# The Australian Primary Health Care Research Institute: rising to the challenge of applying knowledge from research to Australian policy

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*The APHCRI projects in this supplement have strengthened capacity and increased policy-relevant knowledge, but primary health care researchers and policymakers need to work much more closely together if evidence is to contribute to decision making*

The Australian Primary Health Care Research Institute (APHCRI) was established in 2003 with funding from the federal government and began work in earnest in 2004. It represents a distinctive and welcome addition to the health care policy and research landscape in Australia. Nicholas Glasgow, the Director until recently, and his colleagues state in this supplement (*page S46*) that APHCRI

> has a specific focus on the links between primary health care evidence and policy. Its activities not only fund research programs, but also seek to build capacity within the research community and policy community to facilitate the adoption of evidence into policy.[1]

So what do the projects from the Institute's "Stream 4" initiative, reported in this supplement, tell us about the Institute's progress towards its admittedly demanding objectives and the future challenges it faces?

In brief, a report card against APHCRI's three objectives might read:

1. To strengthen the knowledge base of primary health care by conducting and supporting research: sound progress commissioning research on important policy initiatives and issues;
2. To facilitate the uptake of research evidence in primary health care policy and practice: some progress in a difficult environment in building research–policy links, but opportunities ahead to make this a major focus; and
3. To enhance research capacity in primary health care through strategic partnerships with other relevant national and international groups: substantial, well directed investment likely to build future research capacity.

What is the justification for this assessment of the Institute at this interim stage of its development, particularly the verdict in relation to its second objective?

First, the review projects presented in this supplement demonstrate many of the difficulties facing researchers in connecting with the health care policy process (ie, the interplay between government ministers, officials, professional bodies, professionals, patients and their representatives) where there is little tradition of such interaction. This is made more complex in Australia's federal system of government, where health policy decisions, as well as decisions on research, are made at more than one level.

The Box in the overview article by Glasgow et al describes the APHCRI systematic review process as deliberately involving discussions with reference groups and stakeholders on at least two occasions in the development of each review, in order to help provide a policy context for any recommendations that might be produced.[1]

Yet it is a pity that so little of this innovative thinking and activity has found its way into print here, except for a tellingly honest, though understated, comment from Glasgow et al that "participation by policy advisers in the structured sessions in Canberra was…variable".[1] They go on to mention the time pressures on senior officials that hampered their involvement in these sessions and the reluctance of more junior officials to discuss issues arising from the research in the presence of the researchers themselves. There is no analysis of the reasons for this and how APHCRI, researchers and policy agencies might work better together in future to ensure more sustained interactions. Both will be very important for the Institute's future development.

It is also notable that none of the supplement's articles was coauthored with policymakers or policy influentials. In addition, the reflections of policymakers themselves (eg, their reactions to the systematic reviews or the way they were developed or the ways in which they have or have not been able to use them) are completely absent.

All this suggests that the outputs presented here represent the *start* of a process of dialogue, interaction and network building rather than anything like the "finished product" from the point of view of forging a new set of transformative relationships between primary health care researchers, professionals and policymakers. It is now well established that exploiting existing formal and informal networks is crucial for conveying the implications of evidence to clinicians and opinion leaders, as most mainly rely on their own and their colleagues' experience and other sources of largely tacit knowledge for guidance.[2]

A reluctance of officials from departments of health to become visible or comment on the Stream 4 initiative speaks strongly of a policy environment marked by great sensitivity on the part of civil servants to being seen engaging in discussions that may touch on options that turn out to be different from the eventual direction chosen by their ministers. If this is a pervasive concern to avoid accusations of embarrassing the government, it makes it very much harder for the research community to develop the informal relationships of trust needed to contribute to policy development and for officials to feel confident talking with researchers. For relationships to build, it must be seen as desirable for civil servants to inform themselves fully about contemporary policy issues, even if this means discussing topics that do not reach the policy agenda.

The second reason for the above assessment of progress is the lack of discussion of the Australian institutional context. Yet the aim of Stream 4 was to:

> … systematically identify, review, and synthesise knowledge about primary health care organisation, funding, delivery and

performance and then consider how this knowledge might be applied in the Australian context.[3]

If any of the thorough reviews of evidence are to be used, they will have to be applied to, and adapted in, the Australian environment. For example, the current, strongly defended arrangements for organising, paying for and regulating primary health care professionals are highly relevant to most of the implied changes in Australian primary health care discussed by the review teams, but are scarcely mentioned. At the very least, one would have expected reviews explicitly to consider how findings from other countries and systems might have to be adapted, and, in turn, how certain preconditions might need to be in place for interventions known to be effective elsewhere to be implemented in Australia. For instance, Powell Davies et al (*page S65*)[4] show the effectiveness of coordinating mechanisms in primary health care, particularly more structured relationships between providers, multidisciplinary teams and patient enrolment, without mentioning that such arrangements are most difficult to introduce in pluralist primary health care systems like Australia's and that wider, systemic changes might be needed for effective coordination.

Instead, there is a familiar emphasis on distilling a kind of generalised, free-floating evidence unrelated to any specific opportunities for change (perhaps this is not surprising, given the nature of the policy environment). The article by Naccarella et al (*page S73*)[5] goes the furthest to identify the structural and incentive issues at the heart of some of the problems of Australian primary care, but pulls back on the brink of suggesting policy options. In general, the supplement authors need to team up with colleagues who have been analysing and commenting on the wider health system to understand better where the opportunities and "space" for change might lie.

Finally, the articles say little about how the findings can be turned into acceptable, practicable and sustainable changes in primary health care within a complex political system. This is hard to do, but is made even harder if it is not mentioned. For example, McDonald and colleagues (*page S84*),[6] writing about growth faltering among Indigenous children living in poor, remote communities, tantalisingly mention the divergence between recent government policy and their evidence of what would benefit Indigenous children in future, but refrain from analysing why this divergence came about and how it might be overcome.

None of these observations is intended to give the impression that facilitating the use of research evidence in policy and practice is easy or quick work, or that APHCRI is peculiarly deficient. Indeed, a recent distillation of what we know about using evidence for public policy[7] concludes that:

- Use of research is highly contingent and context-dependent (it may well be that Australia's multilevel policy process, and political and public management culture, is particularly inimical to the "linkage and exchange"[8] attempted by APHCRI);
- Multiple sustained, interactive social processes that encourage the use of research hold the most promise;
- Strategies need to be focused on organisational culture rather than individuals; and
- Strategies should recognise that conceptual uses of research (ie, shifting understanding of a phenomenon or introducing new ways of thinking about possible responses) are at least as important as instrumental uses.

These conclusions suggest that it will take more than 4 years for a new research-to-policy Institute to develop its place in the complex policy environment that surrounds governments and to become regarded as a trusted source of "intelligence" and advice. APHCRI should be given the time to do this.

The challenge now for APHCRI and its funded researchers is to work with key policy and management bodies to link into organisational processes and practices so that they can make a clear difference to primary health care policy, services and outcomes over the next 4 years.

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