LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH AND DISABILITY

(Reference: Health sciences in the ACT)

Members:

MS K MacDONALD (The Chair)
MS M PORTER (The Deputy Chair)
MRS J BURKE

TRANSCRIPT OF EVIDENCE

CANBERRA

WEDNESDAY, 23 APRIL 2008

Secretary to the committee:
Ms G Concannon (Ph: 6205 0129)

By authority of the Legislative Assembly for the Australian Capital Territory

Submissions, answers to questions on notice and other documents relevant to this inquiry that have been authorised for publication by the committee may be obtained from the committee office of the Legislative Assembly (Ph: 6205 0127).

WITNESSES

GATENBY, PROFESSOR PAUL ALLAN, Director of Research,
The Canberra Hospital **27**

The committee met at 10.31 am.

GATENBY, PROFESSOR PAUL ALLAN, Director of Research, The Canberra Hospital; and Sub-Dean, Research, ANU Medical School

THE CHAIR: Good morning, Professor Gatenby. You have had a chance to read the yellow card?

Prof Gatenby: Yes.

THE CHAIR: Do you understand the privilege implications of the statement on that card?

Prof Gatenby: Yes.

THE CHAIR: Excellent. For the record, I move:

> That the statement be incorporated in *Hansard*.

The statement read as follows:

> Privilege statement
>
> To be read at the commencement of a hearing and reiterated as necessary for new witnesses
>
> The committee has authorised the recording, broadcasting and rebroadcasting of these proceedings in accordance with the rules contained in the Resolution agreed by the Assembly on 7 March 2002 concerning the broadcasting of Assembly and committee proceedings. Before the committee commences taking evidence, let me place on record that all witnesses are protected by parliamentary privilege with respect to submissions made to the committee in evidence given before it.
>
> Parliamentary privilege means special rights and immunities attach to parliament, its members and others, necessary to the discharge of functions of the Assembly without obstruction and without fear of prosecution.
>
> While the committee prefers to hear all evidence in public, if the committee accedes to such a request, the committee will take evidence in camera and record that evidence. Should the committee take evidence in this manner, I remind the committee and those present that it is within the power of the committee at a later date to publish or present all or part of that evidence to the Assembly. I should add that any decision regarding publication of in camera evidence or confidential submissions will not be taken by the committee without prior reference to the person whose evidence the committee may consider publishing.
>
> I also have a few housekeeping matters which I need everyone in the room to observe:
> all mobile phones are to be switched off or put in silent mode;
> witnesses need to speak directly into the microphones for Hansard to be able to hear and transcribe them accurately;

only one person is to speak at a time; and
when witnesses come to the table they each need to state their name and the capacity in which they appear.

THE CHAIR: I would like to thank you, Professor Gatenby, for your submission to this inquiry, which has been going on for a few years but has been sitting on the backburner not doing anything. Would you like to address any points in your submission in particular, or make an overall comment, before we starting asking you questions? I note that you are making the submission as an individual rather than in any of your official capacities, but you come to the inquiry with a wealth of experience in the medical science area.

Prof Gatenby: I will just answer questions. I think what I have said is fairly clear. I have endeavoured to put in context some of the recommendations that have been made around research, particularly at the Canberra Hospital campus. I have been both positive and negative about that, where I think it is appropriate.

THE CHAIR: I note in your submission that you imply that it is not necessarily the case that the government should be putting in more money, because for a jurisdiction the size of the ACT that would not necessarily be the appropriate thing to do, but you have talked about the possibility of targeting; that the ACT would have to target very specific areas to be able to compete. Do you have an idea of the specific areas that might be appropriate for the ACT to target?

Prof Gatenby: I might answer that a bit more broadly. One of the dangers of targeting in a small jurisdiction is that you end up with a relatively small area of excellence and everything else is moribund. You cannot afford that outcome. So, in a sense, the option of targeting incredibly specifically I do not think is truly available if you want a viable health research community. There are areas that are worthy of discussion in relation to specific targeting attempts, and I suppose in general there are two approaches to take to this. The government could seek expert advice and ask for areas that may hardly exist now and then invest in them after being advised that that was a good idea, or they could look very much at what is quite strong and ask themselves the question: should we make that stronger?

I personally favour the latter because at least you have a critical mass to start with and you are not looking, in what is a difficult recruiting situation, to necessarily try and recruit everyone. One of the problems is that it might not fit in quite with what governments tend to have in mind sometimes. We have our strengths and weaknesses. They have probably changed a little bit since Powell wrote his report, and I do not think he considered community-based research, which is an area in which the ACT government spends money but is not an area that I would regard as a strength.

THE CHAIR: How so?

Prof Gatenby: I do not think the money has been spent with enough academic rigour attached to the way in which the research has been done. This is specifically in the community. A lot of effort was done. For example, the Kindy survey, which is potentially a wonderful instrument, probably needs to be redesigned by someone who is a bit better at knowing how to ask questions that can then be quantified, and things

like that, rather than getting answers that people will not accept because they say they are too vague. Having been involved in a study that used some subsections of it, and having had a great deal of difficulty getting it published, I have to agree with the reviewers that the questions are very vague and not rigorous enough. That is an area where the government does spend some money but I think it could benefit from a greater degree of rigour there.

THE CHAIR: You have done a very helpful table of the recommendations of the Powell review and the progress of those. I note your comment about the establishment of the research foundation—that, although a planning committee was set up, there has not been any recent progress—and that there is little coordinated effort directed at identifying and securing patrons for large donations. How would you suggest that this be changed? Given that the ACT is largely a town full of bureaucrats with not necessarily that many—no offence to the bureaucrats—

Prof Gatenby: Change that mindset to start with. I attend the Cancerians dinner every year. More money is raised for the Australian Cancer Research Foundation, per head of population, in Canberra than in any other city in Australia. More money is raised per head in Canberra for the Westmead children's hospital than in any other jurisdiction in Australia. I do not think it is true. I think that the fact that people go around saying it is true is why the people who work for you do not do anything about it.

MRS BURKE: Well said. Now tell us what you really feel, sir. That was good.

Prof Gatenby: I have heard this nonsense over and over again. I was part of the first Canberra Region Medical Foundation. The tragedy was that they appointed an ex-politician to run it. We have developers in this town who like to wield influence and things like that. There are people with money in Canberra. There are people around Canberra with money, and they are not approached enough to be involved. They are not dealt with. I remember arguments like "you can't have that Greek because this Greek won't talk to you" and that sort of thing. I found it petty when I was a member of the original foundation.

It seems to me that things have just stalled in a morass of bureaucracy. They have been talking about a rejigged foundation for about four years. The Launceston General Hospital foundation raised $12 million in the worst depression Tasmania had had in the 20th century. Admittedly, they have old money. But we have old money just over the border. A lot of farmers around Yass do not have big overheads; everything is paid off. When they get sick, they come here.

THE CHAIR: Fair comment.

Prof Gatenby: Murdoch has got a farm there; Dick Smith—

MRS BURKE: I do not know whether the chair was meaning this—that a bureaucrat's mind is not the mind of, say, a business person or a philanthropist, where—

Prof Gatenby: They should stack the committee with business people.

MRS BURKE: I think that is right—people who have got the money but do not know how to direct that money. That is what you are telling this committee today.

THE CHAIR: So you are suggesting that the committee is stuck in a bit of a rut in its mindset?

Prof Gatenby: As far as I know, the stage we have got to is a committee to select a committee or something like that. Maybe it has moved on from that, but this has been going on for years. When I was dean, my faculty would come to me and say, "Why don't you start a foundation for the university, because they are doing nothing at health?" I resisted that because I thought that there would be a foundation and the worst thing you could have would be two groups fighting over the same dollar. Things are incredibly slow. There has been some spectacular philanthropy at the hospital lately, which suggests to me that that may not be a unique occurrence. There needs to be a vehicle that builds on that, celebrates it and that sort of thing.

I look at other hospitals. I go to Wollongong, where there is a thermometer of how much money they have raised. We have never had that. It is as if we are embarrassed to do it. I get asked every week to donate to various hospitals and organisations—but never my own.

THE CHAIR: Looking outside of the people with lots of money to the average mum and dad investors, do you think there is scope there to get people to put money into medical research in this town?

Prof Gatenby: You do not get much money that way, but I think it is important that you do that. I think every member of staff should be invited to commit from their pay. This happens in other places in Australia, and some will and some will not. But it shows that the organisations themselves are serious about raising funds. It is usual in many parts of the world, including other parts of Australia, that when you go into hospital you get something that tells you how to give money, including in your will—implying that you might not get out of there alive. But we do not do that.

THE CHAIR: Why?

Prof Gatenby: I have heard that some people do not like it; they find it distasteful.

MRS BURKE: The organisation or the person with the idea?

Prof Gatenby: Within the organisation I have heard comments like that made. I have never ever heard a patient express offence at being asked to donate towards the organisation.

MRS BURKE: So there is a lack of will or resistance to change?

Prof Gatenby: At the moment I think the inertia is central rather than peripheral, but I suspect there would be peripheral resistance given that there was before.

MS PORTER: You say in your submission that research is not a democratic activity

and that we should reward excellence and not spread funds evenly across organisations. I wondered if you would like to enlarge on that a little bit.

Prof Gatenby: It is not a democratic activity—it is pointless spending money on people who are incapable of delivering the goods—whereas education is a democratic activity and should be available to all and that sort of thing. I am drawing a contrast between the two. So, when you are in a sense running schemes that provide money for research, you are almost going to guarantee that some people will feel disadvantaged because they are not going to be competitive to meet the hurdles they would have to jump over to get the funding.

It is pointless to say to every department within the hospital, "We will give you $200,000; go away and do some good research." With 50 per cent of them you might as well have torn up the cheque. You would be better off giving the ones that have a track record twice the amount and giving the others nothing. If the hospital or the health system started making strategic investments in research, you could bet that those that were not up to the mark would whinge and moan.

MS PORTER: You talk about larger institutions having more capacity and more funds to back them and therefore, obviously, if you give them a research project they are able to carry that out in a more effective way than if you do not have that backing. Is that what you were saying—that if you give $200,000 to this particular group—

Prof Gatenby: The point I was making was in relation to large jurisdictions. In Victoria they can give $150 million to the Synchrotron. What proportion of the ACT budget would that be? It would be quite a big one; it would not be possible. So there are some games that we cannot even play.

MS PORTER: We cannot get into them because of our size.

THE CHAIR: Is that where we actually need to be working more collaboratively with states like Victoria—

Prof Gatenby: Buy a share of something elsewhere?

THE CHAIR: Yes.

Prof Gatenby: Yes, I think that is quite a reasonable approach. One of the problems is that in some ways it does not appeal to the—it is hard for a minister to stand in front of it and open it if it is next door to Monash University. But I think the reality is that contributing to some things elsewhere may potentially be a better way to spend money in certain areas, particularly the high-tech end of things.

THE CHAIR: The Bio21 Institute has formed as a result. They decided that in order to have these massive pieces of technical equipment they did not need to all buy one; they could actually share the resources for the amount of time that they each used them. That is my understanding of how the Bio21 Institute came about in Victoria as well.

Prof Gatenby: That is pretty much true. I am a great admirer of Bio21. I have been

wondering recently about the prospect of what would be involved in joining. I have not got as far as making a direct inquiry.

THE CHAIR: We visited them. It was not quite finished when we went down there.

Prof Gatenby: That is their physical building, but it is really more an organisation.

THE CHAIR: Yes. We also had a meeting with the organisation as well.

MS PORTER: We did.

THE CHAIR: I note the point that you made that it is not a great look for a minister opening something down in Victoria. But if a minister can demonstrate the outcomes, then surely that does not matter.

Prof Gatenby: One would hope not.

MS PORTER: Through you, chair, I have another question going back to your comments about where resources should be directed. I am reflecting on what one of the other witnesses said to us the other day, which was that sometimes younger researchers have a hard time competing for the dollar because of that very fact that their submissions may not—

THE CHAIR: The rigour.

MS PORTER: have the rigour in them. They may not be as sophisticated as those that come from organisations who have a track record like you are saying. They obviously do not have a track record because they cannot prove that. However, sometimes—and this witness did not say that, but I know it—somebody from left field can come up with a wonderful idea and no-one necessarily may have thought about it or thought about going down that track and doing that research. You can actually have some research that happens on the back maybe of some naivety in the beginning.

His suggestion was that we might need not necessarily to fund these people in the first instance, because I think he was agreeing with you that you do not throw money at people who cannot prove their capacity to do things. His suggestion was that more mentoring be provided for such people in order to assist them in getting to the point where they can compete and bring their ideas forward. Do you have any comments about that?

Prof Gatenby: I agree entirely with it. I think the concept of start-up funds for early career researchers is a good idea, but I also agree that they need to be mentored a lot to ensure that they get as close as they can in a sense to the kinds of issues that any granting body would think was worth while. I think that is a worthwhile group of people to invest in. You are quite right. Ideas do sometimes come from strange backgrounds. Australia's most recent Nobel Prize in medicine was turned down by the NHMRC several times.

MS PORTER: What about your comment about the shortage of qualified academics,

not necessarily in the medical field, but in all fields?

Prof Gatenby: It is true.

MS PORTER: Yes. So what can we do about that? It is a worldwide—

Prof Gatenby: It is worldwide. I think the increased number of graduates from health sciences in general—but I am most familiar with medicine—will probably alter that over a time frame of about 10 years. People will not automatically be able to walk into an extraordinarily well paying job. When we advertise for a job here, we get half an applicant for each job in medicine at the Canberra Hospital. They are medical jobs, senior medical jobs. I remember the days when there would have been five applicants. So the one who had a research track record and a higher degree would get the job. People do not need that any more to get a job. They can walk into a highly paid specialist job having just basically got their fellowship the week before. I think that graduating more people will go a long way to fix it.

There are two reasons why people do not do research, I think. One is that you have to be prepared to earn less money if you are going to do research in our system—substantially less money, particularly for medically qualified people. It is really very difficult for them to seriously contemplate doing a research degree full time at some stage after they have graduated when they are obliged to do their professional training as well, unless they want to work in a research institute. If they want a job that involves patients and research, then they have to get professional training as well.

If you are a registrar getting $110,000 a year with overtime and you have a wife and a kid and a mortgage, you are not going to drop down to a $25,000 a year tax-free scholarship. It is not possible. Your bank manager would sack you! I will tell you what they do in Cambridge, where I spent four months last year. They pay PhD students at Cambridge a registrar's salary just to do a full-time PhD. They are one of the few places in Britain that do that, but that is why Addenbrooke's Hospital is the top ranked biomedical campus in the country. It is almost the only one delivering the government's target figures for people with medical degrees doing PhDs.

THE CHAIR: Are there other places around the world doing that?

Prof Gatenby: Well, the Americans have a number of schemes. They tend to pay everybody pretty badly in their early years and so research salaries are a bit more competitive. There are some supplementations carried out in various parts of Australia, but no-one is that generous.

THE CHAIR: No.

Prof Gatenby: So money is one thing, and I think the other thing is that you have got to be incredibly resilient. Only 25 per cent of NHMRC grants get up, so you have got to be prepared to be kicked and kicked and kicked and kicked unless you are the absolute top of the pyramid, which most people are not.

THE CHAIR: That brings to mind a whole lot of questions from me. It is a very time consuming process to put in research grant applications in the first place. It takes up

the time of those people who would possibly be better placed going and doing research. It is taking up research time. Would you care to comment on that?

Prof Gatenby: The process of writing research grant applications does take time. The putting of ideas onto paper and honing them and the preliminary evidence—I do not think you can escape from that in the sense that you cannot expect people to give you money if you cannot express clearly why you ought to be given it and what it is going to do. The areas where time could be saved are areas like the processing of grants, particularly the ethics processing of grants.

THE CHAIR: Yes. I note the comment you have made about the lack of progress in that area.

Prof Gatenby: Yes. Since I wrote that, just in the last week I have had a meeting with the chair of the ethics committee and I am hoping that will do some things to expedite the process a bit. The lack of trust between different ethics committees is something that drives all researchers crazy. There was recently a paper in the *Australian and New Zealand Journal of Medicine* of a multicentre study where getting ethics approval cost $60,000. They costed out the time of people's salaries. All it was was to collect data from medical records in about 20 hospitals. It was not even actually doing anything to people. There were some amazing differences. The lack of standardisation is a concern.

MS PORTER: Just to clarify, are you talking about the lack of standardisation between different ethics committees in Australia?

Prof Gatenby: Yes.

THE CHAIR: Do the pharmaceutical companies have any role to play? What role are they already playing and should they be playing a further role, or is that problematic?

Prof Gatenby: No, it does not have to be problematic. The role of pharmaceutical companies in the territory at the moment is largely supporting people to do phase 3 studies. There are a number of investigators, particularly at the Canberra Hospital, but maybe some in the community who are doing phase 3 drug trials. Phase 3 drug trials are not terribly exciting research, particularly if it is comparing the 15th with the 16th statin or something like that.

But there are good reasons for doing them. I think that one of the strongest reasons is access to medications. Particularly in, say, oncology, access to medications occurs earlier because oncology units, by and large, are involved in trials and so patients tend to get access to medications before they have gone through the tortuous TGA progress. The imperative is not so strong in other disciplines. I think if you look at other disciplines and say, "Are you really expediting access to medications?" you could say maybe not so obviously as the oncologists.

We have had discussions with a couple of big pharmaceutical companies recently because we have a clinical trials unit at the Canberra Hospital. It is the director of that that has had the discussions, asking the companies if they would consider a further involvement, you know, if they want to establish a base here so that we could look at

offering them a capacity to do phase 2 and phase 1, which are earlier studies. There have been vague murmurs of interest, but nothing definitive. It is something that we will pursue.

Australia does not have a terribly happy record of relationships with pharmaceutical companies when we compare ourselves with other countries, including some that are quite small. Sweden and Switzerland come to mind as two countries that have, I think, smaller populations than Australia. Admittedly, they are geographically better placed than we are, but they have quite a lot of pharmaceutical support, and of the sort that I think most of us would be very happy with—the sort of arm's length research type support, the early development of drugs type of support. I think all of that is really of more benefit to mankind than, as I said, testing the 15th and 16th statins, when we probably only need five.

Why is Australia in this position? I think one is geography. There are only three markets in the world, four now with China—North America, the EU, Japan and China—five with India. We do not count. We have a pretty tough commonwealth drugs policy. The Australian government with its purchasing power is no pushover, like some other governments are, so I think it is payback to not invest here. But they say that clinical trials are cheap here, which makes me worry that they may be a bit too cheap; we may be underselling. I am not sure whether I made a comment on that. Clinical trials are allegedly cheap in Australia for companies to do, and I ask myself why. We do not get paid peanuts. I suspect that we do not charge for every overhead like the Americans or the British would do. It is something that we will be looking at in depth.

THE CHAIR: You have talked about how you need to be prepared to be kicked several times and keep going back, because only 20 per cent of NHMRC grants are being approved. That leads into the issue of federal funding and the approach that has been taken in the past. It seems to me that there is a slight change with the new minister; we are now talking about the department of science and innovation.

Prof Gatenby: They do not run the NHMRC, though. It is very unusual for medical researchers to get ARC grants. We have one at the hospital that will probably be signed off fairly soon, but that is an unusual situation. One of the things that foundations often do within teaching hospitals or area health services is provide funds for people who just miss out on NHMRC, to bridge them for a year so that nobody has to become unemployed, so that they can have another go next year with some more preliminary data. That is something that we do not have enough of in Canberra compared to most of our competitor hospitals, if you like. That is usually soft money that comes from a foundation or something along those lines.

I do not know what impact the sort of attitude about innovation from the new department will have. You would probably be aware that the proposed research assessment exercise that was scrapped, that the previous government wanted to bring in, basically avoided having anything to do with hospital-based medical research. I suspect that is probably because the NHMRC is separate from the ARC and ministers who control the ARC are usually opposed to that particular arrangement.

THE CHAIR: You have talked about how there has been good progress on additional

resources to the research office and that you are getting administrative support. I will go back to the issue of attracting people with good research skills into the jobs and getting people to apply. We know that the United States does not pay good money in the research area and there is potential there.

I mentioned at the hearing on Monday that recently my office has been dealing with a medical research person from the US for whom the department of immigration could not tick the boxes; she was a square peg in a round hole in their terms, so we were trying to work out things for her because she was given the wrong advice by the department of immigration. She was changing from being a researcher in the university to being a researcher within a medical organisation. The ACT has now lost her; she is going to the University of New South Wales. Do you have any comments on that? Have you had any dealings with the department of immigration yourself or had this come up for you as an issue? I apologise that that was a not very well-thought-out question.

Prof Gatenby: I will comment on that generally. The answer is no. But I have had experiences that are very close to that. I have not found the department of immigration to be nearly as bad as our own medical board or our own recruiting services.

THE CHAIR: That is not a very good recommendation for the medical board.

Prof Gatenby: The issue of hiring an overseas person to do research can become a major one, and it happens even if a person does not want a medical licence to see patients. It is even worse if there are reasons why the person ought to have a medical licence. A professor of surgery who does not cut is an oxymoron. So it is even worse if you wish to take the person through the licensing process.

Bringing people in from overseas is a complicated and delicate business, with a large number of people in usually more than one jurisdiction involved, and also extra bodies outside the government involved if the person's qualifications have to be assessed in any way, particularly professional qualifications. Quite frankly, in medicine, the colleges that do that behave in quite varying ways in relation to questions asked. Some colleges are atrocious and others are really not too bad. So we do lose people. You have to be quite nimble when you are hiring good people because they are likely to have several job offers at the same time.

We do not have good start-up funding mechanisms here. We do not have the capacity because we do not have a foundation of soft money to bribe someone to come here with start-up funds. It is not usually their own salary that they are worried about; they are pretty much the same everywhere and there is a capacity to negotiate for higher ones if you are really good and desirable. Then there are immigration issues. I think one of the problems there is that it is quite complicated; there are a number of tracks to come down and people need to be well advised.

I think the ANU has a quite good understanding of the immigration issues for people that it wants to hire. I am not sure that the health department HR people understand which buttons to push terribly well to hire people. I have never been struck that there was a high level of expertise in overcoming those barriers. If people want to get a medical licence, there are ways of doing it and ways of making sure it will not happen.

To an outside observer they are pretty subtle, the differences between them. Personally I think it is outrageous how precious some of these bodies are and how they behave. You have got to play their little games. If you talk to one, the other blacklists you and things like this. It is pathetic, I think.

I think it would be useful if somewhere within health there was a group of people who understood how to get people into the country and what actually needs to be done and in what order, and I have the feeling that there is not a single fount of that information in different categories of people.

MRS BURKE: I think that is a really good plan. I suppose I can only talk from the GP level. I have written to the federal health minister about that to see if something cannot be done. There seems to be certain hurdles because of—

Prof Gatenby: A member of my faculty is currently being treated shabbily by the Royal Australian College of General Practitioners, who are the college I would put on the bottom of the heap in terms of—

MRS BURKE: It is that, and then it gets to the timing between the federal government or agencies dealing with that application and coming to the ACT and then different processes again. However, that was not my question. Taking into account everything you have said about the organisation, the Canberra Hospital—obviously you have a strong passion and a desire to see research embedded as a core business in that organisation—how do you feel the progress is on that? You have alluded to the fact that it is not necessarily about more money because, as a small jurisdiction, we have not got the capacity or the researchers perhaps would not have the capacity to do more. How are we travelling, from your perspective?

Prof Gatenby: I think that, by and large, things are going in the right direction in most parts of the organisation. There is very little resistance to the concept of research anywhere within the organisation—not entirely nil, but very little resistance. Does that mean they are all enthusiastic? No, it does not. But at least that is a start. I think that there are areas of excellence. There are areas that are pretty ordinary where one would perhaps expect a teaching hospital to be a little bit better.

MRS BURKE: Where might those areas be? Can you indentify them?

Prof Gatenby: Yes, I am happy to identify them. The premier unit at the Canberra Hospital is the gastroenterology unit, and another unit that is just as large and of similar size and does almost no research is cardiology. Just read the Brennan report just published on it.

MRS BURKE: Do you think that is because it is maybe left to other bigger organisations and there is maybe a belief that other people are doing that?

Prof Gatenby: What, their view is that someone else is doing it?

MRS BURKE: Yes, for example, the Heart Foundation. Are they reliant upon that research and think it is enough?

Prof Gatenby: I think it is amazing that no-one in that department holds any grants from the Heart Foundation. Two grants are held in Canberra. One is at the John Curtin school and other one is Dr Abhayaratna, who is a cardiologist who does not belong to that department.

MRS BURKE: Yes. It is an interesting conundrum.

Prof Gatenby: My view is it is lack of leadership and lack of responsibility—lack of an understanding of what their role is within a teaching hospital.

MRS BURKE: Sorry, a lack of leadership at department level or—

Prof Gatenby: Cardiology department level. I think generally, where there are issues like those, it is lack of leadership at the departmental coalface level. I cannot think of an example of someone higher up, like a general manager, who might not want to know where the money is coming from but arguing that people should stop doing research. I have not seen anyone stand up and say that for a long time.

MRS BURKE: No.

Prof Gatenby: In fact, most of them know they have trouble recruiting if they do not have active research profiles.

MRS BURKE: That is right. That is the encourager, isn't it, to personal development for any human being?

Prof Gatenby: Yes.

THE CHAIR: We have gone past the time, but I wanted to ask you a question. The other day we had Professor Suresh Mahalingam, who is at the University of Canberra appear before us. We talked about a campaign that he is involved with called the national Tall Poppy Campaign. They bring different people with expertise in science into the schools. He says they are doing a trial at—

MS PORTER: Hawker College. They have got a proposal before the minister at the moment.

THE CHAIR: They have a proposal before the minister for education at the moment to do a trial at Hawker College. He has already got in running in some of the primary schools in Belconnen. Last year I was privileged to have a meeting with some people at the Howard Hughes Medical Institute and talk to them about a number of their different programs, one of which is that they do a number of stuff with primary school age children. It is about getting that interest going, I suppose, in science and medical science in the long run. Do you have a comment about ways in which maybe the different medical research organisations around town and science organisations could possibly better interact with schools in this town or if you believe it is necessary, if you have thought about it?

Prof Gatenby: I think it is a good idea and I think that the researchers in the health sector—and I can probably really only speak for those associated with the medical

school because I am not quite sure about the others—have probably done less of that than they ought to have done. That would be my view. I think that sort of activity is important. Really, in a sense the community buy into the fact that research is an integral part of activities within our health facilities. It has taken a long time to even get any buy-in for there to be teaching in the facilities. That is certainly something where we should probably think about doing a bit more work. It cuts both ways, both in terms of inspiring young minds to maybe consider a career like that but also I think it builds your own profile in the community, too, which we always need to work on.

MS PORTER: That was my next question. You have raised it for me. That is fine.

THE CHAIR: Thank you very much for appearing today. It has been very interesting and very elucidating. We will get a copy of the transcript back to you, which we would ask you to check for accuracy. That will be back to you in the next week. We might actually ask you some follow-up questions. You never know. This being an election year, in spite of the fact that this inquiry has been dragging on now for three years and not really made much progress until this year, we will be reporting to the Assembly by the last sitting day, at the latest.

MS PORTER: We do not have as many sitting days this year. That is what she is trying to say.

THE CHAIR: I suppose I am saying that there will be a report by August. We will keep you informed of the progress of that report and when it is going to come out. Thank you very much for your time.

Prof Gatenby: Thank you for the opportunity.

The committee adjourned at 11.29 am.