

Australian Medical Research and Innovation Five Year Strategy

Title: Focusing on client-centred care and primary health care

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CREATING A TRULY CLIENT-CENTRED HEALTH SYSTEM

The gap: There is now strong rhetoric about patient-centred or client-centred care in the Australian health system. As well as increased consumer expectations, a key driver of this trend is recognition of the limitations of evidence-based medicine.¹ While evidence-based medicine provides important information about treatments and risks at the population level, evidence-based treatment regimes do not necessarily align with the goals, preferences, or values of individual patients. Evidence-based practice guidelines can be of limited value in real-world decision-making.² This is particularly so for people with complex health and support needs (including but not limited to those with multi-morbidities), because guidelines are generally disease-specific, and also do not account for heterogeneity of treatment effects but represent an “average” effect at the population level.

Supporting the creation of a truly client-centred health care system is perhaps the most important innovation that the Australian Medical Research and Innovation Strategy (the Strategy) can deliver, with significant potential to impact on the quality, efficiency and effectiveness of the Australian health system. A more client-centred health system is an end in its own right, with responsiveness one of the defining goals of a health system.³ It also has the potential to increase efficiency of the system, by improving self management and therefore reducing complications of established disease; by better aligning care provision with patient choices and therefore reducing unnecessary or unwanted interventions; and by using efficient technologies that are widely used in other sectors and often preferred by clients (e.g., electronic communications).

Addressing the gap: A commitment to improving client-centred care should be reflected not only in the topics of research funded under the Strategy, but also in the governance of the Strategy and the selection criteria and selection processes for what is funded. The Strategy should support the development of the evidence base relating to client-centred care and the translation of this evidence into more client-centred practice, by:

1. Specifying client-centred care as a priority topic.

There are many existing gaps in knowledge and practice. For example, while there is evidence that goal-directed care planning approaches can improve self-management of chronic conditions and clinical outcomes,⁴ challenges remain in how to embed this in routine clinical practice. Framing the change as a ‘paradigm shift’² underlines the transformational nature of the adjustment required. Another gap is the lack of a consistently-used, standardised, validated measure of client experience; and related questions such as the impact of incorporating client experience indicators into funding incentives or service agreements.

2. Establishing mechanisms for meaningful community engagement in the governance of the Strategy.

The involvement of health service users in decisions about the Strategy and its implementation will support greater prominence of client and patient perspectives in funded research, ultimately leading to better outcomes for people and for the health system. The National Institute for Health and Care Excellence (NICE) in the UK provides multiple avenues for engagement, accessible through a “Get Involved” button on its home page.⁵ At present, such opportunities in Australia are limited.

3. Supporting meaningful community engagement in funded research.

Engaging community members in the design and implementation of research can have positive impacts on quality and appropriateness, but the available evidence is limited and further research is required.⁶ Research funding guidelines need to include resources for client engagement as an approved component in research budgets (where appropriate). Resources

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may be required to support patient or client advisers to engage meaningfully within research project governance structures; to ensure engagement with particular groups who experience barriers to such participation (e.g.: resourcing interpreters or translators; providing training and support for community advisers; resourcing dissemination of research findings in non-traditional modes; etc).

4. **Ensuring that a range of outcome measures are used in research, not just narrowly-defined clinical indicators.**

One of the major limitations of existing research is the use of narrow clinical outcomes, which do not align with the outcomes that are meaningful and important to individuals.¹ Although greater attention is being paid to patient-relevant outcomes (such as social role functioning as well as physical functioning, and symptoms such as pain), research using individual patient-identified goals is scant.⁷

Fit with building blocks: The approaches proposed above align with a number of the Aims and Objectives of the Strategy, particularly “an excellent and responsive health and medical research system that improves lives”. The proposals complement existing processes and approaches (e.g. those of the NHMRC) and will position Australia at the cutting edge of health systems research.

Measures of success: Potential indicators of success include: development and implementation of community engagement mechanisms; number/proportion of funded research projects with community engagement mechanisms; number/proportion of funded research projects investigating client-centred care; analysis of the range and type of outcome measures used in research.

SUPPORTING PRIMARY HEALTH CARE (PHC) RESEARCH AND DEVELOPMENT

The gap: Primary health care (PHC) research has traditionally not fared well in mainstream funding programs. In the NHMRC project grants program, for example, about 1% of funding is directed towards PHC research.⁸ Recognition of this lack of fit, and of the importance of building capacity in PHC research, led to the PHC Research Evaluation and Development (PHCRED) Strategy in 2001. This Strategy incorporated a range of mechanisms and initiatives designed to build the primary health care research capacity and evidence base.⁹ These included the Australian Primary Health Care Research Institute (APHCRI), the Primary Health Care Research and Information Service (PHCRIS), centres of research excellence, researcher development programs and research grants. PHCRED has now concluded, with both APHCRI and PHCRIS ceasing operations and no new research funding available.

However, the systemic barriers experienced by PHC researchers and clinicians, which was part of the rationale for the establishment of the PHCRED Strategy, have not been addressed. Dedicated medical researchers only contribute about half of all research time, with medical professionals who are primarily clinicians contributing the other half.¹⁰ And while 15% of clinical specialists spend some of their time undertaking research, the figure for general practitioners (GPs) is less than 1%.⁹ Unlike specialists, GPs do not have the benefits of an institutional setting to support such work (e.g. salaried roles; research infrastructure).

Despite the cessation of the PHCRED Strategy, the need for research in PHC has not diminished either – if anything, it has increased. There is clear evidence that improvements to the primary care sector have the potential for significant gains across the health system, boosting efficiency and improving outcomes.¹¹ Furthermore, this sector is where the majority of Australians interact with the health system: 4 out of 5 people visit a GP each year.

In addition, primary care providers play a crucial role in relation to chronic conditions, which dominate the burden of disease. First, many chronic conditions are most effectively managed in the primary care setting using a multi-disciplinary team approach, and supported where required with specialist input. Second, the risk factors contributing to the development of chronic conditions are also the focus in primary care rather than acute settings. This further underlines the potential for health system gains through enhanced primary care.

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Addressing the gap: The Strategy should support primary health care research, by:

5. Specifying primary health care as a priority topic.

Many of the most important questions, and those which have the greatest potential to produce gains in efficiency, effectiveness and health outcomes, relate to primary health care. For example, a recent paper identified that, while further research is needed on effective strategies to improve equity of access to PHC for vulnerable populations, a range of innovative strategies could be identified as currently in use, mostly in the community health sector, but also in general practice and using outreach models.¹²

The greatest potential for population-level health gains is through addressing social disadvantage - a leading modifiable risk factor for poor health outcomes.¹³ Groups that experience a higher level of disadvantage have higher prevalence of chronic disease,¹⁴ and are therefore high service users. Therefore research on the social determinants of health, including determinants of access to health care, should be a priority topic under the Strategy.

6. Ensuring that selection criteria and selection processes are appropriate to the types of research questions and methodologies used in primary care research.

Questions relating to models of care, effectiveness of preventive strategies, equity of access etc; are investigated using a range of methodologies and research disciplines other than randomised controlled trial designs and/or clinical outcomes. This is particularly the case for translational research. The selection processes used for research under this Strategy must draw on expertise across a broad range of disciplines and methodologies.

7. Using a range of indicators of the value and impact of research, in assessing applicant track records and proposed and actual research outcomes.

The NHMRC has moved away from the use of Impact Factors and simple quantification of journal publications, and now recognises the value of qualitative as well as quantitative indicators, and the importance of impacts on policy and practice as well as “scientific productivity”.¹⁵ While impact assessment itself remains a topic for further research, a number of approaches have been developed to better capture the range of relevant impacts.¹⁶

8. Providing funding for research translation activities in addition to traditionally-understood “direct” research costs.

Translation of research findings requires dedicated capabilities and resourcing, and should be an approved component under research funding guidelines.

9. Providing a range of different initiatives to support research.

Benefits for the primary care evidence base and practice will be achieved by using a wide range of funding programs, not just project grants. These include for example: collaborative models (multidisciplinary centres, partnership projects); researcher support and development programs; and research translation capability development, including training, exchange, and independent knowledge brokering to facilitate translation into policy and practice.

Fit with building blocks: The approaches proposed above align with a number of the Aims and Objectives of the Strategy, particularly in relation to facilitating translation, enhancing collaboration, building the evidence base and supporting a research-engaged workforce. The proposals complement existing processes and approaches (e.g. those of the NHMRC) and will ensure continued development of the evidence base and practice in primary health care.

Measures of success: Potential indicators of success include: number/proportion of funded research projects on PHC; number/proportion of funded research projects with explicit research translation activities; research impact tracking using appropriate qualitative and quantitative indicators.

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About cohealth

cohealth is a not-for-profit community health service operating across the north and western regions of Melbourne. cohealth provides an integrated platform of health care and social support services, including medical, dental, allied health, counselling, mental health, health promotion and prevention, youth services, community support services and other programs to promote community health and wellbeing. cohealth prioritises people who experience disadvantaged social circumstances and who are consequently marginalised from many mainstream health and other services. This includes people who are homeless or at risk of homelessness, people who live with serious mental illness, vulnerable families, Aboriginal and Torres Strait Islanders, refugees and asylum seekers, people who use alcohol and other drugs, recently released prisoners and LGBTIQ communities. See <http://cohealth.org.au/>

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