

Primary care research networks: an evolving model meriting national evaluation

'To give away money is an easy matter; and in any man's power. But to decide to whom to give it, and how large and when, and for what purpose, and how, is neither in every man's power — nor an easy matter.'

Aristotle.

As part of the wider strategy to expand research and development (R&D) within primary care^{1,2} recent policy documents have highlighted the need to develop a stronger infrastructure for research in primary care. This has been accompanied by new arrangements for R&D funding^{3,4} that aim to support a growth in primary care research capacity. This relates to all of primary care, including general practice, as well as professions allied to medicine.

The past 20 years has seen the development of research networks in North America and the further enhancement of the Medical Research Council General Practice Research Framework in the United Kingdom (UK).⁵ More recently we have seen networks develop rapidly across the country to accompany such changes in funding and research infrastructure. The creation and funding of primary care research networks (PCRN) has been supported by regional R&D directorates or their equivalent across the UK.^{6,7} They are diverse in their aims, governance, size, and organisational structure.^{5,8,9} However, they generally reflect the proposals for networking arrangements set out in the Mant report,¹ which states a need to strengthen and develop the research base of primary care. In the past five years, PCRN have come to be seen as a key route to achieving this end.

Little research has yet been conducted into whether or not PCRN are an effective tool for fostering research and development in primary health care. Do they offer value for money? If so, are some types 'better' than others? These questions in turn raise the problem of defining what PCRN are meant to deliver and for whom. Commissioners, managers, and members of PCRN may have differing views on this issue.⁸ For example, PCRN have been characterised as either 'top down' or 'bottom up' according to whether their primary purpose is to meet commissioners' or members' needs respectively.^{11,12} Primary care research network members are themselves diverse in their needs, which may provoke tension; for example, between different health professional groups or between those whose interests lie more with the application than the generation of research.

As each PCRN strikes its own balance between such competing needs and interests, it seems obvious to suggest that evaluation should be tailored to the objectives of individual networks. Although this is a legitimate approach, we believe that more can be gained from a national evaluation of PCRN that takes a societal standpoint. From this standpoint there are arguably only two meaningful outcomes to evaluate. Do PCRN increase the quality, quantity, and appropriateness both of research into primary health care and evidence-based clinical practice in primary health care?

The ways in which these outcomes might be achieved are various. Most PCRN have focused on removing the known barriers to greater research and development activity. They include: promoting cultural changes that 'value' research, enhancing research awareness, and developing research skills.

From a societal standpoint these are not outcomes in their own

right; rather they are the processes by which the desired outcomes may be achieved. The use of process measures as a proxy for outcome measures in primary care is widespread but can only be justified if the process has been proved to lead to the desired outcome. We do not as yet know whether this is true in respect of PCRN. One important focus of primary care research network evaluation should therefore be to examine the relationship of process to outcome.

A cross-sectional appraisal of networks by the above criteria would enable us to say which networks are more 'valuable' than others by suggesting outcome criteria against which all might be judged. By linking outcomes to process and process to structure/organisation we might additionally begin to uncover what types of networks are best for maximising which types of outcomes. Costs of network operation and set-up would need to be estimated, if only crudely, to support an economic appraisal linking costs to benefits.

The picture will not be complete until a final question is answered. Are PCRN superior to other types of initiatives in achieving the same outcomes? Work needs to be done to clarify whether PCRN are effective substitutes for, or complements to, other initiatives such as:

- capacity-building initiatives targeted at individuals, including research bursaries, training fellowships, and postdoctoral fellowships;
- capacity-building initiatives targeted at individual provider organisations, such as research general practice schemes;
- R&D support services organised by regional National Health Service (NHS) executives;
- development of 'traditional' sources of primary health care research, principally university departments of general practice and primary care; or
- foundation of national centres of excellence for research in primary care such as the National Primary Care R&D Centre.

The supposition is that PCRN complement, rather than compete with, other initiatives. National evaluation would begin to provide the answers needed.

Attention needs also to be given to the role of networks in relation to the development of primary care groups (PCGs). Current discussions have highlighted the opportunity that PCGs have in translating locally owned and relevant findings into changes in practice or service delivery through collaboration with local PCRN.¹⁴ Indeed the integration of primary care research network activity with clinical governance initiatives in primary health care would seem to be a necessary process for achieving the desired outcome of increased evidence-based health care.

In conclusion, there is no doubt that the emergence and success of networks in recent years has provided an important infrastructure for primary care research. Networks have made a great deal of progress in relation to research methods training and have begun to contribute important information to the primary care knowledge base.¹⁶ Despite this, and the increasing number of PCRN, no evaluative work has been undertaken on a national scale. Questions remain as to the role, if any, that PCRN play in enhancing research activity or promoting

evidence-based health care, and whether PCRN offers better 'value for money' than alternative strategies for developing R&D in primary care. These urgently need to be addressed. A national evaluation would allow us to identify the most effective way forward in relation to capacity building for primary care research and to ensure appropriate funding is secured.

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What do patients want from their GP? Common expectations beyond cultural differences

THE importance of taking the views of users of health services into account is increasingly recognised as a way of obtaining a more accurate reflection of the quality of the care delivered.¹⁻⁴ However, we are still far from reaching this goal in terms of the use of such data. Researchers, professionals, and policy makers have been less than enthusiastic in this regard. Questions have been raised concerning the very validity of the process — are patients able to formulate a judgement on the quality of medical care? — and its applicability — what relative weight should be given to these evaluations in systems that are subjected to complex professional and organisational constraints?^{3,4} To justify a certain reluctance to include the patient-consumer's perspective in the formal assessments of quality of services, the methodological weakness of the literature on the subject has long been cited — and with reason, since the issue has been interpreted through the reductionist filter of user satisfaction.⁵

Fortunately, some researchers have left the beaten path of satisfaction to tackle the concept of perceived quality. Their work has shown that users of services can formulate distinct judgements on aspects of the care they receive in terms of its technical characteristics and organisational and interpersonal aspects.^{1,2,6} In this issue of the *Journal*, Grol *et al*⁷ subscribe to this much more promising trend and they propose an original use of such measurement scales: a comparison of perceived quality of services delivered by general practitioners (GPs) in different countries in Europe. In these trying times, when all health care

systems are faced with major restructuring, such data can be very valuable.

What does this study reveal? Or rather, what does a reader such as myself — a GP and researcher in the field of primary care in Canada — notice? The first thing is the high degree of convergence in the patients' perceptions as to what they feel is important in the professional relationship and what services they expect from a GP, regardless of the health system. The patients surveyed in this study have a positive perception of the care they receive from their family physicians. These findings are in line with those reported in other settings.^{1,5,6} Across this high level of appreciation, however, differences do emerge, some of which are perhaps easier to interpret than others. Like the authors, I am interested in the fact that patients in the Scandinavian countries and the United Kingdom (UK) seem less satisfied with organisational aspects such as accessibility ('providing quick services', 'getting an appointment'), with the technical aspects of care ('thoroughness', 'physical examination'), and questions related to the quality of the information provided about the actual episode of care. This finding is all the more significant given that the model of organisation of primary care in these countries is currently being considered as a solution by countries, like Canada, that are grappling with problems of organisation and resources.⁸ From the patient's perspective, are the solutions that we are envisioning likely to create other, just as unwelcome, problems such as those that we are currently facing? This sort of

question certainly springs to mind upon reading this article. However, as proposed by the authors, it is advisable to ask ourselves under what conditions such data can be helpful in the debate about specific strengths and weaknesses of care provision in different countries.

The usefulness of this type of data depends on two equally fundamental conditions. The first — as the authors point out — concerns the validity of the measurement scale. In light of this, their work is important since, for the first time, they are proposing a tool validated in several languages, taking into account the cultural diversity in the various countries concerned (or at least the dominant culture).

The second condition is that of the representativity of the populations from which this information is gathered, as compared with the reference populations, taking into account the final goal of such an exercise: to shed light on the debate about our different health systems. Here we are referring to representativity and not similarity since, as the authors so clearly point out, the goal is to apply the same measurement scale to groups that are, by definition, different. In the absence of being able to ensure representativity, researchers should provide the users of their data with contextual elements so that the latter can determine for themselves the significance and applicability of the results presented.

This information is missing from the article. It is one thing to say that the sampling was stratified but stratified with regard to which reference population? To what extent are the 36 practices per country representative of GPs and of the organisation of primary care in the country? No data is provided on this issue. How many practices were approached initially and how many agreed to participate? Was the invitation to participate in the study closely linked to belonging to an interest group — for example a European research organisation in general medicine — or to a national primary care association? If this was the case, then is the 'national' representativity ensured in a comparable manner between the different countries?

Without a good understanding of the specific contexts from which the data are drawn, the hypotheses put forward to explain the different observations can only be superficial and risk reflecting the prevailing biases in the environment. With regard to this, I am somewhat surprised that the only hypothesis developed by the authors to explain their observations relates to the difference in the remuneration systems and gatekeeping role of the GP. I practice in a system where the GP is paid fee-for-service and where the function of gatekeeper is not established: patients are free to change physicians and to go directly to specialists. Still, Canadians express major frustrations with accessibility to general practice and some of the technical aspects of care, such as doctor-patient communication. Issues related to a relative shortage of GPs secondary to tight government regulations, to the absence of a real primary care network where physicians work in close relationships with other health care professionals for a given population of patients, and to decreasing accountability of the medical profession have been invoked as explanations.⁸ In the present study, it is interesting to note that the European countries where the patients express the greatest satisfaction with regard to accessibility and the technical quality of care are those that are grappling with an excess of physicians and, particularly, of GPs. Can the difficulties expressed by the patients questioned in the UK and Scandinavia be explained as much, if not more, by a relative shortage of resources in general practice than by the mode of remuneration (used by the authors interchangeably with the concept of the patient registration list) or ease of access to a specialist? Many other hypotheses could be formulated, including some related to the medical culture, to the status of the GP, to physician training programs, and to the medical demographics in

each of the different countries studied.

Obviously, the kind of data presented by the authors can trigger interesting questions likely to be useful in our reflections on the organisation of our respective health systems because they offer information that only our patients can provide. Such data must be added to epidemiological data and to the different indicators of performance used in international comparisons. In spite of their limits in this regard, Grol *et al*'s research shows the direction to be taken and confirms that it is possible to conduct international studies on such a complex topic.

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