

Summary Report of the Evaluation of the
Primary Health Care Research, Evaluation
and Development Strategy

April 2005



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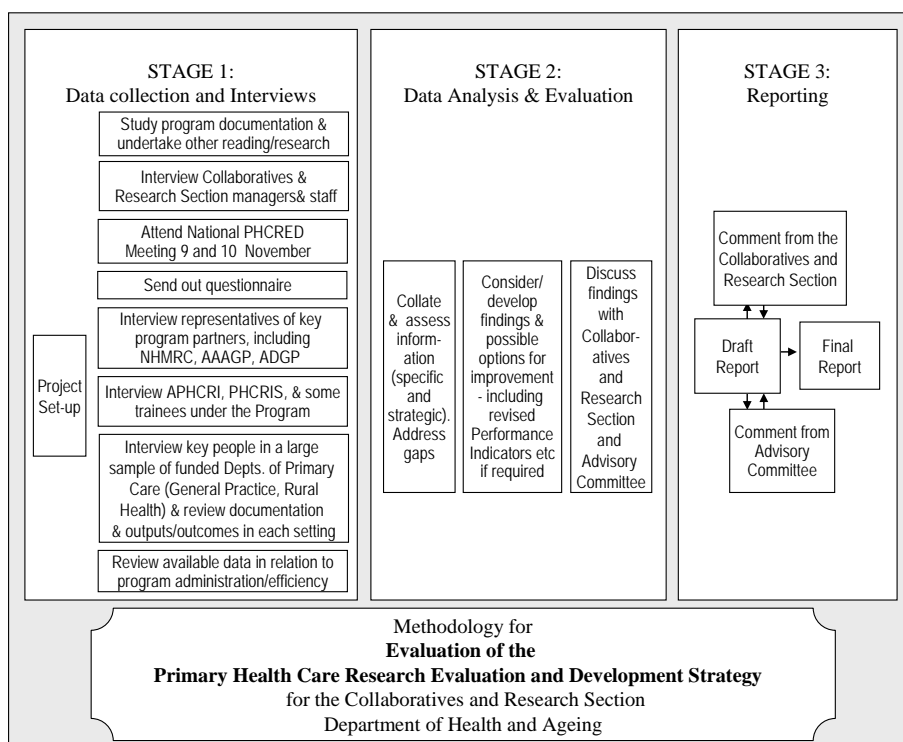
1 Introduction

The Primary Health Care Research, Evaluation and Development Strategy (PHCRED or the Strategy) commenced in 2000, following recommendations of the Review of the General Practice Strategy in 1998. This is the report of the first evaluation of the Strategy.

The overall aim of PHCRED is to embed a research culture in Australian general practice specifically and Australian primary health care more generally. To this end, a range of sub-strategies have been used. These include:

- An initial priority setting process (\$0.15m)ⁱ;
- The Research Capacity-Building Initiative (RCBI), to bolster basic capacity of the University Departments of General Practice/Primary Care/Rural Health to support primary health care (PHC) service providers (budget \$19.2 million not including RDP);
- Researcher Development Program (RDP), to increase the number and range of people with knowledge and skills in PHC evaluation and research (budget \$1.5 million);
- Establishment of the Australian Primary Health Care Research Institute (APHCRI) to improve quality and effectiveness of primary health care through priority-driven health services research and promotion of best practice (budget \$15.8 million);
- A Program of Grants and Awards, which includes Fellowships and Scholarships; and investigator-driven research and priority-driven clinical research, all administered by the NHMRC (budget \$13.2 million).

The methodology for the evaluation process is set out in the Figure below.



ⁱ All budget and allocation figures are GST exclusive.

All of the 22 University Departments that are part of the RCBI program were contacted and as many as possible were visited, except the four that have only recently been funded. A repeat of the 'baseline survey' of the 18 University Departments funded in 2000 was conducted for 2004.

2 Findings In Relation To Individual Strategy Components

2.1 Priority setting

A priority setting process for PHCRED was undertaken in 2000-01 to establish research priorities for the Strategy. Seven thematic areas and three priority populations were identified. As well as this initial process, specific priorities were established to underpin the Strategy's programs of health services and clinical research.

Overall, the objective of the initial process was not achieved. While research priorities were identified, they were not used to underpin the Strategy's research programs as it was found that priorities needed to be more specific. The identified priorities were used only occasionally, for example, to aid the more specific APHCRI priority-setting process. The initial priority-setting process was, nevertheless, efficiently conducted, using an appropriate methodology; it was relatively inexpensive; and an agreed set of priorities was established – which have been used to classify research undertaken within the Strategy.

2.2 The Research Capacity Building Initiative (RCBI)

RCBI commenced in 2000 with an initial grant of \$200,000 to each of 18 UDGP's and UDRHsⁱⁱ. Since then an amount of around \$200,000 has been allocated to each University Department annually, with a further four University Departments funded in 2004. All funding agreements expire at the end of 2005.

Overall, RCBI has been highly effective in achieving its goals and objectives, although in some areas the lack of quantitative data makes this assessment more dependent upon assessment of information from interviews. We feel that the assessment is valid, all the same.

The program has been very effective in enhancing the capacity of University Departments to develop research capacity locally. It is more difficult to assess success against all aspects of the second goal of improving national capacity through cooperative work, sharing specialist expertise and supporting national policy initiatives, in particular the last aspect. Although some relevant work was undertaken under the program, in future a clearer definition of what is expected would make assessment easier.

In terms of the objective relating to establishing and implementing collaborative working relationships in order to foster PHC research, design, implementation and evaluation, this has clearly been achieved. Across the program, collaborations were

ⁱⁱ This initial round of RCBI funding is not included in the \$50 million PHCRED funding; it is in addition to it.

formed at local, national and international levels, focussing on a range of projects and involving a range of relevant organisations and disciplines.

In terms of the objective relating to increased involvement of representatives from the full range of relevant disciplines in the design and conduct of PHC research; it is clear from consultations that this was achieved. It was noted that the involvement of a very wide range of health-related practitioners and individuals from the non-health disciplines (such as demographers) was occurring, much more so in 2004 than in 2000.

In terms of the objective relating to improvement of knowledge and skills of the research community and health care providers in the area of PHC research design, implementation and evaluation, no effectiveness data was available. Nevertheless, the considerable increases in the amount of research training and support delivered under the program are good process indicators that this objective is being achieved.

Finally, in terms of the objective relating to an increased uptake of research findings through effective dissemination mechanisms involving stakeholders and health care providers, it was not possible to assess its success. While there were a number of dissemination mechanisms used under RCBI, little data was collected and effectiveness was not measured.

It is clear that the goals and objectives for this program need to be reviewed, along with the need for measurable indicators of success.

Other Findings

RCBI has been highly flexible and has allowed University Departments to build on their strengths and to meet local needs. This has resulted in a wide range of activities that are not readily collated and compared across the program. This diversity is a strength of the program, despite the difficulties it provides in undertaking assessment. To address this difficulty, a baseline survey, originally conducted in the 18 University Departments funded in 2000 was repeated for 2004. The survey has significant methodological flaws, and the changes that have occurred in the five years cannot be attributed just to RCBI or other elements of PHCRED. The shifts in activity levels are dramatic, however, and the survey results strongly suggest that RCBI is responsible for valuable increases in activity, particularly when taken with the information from the consultations. The overall results of the survey are tabulated below.

Survey topic	Departments of Rural Health			Departments of General Practice		
	Means			Means		
	2000	2004	% change	2000	2004	% change
1. Education						
1.1 Postgraduate academic courses	1	1.4	40%	2.7	3.8	42%
1.2 Short courses	1.6	3	88%	0.2	4.4	1900%
1.3 Other educational modules	0.6	2.6	333%	0.7	3.6	433%
2. Networks and collaborations						
2.1 No of networks managed under PHCRED	3.2	6.4	100%	1.8	8.4	375%
2.2 A Network activities - no persons involved	13.4	49.8	272%	23.9	264.3	1007%
2.2 B Educational activities- total no persons involved	100.2	207.4	107%	56.0	487.0	770%
2.2C Mentoring						
Total number	3	16.2	440%	9.6	128.4	1244%
No of new mentees	2	10.4	420%	2.0	11.2	461%
2.3D Number of new primary health care projects	4.4	9.4	114%	6.7	9.3	40%
3. University Dept research effort						
3A Grants awarded						
Number	2.4	6.4	167%	8.3	19.3	132%
Total Value	\$70,600	\$425,400	503%	\$492,316	\$1,941,532	294%
3B Number of other current research projects	2.8	6	114%	2.3	5.3	129%
3C Number of publications	2.4	7.6	217%	14.4	32.4	125%

Major growth areas have been training, mentoring and networking. It is also very important to note the substantial increase in successful grant applications, reflected in the number and the size of the grants receivedⁱⁱⁱ. The numbers of staff engaged in research had also shown very significant growth. Dissemination is not reflected clearly in these data but it has increased. Uptake of research findings into practice has not been measured to this point.

A national PHC research network

Several times during the consultations, the need for a national PHC research network was promoted as a key gap. It was felt that a national network would provide economies of scale that were not achievable with existing networks under present funding arrangements. It would also provide greater opportunities for linkages between like-minded individuals. There was not a consistent view as to what a national research network would undertake specifically. Proponents usually felt it should be like the one with which they were involved. The larger PHCRED networks are close to capacity under present resourcing arrangements and so a national network would require reorganisation of resources if one is to be established.

Statewide or regional coordination

There is strong support for the statewide coordination process because of the value that being a member adds. Everyone's program is strengthened through the peer support and review process that is intrinsic to statewide coordination. It enhances communication and linkages across the group; mutual support; the ability to undertake statewide planning; and it brings information back to the state level. People get to know each other better and are more willing (even keen) to work together and share ideas and resources. University Departments that are not part of a coordination group are missing out significantly.

RCBI Advisory Committees

In sharp contrast to the statewide coordination and statewide advisory committee arrangements, the advisory committee arrangements in individual departments do not

ⁱⁱⁱ This Table excludes one very large grant that distorts the underlying picture.

appear to have been highly successful. It is necessary to have each University Department linked to an advisory committee but they do not need one each. In the interests of efficiency and effectiveness the main focus should be on either a statewide or regional advisory committee, in line with the coordination arrangements.

Divisions of General Practice

Representatives of Divisions of General Practice that had a successful relationship with a RCBI-funded University Department were highly supportive of the work in general and the services they received through RCBI in particular. Others consulted were critical of the University Departments' activities under RCBI.

Generally, the best relationships between funded University Departments and the Divisions were in regions where there were relatively few Divisions for a University Department to relate to. The less positive relationships tended to be in the larger states where the University Departments had many Divisions to relate to. There is a need for clarity about what University Departments can provide and what Divisions can expect.

Allocation of RCBI funding in future

The allocation of funding such as RCBI on a non-competitive basis is unusual. While there has been no suggestion from anyone that this is under question, we feel this evaluation needs to reflect on the need for non-competitive allocation.

Competitive allocation of RCBI should not be contemplated at this stage. Reasons for this include:

- A competitive system would leave the weak University Departments weak. Marginal performers could be eliminated as well as others that are developing well but not yet mature enough to compete effectively.
- The collegiality that has grown up across the nation is very valuable and thrives due to the lack of competition.
- The commitment and enthusiasm for RCBI activities that most University Departments have displayed could not be bought for the amount of money involved.

The effectiveness, efficiency and appropriateness of RCBI

University Departments had generally used approaches that were shown to have worked elsewhere, were in line with identified local needs, and were in line with the goals and objectives of RCBI. The level of cooperation and integration of the PHC research sector that RCBI has achieved in five years is striking.

One negative unintended consequence is that university staff, particularly the program coordinators, can become burnt out by the demands made on them. Another key negative is that towards the end of the funding cycle, only short-term contracts can be offered to new staff. This is particularly problematic in rural and remote areas. This is not unique to RCBI or PHCRED but has a particularly destructive impact on programs at the end of the cycle.

RCBI experienced ongoing substantial underspending over the first few years. Discussion with the University Departments elicited the same response: initially the

time it took to negotiate the funding agreement meant that commencement was delayed. Then it took time to appoint appropriate staff, particularly in the UDRHs, which have greater recruitment issues to address. Later underspending was said to be due to the carryovers that the initial delays caused. Detailed data on administration costs over time were not available. What is clear is that efficiencies have arisen through the sharing of experiences, resources, and via the networks and collegiality that have developed.

The continuing need for RCBI

The RCBI, and PHCRED as a whole, have made a good start in addressing the gap in PHC research capacity in Australia, but it is only a good start. The sector has by no means reached a point where it can hold its own in competition with other medical research sectors, and where there is an ongoing stream of trainees funded by, or practitioners supported through, other sources. The sector lacks research leaders in sufficient numbers, and lacks the breadth and depth of researcher training and development that is required to support evidence-based practice across the sector.

When such a point is expected to be reached is not ascertainable from the literature. The 'pipeline' is partly dependent upon the setting – for example it is certain to be longer in remote Australia than in capital cities. It is clear that much would be lost if RCBI was substantially scaled down or abandoned at this point. While it has been effective in many areas, and is of increasing efficiency, it is still not self-sustaining, nor even close to it.

It is not clear that RCBI has reached the medically qualified PHC practitioner/researcher sufficiently. We note concerns of stakeholders that RCBI should not become GP-focused, but we also note that future demand for medically qualified academics in PHC is likely to be high.

2.3 The Researcher Development Program (RDP)

The Researcher Development Program (RDP) aims to increase the number and range of people with knowledge and skills in primary health care evaluation and research. Financial support is provided for placement holders to undertake primary health care research and to gain access to existing research support. RDP targeted researchers from a broad range of backgrounds. Existing researchers and those undertaking higher level degrees by full time research were excluded.

The Department approved 21 of the 24 RCBI-funded University Department applications and a total of 60 placements were eventually awarded. RDP is now registered on the Department of Education, Science and Training (DEST)'s Australian Competitive Grants Register which provides additional infrastructure funding to universities.

University Departments undertook their own recruitment to fill individual placements, although core selection criteria and assessment panel composition were set by the Department. Placement holders began in the second half of 2004, with the duration of placements ranging from 1 to 5 days per week, for periods between six and 52 weeks. All placements must be finalised by 31 December 2005.

RDP was highly valued by stakeholders, particularly as a second step in researcher development, ie one step beyond short courses and other introductory training, as a

means of offering protected time for research. There is a lot of optimism about the workforce development outcomes of this opportunity, which starts to address the middle gap in researcher development. In fact, this is more than it aimed to do, so this is an unintended consequence.

RDP has been effective in achieving its goal of increasing the number of people who undertake research in primary health care and who apply research in primary health care. There is no guarantee that there will be a long-term increase in the number of primary health care researchers but there is considerable optimism about the future benefits. The formal evaluation of the program, planned for later in 2005, will more clearly determine the achievement of the goal and the objectives.

In relation to process of recruitment, it has been efficient. In some cases Statewide Co-ordinators (in NSW, VIC, QLD, and SA) undertook joint recruitment processes. This reduced overhead advertising costs as well as minimising times required for recruitment panels and short-listing committees. Significant efficiencies were gained in recruitment of placement-holders under this arrangement.

2.4 Australian Primary Health Care Research Institute (APHCRI)

APHCRI has been established to provide national leadership in improving the quality and effectiveness of primary health care through the conduct of high quality priority-driven research and the support and promotion of best practice. In summary, APHCRI's primary aims are to strengthen the knowledge base in PHC; to facilitate the uptake of research evidence; and to enhance research capacity. It is too early to evaluate APHCRI's performance against its aims, however, steps have been taken towards their achievement, particularly in relation to the generation of new knowledge through their research programs.

APHCRI has a Research Advisory Board (RAB) that oversees the research activities of APHCRI.

The establishment of the hub of APHCRI has been drawn out, due to the complexity of the process. Furthermore, APHCRI is not just a hub, but a coalition of health service research groups, linked in a hub-and-spoke model. Thus APHCRI remains incomplete until a reasonable number of spokes are in place. This has been achieved in part through Stream 1 projects but will be more in line with the vision when the Stream 3 projects are announced later in 2005.

APHCRI was set up, in part, to commission and coordinate research efforts of the spokes, which implies a collaborative relationship, one that is unusual between the research funder and the funding recipient. All the spokes up to and including those from Stream 3 funding will have been selected through open competition, little different from the approach of the NHMRC (although to a smaller pool of potential recipients). It is not clear how the remaining research funding will be expended but it would be a missed opportunity if some more innovative arrangements were not attempted.

APHCRI is making progress with collaborations, which are critically dependent upon the Centre's own research performance. Until APHCRI has commissioned its spokes and is undertaking high quality research of its own, it will have little international credibility.

The establishment of APHCRI and subsequent management issues, such as the delay in appointing a Director and clarifying the governance and contractual arrangements, have led to some inefficiency that has been ongoing. This is being addressed. The effectiveness is too early to judge although steps have been taken towards achievement of aims. It is clear that the sector welcomes APHCRI as an appropriate part of the PHCRED spectrum of strategies to strengthen PHC research, evaluation and development.

2.5 Initiatives administered via the NHMRC

Three elements of PHCRED are administered through NHMRC: investigator-driven project grants; priority-driven project grants in clinical areas; and training awards, ie Fellowships and Scholarships.

2.5.1 Investigator-driven project grants

The program has met its objective of offering support for PHC research, supporting 19 grants to be funded over three years. This is the first key step in achieving the goal of increasing research capacity, knowledge and dissemination in PHC. It should be noted that no specific dissemination strategy has been developed but the usual methods of research dissemination would obviously occur.

The way this program is conducted is highly efficient, utilising work already done by the NHMRC and reviewing the work further, only insofar as is necessary to confirm that it is PHC. The major concern with the process was the lack of a specific primary health care panel in the NHMRC. While we recognise this concern, which has also been identified in a more generic way in a recent review of medical research in Australia, we do not believe PHCRED funding should be spent to establish one, if that is what the NHMRC would require. No doubt reforms will occur as a result of the recent review of medical research and the Department should work through that reform process to address the concerns expressed by the PHC research community.

Providing this additional funding ensures that valuable research capacity in PHC is developed, and that all the work that goes into producing a fundable NHMRC application is not lost. Eventually the amount of PHC research available to inform decision-making in the Australian context will be significantly increased by these project grants. The arrangement is efficient, effective and appropriate.

One issue raised in the context of the project grant arrangements was the lack of any centre doing PHC research that had the standing and capacity to be awarded an NHMRC Program Grant. Clearly this is a gap.

2.5.2 Priority-driven research in clinical general practice

It is too early to assess the success of this program against its aim of expanding the knowledge-base in clinical general practice, although a selection process is underway, through the NHMRC, to award a minimum of eight grants. While it is also too early to evaluate the program against its objectives of building research capacity and producing new knowledge that is high quality, policy and practice relevant and targets agreed priority areas, appropriate processes and program guidelines have been developed to support the achievement of these.

Although there was some criticism of the priorities including gaps and the time it took, the Department's priority setting process was appropriate. Gaps can arise for a number of reasons and must be expected where there are many priorities and limited funding. The need for clinical research funding in general practice was widely supported by the sector.

2.5.3 NHMRC Fellowships and Scholarships

Applications for PHCRED-funded Primary Health Care Scholarships and General Practice Fellowships are administered by the NHMRC under the Training Awards program. Scholarships aim to encourage primary health care graduates to obtain formal training in primary health care related research, and Fellowships provide support for post-doctoral research by GPs. A total of eight Primary Health Care Scholarships and two General Practice Fellowships have been awarded to date.

Both programs have gone some way to achieving their purpose, although the number of Scholars and Fellows is clearly too low to make a significant impact. In the case of Fellowships, the requirements are too restrictive and the money may be too low for them to be attractive to, or even open to, all but a highly committed few. The reasons in the case of Scholarships are less clear, given that they are open to all primary health care practitioners, not just GPs but the level of funding again may be a deterrent *especially* to GPs.

2.6 The PHCRED Strategy as a whole

The overall aim of the Strategy is to embed a research culture in Australian general practice specifically and Australian PHC more generally. Although the Strategy has gone some way towards achieving this aim, the aim itself is too ambitious for a single program focused on only one small part of the PHC system. The drivers to achieve the stated aim do not lie solely within PHCRED. The overall achievement of its aim is also hampered by the fact that it is long-term and could not be achieved within the allocated five-year timeframe, and by the program's reach and scope. There clearly needs to be a review of the aim of the Strategy, along with the measurement of results in the future.

2.7 Measuring PHCRED's success in future

Consultations indicated that there was insufficient clarity about PHCRED's goals and objectives, ie what it is trying to do (especially the RCBI component). At the individual University Department level there are choices to be made about the extent to which scarce resources are applied to higher-level research outputs at one end, or developing capacity at the primary care practitioner level at the other. Clarity is required to ensure that the emphasis placed on program development is appropriate for the future.

It is inappropriate for this evaluation to outline *the* future goals, objectives, strategies and KPIs, but some ideas for consideration are provided. These include the Vision, Goal and Objectives for the Strategy as a whole. These require further refinement,

followed by development of strategies (in the main this would entail marginal change to the strategies in place at present) and KPIs that measure strategy performance^{iv}.

KPIs that are collected across the Strategy should be focused on outputs and outcomes as much as possible. In particular they should focus on: the development of new PHC researchers; the generation of new knowledge – eg research projects completed; and the dissemination of new knowledge – publications, presentations and measures of impact where possible. These outputs will assume that the necessary inputs, eg training and mentoring, have been provided and these inputs need not be measured at a whole-of-program level, although they may be at the individual University Department level. Processes should be measured where processes are critical, eg management of key networks and key collaborations.

A significant effort should be put into developing clear definitions for each indicator. One current gap in the measurement of performance under RCBI is self-evaluation and this should also be reported.

The current arrangements under RCBI are very flexible. We wish to emphasise that a more uniform and robust reporting framework should not reduce this flexibility. There is a risk of some University Departments not performing well, and at present it is hard to identify poor performance. This is a small price to pay for the commitment that RCBI has engendered and it is important that this not be lost. Provided the RCBI component has a reasonably long-term future, an option such as a peer review/continuous quality improvement (CQI) would be useful. Peer-review based CQI process may not be worthwhile if there is only one funding cycle left in the program.

Performance in areas other than RCBI is generally readily measurable and KPIs are not such an issue. APHCRI is managed via its planning process and programs administered through NHMRC are readily countable, and the NHMRC itself has performance monitoring in place, which is effective and should not be interfered with.

^{iv} No KPIs were developed for PHCRED as a whole, only for component parts. That may continue to be the case, although it may be possible to use some very high level indicators, such as number of PHC publications in refereed journals, as whole-of-program indicators, if they are required.

3 Specific issues

3.1 *General Practice or Primary Health Care.*

While we recognise the need for an overall focus on PHC, it is not clear that it is sufficiently accessible to GPs who have an interest in research. The number of GPs involved, while not directly quantifiable, does not seem to be large and is probably insufficient to meet program goals. A study of the workforce needs in PHC research, particularly with reference to the need for medically qualified researchers would make this more objectively assessable.

GP registrars are not specifically targeted under the Strategy, and this is also a gap.

3.2 *Indigenous PHC research issues*

The involvement of Indigenous Australians and the focus on Indigenous priorities tended to be through those University Departments with a specialised interest, not across the board. Given the level of skill that needs to be developed and maintained to undertake good research in this area, it is hard to see what other approach could be taken.

3.3 *Rural PHC research issues*

No particular rural issues required major program change other than the need to move to more secure medium term funding at the end of a funding cycle. .

3.4 *The need for a National Advisory Committee*

There are a number of issues that would be better managed if the model of state coordination was extended and there was a national advisory committee, drawn from the state/regional coordination groups (with other key stakeholders also represented) to advise the Department on the Strategy.

3.5 *Involvement of consumers in PHC research*

Consumers are represented on the advisory committees and should continue to be in future. Consumers have also recently become involved as recruits under the RDP and are proposed to be involved under the commissioned clinical research program through the NHMRC. Guidelines for the NHMRC program require meaningful consumer involvement in each individual project, with this involvement including research and advisory roles.

The NHMRC has published a Statement on Consumer and Community Participation in Health and Medical Research. This highlights the need to involve consumers in research and the need to facilitate consumer participation, including provision of resources.

4 Conclusion

We believe, on the evidence we have before us, that PHCRED has made a great difference to the capacity of the PHC sector to undertake research, evaluation and development.