Feedback form

We would like to capture your feedback to the ‘supporting primary health care research – future directions’ discussion paper. This paper is intended to promote discussion regarding the future of Australian primary health care research funding to inform deliberations of the Australian Government Department of Health on the future of its Primary Health Care Research Development and Evaluation Strategy (PHCREDS).

Feedback and comment would be welcome via email or in the template provided below, by close of business 27 February 2015. Responses should be sent to:

- Associate Professor Terry Findlay; Head of Programs, APHCRI; terry.findlay@anu.edu.au
- Emma Whitehead; Research Implementation Coordinator, APHCRI; emma.whitehead@anu.edu.au

Having read the ‘supporting primary health care research – future directions’ discussion paper, please offer your thoughts and feedback on the following questions:

The discussion paper proposes a greater focus on implementation of research; do you think the proposed model achieves this? If not, what do you think could work better?

Services for Australian Rural and Remote Allied Health (SARRAH), welcomes the opportunity to comment on the discussion paper.

SARRAH believes that the alignment of implementation research with the Primary Health Network (PHN) structures is sensible but there are a number of serious risks that need to be managed:

1. There is a tension between research rigour, service provider interests and public health priorities. These elements need to have equal representation and equal power to make translation research work. What is needed is an integration of these domains, and nothing drives integration more than having to demonstrate teamwork in order to qualify for major funding initiatives. Any funding for proposed Practice Based Research Networks (PBRNs) should have the guidelines to ensure these interests are well integrated at the level of research implementation. As a way to balance these three competing perspectives on a strategic level, the proposed ‘Engagement Board’ and ‘Research and Workforce Board’ would benefit from a balanced representation of these stakeholder groups as well.

2. PHNs have a strong emphasis on GPs and GP services. However, if we are trying to achieve improved access to services with a shortage of rural GPs we may need to look to extended roles, for example nurse practitioners or physiotherapists with limited prescribing rights. These changes are likely to have strong push back from GPs yet are important to explore at
the level of policy and improved public health. Consequently it is imperative to include non-GP health professionals in the process of establishing funding priorities at a high strategic level, for example by including them in the proposed Engagement Board. This approach would also be desirable to mandate inclusion of non-GP health professionals on PHN Clinical Councils.

3. The rural and remote context is resource poor and is therefore a hot bed of innovation to provide services in a context of fiscal constraint. A weighted distribution model of funding for rural PBRNs would enable meaningful implementation research as there is a critical level of infrastructure that could not be met with a simple population-based formula for funding distribution. There is precedent for this, for example rural GP practice incentive programs.

4. Provision of access to technical expertise as proposed is a good way to use resources more efficiently but that support service needs to be adequately funded to meet demands for technical advice and support. This is particularly true if the implementation research activity at the PHN level will tend to favour a service provider approach. For example, many innovative service models are ‘evaluated’ after the fact, which is not a valid form of evaluation without a baseline measure of comparison. Clinicians do not typically know this. There is need for research support in the earliest stages of project development, and that support needs to be adequately resourced proportionate to the emphasis of any PBRN funding models.

5. Medicare Locals were tasked with completing regular needs assessments, a function which will carry through to PHNs. It is entirely appropriate that PHNs act as key informants for setting future primary health care research priorities but they may lack the ability to participate in a balanced way. Research capacity building targeting ‘active recipient’ PHNs is essential to enable meaningful participation in setting implementation research funding priorities.

6. Consequently, the new PHN structure leads into the potential for a much more devolved model of research where the PHNs are not just informants and recipients of research (p8), but actually the drivers and hosts of research and capacity building activity. There is still an important role for the PHCRED strategy of coordinating the PHN’s being an overarching body to support sharing and dissemination of research. However, the PHNs could and should become the hubs of the research activity supported by the universities (not the other way around). This would be further supported by having boundary spanning, primary care academics jointly employed by the PHNs.

7. A SARRAH member advised that she had worked with CLAHRCs in the UK and with former (NHS England) Research Development Support Units as a primary care research coordinator. A key driver for research engagement and implementation by health services was each organisation making a financial contribution to the research activity (cash or in-kind through personnel).

8. One of the big challenges of academics engaging in applied research is that the current Australian funding and academic metrics models do not recognise or reward collaborations well. The move in the UK towards impact outcomes has shifted this culture considerably. Perhaps an important role for PHCRED is to try to shift the research and funding culture nationally towards valuing translational types of outputs (collaborations, capacity and community engagement) as opposed to simple metrics (grants and publication) driven indicators.
We have 14 years of learning from the PHCRED strategy. What elements do you feel are effective and should be kept, and where do you feel gaps/weaknesses exist?

9. The primary health care infrastructure created under PHCRED has been vital for organising and disseminating research and information for what is a highly fragmented/disjointed group of services. PHCRIS is an excellent form of information exchange/brokerage. SARRAH would like to see this maintained and perhaps enhanced (with increased funding) by brokering Sax type rapid reviews around primary health care specific topics (along the lines of the Social Care Institute for Excellence knowledge briefings in the UK).

10. The PHCRIS conference is an effective mechanism for knowledge exchange and transfer as it attracts a broad audience and enables extended conversations to exchange ideas and build pragmatic networks. Online mechanisms for dissemination have been less successful.

11. The APHCRI research workforce capacity building program has been particularly successful in a rural context, with the additional benefits of rural workforce retention and the generation of rural-specific information to help shape policy and practice.

12. The ‘APHCRI conversations’ are also beneficial but the Centres of Research Excellence (CREs) program needs to be reviewed. This program concentrates resources in a way that does not favour broad based implementation initiatives. If the CRE program is to continue, it would be better to reduce their number and scope, and to be highly strategic in their selection to specifically address policy priorities. Changes in CRE funding models with a greater emphasis on requiring implementation outcomes would also help improve this program.

13. In summary, there should be more of a shift to end-user, priority driven research resulting in greater end user engagement groups formally developed and engaged to inform research priorities. As mentioned previously, hopefully, the PHN model will provide PHCRED with a more tangible infrastructure in which change can be fully leveraged across a diverse range of users, professions and services.
On page 9 under ‘realising the concept’ four new work areas are proposed; do you feel these adequately address the concerns you raised above? What else would you add/ remove?

14. SARRAH believes that state/territory based research networks that include various PHNs and jurisdictional participation could be a good way to encourage cross-sector integration. Stakeholders that plan together and have shared projects of concern will improve cooperation and coordination of primary and secondary health services. A sound model would not just have these stakeholders as research advisors, but as collaborators, drivers of research and research partners. This could be realised through a networked model of engagement, coordinated by APHCRI, where all of these stakeholders have a key governance role in driving and advising on research activity undertaken by the PHNs.

15. The effectiveness of ‘research translation enabling’ positions is dependent on the capabilities of the people recruited to those positions. It may be a better use of funds to enhance the funding of existing personnel. An alternate model to source additional academic experts may be for methodological experts to be hosted within a university. The challenges are that university metrics are often at odds with practical health service/organisational needs, so academics are torn between achieving their traditional academic outputs, and working closely with their industry partners. This approach can work if key performance indicators for the role also include collaborative indicators.

16. Continuing support for existing University Departments of Rural Health (UDRH) infrastructure is another cost-efficient way to fund technical expertise in rural contexts, but the number of UDRHs is limited. However, expansion of the program could improve effectiveness of implementation research in rural and remote contexts. Alternatively rather than contracting technical expertise from universities, there should be funding commitments from the PHNs, if not hosted by the PHNs and contracted back to the universities. This approach may encourage PHNs to eventually partner closely with universities to become academic health centres.

Please let us know if you have any other thoughts, comments or feedback on this paper.

No additional thoughts.

Thank you for your time.