Competitive markets for European public health research?

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The growth of European public health conferences, from the first meeting on health services research held in Utrecht in 1988 to the 2007 EUPHA (European Public Health Association) conference in Montreux with more than 100 attendees, shows that public health research in Europe is very much alive. Through the EU-funded study SPHERE (strengthening public health research in Europe), bibliometric studies have also found a steady rise of public health scientific publications over the past 10 years. Moreover, with an estimated world output of more than 20,000 public health research publications per annum, the annual average European production over the period, at 7000, was not far short of 9000 per annum from the United States of America.

Yet, in the European Commission’s Seventh Framework Programme public health research remains the poor relation of biomedicine. An important reason is the capitalist drive in health research. Pharmaceutical companies sponsor big science through laboratories and clinical trials: the ‘hunt’ for the genome has been underpinned by patent rights for drugs which can be sold at premium prices. The health care equipment and devices industry (as large as the pharmaceutical sector) also relentlessly develops new technical products for health care. And these industries are high investors both in basic research and also in lobbying, marketing and sponsorship. Research that does not lead to commercial patents may seem to be for ‘losers’ in the ‘care’ sector where low-paid workers provide human services for growing numbers of patients as Europe’s population ages; and in the public health sector, where better interventions ‘only’ contribute social benefits rather than profit.

European national governments do realise this dilemma, and do support health systems and public health research from public funds, but as a national health ministry official once explained to me, ‘Why should we fund research just for others in Europe to use it?’ He saw his country’s welfare expressed through its economic performance, its international companies, not through its health status (or happiness). And his view has counterparts elsewhere in Europe. As public health researchers, we will carry on—for ethical concerns to find ways of improving the welfare of our fellow humans; and for the esteem that medical research has with the public at large. But could public health research be stronger if it engaged with markets also?

Although public health services are concerned with the ‘public sector’, that is, provision to a population for which a political authority is responsible, public health objectives are also part of individual behaviour, built into our social transactions and choices such as food, transport, or use of media. ‘Social marketing’ includes the concept of generating health-beneficial choices through managing societal incentives. In health care, both public and private providers need to operate alongside each other, with public regulation, to achieve social objectives. Public health services could also operate within markets, for example as non-profit organisations providing services in similar ways for different political jurisdictions. This model is increasingly relevant for other public services (as, for example, environmental services including water and waste are provided in several European countries now), and could both raise standards and demonstrate the case for new service provision as public needs are better understood.

Market incentives could also be proposed for public health intervention research. Research linked to interventions chosen (or funded) by the public authority could pay ‘returns’ to scientists who investigated the interventions and explained how to achieve effective implementation. Public health researchers would investigate population-level interventions in ways similar to clinical scientists demonstrating effectiveness through trials. National (and European) research councils would encourage scientific standards, while the development of interventions could be the joint responsibility of researchers and service providers.

The hazards of moving in this direction are evident: there might be prioritisation of short-term returns based on inadequate analysis, or on common diseases, rather than difficult problems, for wide applications. The system would depend on stable political support, and, for global application, technology transfers from rich to poor countries would need sophisticated economic valuations based on health gains to ensure funding from international banks. Yet, these issues have been encompassed by the biomedical research community, and they can justly claim success in developing products that are valued by national health systems. Public health researchers, working within not-for-profit organisations such as universities and institutes, should consider what can be learned to improve their own competitive position in health research.

At European level, a step along this path could be the development of alliances between research teams in academic institutions and their surrounding public health services, to enable skills transfer and successful competition across national research markets in Europe. The European Commission’s Research Directorate has the ambition of a European Research Area to support a ‘common market’ of research. Public health research markets could develop through exchange of national information on funding opportunities, conditions of research, standards and outputs. EUPHA, and the European Journal of Public Health, can support this, and web-based real-time information is also needed. As we begin to compete internationally in research, we can also draw on the cultural variations in Europe to better understand which public health interventions most benefit which populations, and encourage national governments to
reward public health research commensurately with that of the health care sector.

References


