Medical parasitology
 Oriental medicine and treatments
 Otorhinolaryngology
 Respiratory diseases

Membership

Professor Judith Black
Chairperson
 Associate Professor Elizabeth Burcher
 Professor Roy Goldie
 Professor Henryk Majewski
 Dr Rodney Minchin
 Professor Michael Roberts
 Associate Professor Andrew Somogyi
 Associate Professor Alastair Stewart
 Professor Roger Summers

Professor Susan Tett
 Dr Janet Wanstall

Gender breakdown

7 males
 4 females

Discipline Panel 08 — Cardiovascular/renal

Fields of research

Cardiology (including cardiovascular diseases)
 Nephrology and urology
 Cell physiology
 Medical physiology not elsewhere classified
 Systems physiology
 Biomechanics
 Cell metabolism
 Exercise physiology
 Intensive care
 Sports medicine
 Biochemistry and cell biology not elsewhere classified
 Cell development (including cell division and apoptosis)

Membership

Professor Frederick Mendelsohn
Chairperson
 Professor Lawrence Beilin
 Professor Bruce Hall
 Professor Mark Hargreaves
 Professor Ahsan Husain
 Dr Leonard Kritharides
 Professor Paddy Phillips
 Associate Professor Carol Pollock
 Associate Professor Judith Savige
 Professor Judith Whitworth
 Dr Elizabeth Woodcock

Gender breakdown

7 males
 4 females

Discipline Panel 09 — Gastrointestinal tract/liver/nutrition

Fields of research

Geriatrics and gerontology
Gastroenterology
Hepatology
Nutrition and dietetics
Endocrinology
Systems physiology
Cell metabolism
Clinical sciences not elsewhere classified
Paediatrics
Autonomic nervous system
Cell physiology
Gene expression
Medical bacteriology
Medical physiology not elsewhere classified
Protein targeting and signal transduction
Radiotherapy and nuclear medicine
Surgery

Membership

Professor Graeme Young
Chairperson

Professor Ian Caterson
Dr Gregory Cooney
Associate Professor Robert Cumming
Professor Robert Helme
Dr Barbara Leggett
Associate Professor Christopher Liddle
Associate Professor Michael Murray
Dr Paul Pavli
Professor Arthur Shulkes
Professor Neville Yeomans

Gender breakdown

10 males
1 female

Discipline Panel 10 — Foetal/ paediatrics/respiratory

Fields of research

Respiratory diseases
Foetal development and medicine
Paediatrics
Anaesthesiology
Clinical sciences not elsewhere classified
Intensive care
Medical physiology not elsewhere classified
Systems physiology
Cardiology (including cardiovascular diseases)
Cell physiology
Epidemiology
Nutrition and dietetics
Obstetrics and gynaecology
Reproduction
Therapies and therapeutic technology

Membership

Professor Craig Mellis
Chairperson

Professor Allan Carmichael
Professor Jane Harding
Associate Professor Graham Jenkin
Professor Caroline McMillen
Professor Colin Morley
Associate Professor Paul Myles
Associate Professor Philip Thompson
Professor Adrian Walker
Associate Professor John Wheatley
Dr Paul Zimmerman

Gender breakdown

9 males
2 females

Discipline Panel 11 — Peripheral/ cellular nervous system

Fields of research

Cellular nervous system
Autonomic nervous system
Neurogenetics
Cell physiology
Neurology and neuromuscular diseases
Rehabilitation and therapy: occupational and physical
Central nervous system
Peripheral nervous system
Biophysics
Cell neurochemistry
Motor control
Systems physiology
Biochemistry and cell biology not elsewhere classified
Cell development (including cell division and apoptosis)
Cardiology (including cardiovascular diseases)
Dentistry not elsewhere classified
Genetic development (including sex determination)
Medical physiology not elsewhere classified
Protein targeting and signal transduction
Surgery
Therapies and therapeutic technology

Membership

Professor John Furness
Chairperson
Dr Helen Cooper
Professor Peter Dunkley
Dr Edna Hardeman
Professor G David Hirst
Dr Janet Keast
Dr Phil Marley
Dr Pamela McCombe
Professor Uwe Proske
Dr Pankaj Sah
Professor Peter Schofield

Gender breakdown

7 males
4 females

Discipline Panel 12 — Sensory nervous system

Fields of research

Sensory systems
Ophthalmology and vision science
Central nervous system
Neurology and neuromuscular diseases
Neurosciences not elsewhere classified
Rehabilitation and therapy: occupational and physical
Rehabilitation and therapy: hearing and speech
Clinical sciences not elsewhere classified
Epidemiology
Optometry not elsewhere classified
Otorhinolaryngology
Sensory processes, perceptions and performance
Biological psychology (neuropsychology, psychopharmacology, physiological psychology)
Cell physiology
Cellular nervous system
Complementary/alternative medicine not elsewhere classified
Genetics not elsewhere classified
Human movement and sports science not elsewhere classified
Immunology not elsewhere classified
Instruments and techniques
Oncology and carcinogenesis
Psychiatry

Membership

Dr David Vaney
Chairperson
Professor Michael Calford
Associate Professor James Colebatch
Professor Douglas Coster

Associate Professor Sarah Dunlop
 Associate Professor Glenda Halliday
 Professor Dexter Irvine
 Professor Johnston McAvoy
 Professor Neville McBrien
 Associate Professor Seong-Seng Tan

Gender breakdown

8 males
 2 females

Discipline Panel 13 — Central nervous system

Fields of research

Central nervous system
 Neurology and neuromuscular diseases
 Biological psychology (neuropsychology, psychopharmacology, physiological psychology)
 Neurosciences not elsewhere classified
 Systems physiology
 Basic pharmacology
 Complementary/alternative medicine not elsewhere classified
 Endocrinology
 Autonomic nervous system
 Biochemistry and cell biology not elsewhere classified
 Clinical pharmacology and therapeutics
 Genetics not elsewhere classified
 Rehabilitation and therapy: occupational and physical

Membership

Professor John Willoughby
Chairperson

Professor Wickcliffe Abraham
 Associate Professor Macdonald Christie
 Professor Geoffrey Donnan
 Professor Malcolm Horne
 Dr Trevor Kilpatrick
 Dr Robin McAllen
 Professor John Pollard
 Professor Stephen Redman
 Professor Mark Rowe
 Dr John Watson

Gender breakdown

11 males
 0 females

Discipline Panel 14 — Mental health

Fields of research

Psychiatry
 Mental health
 Health, clinical and counselling psychology
 Biological psychology (neuropsychology, psychopharmacology, physiological psychology)
 Cellular nervous system
 Central nervous system
 Clinical sciences not elsewhere classified
 Complementary/alternative medicine not elsewhere classified
 Developmental psychology and ageing
 Endocrinology
 Learning, memory, cognition and language
 Neurology and neuromuscular diseases
 Neurosciences not elsewhere classified
 Oncology and carcinogenesis
 Psychology not elsewhere classified

Membership

Dr Anthony Jorm
Chairperson

Professor David Copolov
 Dr Phillipa Hay
 Professor David Kissane
 Professor Philip Mitchell
 Associate Professor Bryan Mowry
 Dr Susan Paxton
 Professor Ronald Rapee
 Professor John Saunders
 Professor Susan Spence
 Associate Professor Philip Ward

Gender breakdown

8 males
 3 females

Discipline Panel 15 — Dentistry/ surgery

Fields of research

Dentistry not elsewhere classified
Surgery
Orthopaedics
Medical physics
Biomaterials
Biomechanical engineering
Instruments and techniques
Medical and health sciences not elsewhere classified
Otorhinolaryngology
Radiology and organ imaging
Biophysics
Cardiology (including cardiovascular diseases)
Radiotherapy and nuclear medicine
Biological psychology (neuropsychology, psychopharmacology, physiological psychology)
Biomedical engineering not elsewhere classified
Biotechnology not elsewhere classified
Intensive care
Medical microbiology not elsewhere classified
Medical physiology not elsewhere classified
Paediatrics
Rehabilitation and therapy: occupational and physical
Respiratory diseases
Rheumatology and arthritis

Membership

Professor James Toouli
Chairperson
Dr Amanda Fosang
Professor David Gotley
Professor John Hall
Professor John Hutson
Dr Raymond Norton
Professor Eric Reynolds
Associate Professor Frank Rosenfeldt
Dr Marc Tennant

Professor Grant Townsend
Professor David Wood

Gender breakdown

10 males
1 female

Discipline Panel 16 — Genetics

Fields of research

Gene expression
Genetic development (including sex determination)
Gene therapy
Genetics not elsewhere classified
Medical genetics
Diagnostic applications
Endocrinology
Medical virology
Oncology and carcinogenesis
Population and ecological genetics
Quantitative genetics
Biotechnology not elsewhere classified
Cell development (including cell division and apoptosis)
Genetic immunology
Genetic technologies: transformation, site-directed mutagenesis, etc
Immunogenetics
Meiosis and recombination
Molecular evolution

Membership

Professor Robert Williamson
Chairperson
Associate Professor David Callen
Dr Georgia Chenevix-Trench
Dr Jennifer Donald
Dr Janice Fletcher
Dr Simon Foote
Dr Matthew Gillespie
Associate Professor Phillip Morris
Associate Professor Kathryn North
Associate Professor Elizabeth Rakoczy
Associate Professor Emma Whitelaw

Gender breakdown

5 males
6 females

**Discipline Panel 17 — Endocrinology/
reproduction**

Fields of research

Endocrinology
Reproduction
Obstetrics and gynaecology
Epidemiology
Cell metabolism
Genetic development (including sex determination)
Medical and health sciences not elsewhere classified
Medical bacteriology
Therapies and therapeutic technology

Membership

Associate Professor Gail Risbridger
Chairperson
Associate Professor Caroline Crowther
Professor John Eisman
Professor David Handelsman
Professor Adrian Herington
Associate Professor Richard Jackson
Associate Professor Peter Leedman
Dr George Muscat
Professor Robert Norman
Professor Marilyn Renfree
Associate Professor Jeffrey Zajac

Gender breakdown

8 males
3 females

Discipline Panel 18 — Epidemiology

Fields of research

Epidemiology
Public health and health services not elsewhere classified

Preventive medicine
Oncology and carcinogenesis
Paediatrics
Health information systems (including surveillance)
Respiratory diseases
Applied statistics
Cardiology (including cardiovascular diseases)
Infectious diseases
Medical bacteriology
Molecular evolution
Nephrology and urology
Rheumatology and arthritis

Membership

Professor C D'Arcy Holman
Chairperson
Associate Professor Michael Abramson
Associate Professor Peter Baghurst
Dr Catherine D'Este (nee Boyle)
Professor Robert Donovan
Dr Dallas English
Professor John Hopper
Professor Judith Lumley
Professor Sally Redman
Associate Professor Jeanette Ward

Gender breakdown

6 males
4 females

Discipline Panel 19 — Health sciences

Fields of research

Health, clinical and counselling psychology
Nursing not elsewhere classified
Clinical nursing: secondary (acute care)
Primary health care
Rehabilitation and therapy: hearing and speech
Rehabilitation and therapy: occupational and physical
Aged care nursing

Biological psychology (neuropsychology, psychopharmacology, physiological psychology)
 Public health and health services not elsewhere classified
 Respiratory diseases
 Health counselling
 Social and community psychology
 Medical and health sciences not elsewhere classified
 Mental health nursing
 Midwifery
 Psychological methodology, design and analysis
 Cardiology (including cardiovascular diseases)
 Clinical nursing: primary (preventative)
 Clinical nursing: tertiary (rehabilitative)
 Learning, memory, cognition and language
 Medical genetics
 Neurology and neuromuscular diseases
 Oncology and carcinogenesis
 Preventive medicine

Membership

Associate Professor Mark Onslow
Chairperson

Dr Vicki Anderson
 Associate Professor Robert Bush
 Professor David Hay
 Associate Professor Gail Huon
 Professor Sharon McKinley
 Professor Bruce Murdoch
 Professor Neville Owen
 Professor Judith Parker
 Dr Bryan Rodgers

Gender breakdown

6 males
 4 females

Discipline Panel 20 — Public health and health services

Fields of research

Public health and health services not elsewhere classified
 Health promotion
 Indigenous health
 Community child health
 Health and community services
 Health economics
 Care for the disabled
 Environmental and occupational health and safety
 Human bioethics
 Medical parasitology
 Residential client care
 Epidemiology
 Health care administration
 Nursing not elsewhere classified
 Rehabilitation and therapy: hearing and speech

Membership

Professor Aileen Plant
Chairperson

Professor Ian Anderson
 Professor Adrian Bauman
 Associate Professor John Carlin
 Professor Jill Cockburn
 Professor Ken Donald
 Professor Stephen Duckett
 Professor Lenore Manderson
 Dr Robyn McDermott
 Professor Robyn Norton
 Professor Brian Oldenburg

Gender breakdown

6 males
 5 females

Program Grants Committee

(These functions were fulfilled by the joint Grants Committee in 2000.)

Functions

1. To make recommendations to the Research Committee on policies for Program, Unit and Diabetes Collaborative Research Grants.
2. To make recommendations to the Research Committee on the award and administration of these grants, including establishment of relevant Interviewing Committees and the development of Conditions of Award.
3. To monitor the use of funds provided from the Medical Research Endowment Account for the above grants.
4. Other functions referred to it by Research Committee.

Composition and membership

Chairperson

A member of Research Committee

One other member of Research Committee plus a minimum of two additional members, all of whom would normally be required to serve as Chairperson of peer review panels.

Research Fellowships Committee

Functions

1. To advise the Research Committee (RC) on policy matters relating to the award of:
 - (a) NHMRC Research Fellowships (RF) associated with Project, Program, Unit and Centre grants;
 - (b) Research Fellowships associated with institutions in receipt of Institute Grants;
 - (c) R Douglas Wright Awards; and

(d) Burnet Fellowships and Eccles Awards.

2. To make recommendations on the method of appointment, review of progress, promotion, tenure of appointment and Conditions of Award for the above.

Research Fellowships Committee Members

Professor Daine Alcorn
 Professor Simon Gandevia
 Professor Roy Goldie
 Dr Emanuela Handman
 Associate Professor Jeanette Ward

Gender breakdown

2 male
 3 female

Panel A

Professor Daine Alcorn
 Professor Peter Gunning
 Professor Evan Simpson
 Professor Peter Rathjen
 Professor Michael Waters
 Professor John Finley-Jones

Gender breakdown

5 male
 1 female

Panel B

Professor Simon Gandevia
 Associate Professor Jane Moseley
 Professor Robert Graham
 Professor Iain Clarke
 Professor Ian Gibbins
 Professor Geoffrey Tregear

Gender breakdown

5 male
 1 female

Panel C

Associate Professor Jeanette Ward
 Professor Stephen Harrop
 Associate Professor Flavia Cicuttini
 Professor Dennis Calvert
 Professor Daine Alcorn

Gender breakdown

2 male
 3 female

Training Awards Committee**Functions**

1. The Committee shall rank applicants for all NHMRC scholarship categories and postdoctoral fellowships by methods recommended to and accepted by the Research Committee and advise on the rankings and suitability for an offer of award.
2. The Committee shall advise on the administration of all training awards including variations to the timing of an award.

Composition and membership in 2000

Associate Professor P Fuller
Chairperson

Professor S Berkovic
 Professor J Campbell
 Associate Professor L Campbell
 Professor S Crowe
 Professor T Dwyer
 Professor D Hay
 Dr C Hill
 Professor T Keech
 Dr A Kricker
 Dr M Little
 Professor G Townsend
 Associate Professor K Williams

Gender breakdown

6 males
 7 females

Animal Welfare Committee**Functions**

1. To advise the Research Committee of NHMRC on all matters pertaining to the conduct and ethics of animal experimentation in research.
2. To be responsible to Council, through the Research Committee, for the regular revision of the *Australian Code of Practice for the Care and Use of Animals for Scientific Purposes*.
3. With the approval of Council, to develop and implement ways of ensuring that all animal experimentation funded by NHMRC is in accord with the current Code of Practice.

Composition and membership in 2000

Mrs E Grant
Chairperson

Associate Professor G Jenkin
 Dr C Webb

Gender breakdown

1 male
 2 females

Gene and Related Therapies Research Advisory Panel**Functions**

1. Acts as an advisory body to human research ethics committees and the Research Committee of the NHMRC.

2. Provides advice to researchers to facilitate the design of protocols for gene therapy.
3. Acts as a source of information to the community.
4. Maintains a register of human gene therapy trials undertaken in Australia.

Composition and membership in 2000

Professor R Trent
Chairperson

Professor J Pittard
Dr A Dunn
Dr E Haan
Dr C Morris
Ms L Skene
Professor CJ Burrell
Dr I Alexander
Sister Regis M Dunne RSM
Dr D Roder

Gender breakdown

8 males
2 females

Block Funded Institute Liaison Working Group

Functions

- To liaise with NHMRC Block Funded Institutions with regard to the implications for block funding.

Composition and membership in 2000

Professor Warwick Anderson
Chairperson

Professor Lyn Beazley
Professor Suzanne Cory
Professor Kerin O'Dea
Professor John Shine

Gender breakdown

2 males
3 females

Additional NHMRC Committees in 2000

Biomedical Program Grant Interviewing Committee

Professor Graeme Stewart
Chairperson

Dr Patrick Tam
Associate Professor Jennifer Stow
Associate Professor Toni Antalis
Dr Deidre Coombe
Dr Warren Alexander

Clinical Program Grant Interviewing Committee

Associate Professor Barry McGrath
Chairperson

Associate Professor Paul Lancaster
Associate Professor Michael Abramson
Dr Lee Sutton
Associate Professor Afaf Girgis

NHMRC/JDRF Special Program Grants Advisory Committee

Professor Ian Frazer
Associate Professor Peter Leedman
Dr Paul Baird
Professor Don Cameron
Professor B Wainwright
Dr Anthony Dart

APPENDIX III — STRATEGIC RESEARCH DEVELOPMENT COMMITTEE (SRDC)

The Strategic Research Development Committee and the Research Committee are complementary research funding mechanisms.

8. To liaise with the Research Committee in planning and monitoring national research training needs and outcomes.

Functions

1. In areas of under-developed health research, to develop and build programs of targeted research which may include:
 - contracted or commissioned research;
 - investigator-initiated research;
 - training or the provision of scholarships; and
 - a combination of the above.
2. To develop, research, evaluate and disseminate information on the concept and practice of targeted research in health.
3. To seek and integrate advice from the Council and other relevant bodies on current and likely future priorities for targeted research in the context of the international research scene and gaps in the current research effort and emerging issues.
4. To advise Council and its partners in respect of strategies for translating identified research questions into proposals for targeted research.
5. To manage a research budget for the conduct and promotion of high-quality priority-driven research.
6. To report to Council on the process and outcomes of reviews of all strategic research development initiatives.
7. To provide a resource to Council and its partners for commissioning research or assessing targeted proposals in specific areas of strategic research development.

Composition and membership in 2000

Dr J Best

Chairperson

Health policy, public and population health

Dr S Allen

Health management

Professor J Black

Pharmacology

Professor P Boyce

Psychiatry

Ms K Boyer

General Practice Research

Dr C Brook

Health policy, quality assurance

Professor M Burton

Member in common with the Australian Health Ethics Committee

Professor D Cameron

Endocrinology

Ms G Cantwell

Service and program development, implementation

Mr J Delaney

Aboriginal and Torres Strait Islander health

Professor J Greeley

Psychology

Professor M Khadra

Rural health and palliative care

Professor R Officer

Economics and finance

Dr S Robertson
Obstetrics and gynaecology

Mr M Suich
Media

Dr E Tsironis
Rural and public health

Gender breakdown

10 males
6 females

Mr D Clarkson
Executive Secretary

Subcommittees and Working Groups

Ageing Research Working Group

Dr S Allen
Professor J Greeley
Co-Chairs

Professor J Black
Dr J Byles
Mr J Delaney
Dr P Kennedy
The Hon M Lyster
Professor M Morris
Ms L Racic
Ms D Sargeant
Associate Professor J Vickerstaff

Centres of Clinical Excellence (CCE) Evaluation Committee

Professor D Cameron
Chairperson

Dr M Davey
Mr J Delaney
Associate Professor P Fuller
Ms M Kosky
Professor M Morris

Dr D Roder
Professor J Whitworth
Ms T Dunbar (Darwin CCE)

Electromagnetic Energy Expert Working Committee (EME)

Professor D Cameron
Professor J Black
Co-Chairs

Dr C Bain
Professor A Dobson
Professor M Halmagyi
Dr A Harris
Dr K Joyner (expert observer)
Ms M Kosky
Dr F Khafagi
Dr C Roy (expert observer)
Professor C Thompson

Health and Economics Working Committee

Professor R Officer
Chairperson

Hepatitis C Working Committee

Ms G Cantwell
Chairperson

Professor L Bryson
Professor J Finlay-Jones
Ms M Kosky

Injury Research Working Committee (IRC)

Ms G Cantwell
Chairperson

Professor J Greeley
Professor T Nolan
Dr D Roder
Mr J Moller
Ms A Sewell
Ms G Leach

Injury Partnerships Selection Working Committee (joint committee of SRDC and RC)

Professor P Brooks

Chairperson

Professor T Nolan

Ms G Cantwell

Dr C Coggan

Professor D Else

Associate Professor K Fallon

Professor T Sorrell

Mental Health Research Working Group

Professor P Boyce

Chairperson

Professor J Greeley

Other members to be appointed

National Illicit Drug Strategy Working Committee (NIDS)

Professor J Greeley

Chairperson

Professor M Hamilton

Professor J Najman

Dr D Roder

Professor I Webster

Systems of Care for Chronic Disease Research Working Group

Dr S Allen

Chairperson

Dr C Brook

Ms K Boyer

Dr E Tsironis

Other members to be appointed

Aboriginal and Torres Strait Islander Health Research Agenda Working Group (RAWG)

Mr J Delaney

Chairperson

Dr S Eades

Mr C Weetra

Mr P Bowie

Ms T Dunbar

Associate Professor J Elston

Mr P Thomas

Mr D Clarkson

Ms H Evans

Professor K O'Dea

Mr M Suich

Ms K Boyer

Mr C Ritchie

Mr S Nangala

Mr S Houston

Palliative Care Research Working Group

Professor M Khadra

Chairperson

Other members to be appointed

Oral Health Research Working Group

Dr S Robertson

Chairperson

Other members to be appointed

Urgent Research Working Committee (currently in abeyance)

Professor J Black

Chairperson

APPENDIX IV — HEALTH ADVISORY COMMITTEE (HAC)

Functions

1. To inquire into and advise Council on matters of health, including:
 - health promotion;
 - illness and injury prevention;
 - health service delivery, including methods of diagnosis and treatment;
 - health technology assessment;
 - clinical practice;
 - the impact of the social and physical environment;
 - the assessment of the role of disciplines other than medicine; and
 - the health needs of groups within the community such as Aboriginal and Torres Strait Islander peoples, women, immigrants, older people, children and adolescents.
2. To advise Council on the administrative and legislative procedures that could be introduced to implement recommendations about health.
3. To develop standards, guidelines and strategies.
4. To consult with government, health care professions and the community.
5. To prepare reports based on research evidence, submissions and other documents.
6. To advise Council on ways of informing the community on health matters.

HAC may establish such working parties and expert panels as required to fulfil these functions.

Composition and membership in 2000

Professor A Green

Chairperson

Associate Professor P Glasziou

Professor C Silagy

Members with expertise in evidence-based clinical practice

Dr G Rubin

Member with expertise in communicable diseases/public health

Ms K Arabena

Member with expertise in nutrition and Aboriginal and Torres Strait Islander health

Professor A McMichael

Member with expertise in environmental health

Dr R Taylor

Co-opted member with expertise in environmental health

Professor D Hill

Member with expertise in health promotion/preventive health

Dr R Fordham

Member with expertise in social and economic determinants related to health

Dr T Jackson

Member with expertise in health systems and health technology

Ms S Nathan

*Member with a background in, and
knowledge of, consumer issues*

Dr K Baghurst

Member with expertise in food and nutrition

Dr P Joseph

*A member in common with the NHMRC
Australian Health Ethics Committee*

Professor D Henderson-Smart

Dr R Aldridge

Dr R Grenfell

Ms F Stoker

Dr M O'Callaghan

*Members whose expertise complements and
extends the expertise of other members*

Gender breakdown

11 males

7 females

Mr D Adcock

Executive Secretary

APPENDIX V — AUSTRALIAN HEALTH ETHICS COMMITTEE (AHEC)

Functions

1. To advise the Council on ethical issues relating to health.
2. To develop and give the Council guidelines for the conduct of medical research involving humans.
3. Such other functions as the Minister from time to time determines:
 - 3.1 To develop and give the Council guidelines for ethical conduct in the health field, additional to those required for function 2 above, and for the purposes of the *Privacy Act 1988*;
 - 3.2 To promote community debate, and consult with individuals, community organisations, health professions and governments, on health and ethical issues;
 - 3.3 To monitor, and advise on, the workings of institutional ethics committees;
 - 3.4 To monitor international developments in relation to health ethical issues and liaise with relevant international organisations and individuals.

Composition and membership in 2000

Dr K Breen
Chairperson

Dr S Ahmed
A person who has expertise in religion

Professor M Burton
A person who has experience in nursing or allied health practices

Ms B Byrne
Dr B Tobin
No more than two other persons with expertise relevant to the functions of the committee

Dr C Cordner
A person who has expertise in philosophy

Mr R Griew
A person with understanding of health consumer issues

Dr S Hacker
A person who has experience in clinical medical practice

Dr P Joseph
A person with knowledge of the regulation of the medical profession

Professor J Mattick
A person who has experience in medical research

Professor J McCallum
A person who has experience in social science research

Associate Professor C Thomson
A person who has expertise in law

Reverend B Uren
A person with knowledge of the ethics of medical research

TBA
A person who has experience in public health research

TBA
A person with understanding of the concerns of people with a disability

Gender breakdown

10 males
3 females

Mrs C Clutton
Executive Secretary

AHEC Executive Committee

Dr K Breen
Chairperson

Associate Professor C Thomson
Ms B Byrne
Mr R Griew
Dr B Tobin
Reverend B Uren

Working Parties of AHEC

Development of a Common Application Form

Dr K Breen
Chairperson

Professor M Burton
Ms B Byrne

HREC Support Working Group

Dr K Breen
Chairperson

Associate Professor C Thomson
Ms B Byrne
Dr B Tobin

Inquiry into the Appropriate Use of Genetic Information (joint AHEC/ALRC)

Dr K Breen
Chairperson

Associate Professor C Thomson

National Ban on the Cloning of Whole Human Beings

Dr K Breen
Chairperson

Review of Interim Guidelines on Ethical Matters in Aboriginal and Torres Strait Islander Health Research

Dr K Breen
Chairperson

Associate Professor C Thomson
Mr R Griew

Xenotransplantation Working Party (joint AHEC/RC)

Dr K Breen
Chairperson

Dr B Tobin
Ms M Kosky
Mr T Farrugia
Dr D Dwyer
Professor P O'Connell
Ms E Grant

Diagnosis of Persistent Vegetative States (joint AHEC/HAC)

Dr M O'Callaghan
Professor A Green
Dr P McCullagh
Dr P Saul
Dr S Ahmed
Dr P Joseph
Dr B Tobin
Mrs M Baumgarten
Professor D Simpson

AHEC Communications Group

Professor J McCallum
Chairperson

Mr R Griew
Ms B Byrne
Dr S Hacker

Review of Medical Treatment Overseas

Dr C Cordner

Australians Donate

Dr B Tobin

HREC Handbook

Associate Professor C Thomson

APPENDIX VI — INTERNAL AND EXTERNAL SCRUTINY

Decisions of courts and administrative tribunals

No decisions relating to the National Health and Medical Research Council were handed down in 2000.

Freedom of information

For the purposes of the *Freedom of Information Act 1982* ('the Act'), details of the documents held by the NHMRC are covered by the description of documents held by the Department of Health and Aged Care and published in its annual report. Therefore this statement is restricted to access information and a numerical summary of requests under the Act received and processed in 2000.

In 2000, four requests for access to NHMRC documents were received. There were no outstanding requests from the previous year. Of the four requests, two were granted in part and the remaining two were outstanding as of 31 December 2000.

Inquiries by parliamentary committees

Scientific, Ethical and Regulatory Considerations Relevant to the Cloning of Human Beings

The House of Representatives Standing Committee on Legal and Constitutional Affairs has commenced an inquiry into the Australian Health Ethics Committee of the NHMRC

entitled *Scientific, Ethical and Regulatory Considerations Relevant to Cloning of Human Beings* dated 16 December 1998. The inquiry was referred by the Minister for Health, the Hon Michael Wooldridge MP on 12 August 1999 and is current.

Electromagnetic Radiation Inquiry

'On motion by Senator Allison, an inquiry entitled Electromagnetic Radiation Inquiry' was referred to the Environment, Communications, Information Technology and the Arts Reference Committee. The initial reporting date of 31 October was subsequently extended to Thursday of the fourth sitting week of 2001. The inquiry's terms of reference are listed below.

- An examination of the allocation of funding from the Commonwealth's \$4.5 million fund for electromagnetic radiation research and public information;
- A review of current Australian and international research into electromagnetic radiation and its effects as it applies to telecommunications equipment, including, but not limited to, mobile telephones;
- An examination of the current Australian Interim Standard [AS/NZS 2772.1 (Int): 1998], as it applies to telecommunications;
- An examination of efforts to set an Australian Standard dealing with electromagnetic emissions; and
- An examination of the merits of the transfer of the responsibility for setting a new Australian Standard for electromagnetic emissions to the Australian Radiation Protection and Nuclear Safety Agency.

APPENDIX VII — RESPONSES TO THE PRIVACY COMMISSIONER, COMMONWEALTH OMBUDSMAN AND LEGAL REQUESTS

No reports were served on the NHMRC by the Privacy Commissioner under section 30 of the *Privacy Act 1988* during 2000.

No determinations were served on the NHMRC by the Privacy Commissioner under section 57 of the *Privacy Act 1988* during 2000.

No requests for information were received from the Commonwealth Ombudsman under section 6(1) (b) (iii) of the *Ombudsman Act 1976* during 2000.

The NHMRC received no subpoenas during 2000.

APPENDIX VIII — FINANCIAL STATEMENTS

The National Health and Medical Research Council (NHMRC) does not receive any moneys by way of appropriation, it does not receive revenues from any other source, it incurs no expenditure on its own behalf and has no assets and liabilities.

The administration and other support for NHMRC is funded through the Department of Health and Aged Care.

The NHMRC is responsible for the management of the Medical Research Endowment Account (MREA). The MREA receives Commonwealth Appropriation from the Department of Health and Aged Care. The MREA also receives revenues from external sources by way of bequests, and contributions to undertake directed research from other agencies and other sources. The financial statements of the MREA are included in the Department of Health and Aged Care annual report.

APPENDIX IX — STAFF, CONSULTANTS AND WORKING ARRANGEMENTS

The secretariat support for the Council and its committees is provided by the staff of the Department of Health and Aged Care through the National Health and Medical Research Council Division. To enhance the efficiency and expertise of these staff in assisting the Council and the department in their respective activities, the activities of supporting the Council have, to date, been integrated into the functions of the department. The other resources utilised by the Council are also provided by the department.

This arrangement is authorised by the Act, which provides that the Council may make arrangements with the Secretary of Health and Aged Care for:

- the services of officers or employees of the department employed under the *Public Service Act 1999*, to be made available to the Council (subsection 45 (2));

- persons having suitable qualifications or experience to be engaged as consultants to the Council (subsection 46(1)); and
- the provision of facilities to the Council that are necessary for the Council to perform its functions or to exercise its powers under the Act (subsection 47).

To support the Council's activities, NHMRC Division staffing as at 31 December 2000 was 97 full-time or equivalent staff. 77 members of staff were employed on an ongoing basis. 20 staff members were employed on a non-ongoing basis. The number of staff in NHMRC Division at 31 December 1999 was 112. The current figure of 97 represents a decrease of 13.4 per cent.

The consultancies entered into by the department to perform work for the NHMRC are shown in the department's annual report.

Number of staff in NHMRC Division at 31 December 2000

Ongoing		Non-ongoing		Total
Full time	Part time	Full time	Part time	
73	4	20	0	97

APPENDIX X — REPORTING REQUIREMENTS UNDER SECTION 82(2) OF THE NHMRC ACT

Regulatory and interim regulatory recommendations made by Council in 2000

Council made no such recommendations during the year.

Guidelines issued by Council during 2000

Health Advisory Committee

- Australian Drinking Water Guidelines — Fact sheets for *Cryptosporidium* and *Giardia*;
- Effectiveness of nasal continuous positive airway pressure (NCPAP) in obstructive sleep apnoea in adults;
- Guidelines on the management of uncomplicated lower urinary tract symptoms in men — 2nd edition;
- Guidelines for the prevention, early detection and management of colorectal cancer — A guide for patients, their families and friends;
- Guidelines for the prevention, early detection and management of colorectal cancer — A guide for general practitioners;
- Australian Immunisation Handbook — 7th edition;
- How to put the evidence into practice: Implementation and dissemination strategies;
- Joint statement and recommendations on vitamin K administration to newborn infants

to prevent vitamin K deficiency bleeding in newborns (Interim guidelines);

- Joint statement and recommendations on vitamin K administration to newborn infants to prevent vitamin K deficiency bleeding in newborns (Final guidelines); and
- How to use the evidence: Assessment and application of scientific evidence

Australian Health Ethics Committee

- Guidelines under *Section 95 of the Privacy Act 1988*

Recommendations to the Commonwealth — section 7(1)(c)

The NHMRC makes recommendations to the Commonwealth on expenditure on public health research and training and medical research and training. Details of these recommendations are in *NHMRC Grants 2001*, a supplementary volume accompanying this report.

Ministerial referrals to Council — section 9

The Council is responsible to the Minister for Health and Aged Care. Subsection 9(1) of the Act provides that the Minister may refer to the Council any matter within the scope of its functions, while subsection 10(1) authorises the Minister to give written directions to the Council as to the performance of its functions or the exercise of its powers.

The Minister for Health and Aged Care, the Hon Dr Michael Wooldridge MP, referred two matters to the Australian Health Ethics Committee, a Principal Committee of NHMRC. The details are set out below.

- In September 2000 the Minister requested a joint inquiry into the protection of human genetic information by the Australian Health Ethics Committee and the Australian Law Reform Commission.

- In November 2000 the Minister requested advice on the practice and ethics of the retention and disposal of tissue and organs previously collected at autopsy for medical research and education.

NHMRC Commissioner of Complaints

The NHMRC Commissioner of Complaints considered eight complaints during 2000. One had been carried over from 1999 and one remained unresolved at the end of the year. The full report follows.



7 March 2001

Professor N Saunders
Chairman
National Health and Medical Research Council

Dear Professor Saunders

Annual Report of NHMRC Commissioner for Complaints for 2000

I present my Annual Report as required by Section 68 of the National Health and Medical Research Council Act 1992. Section 83 of the Act requires that this report be included in the Annual Report of the NHMRC.

I was appointed by Dr Michael Wooldridge, Minister for Health and Aged Care, on 21 March 2000. The term of my predecessor, Professor H M Whyte AO, had expired on 31 December 1999. The role of the Commissioner is defined in Part 8 of the Act. In brief, I may investigate complaints regarding process, but I am not permitted to inquire into the scientific merit of a decision. Complaints should be sent to me only after consideration by the Secretariat of the Council.

Complaints received

I investigated eight complaints during 2000, including one complaint carried over from 1999. By the end of the year seven complaints were resolved (including the complaint carried over) and one remained unresolved.

The unresolved complaint related to a complaint previously considered by Professor Whyte, whose conclusion had been attended to by the Chair of Council. A fresh letter sought to reopen the matter, and raised some new issues. I declined to reconsider matters previously dealt with. The new issues remained unresolved at the end of the year.

Complaints upheld

In four of the seven complaints resolved during the year, the argument presented was accepted as valid, at least in part. All these complaints related to events at interviews in 1999. I made the following recommendations as a result of my investigations:

1. Questions at interview should be relevant to the grant application being assessed and questions about related applications should be asked only if relevant. Council should review the instructions given to assessors in relation to comment on related applications.
2. When a conflict of interest is perceived the Committee member concerned should leave the room immediately.
3. Committee reports should not be influenced by matters not discussed or to which the applicant has had no opportunity to respond.

Other outcomes

In two instances I concluded that the complaints related to scientific decisions of the NHMRC or the Research Committee and were beyond my powers to investigate.

One complaint was referred to the Chair of the NHMRC for attention as it related to an administrative action.

General comments

The number of complaints received had been increasing gradually until 1999, when 26 complaints were received. The substantial decrease this year is noteworthy and may reflect the abandonment of Research Grant Interviewing Committees. It may also reflect the delay in appointing the Research Committee, so that for much of the year there was no opportunity for the consideration which precedes referral to me.

I wish to thank those who have taken the trouble to complain, as external examination of procedures can lead to improvements. I also thank those members of the Council Secretariat who have assisted me during the year.

Yours sincerely



JOHN DONOVAN

Commissioner of Complaints

APPENDIX XI — MEETINGS, PUBLIC CONSULTATIONS AND PUBLIC FORUMS HELD IN 2000

Meetings held in 2000

National Health and Medical Research Council

- 135th Session of NHMRC 29 February 2000, Canberra
- Strategic Planning Meeting 26 June 2000, Canberra
- 136th Session of NHMRC 31 July–1 August 2000, Canberra
- 137th Session of NHMRC 12–13 October 2000, Adelaide

NHMRC Executive Committee

- 31 January 2000, Canberra
- 4–5 June 2000, Melbourne
- 30 August 2000, Canberra
- 8 December 2000, Perth

Research Committee

- 11 February 2000, teleconference (Executive meeting)
- 22 February 2000, teleconference (Executive meeting)
- 26–27 July 2000, Canberra
- 25 September 2000, Canberra (Executive meeting)
- 19 October 2000, Melbourne (Executive meeting)
- 20 October 2000, teleconference
- 31 October 2000, Canberra
- 19 November 2000, Canberra (Executive meeting)
- 20–21 November 2000, Canberra

Strategic Research Development Committee

- 24–25 February 2000, Glenelg
- 14–15 August 2000, Melbourne
- 12 September 2000, teleconference (Executive meeting)
- 3 October 2000, teleconference (Executive meeting)
- 13 November 2000, Sydney (Executive meeting)
- 14 November 2000, Sydney

Health Advisory Committee

- 14–15 February 2000, Sydney
- 4 September 2000, Canberra (Planning day)
- 5 October 2000, Canberra (Executive Committee)
- 17 November 2000, Sydney

Australian Health Ethics Committee

- 11 January 2000, (Executive Committee — teleconference)
- 25 February 2000, (Executive Committee — teleconference)
- 11–12 September 2000, Canberra
- 17 October 2000, (Executive Committee — teleconference)
- 24 October 2000, (Communications Implementation Group — teleconference)
- 15–16 November 2000, Sydney
- 12 December 2000, (Executive Committee — teleconference)

Public consultations on NHMRC draft guidelines undertaken in 2000

Research Committee

- Guidelines for Intellectual Property Management for Health and Medical Research

Health Advisory Committee

- Evidence Based Recommendations for the Management of Localised Prostate Cancer
- The Clinical Practice Guidelines for the Management of Early Breast Cancer
- The Clinical Practice Guidelines for the Management of Advanced Breast Cancer
- Management of Acute Back Pain
- Clinical Practice Guidelines for the Management of Kidney Failure
- Australian Drinking Guidelines
- Joint Statement and Recommendations on Vitamin K Administration to Newborn Infants to Prevent Vitamin K Deficiency Bleeding in Infancy
- Clinical Practice Guidelines for the Appropriate Use of Red Blood Cells
- Clinical Practice Guidelines for the Appropriate Diagnosis of Persistent Vegetative States

- Australian Drinking Water Guidelines — Revised Fact Sheets (Coliforms, E Coli, Pseudomonas, Cylindrospermopsin, Nodularin, Saxitoxins, Microcystins, Radiological Water Quality, Uranium, Radium-226 and 228, Beta and Gamma Radioisotopes, Boron, Aluminium, Copper)

Public/community forums held in 2000

NHMRC Executive

- 7 December 2000, Perth

Health Advisory Committee

- 14 February 2000, Sydney

Research Committee

- 30 November 2000, Melbourne
- 1 December 2000, Hobart, Alice Springs, Darwin (teleconference linkup)
- 6 December 2000, Adelaide
- 11 December 2000, Brisbane
- 12 December 2000, Sydney
- 14 December 2000, Newcastle

APPENDIX XII — PUBLICATIONS

Endorsed publications from January 2000 to December 2000

135th session — February 2000

- Australian Drinking Water Guidelines — Fact sheets for *Cryptosporidium* and *Giardia*
- Effectiveness of nasal continuous positive airway pressure (NCPAP) in obstructive sleep apnoea in adults
- Nutrition in Aboriginal and Torres Strait Islander Peoples — An information paper
- Guidelines on the management of uncomplicated lower urinary tract symptoms in men — 2nd edition
- Guidelines for the prevention, early detection and management of colorectal cancer — A guide for patients, their families and friends
- Guidelines for the prevention, early detection and management of colorectal cancer — A guide for general practitioners
- Australian Immunisation Handbook — 7th edition
- How to put the evidence into practice: Implementation and dissemination strategies
- Ethical aspects of human genetic testing — An information paper
- Guidelines under Section 95 of the *Privacy Act 1988*

136th session — July–August 2000

- Joint statement and recommendations on vitamin K administration to newborn infants to prevent vitamin K deficiency bleeding in newborns (Interim guidelines)

- Postnatal depression: A systematic review of published scientific literature to 1999 — An information paper
- Postnatal Depression: Not Just the Baby Blues

137th session — October 2000

- Joint statement and recommendations on vitamin K administration to newborn infants to prevent vitamin K deficiency bleeding in newborns (Final guidelines)
- Vitamin K for newborn babies — information for parents

Endorsed out of session

- How to use the evidence: Assessment and application of scientific evidence

Other publications endorsed from January 2000 to December 2000

- NHMRC Annual Report 1999, tabled 27 June 2000
- NHMRC Grants Book 2000, tabled 27 June 2000
- NHMRC Strategic Plan 2000–03, tabled 3 October 2000
- The Inside Guide to the National Health and Medical Research Council for the 2000–03 triennium
- Report of the 1999 workshops on the National Statement on Ethical Conduct in Research Involving Humans
- Report of the Evidence Based Clinical Practice Workshop

- SRDC Occasional Paper Number 1: Testing the NHMRC's Urgent Research Process
- NHMRC News, Issue 4

Rescinded/withdrawn publications from January 2000 to December 2000

135th session — February 2000

Health Advisory Committee

- Code of practice for the safe use of agricultural chemicals by aerial application (1981)
- Television advertising of foods, directed to children (1981)
- Emergency transport of seriously ill children (Recommendation) (1981)
- Food allergies in children (1991)
- Cows milk intolerance in children (Statement) (1983)
- Chelation therapy (1983)
- Report of the working party to investigate variations in caesarean section rates in Australia
- Veterinary use of chloramphenicol (1984)
- Framework for antimicrobial prescribing guidelines (1984)
- Down's syndrome: Surgery for tongue size (1984)
- Dental anaesthetic gases: Hazards and hygiene (1984)
- The media and public health (1984)
- Resources for health care evaluation (1985)
- Table for acceptable weights-for-height (1985)
- National guidelines for control of emission of air pollutants from new stationary sources: Recommended methods for monitoring air pollutants in the environment
- Biosynthetic human growth hormone (1986)
- Methadone programs (1987)
- Report of the working party on homebirths and alternative birth centres (1987)
- Sanitary precautions in the home in natural disasters (1987)
- Smoking during pregnancy (1988)
- Psychological and psychiatric aspects of HIV infection (1988)
- Safe use of electro-dental equipment (1988)
- Asthma in Australia: Strategies for reducing morbidity and mortality (1988)
- The use of psychoactive agents in childhood (1988)
- Newborn requiring follow-up care (Recommendation) (1988)
- Statement on homebirths (1989)
- Mouthguards (Recommendation) (1989)
- Acupuncture (1989)
- Acupuncture: Consumer information brochure (1989)
- Health effects of ozone layer depletion (1989)
- Implementing the dietary guidelines for Australians: Report of the subcommittee on nutrition education (1989)
- Headlouse infestations (1992)

Australian Health Ethics Committee

- Ethics in medical research involving the human fetus and human fetal tissue (1983)
- Report on ethics in epidemiological research (1985)

- Embryo donation by uterine flushing (1985)
 - In vitro fertilisation centres in Australia: Their observance of the NHMRC Council Guidelines (1986)
 - Consideration by institutional ethics committees of research protocols involving frozen-thawed human ova (1987)
 - Discussion paper on the ethics of limiting life sustaining treatment (1988)
 - Report on round table conference on human gene therapy (1988)
 - Access to information — Background paper to the NBCC report 'Reproductive technology' (1988)
 - Bioethics organisations in the USA — Report of a visit to the USA (1988)
 - Reproductive technology (1989)
 - Developments in the health field with bioethical implications — Discussion paper prepared for the Australian Health Ministers' Conference (1989)
 - Bioethics: Developments in the health field with bioethical implications Vol. 2 — Discussion paper (1989)
 - NBCC Report to the Australian Health Ministers' Conference (1989)
 - Discussion paper on access to reproductive technology (1990)
 - Discussion paper on Surrogacy No. 2 — Implementation (1990)
 - Discussion paper on ethics and resource allocation in health care (1990)
 - Issues paper on infertility counselling (1990)
 - Report on workshops on the constitution and functions of institutional ethics committees in Australia, 1988–1990 Consultation: An appraisal of community perspectives — Background discussion paper (1991)
 - Access to reproductive technology (1991)
 - Reproductive technology counselling (1991)
 - Discussion paper on Surrogacy No. 2 — Implementation progress report (1991)
 - Developments in the health field with bioethical implications, Vol. 3 — Discussion paper prepared for the Australian Health Ministers' Conference (1991)
 - Guidelines for the monitoring of research by Institutional Ethics Committees (1992)
 - The place of ethics in health care resource allocation — where to now? Ethics of resource allocation in health — Discussion paper No. 1 (1992)
 - Choice or chance? The ethics of resource allocation for minority groups — Ethics of resource allocation in health — Discussion Paper No. 3 (1992)
 - Distributing health care resources: Ethical assumptions (1992)
 - The ethics of medical resource allocation (1992)
 - Case study of screening blood donations for human T-cell lymphotropic virus Type 1 (HTLV 1) (1993)
 - Human embryo experimentation — A background paper and select bibliography
 - Human gene therapy and related procedures (1994)
 - Report of the 1995 Ethics Workshops (1995)
 - Aspects of privacy in medical research — An information paper and guidelines for the protection of privacy in the conduct of medical research (1995)
- Out of session — February 2000**
- Review of implementation of strategic plan: 1 July 1993 – 30 June 1994

Additional information — ethics

Supplementary Note 5 was previously part of the NHMRC Statement on Human Experimentation and Supplementary Notes (1992). The NHMRC Statement has been replaced by the *National statement on ethical conduct in research involving humans* (E35) with the exception of this Supplementary Note. This Supplementary Note remains in force from the date it was originally issued in October 1983. It should be read in conjunction with the current National Statement.

Supplementary Note 7 has been replaced by 'Guidelines for Ethical Review of Research Proposals for Human Somatic Cell Gene Therapy and Related Therapies'. This Supplementary Note was previously part of the

NHMRC Statement on Human Experimentation and Supplementary Notes (1992).

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APPENDIX XIII — MEDIA RELEASES

- NHMRC delivers world-leading mobile phone research
- Health Research Partnership delivers \$25.5M for injury research
- \$32.3M boost for national health and medical research funding in 2001
- South Australia to get \$5.16 million in new health and medical research grants
- Control of scabies and Aboriginal Communities boosted by new health and medical research funding
- Tasmania wins share of national health and medical research grants package
- \$5.1 million for health and medical research in WA will help tackle Australia's asthma toll
- Health and medical research boosted by \$16.6M in Victoria
- Research funding for Queensland to aid fight against depression
- New South Wales gets \$13M for health and medical research
- \$690,000 for health and medical research in the ACT
- NHMRC confirms endorsement of new vitamin K guidelines
- Minister announces new CEO to the NHMRC
- New Guidelines on Cryptosporidium and Giardia—Joint release with Warren Truss MP
- Review of Guidelines for the treatment of early breast cancer
- NHMRC implements new interim vitamin K guidelines
- New guidelines for patients and GPs the latest weapon in the fight against bowel cancer
- Australia gains world-first access to international genetic map
- NHMRC delivers historic agreement with Celera Genomics
- Federal Government commits \$15M for stronger medical research capacity
- NHMRC releases Responsible Drinking Guidelines for consultation
- Minister appoints final 22 members of the NHMRC
- Further commitment to illicit drugs strategy
- New Immunisation Handbook will help protect more Australians from disease: Wooldridge
- Minister announces NHMRC key appointments
- \$35M for new research to prevent and cure diabetes
- NHMRC and JDF join forces in \$35M fight against diabetes
- New Immunisation Schedule to provide better protection against disease: Wooldridge
- NHMRC backs Privacy Amendment (Private Sector) Bill 2000
- NHMRC releases information about genetic testing

- Bowel cancer: Guides for patients, their families and friends, and for GPs
- Better Nutrition for Aboriginal and Torres Strait Islander peoples
- Obstructive Sleep Apnoea: now you can sleep easy
- Familial Aspects of Cancer: An Australian cancer world-first
- Guidelines for the management of localised prostate cancer
- Managing melanoma: putting a stop to a silent killer
- New Dietary Guidelines for Older Australians confront life and death issues
- New Breast Cancer Guidelines a world first in quality of care
- Guidelines for consultation on the management of low back pain

APPENDIX XIV — ACRONYMS AND ABBREVIATIONS USED IN THIS REPORT

AHEC	Australian Health Ethics Committee	MEN2	Multiple endocrine neoplasia type 2
AIHW	Australian Institute of Health and Welfare	MREA	Medical Research Endowment Account
ALRC	Australian Law Reform Commission	NHMRC	National Health and Medical Research Council
APMA	Australian Pharmaceutical Manufacturers' Association	NIDS	National Illicit Drug Strategy
CCE	Centres of Clinical Excellence	PHRDC	Public Health Research and Development Committee
CEO	Chief Executive Officer	RAWG	Aboriginal and Torres Strait Islander Health Research Agenda Working Group
CHO	Chief Health Officer	RC	Research Committee
DHS	Department of Human Services	RDW	R Douglas Wright
EME	Electromagnetic energy	RGIC	Regional Grant Interview Committees
GIT	Gastrointestinal tract	RF	Research Fellowships
GMCS	Greater Murray Clinical School	SRDC	Strategic Research Development Committee
HAC	Health Advisory Committee	TBA	To be advised
HREC	Human Research Ethics Committee	UK	United Kingdom
ICU	Intensive care unit	USA	United States of America
IP	Intellectual property	UWA	University of Western Australia
IRC	Injury Research Working Committee	VKDB	Vitamin K deficiency bleeding
IT	Information technology		
IVF	in-vitro fertilisation		
JDRF	Juvenile Diabetes Research Foundation International		