

**Final Report of the
International Review Panel
To the
Board of Trustees,
Canadian Health Services Research Foundation**

November 29, 2001

Summary:

To paraphrase its terms of reference, the Panel was asked:

1. *whether the present strategic approaches are the best way of achieving CHSRF's goals.*

We believe CHSRF is solidly “on track” although we do suggest that its approaches be modified somewhat, particularly in light of formation of the Institute for Health Services and Policy Research of the Canadian Institutes for Health Research.

2. *whether CHSRF has achieved an effective balance between funding research, developing capacity for health services research, conducting research, and fostering its “uptake” by decision and policy makers.*

This question cannot be answered at present. It's too early! An additional 3 to 5 years at least will be required to achieve a steady-state balance among those thrusts and to accumulate the bare minimum of evidence necessary for an informed, evidence-based judgement to be made.

3. *how CHSRF compares with comparable organizations in other countries.*

There are no directly comparable organizations but the young CHSRF is already highly regarded by representatives of the somewhat similar bodies in the U.S. and U.K. with whom the Panel consulted. It also compares favourably with others with which the Panel's members are themselves familiar.

4. *how successfully CHSRF has integrated its remit for nursing research.*

The “remit” has been very successfully integrated into CHSRF’s programs with a strong promise of benefit to and by nursing research. But the way that integration has been accomplished has engendered substantial resentment among some representatives of the profession. This should be corrected forthwith.

5. *make observations on the most appropriate role for CHSRF in the next 3-5 years and recommend criteria to assess its future performance in that role.*

CHSRF’s current role should continue for the next 3 to 5 years but with stronger focus on fostering the transfer to and incorporation of the fruits of health services research (knowledge transfer) in policies and decisions bearing on the provision of health and health care services throughout Canada.

Some suggested reassessment questions and criteria follow at the end of this report.

Summary of Recommendations:

Recommendation 1: In the near future CHSRF should conduct a comprehensive synthesis of existing research related to knowledge transfer and either conduct itself or contract with others basic and applied research into the subject.

Recommendation 2: CHSRF should work closely with IHSPR¹ with a view to forging a partnership (or at least a well-defined working relationship as a framework for close, on-going collaboration between them) to ensure that their work is complementary and synergistic.

Recommendation 3: CHSRF should be maintained separate from CIHR² for the immediate future. The question of whether it should be merged with IHSPR and brought under the umbrella of CIHR should be re-examined, however, in 5 years or thereabouts.

Recommendation 4: CHSRF should concentrate in this next stage of its development on fine tuning, focusing and bringing its programs to maturity rather than initiating new ones.

Recommendation 5: The Board of Trustees should immediately concern itself with succession planning for CHSRF’s Executive Director.

¹ Institute for Health Services and Policy Research within the Canadian Institutes for Health Research

² Canadian Institutes for Health Research

Recommendation 6: The Board of Trustees should immediately concern itself with planning for its own succession and with implementing those plans.

Recommendation 7: Consideration should be given to ways and means of addressing the question of interregional equity. This might be done in the decision-making processes of CHSRF itself, both at the level of the Board (governance) and operationally (in merit review). Greater use might also be made of CHSRF's Regional Officers in this regard.

Recommendation 8: CHSRF should emphasize health services research programs over projects.

Recommendation 9: CHSRF should continue its practice of limiting its support of health services research to programs that address clearly identified themes of research.

Recommendation 10: CHSRF should continue its policy of excluding from funding consideration the category of "clinical" research but should make more clear both its definition of what kinds of research are excluded and why. It should also work with IHSPR (see below) to find ways to increase the access to research funding of those excluded researchers who submit applications of good quality.

Recommendation 11: CHSRF should enter into discussions with CIHR with a view to tailoring its health services research support programs to complement those offered by IHSPR and *vice versa*. The 'tailoring' should produce a mutual fit.

Recommendation 12: CHSRF should enter into discussions with CIHR with a view to tailoring its health services capacity-building programs to complement those offered by IHSPR.

Recommendation 13: CHSRF should consider reorientation of its capacity-building programs (or the development of a new one) to focus on the education and training of people in the field, working on the knowledge utilization side of knowledge transfer, in accordance with the concept of "double apprenticeship".

Recommendation 14: CHSRF should accord highest priority over the next 3 to 5 years to its knowledge transfer thrust. To complement the research referred to in Recommendation 1, CHSRF should develop measures of the outcomes and impact of all of its programs but especially of knowledge transfer.

Recommendation 15: CHSRF should re-examine its communications strategy with particular reference to the focus that the Panel recommends be put on knowledge transfer. Serious consideration should be given to including the general public as a potential audience for CHSRF.

Recommendation 16: The Board of Trustees should take immediate steps to resolve difficulties that are perceived by some members of the nursing profession to affect the Nursing Advisory Committee, the availability of funding for “clinical” nursing research, and communications generally between CHSRF and the nursing research community.

Introduction:

The Canadian Health Services Research Foundation (hereafter CHSRF) was incorporated early in 1997 with an initial endowment of \$66.5 million. It received an additional \$60 million in 1999 of which \$25 million was earmarked for the development and support of nursing research.

CHSRF's initial programs (in support of health services research) have been operating for about 3 ½ years. Its programs to build capacity for health services research (in support of health research personnel) began about 2 years ago. Its thrust to foster quicker and more effective incorporation of evidence derived from research into decisions and policies affecting health and health care in Canada (in support of health research uptake/knowledge transfer) is just now gathering momentum.

The Board of Trustees commissioned the International Review Panel (hereafter the Panel) to evaluate CHSRF's performance since its inception and to make observations on future directions. The Panel's Terms of Reference are attached as Annex A which includes also the timetable it followed; brief biographies of its members are given in Annex B.

Review Process:

Mr. Michael McKeown, Executive Assistant to Mr. Jonathan Lomas, Executive Director of CHSRF, provided administrative support for the work of the Panel³.

We were provided the following materials:

<u>Briefing Book 1</u> (July 2001)	(Appendix 1)
Terms of Reference	
History of the Foundation	
Other Evaluations ⁴	
Philosophy (of CHSRF)	

³ The Panel's members are grateful to Mr. McKeown for his excellent work, cheerfully performed, and for his thoughtful anticipation of ways to make our participation in this review as informed and pleasant as possible. We appreciate particularly his looking after us so solicitously and well during our three days of meetings in Ottawa.

⁴ ...of which there have been five to date:

- Report of Scientific Officer, August 1999
- Staff Evaluation of Policy Synthesis Program, May 2000
- Canadian Facts Group, Evaluation of Dissemination Strategy for Policy Synthesis, November 2000
- Strategic Review Group, Audit and Evaluation of CHSRF-Funded Projects, March 2001
- Strategic Review Group, Audit and Evaluation of CHSRF's System Processes and Project files, March 2001

Organizational and Program Chart

Briefing Book 2 (September 2001) (Appendix 2)

Programs, Activities and Budget

Approach #1: Innovative Research Funding

Approach #2: Synthesis and Dissemination

Approach #3: Research Use

Approach #4: Sponsorships and Co-sponsorship

Budget Issues

Letters were sent by the Chair of the Panel inviting responses from people drawn from the following 8 groups:

1. Funded investigators (researchers and decision makers)
2. Unfunded applicants
3. Decision makers
4. Knowledge brokers
5. Research funders
6. Nursing research community
7. University departments
8. Merit review panellists

The responses not submitted as confidential were reviewed by Ms. Marilyn Kuhn, an independent contractor to CHSRF, and summarized⁵ in:

Briefing Book 3: Achievements, Perceptions and Possibilities (September 2001)

Binder 3a

Summary of Replies by Ms. Kuhn (Appendix 3)

Letters of Comment

Binder 3b

Letters of Comment (continued)

Binder 3c

Case Studies: (Appendix 4)

- Original Open Grants Competition Funding Formula
- Partnerships Promote Evidence-based Decision-making
- Policy Syntheses Make Complex Information Easy to Understand
- Letter of Intent Preparation Grants
- Communications Infrastructure Development Grants
- CHSRF/CIHR Chair Award in Dissemination and Uptake
- “Invited Exchange” between Researchers and Decision Makers

⁵ The Panel commends Ms. Kuhn for her excellent work. Her summary accords well with the Panel members’ independent reviews of the individual letters on which her summary is based.

Copies (made by Ms. Kuhn) of all letters submitted on a confidential basis.

The originals and copies of these letters have been retained by Ms. Kuhn and the four panellists and will be destroyed when the final report has been submitted to CHSRF's Board of Trustees.

Additional letters of comment received too late (up to November 1, 2001) to be incorporated in Ms. Kuhn's summary or Binder 3

CHSRF 2000 Annual Report

From Sunday, October 13 to Wednesday, October 17, the Panel held hearings with 'witnesses', both in person and by conference telephone, drawn from the ranks of health services researchers and policy- and decision makers coast to coast from governments, universities, health authorities, hospitals and other providers, health-related associations and organizations, and granting councils. We also met and talked with people expert in communicating health information to researchers, policy- and decision-makers and the general public. We talked also with representatives of international agencies involved in work similar to that of CHSRF. The panel was very well informed by the forthcoming nature, candour, and remarkable consistency of the views expressed in the correspondence received and these diverse conversations.

Prefatory Remarks:

This must be considered a formative, not a summative review. After only 3 ½ years of operation of CHSRF's longest standing programs (in support of health services research), it is far too early to do more than:

- a) advise the CHSRF about the track it is on toward achieving the goals and objectives set out in its mission
- b) recommend course corrections for the next 3-5 years and
- c) suggest questions and criteria that should be considered in the next evaluation. We suggest that this should be next undertaken when CHSRF approaches the 10th anniversary of initiation of its operations.

CHSRF has been over-reviewed in its short life. This review by the Panel is the sixth of one kind or another⁶ conducted since operations began. Such introspection, while undoubtedly intended to serve the essential goal of accountability, consumes resources and, more importantly, time and energy. It is time for CHSRF to 'plateau', to enjoy greater stability over the next 3 to 5 years during which it can consolidate and bring to maturity the initiatives of its early founding years.

⁶ See Footnote 4, page 4

The Panel's overall conclusion is that CHSRF has achieved a fast and effective start toward achieving its mandate using three major distinct but closely interrelated, overlapping thrusts:

- a) programs in support of health services research that are just beginning to generate results or 'product',
- b) programs in support of the development of 'capacity' (health services researchers) that are fairly launched and underway, and
- c) what might be called 'receptor' development programs, dissemination and uptake initiatives to reach health policy and decision makers, that are just now being launched.

CHSRF also has conducted research itself. We have not commented directly on this aspect of its mandate as a "thrust". The research that CHSRF has done and should continue to do is designed to advance one or another of the three overlapping thrusts described above.

The Panel has taken particular note that CHSRF is not a traditional granting agency.

First, it is different because it was created as a foundation with the ability to develop programs quickly outside usual bureaucratic models, to utilize capital to earn money, and to raise additional funds from other sources.

Second, it is and was intended to be from the outset different, given that its focus is on research that can and should be *applied* to the development of policies and the making of decisions that impact on health and health care services throughout Canada (and elsewhere). It is not sufficient just to facilitate the conduct of health services research or to increase the number of people trained and experienced in research of this kind – the "Field of Dreams" strategy. The special mandate of CHSRF requires it to ensure that evidence and new knowledge, the principal fruits of research, are *considered and used* by the governors and managers of Canada's health services 'system(s)'. The Panel is aware that discharging this special mandate will require nothing short of an attitude change both on the part of researchers and of decision and policy makers. It will take innovative approaches. It will take persistence. It will take considerable time. This special mandate also explains the high cost and relative "hands-on" character of the way CHSRF's applications and programs are managed.

To use a nautical metaphor, the Panel recommends that CHSRF continue its fast but well-ordered progress toward the same destination it selected at the outset but, given changes in the weather, that it make some course corrections soon. We suggest what these should be in what follows. But we cannot prescribe the extent and pace of those corrections. Those on board, CHSRF's Trustees and managers, must navigate and sail the ship themselves.

The Panel's Findings:

CHSRF – The Organization

First, CHSRF is distinguished from the federal and provincial granting councils and other organizations that support research in Canada by virtue of its special focus on knowledge transfer – fostering the incorporation of new knowledge and evidence into policy and operational/managerial decisions related to health and health care. Although there are other ‘players’ interested also in the process of knowledge transfer, it is fair to say that it is more in the nature of a by-product of their work. For CHSRF knowledge transfer is the prime ‘product’. It is, at root, CHSRF’s very *raison d’être*.

Two recommendations follow from this fundamental point.

Recommendation 1: In the near future CHSRF should conduct a comprehensive synthesis of existing research relating to knowledge transfer and either conduct itself or contract with others basic and applied research into the subject.

CHSRF has the mandate and capacity to do research itself. There is need for a lot of new knowledge about how evidence and knowledge is effectively transferred from those who generate it to those who do or should incorporate it in policy- and decision-making. To discharge its special mandate, CHSRF must understand the knowledge transfer process – what works and what doesn’t. It needs to know and understand the range of factors that policy- and decision-makers must take into account, including the place of knowledge, in that difficult, complex and varied calculus. It needs to know whether knowledge transfer as it applies to policy- and decision-making in health differs from knowledge transfer in other fields and, if so, in what respects. This calls for fundamental research on the knowledge transfer process in many fields.

It calls also for applied research on the question of to whom is the Foundation trying to transfer knowledge. Do the audiences include the general public in addition to politicians, bureaucrats and managers and, of the latter, what should be the order of priority? Clarity on the audiences CHSRF is trying to reach is vital!

It is the Panel’s firm opinion that this is work that must be conducted or stimulated by CHSRF as a matter of high priority either acting alone or in partnership with others, including The Canadian Institutes for Health Research (hereafter CIHR) through the Institute for Health Services and Policy Research (IHSPR).

Our second recommendation comes out of the observation that CIHR and IHSPR constitute very significant ‘players’ new on the scene since CHSRF was founded. Arguably were they in place in 1996/7, CHSRF might not have been created. But CIHR and IHSPR are still in a very early stage of development. The more traditional, biomedically-oriented Institutes will probably pick up relatively smoothly from where the previous Medical Research Council left off. As a result CIHR will almost

certainly continue to play a dominant role in biomedical research in Canada. But it is impossible to know at this stage what the particular role/niche of the Institute for Health Services and Policy Research will be over time and especially how its work will impact that done by CHSRF. The Panel believes that at this stage high priority should be given to developing a complementary and mutually supportive relationship between CHSRF and IHSPR.

Recommendation 2: CHSRF should work closely with IHSPR with a view to forging a partnership (or at least a well-defined working relationship as a framework for close, on-going collaboration between them) to ensure that their work is complementary and synergistic.

The Panel believes that CHSRF would be best advised to intensify the focus of its efforts over the next 3 to 5 years on its particular mandate for knowledge transfer and those programs that are just now getting underway to serve that end. Accordingly it should put somewhat less emphasis on its programs of support for health services research and ‘capacity-building’ provided, of course, that IHSPR is prepared to work with CHSRF and encompass or, at the least, accommodate these thrusts within its primary focus.

Some of the Panel’s correspondents and ‘witnesses’ raised the question whether CHSRF should be merged with IHSPR under the umbrella of CIHR. Those in favour point out the high degree of overlap between the mandate of CHSRF and the terms of reference of IHSPR, including their shared interest in knowledge transfer; they see the opportunity to eliminate duplication of effort and to achieve administrative savings; they mention also the anticipated limited lifespan of CHSRF (given that its operations encroach on the principal of its endowment) versus the presumed continuance long-term of CIHR and IHSPR. Those opposed point to the advantages to the research community of retaining two sources of potential funding, to the differences in primary focus (knowledge transfer versus research support and capacity-building), to the fact that it is yet too early to know just what IHSPR is going to do, and to uncertainty whether IHSPR can develop sufficient strength to play a significant role within CIHR and in the ‘field’ next the “800 pound gorilla” of biomedical science.

The strong majority of opinion reflects the latter view of which the Panel is also persuaded.

Recommendation 3: CHSRF should be maintained separate from CIHR for the immediate future. The question of whether it should be merged with IHSPR and brought under the umbrella of CIHR should be re-examined, however, in 5 years or thereabouts.

To repeat, CHSRF has made a good, fast start on achieving its mandate. It has initiated a wide variety of ambitious, innovative, complementary programs that are well and truly targeted on the Foundation’s mission. The Panel recognizes especially

the innovative way of working CHSRF has adopted, especially its involvement of ‘practitioners’ from the policy- and decision-making worlds as well as researchers in identifying research priorities and themes and in adjudicating applications for funding. It has forged a very impressive array of partnerships. The Panel trusts CHSRF will apply to comparably good effect the same energy and innovativeness to forging the new partnership we recommend with CIHR and IHSPR. CHSRF has accomplished a great deal in a very short period of time and deserves the praise so many of the Panel’s correspondents and ‘witnesses’ give it.

But the next 3 to 5 years is a time for consolidation of those early initiatives. A period of relative stability is necessary both for the staff of CHSRF and for the research and decision/policy making communities with which it deals.

Recommendation 4: CHSRF should concentrate in this next stage of its development on fine tuning, focusing and bringing its programs to maturity rather than initiating new ones.

Turning to another issue, it is very apparent that the reputation of CHSRF is closely associated with the *persona* of its Executive Director, Jonathan Lomas. The Panel concurs in the overwhelming majority of opinion that the success of CHSRF in building national and international credibility in such a short period of time is largely attributable to Dr. Lomas’ leadership coupled with his reputation and previous work in the field. He was indeed “the right person at the right time” when CHSRF was founded. Although this matter is not within our purview, the Panel believes that Jonathan Lomas continues to be the leader best suited to the challenges CHSRF faces now and will continue to face over the next 3 to 5 years; now is not a time to make a change in leadership.

From an internal focus, we were very favourably impressed by the glowing observations we received directly from the staff of CHSRF about Dr. Lomas’ leadership and about the Foundation as a place to work. The Board of Trustees can be proud of what it has created and governs, as proud as the staff members obviously are of what they have helped create. Dr. Lomas has set a very good example of leadership/management. These compliments by the Panel echo the very positive comments of the great majority of respondents who communicated with the Panel about their interactions with CHSRF and its staff. CHSRF works well with and is highly appreciated by the great majority of researchers and policy- and decision-makers with whom it interacts.

We draw to the Trustees’ attention, however, two concerns.

The first is with succession planning. It is important to escape the vulnerability associated with CHSRF’s being and being regarded as Jonathan Lomas’ ‘show’. No organization should depend so heavily on a single person, no matter how good, healthy and vigorous. Accidents happen. Prudence and realism dictate that the Board

of Trustees take steps immediately to identify and, optimally, put in place others who could smoothly pick up the mantle of leadership should that become necessary.

Our second concern has to do with the sense we have taken from the correspondence and interviews that CHSRF may be in danger of being cast as having a “single point of view”; i.e., a predictable ideological perspective that, in this case, is synonymous with that of its Executive Director. We have no comment to offer on what that perspective might be but it is very clear to the Panel that discharging CHSRF’s primary mandate for knowledge transfer depends absolutely on establishing and maintaining its reputation for strict objectivity in relation to any issue on which it or its representatives may comment. It must also guard against the perception that it serves as an apologist for or supporter of government, whether federal or other. CHSRF’s mission, “making research work” cannot be achieved if its independence and objectivity are suspect! That danger would be reduced were CHSRF to utilize additional spokespersons to complement independently the widely sought opinions of the Executive Director

The Board of Trustees must, of course, consider and decide itself what action, if any best meets the present and long-term needs of the Foundation. Among the approaches that could be considered, however, the Panel discussed the possibility of appointing a deputy Director and/or of creating more prominent roles for CHSRF’s new regional representatives. Another possibility is to create the opportunity for senior individuals (whether researchers or policy-/decision-makers) to come to CHSRF from the ‘field’, as sabbaticants for example. One bonus to any of these possibilities would be to provide Dr. Lomas with time (a mini-sabbatical perhaps) to read, write, think, and recharge his own research ‘batteries’; he might take the lead himself in undertaking basic and/or applied research on knowledge transfer and the complex calculus of policy- and decision-making in health (see recommendation 1).

Recommendation 5: The Board of Trustees should immediately concern itself with succession planning for CHSRF’s Executive Director.

The need for succession planning extends to the Board of Trustees as well. The Panel has taken note that the Board’s membership is relatively narrowly cast with a preponderance of people with expertise and experience either in research or decision-making in health. We observe, for example, that the Board has no regular member drawn from the world of finance/investment; it depends on two “external members” of the Finance, Audit and Investments Committee for the discharge of its fiduciary responsibility to optimize the value and performance of its endowment. The Panel believes that with CHSRF now well and truly ‘up and running’, the Board of Trustees would be well advised to extend succession planning to its own membership and to broaden its focus to encompass a wider and more diverse reach of Canadian society.

On a related point, some correspondents commented on the proportion of the budget CHSRF spends on overhead (administration and internal costs of running its programs). We have reviewed the study provided to us (in Briefing Book #2)

comparing the overhead costs of CHSRF relative to a number of similar organizations but are not entirely persuaded by those results that CHSRF is really “administratively lean”. As we said before, we do appreciate that CHSRF is more than a granting council and that its particular mandate relating to knowledge transfer imposes on it higher than ordinary costs. But it remains that we are not convinced that CHSRF’s strategic plan is driving the budget as effectively as it could. Again, inclusion on the Board as regular board members of people with experience in the financial/business/industrial world could be beneficial.

Recommendation 6: The Board of Trustees should immediately concern itself with planning for its own succession and with implementing those plans.

The Panel’s Terms of Reference call for us to venture an opinion on CHSRF’s “standing” *vis-à-vis* other organizations working in the same field in other countries. As noted above, there are no closely comparable organizations of which the Panel’s members are aware. There are many that offer programs similar to those of CHSRF but none whose programs cover the spectrum of research support, capacity development, and knowledge transfer in such a closely integrated, interrelated way.

Two themes are clear. CHSRF is rapidly emerging as an innovative organization in the field of health services research/knowledge transfer that compares very well with similar organizations in other countries, most of which are of much longer standing and are far more richly endowed/funded. Second, CHSRF should be encouraged to continue over the next 3 to 5 years to build its links to those related international organizations (The Commonwealth Fund and the U.K. Department of Health, for example). But in doing so it should guard its focus on the core mission here in Canada and, in particular, its special thrust in the difficult area of knowledge transfer.

The Panel offers one final comment in this section.

It is clear that there is some unhappiness west of Ontario and south and east of Quebec based on the perception that investigators and institutions/organizations in those two provinces are disproportionately successful in the competition for grants and awards by CHSRF. The Panel is aware of the study (Briefing Book 2) demonstrating that funding by CHSRF is, in fact, roughly proportional to population, province by province but that awareness does not seem to extend throughout Canada. It would be a good idea were CHSRF to repair quickly any communication problem that may exist. But beyond that it should consider explicitly what should and can be done about the real issue of regional disparity in health services research capacity and the perceived issue that out of CHSRF’s competitions “them what has, gets” more. Disgruntlement at both ends of the country is just not helpful either to CHSRF or to the broad goal of making more and better evidence derived from health services research available to those making health-related policies and operational decisions. It is clear to the Panel, however, that the limits on CHSRF’s financial resources and its clear responsibility to give priority to funding those applications with what its peer

review processes judge to be the greatest change of success provide the Foundation with very little latitude to deal other than it is now doing with regional disparity.

The Panel commends CHSRF for its recent appointment of two Regional Officers, both highly respected, experienced researchers who will, no doubt, be invaluable in opening up direct lines of communication both with researchers and policy- and decision-makers “on the ground”. These appointments (possibly augmented by others) should help alleviate the sense of regional disparity we have observed.

Recommendation 7: Consideration should be given to ways and means of addressing the question of interregional equity. This might be done in the decision-making processes of CHSRF itself, both at the level of the Board (governance) and operationally (in merit review). Greater use might also be made of CHSRF’s Regional Officers in this regard.

CHSRF’s program thrusts:

We will complete our report with comments on CHSRF’s three principal thrusts, research support, capacity building, and knowledge transfer.

Support of Health Services Research:

There are four principal matters to discuss:

- a) research projects versus programs
- b) research themes
- c) CHSRF’s definition of health services research that excludes studies of clinical efficacy, and
- d) future coordination in respect to this thrust with IHSPR.

Despite the observation that policy- and decision-makers usually need urgently research-based evidence bearing on very short-term issues, we believe it impossible first for any organization or individual to predict those needs throughout Canada’s provinces and territories and second for university-based researchers to design, secure funding and conduct the work fast enough to meet them. On the other hand, CHSRF has some short but good experience in picking research themes relevant to contemporary issues based on its wide (and widely praised) consultation with policy- and decision-makers throughout the country and with its support of programs of research focused on those themes.

The Panel believes CHSRF is best advised to give priority to research programs over projects, although it might retain a small quick-response fund for timely work related to particularly urgent, newly identified health policy issues. But research in the latter category should be commissioned and to a considerable degree managed or even conducted by CHSRF; it should not be investigator-initiated. Although some of the commentary made to the Panel called for longer time to accomplish the goals of funded research programs, our view is that CHSRF’s guidelines should continue to

put pressure on researchers to make as much progress as possible in the shortest possible time.

Recommendation 8: CHSRF should emphasize health services research programs over projects.

As for research themes, given CHSRF's limited resources there is no escape from the need to focus on those themes considered most directly relevant to the present and anticipated needs of policy- and decision-makers. The present process of setting themes does exclude some potential applications and first-class researchers and also presents the danger that some proposals will be 'tailored-to-fit' regardless of the themes selected. Such is life in the granting business!

The present process of establishing research themes is fundamentally good, although more attention should be paid to reporting to those consulted (and others) on the reasons why some themes were selected over others. The Panel is mindful, however, that the theme-setting exercise is essentially complete for the time being. It would be a very bad idea to change research themes too quickly; it would defeat the whole principle of funding programs over projects. We point out that the Robert Wood Johnson Foundation has had the same four themes for a very long period of time; the Kellogg Foundation has three global and long-lasting themes.

Recommendation 9: CHSRF should continue its practice of limiting its support of health services research to programs that address clearly identified themes of research.

The Panel understands and agrees with CHSRF's decision from the outset to eschew support of research related to clinical efficacy; it could and likely would overwhelm other programs of health services research. Such decision is in the same category as the decision to support particular research themes. But there are consequences to this decision that should be ameliorated, notably the sense of exclusion from CHSRF of medical and nursing investigators who believe (rightly) that work of this kind is genuinely in the "health services" genre and observe that their applications too often get short shrift when considered by agencies primarily concerned with biomedical research. This is a particularly sharp irritant among some members of the nursing research community. We will refer again to this later.

Recommendation 10: CHSRF should continue its policy of excluding from funding consideration the category of "clinical" research but should make more clear both its definition of what kinds of research are excluded and why. It should also work with IHSPR (see below) to find ways to increase the access to research funding of those excluded researchers who submit applications of good quality.

To repeat, it seems to us imperative that CHSRF seize the initiative now as a matter of high priority to work with IHSPR and CIHR to achieve optimum complementary and synergy in both their support of health services research and the development of

greater health services research capacity throughout the country. Given the general orientation of CIHR toward research support and training, it seems both likely and logical that the outcome of that complementarity and synergy would be that CIHR and IHSPR should concentrate more on health services research and training, particularly that which is based in university/health sciences centres, and the focus of CHSRF should shift more toward its thrust to knowledge transfer and the development of both ‘receptor’ and research capacity in the field. In making this recommendation, the Panel emphasizes that the requirement should continue that supported research involve policy- and decision-makers from its conception through execution and that “matching money” still be required. These requirements are vital to support CHSRF’s thrust to knowledge transfer.

Recommendation 11: CHSRF should enter into discussions with CIHR with a view to tailoring its health services research support programs to complement those offered by IHSPR and *vice versa*. The ‘tailoring’ should produce a mutual fit.

Finally, it is apparent to the Panel that the competent health services research community (capacity) in this country is essentially saturated with work. The number of applications to CHSRF’s research competitions has been falling (although the data from this year are not yet available⁷). The lower number may be related to better understanding of the purpose and procedures of applying to CHSRF. It remains to be seen what proportion of researchers will switch to IHSPR. Applications there are likely to be considered easier to put together given the absence of CHSRF’s requirement for the time-consuming and often frustrating linkages with policy- and decision-makers willing to make definitive commitments of money and contributions of effort. The Panel anticipates that CHSRF and IHSPR together could well have some difficulty placing their available support in high quality projects/programs over the next two or three years. If so, it is particularly propitious for CHSRF to ‘tilt’ its focus now toward the thrust to knowledge transfer.

Support of the Development of Health Services Research Capacity

Here also our comments in relation to CIHR and IHSPR apply. Forging partnership/complementarity with respect to the training/development programs of both agencies is essential, particularly with respect to university/health sciences centre-based students and researchers.

Recommendation 12: CHSRF should enter into discussions with CIHR with a view to tailoring its health services capacity-building programs to complement those offered by IHSPR.

⁷ Subsequent to the submission of this report, the data reveal that applications to CHSRF are up, not down. The data for the current and preceding 2 years are as follows:

2002 OGC	92 letters of intent
2001 OGC	60 letters of intent
2000 OGC	117 letters of intent

Despite the Panel's recommendation to be wary of developing new programs over the next 3 to 5 years, depending on the outcome of discussions with IHSPR, CHSRF might consider re-orienting somewhat its capacity-building thrust to target current and potential researchers who now work in the 'field', i.e., for health authorities, hospitals, or government agencies for that matter. It might expand its program to retrain/reorient researchers in fields not now considered within the ambit of health services research. Consideration should be given to building health services research capacity in people who are or will be policy- and decision-makers, those who are or will be at the cutting edge of the knowledge utilization side of knowledge transfer. The Panel believes the term "double apprenticeship" is particularly apt to describe the most fruitful approach to knowledge transfer – where those generating knowledge work with those who use it (CHSRF's current emphasis) and *vice versa*, those who use evidence/knowledge have the opportunity to work closely with those who generate it (the new focus the Panel is now suggesting be considered).

Recommendation 13: CHSRF consider reorientation of its capacity-building programs (or the development of a new one) to focus on the education and training of people in the field, working on the knowledge utilization side of knowledge transfer, in accordance with the concept of "double apprenticeship".

With respect to 'capacity building' in health services research the Panel observes that the tendency of most universities in Canada to adhere rigidly to traditional criteria for promotion, tenure and 'progress-through-the-ranks' and particularly their regard of publications in peer-reviewed journals and references from academia as the 'gold standard' of qualitative productivity remains a problem. This should be a matter of joint concern to CHSRF and IHSPR/CIHR especially in that it affects most young investigators at the start of their careers when much of their research output, even though voluminous and of high quality, may be discounted heavily or not 'counted' at all. The Panel has no recommendation to make. We suggest that CHSRF and IHSPR jointly consider ways and means of trying to alleviate more quickly the academic snobbery that affects applied research generally and health services and policy research in particular.

In addition to working on this problem and creating complementarity between the capacity-building programs of CHSRF and IHSPR, there is scope for CHSRF and CIHR to work together to build a stronger community of health services researchers throughout the country. Some strategies might include creating a Health Services Research Association with an annual meeting where like-minded people could gather, build their networks, and feel at home. Perhaps a journal (modelled on Health Affairs, for example) and other publications (an electronic Newsletter, for example) could be created tailored specifically to topics of interest to both researchers and policy- and decision-makers in health and health care.

Support of Knowledge Transfer

As pointed out previously, although the research support and capacity-building programs contain important elements of CHSRF's thrust to knowledge transfer, the special programs it is targeting directly at this objective are just beginning. We also reiterate our repeated earlier comments that this thrust should engage CHSRF's highest priority over the next 3 to 5 years. The successes achieved will essentially "tell the tale" whether CHSRF has been itself a success or failure. But we should add that that "tale" won't be told in 3 to 5 years; it will take longer, probably much longer.

It is vital, therefore, that attention be given now to devising and developing measures of successful knowledge transfer, evidence derived from research that is applied by policy-and decision-makers to improve the quality and effectiveness of their 'products'. Those measures must be developed in full understanding of the fact that evidence and knowledge are but one (an increasingly important one, we trust) of the many factors that must be taken into account in making policies and decisions relating to health and health care.

The Panel refers to the content of Briefing Book 2 and notes that the next evaluation has to go beyond the measurement of deliverables. The mere counting of what has been done is now modestly helpful at best and will be essentially useless in 3 to 5 years. CHSRF must develop a capacity to go beyond 'inputs', to measure 'outcomes' and then to go beyond that to measure the 'impact' of evidence based policy- and decision-making. We acknowledge that this represents uncharted water and will be difficult. But it must be done! As an example of the kind of data we have in mind, it will be helpful to future evaluations to have available records of all those who have been supported by CHSRF under the 'capacity building thrust' that will show where they have gone, what positions they hold and have held, what kinds of policies and/or decisions they have been called on to make, and how fast has been their progress to high levels of responsibility relative to those who have not been connected with CHSRF.

Recommendation 14: CHSRF should accord highest priority over the next 3 to 5 years to its knowledge transfer thrust. To complement the research referred to in Recommendation 1, CHSRF should develop measures of the outcomes and impact of all of its programs but especially knowledge transfer.

Communications constitute a key element in knowledge transfer. The Panel, both from its own knowledge and by virtue of the 'feedback' it has received during this review, commends CHSRF for the informative easy-to-read character of its publications, especially Links and Mythbusters. The language used is pitched at the right level and there is no doubt that these publications are reaching their audiences. We have been told of some concern that the Mythbuster series deals with 'myths' in ways that are too predictable, even "government-like". Such concerns should be

explored, perhaps by including ‘feedback’ invitations from time to time in all publications.

That having been said, even an excellent communications strategy can be improved. The best place to start is with representatives of the communications industry, the media and others – those who are expert and involved every day in communicating news, ideas, and opinions to many audiences, including the public. As one of our ‘witnesses’ put it, “it is vital that communications be done with a view to meeting the needs and interests of the readers and viewers, not the writers”. Those of us who have experience in writing, editing, and publishing scientific papers know well how many publications fail that test!

The same test should be applied to all the ways in which CHSRF seeks to communicate with its several audiences. We reiterate the importance of clearly identifying those audiences. Whether publications, web site, face to face meetings, e-mail, the telephone, letters, *etc.*, it is vital that CHSRF present a consistent, persuasive and understandable message in accordance with a well developed, comprehensive, and focused communications strategy.

CHSRF should seek partnerships to help it deliver on its communications strategy. For example, university departments of continuing education share interests in communicating research results to policy- and decision-makers, both at the highest levels and among those middle managers who are most frequently concerned with implementing changes. More partnership building is in order!

Recommendation 15: CHSRF should re-examine its communications strategy with particular reference to the focus that the Panel recommends be put on knowledge transfer. Serious consideration should be given to including the general public as a potential audience for CHSRF.

We recognize the difficulties of communicating with the general public and of engaging the popular media in that process. We recognize also the potential expense of such course of action. None-the-less, given the poll-oriented political culture in Canada and the strong influence of public opinion on policy-making, CHSRF should seek expert opinion on and give very serious consideration to including the public as an audience when revising its communications strategy.

Nursing Research

As noted previously, the Panel believes that CHSRF has done a good job of incorporating its special remit for nursing research into its programs, both of research support and capacity building. The strong support for nursing research is very evident in, for example, the five CHSRF/CIHR Chairs held by nurses. The Panel notes also the very strong contributions being made to CHSRF’s mandate by nursing researchers. It is a great pleasure to see such “win-win” strategies working so well.

Yet of all the topics discussed by correspondents to and ‘witnesses’ with the Panel, that of CHSRF’s relationship with the nursing profession received by far the greatest number of negative comments, some of them very negative indeed. Some nurses do not perceive CHSRF to be “their” advocate and funding agency. That is not to say that those in nursing are united in their negativity – far from it. The profession appears to be very divided in its view of how CHSRF is discharging its special responsibility over its \$25 million endowment for the support of nursing research. Some seem to regard research other than nursing research as their own proverbial “800 pound gorilla” and want to put a fence around nursing research to protect it; others, however, believe their best interests are served by getting in the same pen with the beast and making it their friend. But it remains that some members of the nursing community are unhappy with CHSRF and this unhappiness must be addressed now.

Recommendation 16: The Board of Trustees should take immediate steps to resolve difficulties that are perceived by some members of the nursing profession to affect the Nursing Advisory Committee, the availability of funding for “clinical” nursing research, and communications generally between CHSRF and the nursing research community.

There appear to be two major issues.

One has to do with ways and means of allocating income and capital derived from 20% of the nursing research endowment (a total of \$5 million) that are supposed to be available for the support of ‘clinical’ research in nursing. These funds should be made available to applicants soon but in ways that meet CHSRF’s fiduciary responsibility to ensure that they are used to the best possible effect.

The second relates to a lack of transparency (opacity) of communication among CHSRF’s management, the Board of Trustees, the Nursing Advisory Committee, and the profession in general.

The Panel is very clear on one point and that is that the endowment earmarked for the support of nursing research is part of CHSRF’s endowment. These funds are not “nursing research funds”. CHSRF carries the same fiduciary responsibility for the management of this part of its endowment and for the effective use of the interest it generates as it has for its general endowment and interest. In that respect, it should be pointed out that at a guaranteed rate of allocation of \$2.5 million per year in support of nursing research CHSRF has exceeded by far and away the minimum expenditure needed to meet the terms attached to the \$25 million with which it was endowed in 1999 to support nursing research.

Criteria for Future Evaluations:

To complement the discussion above directed to the development of data that will permit future evaluators to move beyond inputs to outcomes and impact, following are some suggested questions/criteria, listed in a very rough order of priority, CHSRF should have in mind for the next International Review Panel:

- What has happened to the young researchers supported to this point by CHSRF? What has happened to the CHSRF/CIHR Chairs? CHSRF's capacity development programs should be evaluated from the perspective of those who have been "developed". To answer these questions a database/register of both young and experienced researchers should be established to track their careers.
- With respect to the evaluation of supported research, CHSRF should collect information on the number of publications that result from research it has supported, where the publications are placed, and the proportion of them in international journals of the highest quality. It should also develop comparable criteria to judge contributions to the 'grey' literature, policy papers and the like.
- The real test of CHSRF's success will be measured by the change in attitude toward the application of evidence to policy- and decision-making. "Before and after" surveys of such attitudes within the research and policy/decision-making communities will be essential. In addition to surveys of attitude, a survey of policy- and decision-makers should be conducted now and again in 3 to 5 years to measure what changes there may have been in the actual use of evidence derived from research. The questions should be asked whether those surveyed depend on CHSRF and/or researchers supported by it and/or CIHR to provide them with access to reliable information, data and/or evidence to support their policy- and/or decision-making.
- Has CHSRF enlarged its circle of partners, how and with whom? What benefits have resulted? What is the nature of the relationship between CHSRF and IHSPR/CIHR now versus in 2001?
- Has CHSRF developed good measures of the quality of qualitative as well as quantitative research? How effective are those measures?
- What are the knowledge transfer and dissemination activities that have been the most successful in terms of outcomes and impacts on the policy- and decision-making processes?
- What is the involvement of people new to the field of health services research, especially from the social sciences, in CHSRF's thematic research? Is recruitment into the field growing and, if so, from what sources of expertise/experience?
- What is the public perception of CHSRF?
- How has CHSRF managed its endowment and finances generally?

The Panel recognizes that creating specific measures to answer these and related questions and to support application of the criteria they represent will be very difficult. But such measures (and the more specific the better) have to be developed and implemented. Attention should be paid now to putting in place as much in the nature of control data and measurement instruments as time, money and human

ingenuity allows. Therefore CHSRF should think through these issues now and make a start on developing the measurement tools and databases to support the next evaluation in 3 to 5 years time.

What Has Not Been Discussed:

By way of final commentary, the Panel was struck by three important issues that were missing from the commentary it received and discussion it had with its 'witnesses'. Those issues are:

- information management. Health services research and policy- and decision-making in health and health care are highly dependent on the capacity of the 'system' to manage health information. This capacity is seriously underdeveloped everywhere but particularly so in Canada. Correction of that deficiency is well beyond the financial and other means of CHSRF and we have no recommendation to offer in this respect. But it is a matter that should be of great concern to CHSRF and the research and policy- and decision-making communities it serves. CHSRF's voice could be added to others to urge governments and health service providers to accord this key issue higher priority.
- information and communication technology – ways and means of linking both education and research at a distance to policy- and decision-making. CHSRF's Web site has been redesigned; the previous one generally receives modest praise. But the potential of internet-based communication technologies for the support of policy- and decision-making remains in its infancy. It behoves CHSRF to think about ways and means of proceeding at least to adolescence if not maturity in its use of these technologies. To some degree this was discussed under the heading of communications but in the Panel's opinion, it has received far less emphasis than is now necessary.
- diversity of approach in patient care. Cultural, ethnic and gender diversity are issues that are being recognized internationally as very important contributors to the efficacy of service provision, including health, health care services and education. They seem strangely absent from the present review given the attention now being paid to them in other countries, especially in the United States.

These are high on the list of issues futurists are talking about. They should not be ignored by CHSRF.

We trust this report of the International Review Panel will be helpful to the Board of Trustees of the Canadian Health Services Research Foundation. It has been a pleasure to conduct our review of what is clearly a very innovative and successful young organization well started on the path to achieving its potential in a vitally important area of public policy.

Respectfully submitted:

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