



Tom Brett

The Inverse Care Law

Is Australian primary care research funding headed this way?

Tudor Hart's Inverse Care Law¹ classically described the inequity in medical service access in South Wales. From his primary care perspective, the availability of good medical care varied inversely with the need and the population served. In Australia, future funding for primary care research capacity building appears headed in a similar direction – at least for newly established medical schools.

In 2000, Phase 1 of the Primary Health Care Research, Evaluation and Development (PHCRED) Strategy² helped raise the profile of primary care research, both nationally and internationally. The large gap identified in quality research in Australian primary healthcare³ provided the initial impetus to drive the strategy.

The noncompetitive nature of the strategy provided essential establishment funding allowing university departments of general practice and rural health to develop research plans tailored to their region. This funding was vital in providing early career researchers with a hands-on primary care experience, instilling a culture of evidence based practice and providing essential infrastructure and mentoring to enhance research capacity.

At The University of Notre Dame Australia (UNDA), we benefitted from Phase 2 funding in 2006. We provided research bursaries or Researcher Development Program (RDP) fellowships to 23 general practitioners/new doctors, four practice nurses, two practice managers, 13 medical students, two Aboriginal researchers, one student nurse and one Aboriginal high school student.

Through direct involvement in our research into cardiovascular disease prevention⁴ and multimorbidity, GPs and practice nurses reflected on their clinical practice, while students got invaluable hands-on experience. Learning firsthand that even small changes across a number

of cardiovascular risk factors made significant improvements to global absolute risk was a powerful reminder to clinicians that it was possible to effect change through a structured approach in everyday practice. In a study among men aged 16–29 years, we found little relationship between reported sexual behaviour and chlamydia infection, concluding it may be more appropriate to offer screening to all at risk individuals.⁵

In 2012, Phase 3 funding moves to a competitive grants program built around centres of research excellence.² This will provide the mechanism to further develop quality primary care research, including research capacity building. The emphasis will shift toward robust primary care evidence contributing to policy development. A further key shift will encourage collaborations (both nationally and internationally) with the expectation that newer institutions will be mentored by their well established collaborators.

This development poses significant risks for newer schools. Unlike established medical schools who have received 12 years of PHCRED funding to date, some of the newer schools have received funding for half that time, while others have received none. Ironically, improving access and reducing inequity are listed among the Phase 3 priorities, which brings us back to the Inverse Care Law. Here too, those with greatest need (for primary care research funding) appear destined to get the least. From an ethical and distributive justice viewpoint, the newer schools request for a fair distribution of resources to help develop and nurture their emerging research capacity, especially early career researchers, is strong.

Newer medical schools are at greater risk to the continuing development of their primary care research units. It would appear logical that they receive a minimum of 12 years research capacity building funding, similar to that of the established schools. Failure to do so places at risk the survival of fledgling primary care research units. It would

be a tragedy for new schools to lose funding just when their research teams are attempting to consolidate and develop track records. It is unrealistic to expect established medical schools to place the research interests of new schools on a par with their own – especially in a competitive research environment.

A key focus of UNDA has been to encourage our postgraduate medical students to become involved in primary care research projects. Our hope is that this will translate into increased consideration of a general practice career, while providing valuable primary care research experience. Our strategy and vision is to nurture this potential talent into the primary care GPs, academics and researchers of the future.

The cost of maintaining a noncompetitive stream of PHCRED funding for newer medical schools would be less than \$3 million a year. It is certainly an investment worth spending.

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