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In practice

Partnering to prevent chronic disease: reflections and achievements from The Australian Prevention Partnership Centre

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Key points

- The Australian Prevention Partnership Centre is one of three National Health and Medical Research Council (NHMRC) Partnership Centres for Better Health, which aim to increase the use of evidence in policy and practice through coproduction
- The Partnership Centre model enabled us to complete an ambitious program of research that may not have been possible within other funding structures
- Challenges to coproduction included competing demands for resources and time, trust building between stakeholders, and investigators' willingness to embrace this new way of working

Abstract

Objectives: To accelerate the use of evidence in policy and practice through cross-sectoral, multidisciplinary partnership research, founded on shared governance and coproduction.

Type of program or service: A National Health and Medical Research Council (NHMRC) Partnership Centre for Better Health.

Methods: We present our views and experiences based on the first 5 years of operation of The Australian Prevention Partnership Centre.

Results: We have undertaken an ambitious and complex 5-year program of work taking a systems approach to prevention research, and have grown the size and reach of the collaboration to become a focus for prevention research in Australia. We have progressed towards reaching our objectives. However, there have been challenges including trust building between stakeholders, the complexities of incorporating coproduction into every research project, and the production of research that is implementable within different policy environments.

Lessons learnt: Working within the partnership model has provided the time, resources and flexibility to coproduce policy-relevant, timely research.

Background

In 2011–12, the National Health and Medical Research Council (NHMRC) established the Partnership Centres for Better Health scheme – a new initiative to improve the availability and quality of research evidence to inform policy decision making. The goal was to bring teams of researchers, practitioners and decision makers together to create better health and health services by working collaboratively on priority themes determined by the needs of healthcare systems.[1]

The Partnership Centre model is based on the concept that research is more likely to influence policy and practice if it is coproduced by policy makers and researchers working together, rather than through a linear model in which academics produce and then transfer knowledge to policy makers.[2] The model promotes innovative, multidisciplinary, cross-sectoral research that has the potential to improve health and health services, especially where the issues being addressed are complex and beyond the capacity of a single agency or field of expertise to solve, as they are in lifestyle-related chronic disease.[2]

The Australian Prevention Partnership Centre (hereafter 'the Prevention Centre') was established in June 2013 to explore the systems, strategies and structures needed to inform decisions about how to prevent lifestyle-related chronic disease. Key features of the Prevention Centre and its funding model have been published previously in this journal.[3,4]

This paper aims to provide insights into how the Prevention Centre has progressed during the first 5 years of funding and our key achievements and learnings in this time.

What did the Prevention Centre aim to achieve?

In line with the NHMRC's objectives, we aimed to strengthen the evidence base for the prevention of lifestyle-related chronic disease; create knowledge and make it readily available; and build capacity to make more informed choices about prevention at policy, strategy, program and implementation levels.

To achieve these aims, we provided new ways for researchers, policy makers and program practitioners to work together to form strong national networks; generated internationally significant research; provided new ways of communicating the value of prevention to governments; developed tools, frameworks and strategies for an effective, efficient and equitable prevention system; and increased the capacity of researchers, policy makers and practitioners to use evidence and systems approaches in the design, implementation, evaluation and communication of prevention.

The Prevention Centre's inbuilt evaluation strategy aimed to address accountability for goals, funds and resource use, as well as provide a feedback framework for insights and learnings for improvement and growth. Evaluation data collected to date (yet to be published) demonstrate the Prevention Centre is functioning well in a complex environment, with barriers being currently identified and analysed.

Building the collaboration

We offered a new way of bringing together the prevention community in Australia. The Prevention Centre initially included 31 Chief Investigators: 17 from academic-based research environments, 11 from practice and policy environments, and 3 working across both. However, across the 5 years the overall numbers changed substantially. We were able to do this because we did not limit involvement in our projects to the named investigators and institutions on the original proposals. We committed to our funding partners that if we didn't have the expertise in the investigator group, we would find it elsewhere. We envisaged that the research program would be dynamic, responding to changing needs of the funding partners and the changing research knowledge and methods. During the 5 years, the Prevention Centre expanded to include more than 150 individuals implementing 40 separate research projects from 15 research institutions and additional practice settings. We actively sought settings that presented opportunities to address specific research interests, even when the sites were not in the same jurisdiction as the funding partner. We were able to fund new opportunities that aligned with our interests, such as the benchmarking work described below.

With a large, diverse and geographically dispersed network of stakeholders working in a variety of settings, our funding model allowed us more scope to build partnerships and foster engagement through many face-to-face meetings between practitioners, policy makers and researchers. A key element was a well-supported communications capacity that facilitated the sharing of ideas and knowledge, promoted networking and informed the broader prevention community about prevention research.

We have implemented key mechanisms that are crucial for mobilising new knowledge and influencing policy and practice through: leadership and governance structures; capacity building and skill development; networking and relationship-building activities; coproduction of research; and strategic internal and external communications.

Coproduction of research

Knowledge coproduction, whereby researchers and research users collaborate in all stages of the research process, is recognised as a key driver for generating relevant knowledge and facilitating its use in policy and

practice. All our research involved partnerships between researchers, policy makers and practitioners, and all our research was guided by government and industry funding partners. We actively promoted opportunities for policy and practice partners to be engaged in, inform and influence the direction of our research.

One example of coproduction is a project in which we worked with government officials in each jurisdiction and more than 100 nongovernment experts from 53 organisations to benchmark current policy actions to address unhealthy diets and obesity.[5] Another example is a project in partnership with the New South Wales (NSW) Ministry of Health and Local Health Districts that explored the implementation of the NSW Ministry of Health's Population Health Information Management System.[6] In the Prevention Tracker project, we are working directly with local stakeholders to help them understand the health needs in communities in Tasmania, Western Australia, NSW and Queensland, and to map existing prevention activities.[4] Our longer-term evaluation will help us understand whether the coproduction approach has produced improved outcomes. Early feedback has been very positive.

Capacity building in systems thinking and prevention research

Similarly to program grants, we have established more than 20 early- to mid-career research positions and awarded five scholarships for higher degree studies. We treated these fellows as a developmental cohort, fostering them as a support network and creating opportunities for them to interact among themselves and with policy makers, practitioners and other senior researchers.

We have brought together more than 700 researchers and policy makers in more than 80 seminars and other training opportunities.[2] In addition to building expertise in areas such as taking a systems approach to prevention, it has enabled us to identify new opportunities and needs.

We have established a national network of Commonwealth and state/territory evaluation managers from all jurisdictions to build new skills in evaluating complex public health interventions. We have also developed and delivered an intensive online training course in complex evaluation methods, targeted at stakeholders in academic, policy and practice settings in Australia and internationally.[2]

We have a program dedicated to developing systems thinking skills, defined as a way to make sense of a complex system that gives attention to exploring the relationships, boundaries and perspectives in a system. The program includes the development of resources, provision of workshops, and development of a postgraduate course on Systems Thinking in Public Health.[7]

Evaluation of our capacity-building activities demonstrated participant satisfaction with specific events as well as satisfaction with the range of events and training provided by the Prevention Centre. The activities facilitated participants' access to national and international experts, and helped them develop new knowledge and skills in areas such as coproduction with policy makers, systems approaches and science communications.

New knowledge and methods in chronic disease prevention

We have demonstrated the value of using participatory processes to develop dynamic system models that test the likely impacts over time of a range of policies and programs to address complex issues. We have developed six models in collaboration with policy makers to examine the impacts of prevention programs addressing alcohol harms, childhood overweight and obesity, tobacco control regulations, chronic obstructive pulmonary disorder and gestational diabetes.[8-13]

We undertook the first systematic application of liveability indicators to identify which built environments optimise health and wellbeing, and produced the first baseline measure of liveability in Australia's state and territory capitals. We are currently developing a national liveability indicator platform for use by our stakeholders.[14-20]

We found that recommended (healthy) diets are 12–15% cheaper than unhealthy diets for a family of two adults and two children. Based on this research, we developed a nationally standardised tool for determining the price and affordability of healthy and unhealthy diets.[21,22]

The challenges

Establishing a 5-year program of work taking a systems approach to prevention, grounded in partnership research, has provided many learnings. The size and complexity of the program of work we undertook was substantial. It took longer to become operational than originally anticipated, and engagement across multiple geographic locations was at times difficult. Building trust and relationships among researchers, policy makers and practitioners also took much longer than expected. Although funding bodies increasingly require researchers to address knowledge translation and implementation, our experience demonstrates that to do this well requires significant resource commitment.

Our intent to have knowledge coproduction embedded in every project was not achievable. Researchers, policy makers and practitioners had to learn new skills for working together and not all were interested in doing so. Coproduction usually requires substantial time commitments from all parties and this was not always possible. Health departments are subject to a range of competing demands for time and resources,

and changes in staff involved in research projects was not unusual. For policy makers used to commissioning research and controlling the product, coproduction requires a new, different level of trust. Practical issues like accessing health agency information systems or policy and procedure-related documents also influenced the nature of the research partnerships.

The coproduction of research has been challenging for our academic researchers. For example, one concern is that publication rates have been lower in their Prevention Centre projects than in their other work. This is due in part to time invested in building partnerships and dialogue with policy makers, which was seen as crucial for coproduction. The need to discuss research outputs and involve practitioners and policy makers in interpreting the findings before public release was uncomfortable for some researchers, even though they knew a condition agreed to with funding partners was that all research would be published. Moreover, this iterative approach took additional time, a frustration for researchers who need the publication achievements. Our partners wanted clear and concise evidence delivered within the tight time frames often required in policy settings. The demands and timelines of research and policy contexts are very different, and academic research is often perceived to be produced too slowly to be of use to policy makers.[23] However, we were able to produce high-quality research in timelines appropriate for decision making. More importantly we were able to demonstrate that truly coproduced research is informative to decision making as it is codeveloped.

There were some projects that were largely researcher driven with relatively passive partner engagement, and some that were similar to commissioned research with a high level of specification by the policy maker partner with methodological guidance from the researchers. More commonly, there was a high level of initial engagement between policy makers, practitioners and researchers leading to agreement around the research questions and methods, with the research proceeding under oversight but not fully coproduced. Indeed, only a minority of projects met the criteria of full research coproduction. It was particularly difficult to negotiate Prevention Centre involvement in projects that had a high level of political investment because of our commitment to evaluation and open publication.

Finally, there are external barriers which influence decision making in prevention. The nature of the current political climate and decision making in policy generally, where evidence is only one influencing factor, and the issue of the time lag between research and policy, remain key challenges. Although these issues will affect the degree to which Prevention Centre findings are ultimately implementable, we remain confident that we are establishing a new way of working in coproduction that will benefit researchers and policy makers, and ultimately the health outcomes of Australians.

Conclusions

The Prevention Centre was established to increase the use of evidence in policy and practice through enabling closer partnerships between researchers and policy makers, and focusing on coproduction of timely and relevant research in chronic disease prevention.[3] In our first 5 years, we have progressed towards our vision of providing a program of work that will help establish an effective, efficient and equitable system for the prevention of lifestyle-related chronic disease.

In this time, we have established new ways of working together, embedding policy makers into research projects and researchers into policy environments, ensuring that outputs are policy relevant and building a prevention workforce for the future. We have built a national profile and are widely recognised and highly regarded by academics and policy makers in the prevention space.

We believe these achievements have been made possible by the Partnership Centre approach. Working in partnership has provided the time, resources and flexibility to coproduce large-scale, policy-relevant research in ways that would not have been possible without the size of the collaboration, the networks we have established, our national reach and the diversity of our expertise.

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Competing interests

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Author contributions

ES, SW, and AW led the writing of the manuscript. SR, HS and AB contributed to critical revision and editing of the final manuscript. ES, AW, SR, HS and AB approved the final manuscript.

Dedication

We dedicate this work to our colleague, mentor and above all, friend, Associate Professor Sonia Wutzke (1970–2017). The public health community is richer for having had Sonia as one of its most passionate advocates.

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