Minutes of the AAAPC Executive Committee
Held 19 October 2010

1. Attendance: Richard, Dimity, Danielle, Jon, Marie, Deb, Marjan, and Kitty

2. Apologies: Joachim, Faline Sarah, and Ellen

3. Minutes of last meeting of the AAAPC held 21 September 2010 were approved. The spelling of one name needs amending to 'Chris Bagley'.

4. Business Arising:

4.1 Marie spoke with Jane who agreed that the issue of the grading of medical journals is not about to be reviewed. The list of journals is now on the website which has recorded an additional one hundred hits. Jane thought that the AAAPC might wish to lobby on behalf of its members. It there is to be a working group, Jane suggested that it might be useful to co-opt Tanya Wizenberg as she was involved with this the first time around. Jon suggested that we should go through the list and flag journals that the AAAPC might want to have re-rated. No one was sure about the criteria used for the ranking of journals; Kitty is to email Tania to see if she has a note of the criteria and to see if she would have the time to be involved in a working group. Danielle commented that there were two issues:

- Whether the journals met the criteria but were not awarded the correct ranking, and
- Parallel disciplines – General Practice journals tend not to be highly ranked.

Dimity suggested that a working group be formed. Marie is happy to join this group but will be away until December. Danielle and Dimity are also willing to be part of the working group. Marie stressed that it would be helpful to include Tania Winzenberg

4.2 Dimity has yet to complete the position statement on the developments in the PHCRED funding model. There has been good feedback from discussions on this topic. Dimity and Joachim were involved in discussions in Canberra, after which Dimity sent out a report; it is OK to share this report with other colleagues. There was also a meeting in Sydney. Marjan thought it was up to each CRE to decide how it is going to build up its capacity. Jon commented that there was a shift away from a broad brush approach to capacity building, to assuming that the Centres for Research Excellence (CRE) have an important role in capacity building but in a more focussed way. Jon suggested that the discussion groups are 'information sessions' which will not shape policy. Nonetheless, there is now talk of four CREs in the next round of CRE funding. Danielle commented that this focuses the PHCRED funding and research capacity building into research around primary care reforms and takes away the ability to build capacity in other areas of clinical research, and the only avenue for other clinica research becomes the NHMRC or other granting bodies. Marjan agreed, commenting that at the Canberra meeting, DOHA was very specific in stating that research needs to involve the health reforms and not clinical research into areas such as diabetes or asthma. Danielle felt that the

AAAPC has an important role in tracking and publicising the success of general practice investigators in NHMRC processes; this she argued is where the AAAPC has an important advocacy role. Richard reported that Nigel Stocks, now the chair of the Council, indicated that the College would be very supportive of the suggestion that more CREs were required and that a broader mandate was important. There would also be support from some of the other general practice organisations. Dimity asked if the AAAPC should link up with the College to lobby Vicky Murphy on PHCRED phase 3. Jon agreed with this suggestion, because it would give a broader 'general practice' backing to the concerns of the AAAPC. Deb felt that Vicky Murphy saw PHCRED phase 3 as a means of evaluating the impact of the health reforms on the primary health care strategy. There seems to be little shift in the thinking. The importance of clinical research is either ignored or rejected.

Dimity mentioned that, in general, community based primary care nursing and allied health cannot be expected to do sophisticated health services analysis when in many cases they do not have the necessary information or skills to do research and so there is a real need for capacity building in those sectors as well as in general practice before centres of research excellence are formed. Marjan commented that the CREs are supposed to have links with allied health areas and so it could be argued that the CREs will build the capacity of the allied health areas.

Deb suggested that Vicky appears to have made up her mind on the PHCRED phase 3 strategy and that the AAAPC will lose its credibility if it lobbies to change a strategy that is set in stone. There may be other ways to influence the policy makers to think about the importance of funding primary care clinical research. Danielle argued for different strategies, such as developing researchers in the field. She commented that we have not been told of the basis of its evaluation that resulted in the move towards CREs. Marjan advised that there was an evaluation carried out last year, albeit that it was not released to the public. Marjan picked up on and endorsed an idea that Dimity raised at the Canberra meeting: that one of the CREs should be nationwide, incorporating all the medical schools with a role or excellence being to do something about health services and education.

Richard commented that in going from 26 centres to 4 or 7, is a substantial change, putting the eggs in a very small number of baskets. Marie agreed with the idea that the AAAPC needs to be aligned with the College and to have a clear message. Dimity summarised the AAAPC position: there needs to be funding for capacity building for clinical research, this is a pre-requisite for getting NHMRC grants. Danielle raised the equity issue, given that there will only be a handful of CREs, some States and departments will have no funding for capacity building. Marie will bring this up at the next NSCR meeting and see if it has the same take on this issue as the AAAPC. Richard mentioned that at a AAAPC meeting, Geoff Mitchell was saying that the palliative care funds were of the same order as

the PHCRED; he suggested that it could be argued that the pot needs to be bigger as the current proposal is to fund four centres each with $2 million. It could be argued that although there is provision for 7 centres on health reform, additional funding should be found for 4 more centres on clinical research. Danielle mentioned benefits of the current approach: 3 years funding, a collaborative adventure, etc. Richard asked about the transition phase between the current 26 research centres to the proposed 4 or 7 CREs.

4.3 Dimity advised that the comments on the new PIP payment form are due at the end of October 2010.

4.4 Dimity advised of a possible agenda for the Sydney meeting, 23 November 2010. This will include each university's problems – such as the loss of supervisors, the absence of data on practices that take more than one student at a time, the model that bureaucrats have of student placements may be restricted to a student sitting in on a consultation. Possible solutions: funding at least two students per supervisor, looking at a fixed payment on top of the PIP payment, identifying certain practices that might merit funding for more than one student which would look towards quality of supervision.

Jon commented that it is important to have an idea as to what might come out of the meeting, in particular what we then take back to Medicare. Also, we need to think about we link in with the AMA survey. Marie advised that the College is interested in the AMA survey. Jon also mentioned the GP United group which meets regularly with the Health Minister. To have the College and the AMA all pushing the same line on the PIP issue as the AAAPC would be beneficial. We need models of supervision that can be advanced for consideration. Dimity has talked with Simon Wilcox of the Health Workforce Australia who takes the view that there should only be funding for one student per GP although he admitted that there are different models of supervision. Richard felt that the AAAPC should be drafting guidelines on where it would be appropriate to have more than one student and to request an additional PIP payment if these conditions were met.

5. The Newsletter: Marie is going to the NAPCRG and is happy to write a report on this conference. Dimity suggested that it would be good to include a primary care article in each newsletter. Louise Stone has promised an article. A main article is missing. Danielle suggested an article of capacity building, Dimity agreed to write this. Kitty and Sarah to continue to collect articles

6. General Business

6.1 Membership

6.1.1 New members: None

6.1.2 Finances: The current balance is $12,500. A reminder has been sent out to those with unpaid subscriptions.

7. Next Meeting: 30 November 2010

Danielle asked that the issue of academic registrars and the GPET requirements for academic registrars go on the next agenda.

9. Other Business:

- Faline is having difficulties attending due to childcare commitments. She is happy to stand down or just take maternity leave. Tania was suggested as a replacement.
- Dr Caroline Laurence from Adelaide has applied for the travelling fellowship. Kitty to send the application to Dimity and Jon.

Assigned Actions

Dimity is to:

- Write an article of capacity building for the next Newsletter, based around the executive committee's discussion of this topic

Danielle, Marie and Dimity are to:

- Form a working group to look into the ranking of the journals, possibly with the assistance of Tanya

Jon and Dimity are to:

- Assess the application of Dr Caroline Laurence for the travelling fellowship

Kitty is to:

- Write to Tania to see if she has a note of the criteria used to determine the ranking of journals and to see if she would have the time to be involved in a working group on this issue
- Write to Tania, asking if she is willing to take over as the Tasmanian representative whilst Faline is on 'maternity leave'
- Send the application of Dr Caroline Laurence for the travelling fellowship to Jon and Dimity for assessment