

Guest editorial

Supporting research in primary care: building capacity from within

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An over-riding observation in the international literature on capacity building in primary care is the twin importance of the need for an improved evidence base to support decision making and the development of high-quality primary care research.^{1–5} Campbell *et al* provide different perspectives on how primary care research can be categorised: research *by* primary care staff, where at least one principal investigator is a primary care professional; research *on* primary care, where research relates to the work of primary care professionals but is undertaken by others; and research *through* primary care, where health professionals are the source for patient recruitment and data collection.⁶ In this paper, supporting research in primary care is seen as assisting primary care practitioners to increase their involvement in primary care research, which addresses problems of daily practice so that findings are relevant and meaningful to them. Research and interventions undertaken in secondary care and which have been shown to be effective may have limited value in primary care because of case selection and referral biases, and may underestimate disease prevalence while overestimating the impact on quality of life compared with observations in primary care.⁷ Further, management decisions by secondary and primary care doctors may vary according to different experiences, values and priorities.⁸ Capacity building on the other hand, seeks to foster the conditions that increase the abilities and resources of individuals, organisations and communities to plan, develop, implement and sustain research projects according to changing/emerging needs.⁹ Trostle defines research capacity building as ‘a process of individual and institutional development which leads to higher levels of skills and greater ability to perform useful research’.¹⁰ Capacity in this context includes awareness, skills, knowledge, motivation, commitment and confidence to manage changing circumstances in an ethically defensible way. Thus, capacity building should be seen as a process rather than a means to an end. A process approach entails focusing on coherence as well as effectiveness.

The debate about high-quality research in primary care becomes stark when we consider that in England over 90% of patient contacts with the NHS begin in primary care,^{11,12} but there is inadequate funding and a lack of capacity of primary care staff to undertake the required research and development.^{2,6} Inadequate funding in health research is reflected globally, where only 10% of the world’s research and development spending is directed towards 90% of health problems faced by the world’s population – many of which are addressed in primary care. This is referred to as 10/90 disequilibrium. Efforts of the international community continue to address the 10/90 gap and are based on evidence, so that resources available to finance the measures are used in an efficient and effective manner.¹³ The recommendations of the government-initiated Mant report paved the way for increased government recognition of the importance of primary care research.² Most notably was investment in research networks to develop an evidence-based culture in primary care.

The establishment of the networks along with available government funding in 1998, were seen as a route for the inclusion of primary care practitioners in research. In the same year the United Kingdom Federation of Primary Care Research Network was formed with the aim of bringing together research networks from around the UK to promote their research interests at a national level and to encourage cross-network collaboration and learning.

However, as part of the UK’s current Labour administration’s programme of modernisation of the NHS, a new national health research strategy has been developed, which provides direction on addressing identified challenges to create world-class research, focusing on public health and needs of patients.¹⁴ Under the new health research strategy umbrella is the establishment of the UK clinical research networks whose function is to improve and expand the clinical research environment across the UK. The networks cover topic-specific areas such as: diabetes, cancer, medicines for children, dementias and neurodegenerative

diseases, mental health and stroke. Of particular relevance to the primary care community is the development of a Primary Care Research Network for England (PCRN-E) and a National School of Primary Care Research. The objectives of the PCRN-E are to inform the prevention, diagnosis, treatment and management of illness and disease in primary care. The school is the first of its kind to be established in England and will concentrate on research that increases the evidence base in primary care. Annual funding of £3 million will be available to support research programmes. These policy changes in primary care will go some way to address the challenges identified in the new national health strategy.¹⁴ However, capacity building, particularly with novice researchers, is needed before we can achieve the government's vision of a world-class health research environment.

The international literature on reasons for a lack of capacity building in primary care is replete with similarities: heavy workload of staff which leaves little time for submitting research proposals; shortage of staff means that there is a lack of capacity to enable the pursuit of writing research bids; staff do not have the required skills needed for submitting proposals; a belief that research writing is a luxury; and tension between collaborating centres.^{4,6} Community involvement is an important theme in UK health policy, but issues such as working with individuals or groups that have diverse perspectives on timeframe, notions of power, status and accountability can be challenging.¹⁵

Policy initiatives to increase research capacity *by, on* and *through* primary care professionals include support for individuals, groups and organisations by way of fellowships, training and bursaries.^{6,16,17} In the UK, primary care trusts (PCTs) control 75% of the health service budget and are the main commissioners of services for the population they serve. One of the key features of PCTs is the discretion they have to set up systems to meet local needs, including research capacity building to support good clinical practice and local service development. However, many PCTs are operating within a deficit budget and are concerned with meeting government targets. Consequently, establishing research priorities or building research from within are not uppermost in their minds. From the end of 2006, general practitioners and other primary care professionals in the UK will be directly engaged in the commissioning of services for their patients through practice-based commission (PBC). Information received by the practices on how their patients use health services can be used for the redesign of services.¹⁸ Chen and Majeed suggest that all practices will be significantly engaged in preparing for PBC, which means that research issues will be a low priority while these arrangements are put in place.¹⁹

A critical factor in capacity building in primary care research lies in effective collaboration between academic

institutions and PCTs, which helps to build knowledge and add to the evidence base. The perspicacity of this arrangement allows for winners on both sides: both meet their capacity-building and research objectives. However, some universities may be selective in their collaborative partners and in the type of research undertaken, as some research projects may not rate highly in the UK's prestigious 2007 Research Assessment Exercise for universities.¹⁹

The main emphases in the literature on capacity building relate to five key points and include: the development of a research infrastructure best suited to address the organisation's research needs; collaborative links with others including academic institutions so that strategic partnerships can be developed – this is particularly important for smaller professional groups or those with little infrastructure; investment in training and development; and management of relationships and effective use of existing systems and expertise required for capacity and long-term sustainability rather than short-term unsustainable initiatives – this includes the view that universities should not see communities as passive subjects of research or as markets for their educational products. The research on capacity building shows that different primary care professional groups are at different stages of development, and much of the research undertaken is characterised by a small number of enthusiastic people who may not be willing collaborative partners with smaller low-profile groups or institutions.

Having introduced structures for capacity building from within the organisation, there is a requirement to measure or evaluate progress and sustainability. The literature makes little mention of this. Cooke's paper initiates the debate on how measurement may be achieved using four structural levels of developmental activities: individual; team; organisational and network and support units.²⁰

Continued focus on primary care is envisaged, requiring strategies based upon collaboration and reducing barriers to participation to enable sustainable expansion in research capacity. Opportunities for research and development in primary care are increasing, and the scope for those wishing to become involved is widening. The challenge in the new NHS is to ensure that primary care is underpinned by rigorous research and sustainable capacity to become part of the government's vision of a world-class health research environment.

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