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lack evidence on their effectiveness. In 1988 we noted that lack of outcome evaluation makes it impossible to judge the effectiveness of these rehabilitation programmes in facilitating recovery from the trauma of torture. Unfortunately, evidence is still lacking. A recent report based on the work of the Rehabilitation and Research Centre for Torture Victims in Denmark is a sobering reminder of where we stand after two decades. The Danish centre is a pioneering organisation, serving as a model for more than 90 similar centres around the world. An outcome evaluation study based on 55 people admitted to the centre in 2001 and 2002 showed no improvement in post-traumatic stress disorder, depression, anxiety, or health-related quality of life after nine months' treatment.^{1,2} These findings led the authors to conclude that future studies are needed to explore effective interventions for traumatised refugees, including cognitive behavioural therapy. This is indeed what we had recommended in 1988.¹

Lack of progress among torture survivors partly stems from the fact that scientific approaches to the problem are often dismissed as reductionist "medicalising." Many of those working with torture survivors advocate a solely political approach to the problem in the belief that recovery from trauma is only possible through eradicating impunity for the perpetrators of torture. Research evidence does not support this view.³ Although advocacy against torture is certainly important, as long as the problem lasts rehabilitation centres also have a moral obligation to provide effective psychological treatment for their clients. After more than 30 years of work, those working with torture survivors need to confront the uneasy but important question of whether their approach is helpful. This issue can be addressed only by proper outcome evaluation. Given that there are now very brief and highly effective interventions available for survivors, the public have a right to know the justification behind lengthy and expensive rehabilitation programmes without demonstrable beneficial effects.

Funders of rehabilitation programmes are in an excellent position to promote progress here. They also need to adopt an evidence-based approach and

consider the following questions in their review of funding applications: (a) is the proposed intervention based on sound theory; (b) is there is sufficient evidence on its effectiveness; and (c) does the work involve outcome evaluation? Making grant support conditional on such requirements would certainly enhance the quality of work in the field. Given the painfully slow progress this appears to be the only hope for change.

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The Cooksey review of UK health research funding

The art of being all things to all people

News p 1239

Prompted by concern that the drug industry might reduce its investment in research in the United Kingdom, the chancellor of the exchequer asked the distinguished venture capitalist Sir David Cooksey to lead a review. Widespread consultation showed that it is not only the Treasury that is concerned about the current state of health research funding, organisation, and performance.¹

Four principal criticisms emerged. Firstly (confirming the Treasury's view), the drug industry is frustrated by what it sees as increasing obstacles to gaining access to patients and over-regulation leading to unacceptable delays and extra costs. Companies claim that developing products and conducting research in other

countries is increasingly attractive and an inevitable consequence. Secondly, those responsible for providing health services—politicians, managers, clinicians—as well as research funders are concerned at the delays in translating advances in basic science into clinical applications and then translating such innovations into routine practice. This is seen as reflecting an unsupportive culture in the National Health Service, institutional barriers, and perverse incentives, such as greater regard and reward for basic research than for applied research. Thirdly, the distribution of research funds does not always reflect the burden of disease in the UK, which reflects the lack of a transparent mechanism for determining research priorities. This is partly

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explained by the final concern that Cooksey identified—the lack of coordination and a supposed resulting inefficiency between the principal funding bodies and, in particular, the two public funders, the Medical Research Council (MRC) and the NHS National Institute for Health Research (NIHR).

Together with criticisms came solutions. Faced with more than 300 responses from individuals and organisations, each with their own interests to defend and promote, the review team have constructed a strategy that tries to deal with the four principal concerns. Given the disparate nature of those concerns, the strategy is a masterful attempt at coherence.

The concerns of the drug industry (and the Treasury) are to be met by bringing new drugs to market faster, without compromising patient safety, and more cheaply. A new “drug development pathway” will include streamlining clinical trial procedures, “conditional licensing,” earlier involvement of the National Institute for Health and Clinical Excellence (NICE), and ensuring NICE’s recommendations are implemented. The aim is to “send a signal to industry that the UK is a world leader in research and development.”

The challenge of promoting translation is to be met in several ways. The recently ring fenced budget for the NIHR is seen as a useful development though other funds, such as research training budgets for young clinicians, need to be brought inside the fence. More funding for the NHS Health Technology Assessment programme is proposed, together with the creation of a new Translational Medicine Funding Board, accountable to the NIHR and MRC. All of these initiatives are seen as part of creating a stronger research culture in the NHS that facilitates rather than discourages innovation.

To encourage greater attention to currently unmet health needs, research on neglected areas will be identified through burden of illness analyses, and designated topics will be labelled as UK Priority Health Research Projects. Public, private, and charitable research funders will hopefully respond to the institutional and procedural advantages that such priorities will benefit from, such as faster approval of trials and expedited approval from NICE.

The final criticism of the status quo, namely lack of coordination between public funders, is the one that has probably attracted the greatest interest, concern, and often heated debate. The proposed solution is to strengthen coordination by establishing an overarching Office for Strategic Coordination of Health Research (OSCHR, pronounced “Oscar”) that is accountable to both the Department of Health and the Department of Trade and Industry. Its tasks include setting a health research strategy that both the MRC and NIHR must comply with, agreeing their funding needs, submitting those needs to the Treasury, and monitoring the results. To reduce duplication, some areas currently funded by MRC (including clinical research, health services research, and phase IV clinical trials) will become the sole responsibility of the NIHR so that the MRC can concentrate on basic and underpinning research. In addition, some structural changes are advocated—members of MRC boards are expected to become more representative of the broad spectrum of health research while the NIHR should become a

real, rather than a virtual, institute and be separated from the Department of Health from 2009 as an executive agency.

Cooksey’s proposals, which the government has welcomed and accepted, are in the great tradition of compromise solutions. The two major public funders, MRC and NIHR, are to work more closely, but a third public funding stream is to be created; more funding will be provided for translational research but funds for basic research will not be reduced; “blue skies” investigator led research will continue to be supported but national research priorities will be instigated. Anyone wanting and expecting more radical change to the structure and processes of research funding will be disappointed. Merger of the MRC and NIHR was rejected because of a fear that the larger MRC would dominate, and that this would jeopardise the development of translational and applied research.

Although, potentially, there is something for everyone in the overall package of proposals, for several reasons its success is not guaranteed. Firstly, the review is predicated on the view that we stand on the threshold of “a seismic shift in medical science” in which molecular medicine, gene therapy, stem cells, and other initiatives will revolutionise health care. Such faith in technology as the principal driver of improvements in people’s health may prove over optimistic. Secondly, while the strategy shares much in common with reforms enacted in Canada in recent years, their success was facilitated by a 130% increase in research funds over five years, a level of investment not envisaged in the UK. Thirdly, key aspects depend on private industry responding to new incentives. On the one hand, the sorts of incentives that might motivate public researchers, such as those associated with Priority Health Research Projects, may be insufficient to influence private companies. On the other hand, there is a danger that incentives offered to private industry in which they can dictate the agenda of NICE and the Health Technology Assessment programme risks those bodies being co-opted and becoming adjuncts of the drug industry.² And lastly, while the strategy involves some straightforward structural changes that can be implemented from the centre, much of it relies on widespread cultural and behavioural changes within the NHS and research community, which will be hard to ensure take place.

Much also depends on the alignment of other policies such as those concerned with NHS finance, research assessment exercises, and postgraduate training. Perhaps it is for these reasons that Cooksey recognises the need to review progress in 2010.

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