Primary Health Care Research in Australia:
Considerations for the Future

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EXECUTIVE SUMMARY

This paper concludes a body of work undertaken by APHCRi to consider how dedicated primary health care (PHC) research may be funded, informed and delivered in Australia in the coming years.

Fundamental principles have shaped our thinking. Firstly recognising that PHC with its place firmly in the community, is the backbone of all health care in Australia and a vital part of a unified health system. Secondly as evidence demonstrates, PHC is an essential function of and support to the wider health system, in rising to meet the contemporary challenges of increasing health need and growing system costs. Thirdly that to develop approaches to meet these needs, policy and practice must be informed by evidence. Lastly that Australia, with the Commonwealth Government’s commitment to, and investment in PHC research, is well positioned to meet these challenges.

This paper acknowledges and wishes to build upon the work and investment in PHC research, evaluation and development which has taken place since 2000. It represents the opinions of over 50 individuals and organisations on the future of PHC research in Australia, including formal responses to a discussion paper, led by APHCRi over the last year. From these conversations and consultation we found:

- unconditional support for continued dedicated investment into PHC research, knowledge creation, translation and dissemination
- united agreement that future PHC research should be orientated to improve implementation of research outcomes into both policy and practice
- unanimous support for wider engagement of research users, including consumers, into research processes from priority setting to dissemination

Our discussions affirmed the value of existing knowledge translation and exchange mechanisms and recognised the significant successes of funded research. However our respondents wanted future PHC research and research capacity building strategies to expand to be more multidisciplinary and to support PHC practitioners undertaking formal research; including through practice based research networks, Local Hospital Networks and Primary Health Networks. Respondents looked to overseas models of PHC research funding to seek good practice which could be replicated in Australia; including moving to broader measures of research impact, engaging in formalised, supportive research to practice partnerships, and ensuring engagement of stakeholders in all elements of the research process. Building research capacity in research professionals and practitioners undertaking research, and PHC organisations using research evidence, was seen to be an area needing expansion and technical expertise.

Despite the responses being from disparate groups and individuals there was a remarkable consensus in the key elements that respondents believe should sit behind future PHC research strategies and recognition of the benefits of the strong foundation that has been established in Australia.

BACKGROUND

In 1978 primary health care (PHC) was recognised internationally through the Declaration of Alma-Ata1 as:

> ‘essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination’.

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1 [http://www.who.int/publications/almaata_declaration_en.pdf?ua=1](http://www.who.int/publications/almaata_declaration_en.pdf?ua=1)
PHC acknowledges an important fact of human health; that social determinants are a significant contributor to overall health (diagram one). It operates in a highly complex and uncontrollable environment; our communities.

Diagram one: Determinants of health are multi-layered, ranging from individual to societal factors.

In the early 2000s analyses of international evidence started to demonstrate that PHC systems at a national level are associated with lower overall national health care costs\(^3\) and that the strength of a PHC system is significantly associated with a number of important health measures\(^4\).

The World Health Organisation (WHO) considers PHC to be the pivotal factor in the design and implementation of robust health care systems\(^5\) and mounting evidence has continued to support PHC as an essential and significant contributor to the overall performance and equity of, and access to, health systems across the world.

In order to develop a strong PHC system, as an integral part of the overall health system to meet future Australian health needs and reduce overall health care costs, we need robust PHC research, based in the Australian context, which reflects policy priorities and responds to the community's needs. It is critical that this research is both driven by and informs health care policies and practice.

The current Primary Health Care Research Evaluation and Development (PHCRED) strategy (Appendix A) established in 2000 by the Commonwealth Government, acknowledges and actively addresses the crucial link between effective PHC systems, services and practice and good evidence. This recognises that understanding these system complexities is essential to PHC improvement:

> ‘The purpose of the Strategy (PHCRED) remains as being improvement to patient outcomes through better primary health care systems, services and practice. High quality and robust evidence is a critical element in health policy development’.

The investment into PHC research through the Australian PHCRED strategy over 15 years has led to significant improvements and successes in:

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\(^5\) WHO 2009

• capacity building with a growth of researcher numbers, research teams and organisations.
• increasing the body of PHC knowledge through greater research outputs, including peer-reviewed publications, reports and conference presentations, and publications in line with priority policy areas7 (also see annual reports of the Research Capacity Building Initiative grants (www.phcris.org.au) and Centres of Research Excellence (http://aphcri.anu.edu.au/)).
• knowledge translation and exchange including through formal partnerships, an esteemed national annual conference, the Primary Health Care Research and Information Service (PHCRIS) website, tools and resources.

APHCRI has a strong history of orientating its funded research to inform policy, led through a seconded Department of Health PHCRED liaison officer who, with APHCRI funded researchers and staff, delivers a program of knowledge translation events known as the ‘Conversations Series’ to the Department. There is now over two years of data on the past Conversations Series and analysis shows that this is a positive approach to presenting research findings to Departmental policy makers; from 2012-2014 there were over 1,000 attendances at Conversations Series events. A formal analysis of the 2013-14 Conversation Series was presented to the Department, by APCHRI in late 20148.

The Commonwealth Government’s insight in developing PHC research through dedicated funding is to be commended and, as our consultation verifies, is seen by stakeholders as an essential foundation in a continuing journey to build a strong PHC system to improve Australian health outcomes while ensuring system sustainability. This paper complements and supports continued efforts to focus on whole system integration demonstrating the role of PHC research and its place within and impact upon the wider health care system and health policy.

DISCUSSIONS ON FUTURE PHC RESEARCH STRATEGIES

In February 2015 APHCRI issued a discussion paper intended to stimulate discussion and thinking on PHC research and to inform the Department of Health in its future thinking on PHC research strategies, 26 responses were received from a variety of organisations.

The discussion paper was developed from a wider piece of work, following an internal review of APHCRI’s performance and a reorientation of its strategic objectives (in late 2013), to improve the implementation of funded research. This was followed in 2014, with conversations with 25 PHC research stakeholders9 and with international research partners and colleagues. These conversations were undertaken to inform APHCRI’s thinking around how to improve on the successes of the PHCRED strategy and to better understand the experiences and lessons from international PHC research strategies and models (see Appendix B for an overview of the discussion methods and respondents).

By April 2015 APHCRI has therefore gathered a considerable volume of opinion about the value of PHC research funding in Australia, the strengths and weaknesses of the approach to date, lessons from

8 Where approval from the presenters has been given, all 2014 Conversations Series presentations are available on the APHCRI website.
9 Research stakeholders include, but are not limited to; policy makers, educators, researchers, consumers/patients, communities and service deliverers/ practitioners/ providers.
international models of health and PHC research funding, and opinion on what the future of PHC research could and should look like.

The combined consultations and conversations, formal and informal, that we have had with research stakeholders in the last year offer an interesting perspective on the Australian PHC sector and the place of PHC research within it.

When combined with successful evaluations of the PHCRED programme over its lifespan and the Commonwealth Government’s intent to have greater evidence based policy and to support Primary Health Networks (PHNs) access to research, the consensus view from our extensive discussions is to continue dedicated investment into PHC research, and additionally, to expand upon current functions to improve the impact and implementation of research outcomes.

PHC RESEARCH FUTURE FUNDING PRIORITIES

Based on the feedback to our consultations, several core functions/activities were consistently identified as PHC research strategy priorities by respondents.

1. A COMPETITIVE COMMISSIONED PHC RESEARCH PROGRAMME

The rationale for a dedicated, priority driven research funding programme focused on PHC is built on recognising the importance of PHC in an effective health system. This cannot be left to chance in mainstream, researcher-driven, health and medical research funding programs. This is not to say that researchers concerned with PHC issues will not continue to compete for funds through traditional sources, however it is noted that from 2008 – 2010 NHMRC data showed that only 1% of applications for project grant funding were from the field of PHC.11

PHC research methods, and consequently assessment criteria for research proposals, reflect the essential nature of PHC which is focussed on individuals within their social, physical and cultural contexts. As such, many PHC research projects don’t fit conventional research models, such as a randomised clinical trial. It can therefore be difficult for many researchers to obtain funding under mainstream research programs. This supports the need for a dedicated PHC funding organisation and is indeed very widely supported by our discussions.

Our discussions have highlighted the value of priority driven research to respondents and their preference for future PHC research funding to remain priority driven. In the past, priorities have largely come from the National PHC Strategy and emerging needs and issues within the Department of Health and the PHC sector. However, the vast majority of respondents agreed that the nature of determining research priorities must be more inclusive, with wider engagement at all levels with stakeholders and research end users. This would have the additional benefit of improved opportunities for implementation, and was a foundational value which sits behind and complements all other feedback elements.

The preferred approach by respondents is for dedicated PHC research funding across a broad spectrum of research. This would include the continuation of Centres of Research Excellence (CREs) and ‘stream’ research (shorter research projects focused on emerging issues and responsive to changing needs) but shows an appetite for other funding approaches including ‘foundation’ grants, rapid response research and practitioner focused research (e.g. with PHNs and Practised Based Research Networks (PBRNs)).

2. KNOWLEDGE TRANSLATION AND EXCHANGE

10 The Department of Health primary health networks Grant Programme Guidelines November 2014 – Version 1.0
The feedback we received unanimously supported the functions of Knowledge Translation and Exchange (KTE). KTE was highly valued by different groups of responders for different reasons. For example, for many PHC organisations and PHC service providers, information disseminated by PHCRIS gives them easy access to best practice literature, resources, tools and information and in some cases may be their only access point to this information. For academics, PHCRIS services and tools give a central point for the PHC research community to exchange information and ideas, share expertise and opportunities, develop collaborations, and build capacity through shared resources, events and knowledge dissemination activities.

Improvements were suggested around KTE approaches, largely by extending the current platforms. For example one response noted that a route to better sharing PHC research outcomes could be to take an approach like the UK National Institutes of Health Research (NIHR) journals library\(^\text{12}\) to include a publication for the PHC sector specifically dealing with the application of applied PHC research. Other feedback included targeting a wider range of professional groups in KTE strategies, for example schools of nursing, pharmacy and dentistry.

### 3. ENGAGING THE BENEFICIARIES OF RESEARCH

PHCREDS has focused clearly on health policy development as an outcome of the strategy. Whilst this is recognised as a vital requirement in our consultations, a much wider group of beneficiaries of PHC research outcomes have been identified. Specifically, this has acknowledged the benefits of research outcomes for: consumers as patients/carers and community members; service providers as individuals looking to improve practice or organisations (Indigenous health, primary health care, non-government organisations and acute sectors) looking to improve systems; educators in workforce planning and development for future PHC service providers and researchers; policy makers in supporting and building evidence-based policy; and of course researchers in growing the body of knowledge to be developed and shared.

In discussing beneficiaries of research we identified a perceived barrier to implementation; whilst the outputs of PHCREDS were very warmly regarded many people felt that their knowledge needs were not currently met by PHCREDS priorities and supported this with the growing evidence on improving implementation of research evidence through better engagement, co-creation, co-design, co-researching and partnerships. It was noted that the PC4 initiative\(^\text{13}\) has demonstrated benefits of consumer engagement early on in research processes. An appetite for greater engagement across disciplines, with peak bodies, PHC organisations, representation bodies, and the wider health industry was also established.

It was noted that with increased focus for both PHNs and LHNs on reducing avoidable hospital admissions, improving integration between health sectors and reducing duplication of effort and resources; prioritising systems research and engaging widely to improve implementation of outcomes in these areas would be invaluable.

Unanimously, our respondents saw significant benefits in terms of achieving the purpose of the PHCREDS strategy, ‘improvement to patient outcomes through better primary health care systems, services and practice’, in the engagement and involvement of a far wider breadth of research users in the whole PHC research process from research priorities to grants, projects to dissemination. It was proposed that a clear set of principles to underpin and drive the next phase of PHC research funding should be developed, articulating this wider engagement approach.

### 4. BUILDING RESEARCH TO PRACTICE IMPLEMENTATION PATHWAYS

All respondents agreed that a focus on implementation is of key importance and wider stakeholder engagement into, and throughout, the research processes at a national and project level would support this. Co-production and co-design

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\(^{12}\) [http://www.nihr.ac.uk/research/nihr-journals-library.htm](http://www.nihr.ac.uk/research/nihr-journals-library.htm)

are seen as a way forward to better achieve current PHCRED objectives and improve implementation of research outcomes.

Many responders felt that PHCRED has been too General Practitioner (GP) focused and has not therefore maximised opportunities to engage with and make the most of other health professional’s skills and expertise. The majority of respondents felt that future strategies need to support capacity building, knowledge creation and sharing across a much broader range of PHC professional groups and into the wider health system to expand capacity building and implementation pathways.

PHNs were seen as both drivers and hosts of research projects and research capacity building initiatives, with academic support. Their role as both feeding into priority setting and providing pathways for implementation was widely supported. Similarly, existing local research partnerships between PHC organisations (Medicare Locals), Local Hospital Networks (LHNs) and academic institutions in some local and regional areas are seen as a successful and established conduit for driving; research to practice translation, evidence based practice, performing partnerships and better research implementation. Whilst many respondents saw benefits of linking with LHNs, PHNs and PBRNs, there was a concern that challenges may be met in engaging PHNs to develop research partnerships given that this is not mandated in their brief; though it could form part of their contract with their funder, and engaging LHNs. In addition to the issue of engagement of PHNs some responders raised questions about coordinating PHNs, sharing learning and disseminating evidence across the national network in the absence of a national coordinating body. However the Department of Health in the PHN Grant Programme Guidelines November 2014 – Version 1.0 commit to drive this coordination:

‘The department will carry out a range of support functions for PHNs to provide national direction and to support high performance of PHNs... National systems will be developed to encourage the sharing of information, improve administrative efficiencies and minimise infrastructure costs across PHNs. The department will also encourage continuous improvement through collaboration, assist in the analysis of needs assessments to inform national priorities and ensure PHNs have access to best practice research.’

Increasing investment through these existing support structures to PBRNs, LHNs and PHNs to better enable access to and engagement in research lifts the possibility of widening current PHCRED objectives in a future PHC research strategy. If this is coupled with expanded academic leadership and wider KTE platforms, respondents suggestions in relation to supporting delivery of their suggested core functions, can arguably be achieved.

Discussion around the best research translation approach by respondents was also helpful. Use of the US National Institutes for Health (NIH) research translation model as a potential model for Australia met with polarised views. Several respondents felt the NIH model is too clinically focussed to allow for the health systems research largely funded by APHCR (PHCRED) at present. Other feedback included concerns around a perceived lack of potential for consumer involvement at each translation stage in the NIH framework.

Many respondents felt strongly that an approach for future Australian PHC research funding should be more similar to that of the UK’s National Institutes of Health Research (NIHR) (see Appendix C). Specific strengths of the NIHR model valued by respondents included:

- it’s focus on measuring research impact (discussed above);
- wide engagement mechanisms with multiple stakeholders (particularly consumers); and,
- the benefits of formal research to practice links.
The latter point was highlighted by several respondents; specifically the NIHR Collaborations for Leadership in Applied Health Research and Care (CLAHRCs), collaborative partnerships between universities and their local NHS organisations which are focused on improving patient outcomes through the conduct and application of applied health research.

5. RESEARCH OUTCOMES: IMPACT

Several respondents discussed perceived barriers to implementation of research evidence, one such being the performance measures of research. Traditional academic metrics of grant funding and publications don’t generally drive researchers to look at the impact of their work on practice and policy. Respondents suggested that more emphasis on measuring impact indicators focused on outputs such as collaborative partnerships, capacity building and community engagement would considerably change the research process itself. Several respondents felt that an important role for any future Australian PHC research strategy is to try to shift PHC research performance measures from traditional metrics to translational types of outputs and impacts. This was seen to be a significant achievement of the UK’s NIHR and suggestions were put forward that Australia could learn from this example. APHCRI’s discussions with international colleagues also reveal that a body of work around impact outcomes measures is developing in the Canadian Institutes of Health Research (CIHR).

Other suggestions to improve impact focused on developing stronger research partnerships with support for stronger partnerships between research organisations and practitioners/service providers. Partnerships provide organisations with opportunities to create greater impact and to bring to bear results that they could not have produced alone. Anecdotal evidence from established and emerging research/practice partnerships between academic institutions and LHNs and/or Medicare Locals supports this.

6. RESEARCH CAPACITY BUILDING

Most respondents to our consultations felt that PHCRED has excelled to date in building capacity in a sector that had suffered from a paucity of investment before the strategy was developed. Given that we are in a time of significant PHC reform and given the recognition that PHC offers significant benefits to the health sector and health economy, most respondents stated the necessity to continue to build PHC research capacity. Whilst there was a spectrum of opinion on how this may be delivered and targeted, common feedback themes included:

- Research leadership providing technical advice and support to PHC researchers, service providers and PBRNs. Suggestions included academic outreach, training and mentorship, ethics approval guidance, evaluation methods, health economics, implementation research and sharing outcomes. Within this approach was recognition for a wider focus on capacity building to target PHC practitioners (clinicians) and PHC organisations which are already developing and undertaking research; specifically support to build robust evidence. Feedback importantly noted the need for planning around workforce development needs of ‘non-academic’ researchers (e.g. practising clinicians and/or staff in PHC organisations).
- In phase three of PHCRED the role of capacity building was redirected from the Research Capacity Building Initiative (RCBI) and built into Centres of Research Excellence (CREs) activities. Feedback showed that whilst this has been beneficial to career pathways in CREs it was perceived to be at the loss of wider capacity building initiatives targeting non GP PHC researchers, part-time academics or clinicians undertaking research. Many responders supported more ‘bottom up’ capacity building initiatives; targeting junior and mid-career researchers, through knowledge sharing more broadly and supporting more PHC practitioners as researchers and research informers.

14 http://www.clahrcpp.co.uk/
To increase opportunities for implementation, several respondents noted the need to build capacity for research literacy and implementation research literacy across universities, agencies, non-government organisations and others, not just amongst researchers, for example, through practitioner support and scholarships.

Engagement with stakeholders was very widely supported with acknowledgement of a required investment to build research engagement and research literacy with consumers.

7. HOW SHOULD CAPACITY BUILDING STRATEGIES BE TARGETED?

Identifying who undertakes PHC research and how this adds value to the creation and sharing of knowledge has been a very useful discussion. Two valued researcher profiles were identified by respondents: ‘career researchers’, usually working in an academic institution which may run a conventional research program (e.g. through an APHCRI grant or a CRE) and ‘practitioner-researchers’ (e.g. a GP/researcher possibly even with a joint appointment) who are supported, often on a shoestring, to engage in research by local/ regional initiatives, networks (e.g. PBRNs) and/ or organisations. The responses to our discussion paper showed that funding to both of these research professionals offers different PHC benefits and builds different capabilities, knowledge bases and platforms for implementation.

APHCRI and PHCRIS have recently undertaken a joint project; ‘Building the primary health care research workforce in Australia’, to investigate the PHC workforce and strategies to develop it. This body of work forms an essential background to future PHC research workforce development strategies. Responses to our discussions and evidence from the ‘Building the primary health care research workforce in Australia’ project show that future PHC research strategies should support both professional groups of ‘career researchers’ and ‘practitioner researchers’ in line with strategy objectives. This recognises that PBRNs, PHNs and other practitioner based research programs bring a different element into the research undertaken than the more structured CRE and stream approaches.

8. PRACTICE BASED RESEARCH NETWORKS (PBRNS)

PBRNs are local networks of PHC professionals and academics who work together to answer PHC questions to improve health, to translate research findings into practice and to engage clinicians in quality improvement activities and an evidence-based culture in PHC practice. PBRNs serve as a ‘laboratory’ for the study of populations utilising PHC services, and investigating problems seen in PHC, focusing research firmly on patients and diseases in the community. PBRNs therefore offer an implementable evidence opportunity for both clinical practice improvement and for supportive policy to underpin good practice.

The PHCRED Strategy has provided an important step in the development of PBRNs in Australia with phase two PHCRED goals enabling some universities to establish PBRNs for GPs and allied health professionals, many of which floundered in PHCRED phase three where these capacity building funds were re-directed. Recently APHCRI has commissioned the Australian Primary Care Research Network (APCReN) run by the Australasian Association for Academic Primary Care (AAAPC) and the University of Melbourne, to provide national support and resources to PBRNs (a larger but similarly oriented PBRN resource centre also operates in the USA10). The work of APCReN to support PBRNs has been highly valued and many respondents felt that investment into building PBRNs would offer a future PHC research strategy valuable knowledge creation coupled with valuable implementation opportunities. APCReN has recently surveyed 23 PBRNs on a range of issues including support needs and research interests, offering an evidence base on which to build future PBRN support strategies.

16 The USA’s PBRN Resource Centre at the University of Indiana provides resources and assistance to clinical and health services research taking place in Primary Care PBRNs. http://pbrn.ahrq.gov/resource-center
The provision of resources and research supports is closely aligned with building capacity initiatives. However in addition to technical expertise KTE (point two, above) and building research to practice implementation pathways (point four, above), specific research support tools were identified by respondents as being required to better equip PHC researchers to do their jobs, for example pointing to overseas tools such as the Dartmouth Atlas/ NHS Atlas which allow researchers to better understand local and regional health profiles. Whilst there have been improvements in access to population health data availability in Australia (Medicare Local / PHN objective) health service use data is much less accessible. Respondents supported investment into developing such resources.

A greater emphasis on quality improvement in PHC service delivery is a key feature of the new PHN environment and the link between implementation research and quality improvement was also brought into the discussion. Despite a significant body of work undertaken by the RACGP, Australia does not have a comprehensive, structured approach to PHC quality improvement. Similarly no organisation is tasked to systematically support quality improvement; the Australian Commission on Quality and Safety in Health Care has not addressed PHC to date, whilst the Improvement Foundation’s delivery of the Australian Primary Care Collaboratives has not been able to comprehensively reach the bulk of General Practice.

Continuous improvement requires a more pragmatic approach than standard research methodologies allow and it was suggested by responders that a future support service should provide quality improvement services to PHC organisations and providers to create “learning communities, providing grounds for generalizable solutions to clinical problems, and engines for improvement of primary care delivery systems.” By linking quality improvement strategies to PHC research structures including PBRNs and PHNs a future PHC research strategy could begin to provide activities and resources to enable continuous quality improvement strategies.

**DELIVERING THE VISION**

APHCRI’s focus in undertaking a wide discussion with research stakeholders about the future of PHC research has not primarily been concerned with how the future strategy might be delivered. Our intent was to stimulate discussion and thinking on future PHC research and to inform the Department of Health in its future thinking on PHC research strategies. However, in determining how a future PHC research strategy could be delivered, several of principles were established by respondents:

- Firstly, to deliver a PHC research strategy to meet contemporary PHC issues/ requirements, a single governance structure, with broad representation from research stakeholders, should be established.
- Secondly, new skills and competencies need to be brought into the delivery model; to widen the scope of research, support priority setting and better enable implementation.
- Thirdly, structures and enablers to support research to practice implementation should be facilitated.

It is initially more important to establish the rationale, benefits and approach to dedicated PHC research funding that is implementation focused rather than organisational arrangements. The structure and organisational/hosting arrangements we expect to follow and be fit for purpose.

**CONCLUSION**

This discussion was intended to build on the excellent work of the PHCREd strategy, the existing commitments and interests of the Department and to improve future PHC research strategy alignment with health reforms which have taken place since the establishment of the PHCREd strategy (such as the establishment of LHNs and PHNs).

As with any discussion, opinion varied, organisations and professional groups pursued agendas which are important to them and gaps in the information presented by APCHRI were identified. However, this discursive process has led to identification of common values about the place of and future investment in PHC research in Australia. Respondents acknowledged that with the growing pressures of increasing chronic conditions, ageing and expectations of health consumers leading to expected health care costs in an era of tightening economies, PHC has a vital and growing role to play. The response to this fact, from our discussion, is to invest wisely in evidence based strategies to drive informed PHC policy and practice.

The vast majority of respondents to our discussions believed that the future delivery model for a PHC research strategy should include:

1. dedicated funding for PHC research
2. support for engagement of stakeholders including policy makers, educators, researchers, consumers and PHC service providers/ organisations and peak and representative bodies across the research process
3. establishing and supporting an implementation orientation in all research processes
4. an organisation to:
   a) form formal relationships with a wide range of stakeholders and research end users, at all levels, including at a governance level
   b) set research priorities, commission, support and manage and disseminate research with a single governance process
   c) commission research at multiple ‘levels’ from CREs to PBRNs
   d) provide skills and technical expertise to build capacity across a broad spectrum of stakeholders (for example: implementation research methods, evaluation, health economics, statistical analysis, literature reviews, ethics approvals, implementation advice and research literacy)
   e) continue and expand wide ranging KTE activities
   f) work closely with the Department in their role as the national support to PHNs; this may include working in partnership to develop quality improvement and best practice approaches
   g) move towards measuring impact outcomes in commissioned research
   h) build capacity for rapid response research to meet the needs of Departmental policy makers
5. recognition that implementation approaches will necessarily include activities to engage and support a wider range of researchers, across professional disciplines and with organisations to increase the creation of knowledge in ‘real world’ settings. Specifically this included PHNs and PBRNs
6. investment in formal research partnerships to support and inform alignment of LHN’s and PHN’s priorities around integration, hospital avoidance and reduced admissions with a suggestion that all organisations in a partnership should make a financial or in kind contribution (evidence from CLAHRCs in UK has supported this).
APPENDIX A: PHCRED STRATEGY

The Primary Health Care Research, Evaluation and Development (PHCRED) Strategy was established in 2000 by the Australian Government to improve Australia’s capacity to produce high quality research and increase the capacity of the primary health care sector to meet the health care needs of the Australian community.

Currently, the PHCRED strategy is in its third phase and focuses on three broad elements\(^{22}\), to:

- continue to build capacity in the primary health care research sector
- add to the body of knowledge and evidence of primary health care research and
- actively promulgate primary health care research to engender effective knowledge exchange.

The third phase of PHCRED consists of the following three components:

- The Australian Primary Health Care Research Institute (APHCRI) which supports priority-driven research and embeds it into policy and practice.
- The Primary Health Care Research and Information Service (PHCRIS) which collects and disseminates relevant primary health care information and knowledge.
- National Health and Medical Research Council (NHMRC) Career Development and Early Career Fellowships which provide direct support for research in priority areas.

Over this period (2010-2014), the PHCRED Strategy is focused on the following priority areas of the National Primary Health Care Strategy\(^{23}\):

- improving access and reducing inequity
- better management of chronic conditions
- increasing the focus on prevention and
- improving quality, safety, performance and accountability.


APPENDIX B: CONSULTATION METHODS AND RESPONDENTS

In late 2013 APHCRI undertook an internal evaluation of its effectiveness in delivering the objectives of the PHCRED strategy; this was in addition to the Commonwealth Governments formal PHCRED evaluations. The outcomes of this evaluation noted APHCRI’s successes in building PHC research capacity, increased PHC research knowledge outputs including publications, and effective translation of knowledge; particularly to policy makers.

Despite these successes however, APHCRI recognised that similar to many other research fields, evidence of implementation of its funded research outcomes (as opposed to traditional research performance metrics), particularly with regard to PHC practice, could not be quantified. Furthermore, anecdotal evidence suggested that as in other research sectors, capability in research implementation was underdeveloped within the PHC research sector.

Based upon the outcomes of its internal evaluation APHCRI reviewed its strategic objectives and included a goal to drive the implementation of research into primary health care policy and services. Specific activities to achieve this goal included recruiting a Research Implementation Coordinator in November 2013 with a brief to build an understanding of implementation research approaches with respect to PHC research and to develop thinking to support its achievement in future Australian PHC research strategies.

As part of this process the Research Implementation Coordinator undertook interviews with leaders in the fields of PHC policy, practice, research, education and experience (as consumers) in 2014. A small group of individuals were identified and contacted for interview; snowballing techniques were then used to engage other PHC, health and research leaders in these conversations. Semi structured interviews, lasting between 30 – 60 minutes were held with a total of 25 individuals by telephone. Interviewees were asked questions including:

- What do you understand by the term implementation research?
- Do you feel research generally is well implemented into policy and/ or practice?
  - Can you give an example of this?
- What PHC research are you aware of?
- Do you feel that PHC research priorities reflect your priorities?
- In your experience have PHC research outcomes been available to you/ how have you used these research outcomes?
  - What would help you in terms of accessing PHC research or influencing PHC research?
- Engaging a wide range of research users into PHC research has been shown to have an impact upon the implementation of research outcomes. How would you feel about engaging with researchers/ research users more?
  - Have you done this?
  - What have the results been?
- What kind of research/ practice/ policy relationships do you have locally/ regionally/ nationally?
  - What are the strengths and weaknesses/ benefits and challenges of these approaches?
- Do you know of any effective local/ regional/ national/ international research – policy/ practice relationships?
- Have you ever been part of a funded research project by APHCRI/ NHMRC/ ARC – what learning would you share from that?

Interviewees included representatives from:

- Commonwealth Government Department of Health staff
- Medicare Local Board Members and Executives
- PHC research leaders (Chief Investigators)
- Health systems research leaders (Chief Investigators)
- Consumer representatives
- Senior health care providers (including Local Hospital Networks)
- National Health Performance Authority
- Implementation research experts

Further to these interviews, the Research Implementation Coordinator investigated International PHC research strategies and models and held conversations with international research organisations, partners and colleagues (including the Canadian Institutes of Health Research, The Robert Graham Center (USA), the Agency for Healthcare Research and Quality (USA), the National Institute of Health Research (UK) and ZONMW (the Netherlands)).

Based on its internal evaluation, national and international conversations, APHCRRI developed and issued the ‘Supporting PHC Research – Future Directions discussion paper’ for national consideration in February 2015 and received 26 responses from individuals and Organisations. Respondents who agreed had their feedback shared with the Department of Health, and all responses were analysed and collated into this paper. A list of respondents who agreed to share their responses to the discussion paper is provided below:24

- Dr Paresh Dawda, Adjunct Associate Professor; Visiting Fellow APHCRRI, Australian National University, ACT.
- Dr Chris Del Mar, Professor of Public Health; Bond University Gold Coast, QLD.
- Dr Oliver Frank, General Practitioner; Oakden Medical Centre, SA.
- Professor Jeanine Young, Professor of Nursing, University of the Sunshine Coast, QLD.
- Professor Lyndal Trevena, Primary Health Care Head, on behalf of Discipline of General Practice, University of Sydney, NSW.
- Dr Kirsty Douglas, Professor of General Practice, Australian National University Medical School, ACT.
- Dr Kevin McNamara, Senior Research Fellow Flinders University SA and Deakin University VIC/ Adjunct Senior Lecturer, Centre for Medicines Use and Safety, Monash University, VIC.
- Services for Australian Rural and Remote Allied Health (SARRAH), Deakin, ACT 2600.
- Dr Ian McRae, Research Fellow, APHCRRI@ANU, Australian National University, ACT.
- Dr Kim Boyer, Senior Research Fellow, University of Tasmania, TAS.
- Townsville Mackay Medicare Local, QLD.
- Dr Ian McRae, Research Fellow, APHCRRI@ANU, Australian National University, ACT.
- Services for Australian Rural and Remote Allied Health (SARRAH), Deakin, ACT 2600.
- Dr Ian McRae, Research Fellow, APHCRRI@ANU, Australian National University, ACT.
- Dr Kim Boyer, Senior Research Fellow, University of Tasmania, TAS.
- Townsville Mackay Medicare Local, QLD.
- Australian Nursing and Midwifery Federation (ANMF), ACT.
- Public Health Association of Australia, Primary Health Care Special Interest Group, ACT.
- Dr Rosalie Schultz; Central Australian Aboriginal Congress.
- New South Wales Medicare Locals, NSW.
- Southern Cross University.
- Australasian Association for Academic Primary Care (AAAPC), VIC.
- Primary Health Care Research and Information Service (PHCRIS), SA
- Cohealth, VIC.
- Dr Margaret Allman-Farinelli, Professor of Dietetics, University of Sydney, NSW.
- ACT Medicare Local
- ACT Health
- Consumers Health Forum of Australia

24 NB some organisations chose to respond anonymously
APPENDIX C: NIHR (UK)

The UK’s National Institutes of Health Research (NIHR) funds innovative scientific research, driving more rapid translation of scientific research outcomes into demonstrable benefits for consumers and the community. It works in partnership with many sectors including other Government funders, academia, not for profits and industry.

The NIHR manages its health research activities through four main work themes:

- Infrastructure: providing appropriate facilities and people for a flourishing research environment
- Faculty: supporting individuals undertaking and participating in research
- Research: commissioning and funding research
- Systems: creating unified, simple, streamlined systems for managing research and research outputs.

The following diagram shows the NIHR health research system, with the interests of patients and the public at its heart.

25 [http://www.nihr.ac.uk/about/]