Study of Canadian Health Policy Research Centres: Final Report

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STUDY OF CANADIAN ACADEMIC HEALTH POLICY RESEARCH CENTRES: FINAL REPORT

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March 2005
ACKNOWLEDGEMENTS

The authors would like to express their gratitude to the following organizations and individuals:

- The Fulbright Program for awarding the Grant for Research Abroad, which made this study possible;

- The Canadian Health Services Research Foundation and Chris McCutcheon for input into study design and for serving as a relationship broker;

- The Network of Applied Health Services Research Centre Directors for providing a forum to present results;

- The directors of the participating Canadian health policy centres for their time, interest, and participation in this project;

- Dr. Karen Edison at the University of Missouri-Columbia School of Medicine for her mentorship during the study of United States health policy centers and for her support of this project during its formative phases;

- Dr. Heather C. Lambert at the Queen’s University Centre for Health Services and Policy Research for her French translation services; and

- The faculty and staff at the Queen’s University Centre for Health Services and Policy Research for their interest in and support of this project.
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*Study of Canadian Academic Health Policy Research Centres, 2005*
STUDY OF CANADIAN ACADEMIC HEALTH POLICY RESEARCH CENTRES:

MAIN MESSAGES

- Capitalizing on the collegial environment among Canadian health policy centres, such centres must work together to develop systematic, centre-specific performance measures to address funder concerns about accountability.

- Creative infrastructure funding mechanisms and faculty sponsorship will emerge as a critical survival strategy for centres as infrastructure support remains stagnant and as universities continue to experience financial challenges.

- Utilizing this report as a starting point, centres should engage their core funders, including ministries of health and affiliated universities, and educate them on: the challenges faced by centres; the importance of centre contributions through applied research and knowledge-transfer activities to health policy development; and the value of having independent health services and policy research capacity available within the province. Such discussions with university administrators should also highlight the need to recognize applied research and knowledge-transfer activities on par with peer-reviewed publishing and teaching in faculty review criteria.

- Developing a centre communications and knowledge-transfer strategy and designating a lead person to oversee this initiative is essential to the success of centre outreach efforts. This initiative should include mechanisms for tracking centre-audience interactions, which are often used as a proxy for measuring centre effectiveness.
STUDY OF CANADIAN ACADEMIC HEALTH POLICY RESEARCH CENTRES:  

EXECUTIVE SUMMARY

With today’s escalating demands for accountability, Canada’s academic-linked health policy centres are feeling pressure from key funders to prove their effectiveness. At the same time, their contributions through applied health services and policy research and knowledge-transfer activities have become increasingly critical to health policy development and decision making.

To assist in easing the tension, this study identifies key operational success strategies so individual centres can adopt those that are most suited to their particular structural model. Furthermore, this study documents the challenges shared by centres so that they can jointly develop tools and solutions. Utilizing the findings in these ways, Canadian health policy centres can increase their individual and collective effectiveness in informing regional, provincial and national health care debate and policy formation.

Predominant Challenges

Centres’ challenges fall into three overarching categories: infrastructure funding, performance measurement, and university faculty promotion. More specifically, with regard to infrastructure funding, the challenges are as follows:

- stagnant and often shrinking infrastructure funding from ministries of health and affiliated universities coupled with rising operational costs;
- dependence on ministries of health as the sole source of core funding, especially by those centres delegated as provincial health data custodians;
- term-limited funding opportunities, such as grants and contracts, which lead to unstable revenue streams;
- lack of grant-based investigator salary support; and
- university financial conditions that threaten tenured faculty positions.

As to performance measurement, which is crucial for demonstrating accountability to various audiences, centre concerns relate to:

- a dearth of systematic, centre-specific performance metrics; and
- an absence of meaningful “best-in-class” benchmarks for centres that do not serve as data custodians.

Finally, university faculty promotion criteria generally fail to recognize and reward multidisciplinary applied research and knowledge-transfer activities, which are centres’ core functions, on par with traditional academic endeavors, such as teaching and publishing.
Key Success Strategies
To cope with and overcome the above-noted challenges, centres have developed a number of operational success strategies. The most commonly utilized strategies are the following:

- ensuring university affiliation, as well as administrative buy-in from the highest levels within affiliated universities;
- developing and maintaining a critical mass of high-quality, multidisciplinary faculty investigators;
- attracting funding – especially for infrastructure support;
- fostering relationships with national and provincial health care decision makers, particularly those in the public-service sector; and
- building a reputation for centre excellence by generating first-rate, policy-relevant work products.

Emergent Themes
While no two Canadian health policy centres are identical, three universal themes emerged during the course of the study.

Theme One: Centre-Ministry Symbiosis
Most centres have a symbiotic relationship with their respective ministry of health. As rule, centres depend heavily on their ministry for core funding, which is often provided through long-term, renewable contracts, and, as a result, centres focus a portion of their research efforts on provincial health care efforts of interest to the ministry, which they view as a primary target audience. Ministries, in turn, benefit as the recipients of applied research and consulting services targeted toward their needs. In addition, by funding such centres, ministries ensure the existence of independent health services and policy research capacity within the province. These centre-ministry linkages, however, are experiencing some discord due to concerns regarding accountability for funding and infrastructure funding levels. As a result, centres and ministries should look to this report as a starting point for discussions for developing more appropriate funding mechanisms and instituting mutually agreed upon performance measures.

Theme Two: Core Funding Concerns
Although project funding has been on the rise in the field of health services research, core funding is failing to keep up. Such core support typical comes from ministries of health and centre-affiliated universities. Such funding enables centres to provide the basic research infrastructure necessary to entice and maintain a cadre of affiliated faculty investigators, who, in turn, leverage these infrastructure resources to attract additional research funding to the centre.

Theme Three: Centre-University Connections
Centres are not only dependent upon their ministry of health but also upon the university or universities with which they are affiliated. Such university dependence manifests
philosophically and fiscally, as centres often look to universities for limited financial support and for formal recognition as an integral part of the institution or as a valued institutional partner. The philosophical recognition imbues centres with an aura of credibility and integrity that makes them attractive to faculty investigators, funders, and key audiences.

While university affiliations are highly prized, in many instances, these relationships are also enduring some growing pains. First, university funding of centre operations is stagnant, declining, or entirely non-existent due to the state of financial stresses institutions of higher education are currently experiencing. This financial crunch extends beyond funding centre operations to funding tenured faculty positions throughout the university, which ultimately impacts centres’ ability to recruit investigators with the requisite skill sets. Second, the faculty review-and-reward systems in place at many universities undervalue applied research and knowledge-transfer activities, which are centres’ core functions, when compared to the more traditional academic endeavors of teaching and publishing. As a result, these mechanisms serve as a disincentive for faculty considering centre affiliations.

**Comparative Analysis**

To augment these key findings, the report provides some comparisons with U.S. health policy centers for added perspective. Overall, centres on both sides of the border face virtually identical challenges and employ analogous success strategies. Nevertheless, Canadian centres differ slightly from their peers to the South. As a whole, they:

- focus heavily on provincial health care issues;
- target public-sector policy makers rather than legislative policy makers;
- are differentiated based on health data oversight (i.e., whether they serve as delegated repositories for provincial health care data) rather than on the type of research undertaken; and
- operate in a generally more collaborative and open environment.
STUDY OF CANADIAN ACADEMIC HEALTH POLICY RESEARCH CENTRES: FINAL REPORT

I. CONTEXT & OBJECTIVE

A. Context
In a health care environment where rapid change and growing demands for efficiency and accountability are the only constants, entities equipped to inform the policy-development and decision-making processes through their research and knowledge-transfer expertise are increasingly valuable resources. Canada boasts 13 prominent academic-linked health policy centres that fit this description. Nevertheless, the resources – financial and otherwise – available to these centres are finite, and the competition for such resources continues to escalate.

B. Study Objective
In an effort to assist such entities, this study was designed with the objective of identifying the structural models and operational success strategies of selected Canadian health policy centres. Additionally, this primarily qualitative, descriptive study lays the foundation for a Canadian complement to the small body of previously conducted qualitative research on American health policy and health services research centers. (See Appendix A for a list of these studies.) To provide added perspective, some comparisons with the U.S. research have been included.

II. IMPLICATIONS & AUDIENCES

A. Practical Implications
The findings of this study will allow Canadian health policy centres to identify, explore, and adopt success strategies that are particularly suited to their operational model. The report also documents shared challenges, enabling centres to jointly develop tools and brainstorm solutions through forums such as the Network of Applied Health Services Research Centre Directors (Network) recently spearheaded by the Canadian Health Services Research Foundation (CHSRF). Utilizing study results in these ways, Canadian health policy centres can enhance their individual, as well as their collective, contributions to regional, provincial, and national health policy debates and formation – ultimately benefiting the end users of health services.

Furthermore, the report’s comparative component, which highlights similarities and differences between Canadian and American health policy centres, identifies issues beleaguering centres on both sides of the border – presenting a potential opportunity for international collaboration.

B. Relevant Audiences
As is clear from the study objective and practical implications set forth above, the primary target audience of the study and of this report is Canadian health policy centre leadership. Other relevant audiences are: university leadership; national, provincial, and regional governmental bodies charged with overseeing health services; and health services research
funding agencies. These secondary audiences will find the results informative, as their resources support such centres. In particular, provincial ministries of health, which provide core funding to many of the participating health policy centres, may view the report as especially helpful in gaining insight into such centres’ operational challenges. As a result – in conjunction with their centre partners – they will be better equipped to devise funding mechanisms that ease some of the identified difficulties.

III. APPROACH & SUBJECTS

A. Study Design

This largely qualitative, descriptive study was conducted using semi-structured telephonic interviews with Canadian health policy centre directors. A copy of the interview instrument is included in Appendix B. The interview tool, containing approximately 50 questions, covered five overarching areas of centre operations: (1) general information (i.e., history, target audience, etc.); (2) staffing and collaboration; (3) structure; (4) funding; and (5) external resources, performance metrics and benchmarking, and miscellaneous items. These themes were selected a priori by the investigators as those most relevant to describing health policy centre structure and operation. That these themes capture the salient features of centres was confirmed during the conduct of the earlier American-focused study.

Because detail and description were deemed critical to garnering a full understanding of the structure and operations of participating centres, the study was designed to be primarily qualitative, rather than quantitative, in nature. Furthermore, as not all questions were applicable to all centres, the semi-structured nature of the interviews enabled the interviewer (MM) to tailor questions based on responses and elicit further information where warranted.

The project findings and conclusions are based on data aggregated from the 13 health policy centre director interviews that were conducted during October, November, and December of 2004, and from participating centres’ web sites. The duration of the interviews was typically in the range of one hour, with the extremes being 45 minutes and an hour and a half.

B. Population Studied & Response Rate

For inclusion in the Canadian study, centres had to have a: (1) primary focus on health services and/or health policy research, and must be formally established for and devoted to such research generally (rather than being established for a specific project or being devoted to a particularly narrow and/or highly specialized health policy issue); (2) designation in name as “center,” “unit,” “institute,” “group,” or an equivalent; (3) Canadian situs; and either (4) university affiliation; or (5) inclusion in CHSRF’s Network.

Fifteen entities met these criteria, and, of those, 13 – or 87% – participated. This unusually high response rate is attributable to a number of factors. Among them are the heightened interest in this type of project due to the recent establishment of the Network of Applied Health Services Research Centre Directors, and the generally collaborative and collegial environment among Canadian health policy centres.
Table 1 in Appendix C contains a list of entities invited to participate and identifies those centres that opted to do so.

C. Decision-maker Involvement
Primary and secondary end users of the research have been involved in the project from start to finish. When the project was initially proposed for funding, five of the participating Canadian health policy centre directors were contacted to determine their interest, as well as to gauge the overall value and viability of such a study. Having received positive feedback from all contacted directors, the grant application was submitted. Upon commencement of the project, a member of the secondary audience, CHSRF, was engaged to obtain input into project design in the areas of inclusion criteria and interview questions. Subsequently, preliminary findings were presented to centre directors and representatives from CHSRF, the Canadian Institutes of Health Research (CIHR), and the Canadian Association of Health Services and Policy Research at the November 2004 meeting of the Network. Following this presentation, input was received from these audiences, and that input has been factored into the final data analysis and the findings presented in this report.

D. Dissemination
In addition to this report, the project’s findings will be disseminated by way of articles submitted for publication in peer-reviewed academic journals, presented to various interested primary and secondary audiences, and shared in poster sessions at international health care- and policy-oriented conferences.

IV. RESULTS
A. Presentation of Findings
The five global areas of centre structure and operations covered by the interview instrument will serve as themes for presenting the findings. Results will also be given in the aggregate, to the extent possible, to maintain interviewee confidentiality; thus, responses given by only single centres are generally not included. Finally, comparisons to findings about the structure and function of American health policy centers will be provided where appropriate. (See Appendix D for more detailed information regarding a nearly identical study of American academic-affiliated health policy centers.)

B. Findings
1. General Centre Information
   a. Centre Longevity
   The longevity of participating centres ranges from a high of 27 years (n = 1; 7.69%) to a low of three years (n = 1; 7.69%). The majority of centres (n = 7; 53.85%), however, have been in existence for between 11 and 15 years.

   b. Mission Foci
   Centre missions vary widely depending on the centre’s particular focus or core competency and its key audiences. Nevertheless, centre missions typically contain a component addressing health care quality, efficiency, effectiveness, equity, or access (n = 8; 61.54%). In addition, many centres highlight their commitment to high-quality (n = 5; 38.46%), policy-relevant (n = 4; 30.77%), interdisciplinary (n = 4; 30.77%) research. Nearly all participating
centres (n = 12; 92.31%) also make some reference to their primary audiences, such as health care policy makers, clinicians and other health care providers, the private sector, and funding agencies, in their mission statements.

c. Centre Focus
All but one centre (n = 12; 92.31%) listed the provincial health system as a primary concentration. In fact, four centres (30.77%) focus exclusively on provincial matters, and six centres (46.15%) devote their efforts to provincial and national health care concerns. As to the remaining three centres:

- one addresses regional, provincial, and national issues;
- another focuses on provincial, national, and international issues; and
- the third concentrates solely on national and international interests.

Close ties to provincial health systems emerged as a recurring theme throughout the study. This phenomenon is due, in part, to the fact that provincial ministries or departments of health contribute core funding to 11 (84.62%) of the 13 centres participating in the study. In addition, four centres (30.77%) serve as delegated repositories for and custodians of provincial health data (data centres). Thus, they have further incentive to concentrate on provincial issues.

The predominance of the combined provincial-and-national orientation and the dearth of solely federally focused Canadian health policy centres contrasts with the orientation of American academic-based health policy centers, which commonly concentrate exclusively on federal or state health care issues. These differences are, no doubt, attributable to multiple factors; among them is the pervasive role of the federal government in the U.S. health care system. Nevertheless, the focus of an increasing number of American centers may shift to a
combination of state and federal issues as the federal government’s authority over health care programs increasingly devolves to the states.\(^{(2)}\)

d. **Key Audiences & Communication Methods**
Provincial ministries of health were the most frequently cited target audience (n = 12; 92.31%), and ten centres (76.92%) consider the ministry their primary audience. The next most commonly identified audience was federal health care policy makers, such as Health Canada (n = 9; 69.24%). When referring to provincial or federal health care policy makers, it bears noting that Canadian centres generally exclude legislative or political policy makers, choosing instead to focus on public service policy makers. This decision stems from the previously explored centre-ministry relationship, as well as from centre concerns about having their reputations for objectivity and nonpartisanship tarnished by political affiliations.

Among other repeatedly mentioned centre audiences were: researchers and research organizations (n = 7; 53.85%); health care organizations, including provider organizations and professional health care associations (n = 6; 46.15%); clinicians and other health care professionals (n = 4; 30.77%); regional health authorities (n = 4; 30.77%); and the public (n = 2; 15.38%).

![Figure 2: Centre Target Audiences](image)

*Note:* Prov. = provincial; Fed. = federal; PMs = policy makers; HC = health care; Orgs = organizations; and RHAs = regional health authorities.

Although the needs of audiences differ, 12 centres (92.31%) reported a universally effective strategy for reaching key audiences: relationship-based efforts, especially those involving face-to-face interaction. Examples of such efforts employed by centres include:

- regular meetings with key funder audiences, such as ministries of health (n = 4; 30.77%);
• audience member appointments to centre work groups and advisory panels (n = 3; 23.08%);

• collaborative research projects that have audience involvement from start to finish (n = 2; 15.38%);

• informal, ongoing individual centre investigator-audience member linkages (n = 2; 15.38%); and

• a designated centre-audience liaison charged with outreach (n = 2; 15.38%).

The second most often reported audience outreach tool was hosting educational events on issues of audience interest (n = 9; 69.23%). These events range from large annual symposia (n = 6; 46.15%) to tailored workshops for specific audiences and their particular needs (n = 4; 30.77%). A number of centres (n = 5; 38.46%) also offer a monthly seminar series, which, while generally open to the public, is geared toward researchers. In addition, one participating data centre created a data base users’ group, which enables key audiences to meet, provide the centre with critical feedback, and become involved in centre strategic planning.

Publications are also frequently used by centres in reaching their key audiences (n = 7; 53.85%). The most effective publication format for targeting policy makers is reportedly one- or two-page project briefs, which summarize key findings in bullet-point format. Other publication formats cited as effective by multiple centres are project reports (n = 3; 23.08%) and newsletters (n = 3; 23.08%). Four centres (30.77%) noted that most publication formats, especially project briefs and newsletters, lend themselves to electronic distribution, which centres find highly effective for dissemination to policy makers. In addition, these publications can be posted on centre web sites, which are the fourth most utilized communication vehicle (n = 4; 30.77%).

With increasing funder emphasis on accountability, centre-audience communications also serve as a proxy measure of centre effectiveness. Hence, centres find it necessary to track contacts with key audiences. Ten centres (76.92%) monitor their interactions by employing informal (n = 7; 53.85%) and/or formal tracking mechanisms (n = 5; 38.46%). Among those informal mechanisms are direct contacts, inquiries and unsolicited feedback from audience members (n = 5; 38.46%), and invitations to provide presentations, consultations and reports (n = 3; 23.08%). Formal mechanisms include: web site “hits” (n = 3; 23.08%); peer-reviewed article placements (n = 3; 23.08%); media contacts and coverage of the centre and centre-generated research (n = 2; 15.38%); and project evaluations to determine uptake (n = 2; 15.38%).

Nevertheless, tracking centre-audience interactions is fraught with difficulty for some centres because they lack the resources to institute and maintain tracking efforts, or because their size and the geographical dispersion of their investigators makes monitoring informal contacts impossible. Other centres raised the concern that tracking audience interactions is not necessarily an effective proxy for capturing the efficacy of knowledge-transfer efforts. Centres, however, universally acknowledge the need to engage in tracking activities due to
the increasing importance core funders are placing on such non-research activities that demonstrate accountability.

Other lessons emerged with regard to effective audience communication and knowledge transfer. First, regardless of the tools a centre employs to reach its target audiences, centre leadership must formulate a communications and knowledge-transfer strategy and must designate an individual to oversee its day-to-day implementation. The second lesson addresses knowledge transfer generally. A few centres made the pithy observation: no matter how good a centre’s research may be, if the topic is not on policy makers’ radar at the time, the results will garner little interest or uptake. To an extent, this can be tempered by jointly selecting research projects with policy-maker partners and by involving them from project commencement through project conclusion. However, care must be taken to maintain centre autonomy by balancing this approach with investigator-driven research, and by declining projects with little policy relevance or with timeframes that do not allow for proper investigation.

As with the Canadian findings regarding key audiences, American academic-based health policy centers cited governmental policy makers at the top of the list, followed by academics and then health care providers. American centers, however, are far less likely to draw a distinction between legislative and public service governmental policy makers as target audiences, although their applied research projects for governmental decision makers tend to skew toward agencies due to the availability of longer project timeframes, investigators’ inexperience with legislative processes, and a lack of funding for legislative analysis.

Another point of difference between the Canadian and American findings is the emergence of a center model dichotomy surrounding target audience. Specifically, American centers listing researchers among their key audiences often view themselves as having a traditional, academic research role, whereas centers listing policy makers among their key audiences often view themselves as having a service-oriented role geared toward providing applied solutions. This dichotomy may be driven, in part, by the lack of recognition in the university setting for applied research.

Otherwise, the communications tools and the tracking mechanisms utilized by centres on both sides of the border were consistent. Moreover, American centers echoed the importance of dedicating a center staff member to the knowledge-transfer functions of “boiling down” research results into non-technical, non-academic communications and “pushing” information out of the center.

**e. University Linkage**

All participating centres reported some level of university linkage. Ten centres (76.92%) are a formal part of their affiliated university, either as a stand-alone, university-level centre (n = 4; 30.77%) or as a faculty-linked centre (n = 7; 53.85%). Of those faculty-based centres:

- four are housed within the faculty of medicine;
- one is located within the faculty of health sciences;
• one is in the faculty of nursing; and

• one is part of the college of health disciplines.

The remaining two centres have looser university ties. One centre has formal membership agreements with its university partners. The other centre has no formal relationship with a university, but it is located on the campus of a teaching hospital and draws all of its affiliated investigators from university faculties.

Regardless of the formality of their university connection, all centres highly prize this association due to the heightened perception of integrity and objectivity that accrues from such affiliation. This finding is consistent with U.S. results, as American centers also underscored the importance of having an academic “home.”(1;4)

Nevertheless, those Canadian centres that were formally part of their university cautioned that care must be taken to ensure centre establishment at the proper institutional level to garner visibility, continued university support, and the ability to attract investigators from multiple disciplines. In their study of American health policy centers, Osterweis and Evans made similar findings, specifically stating: “the smaller the ‘setting’ within which the center is located, the narrower the focus,” and “[t]here is no substitute for support at the highest institutional levels.”(3)

f. Objectivity

The importance of being perceived as objective was another universal theme among participating centres. Centres agreed that objectivity is an issue of perception, and the most commonly shared challenge (n = 3; 23.08%) is being seen as tightly tied to the centre’s primary funder – often the provincial ministry of health. Despite this concern, the majority of centres believe their efforts to maintain an objective reputation are very effective (n = 10; 76.92%).
While centres share a common view on maintaining objectivity, the efforts utilized to do so vary widely. These efforts, however, can generally be classified as legal, collaborative, funding, research, or dissemination mechanisms. In terms of legal mechanisms, centres adopt policies and contract language to address academic freedom, publication rights, and conflicts of interest (n = 2; 15.38%). Collaborative tools include: maintaining university linkages (n = 2; 15.38%); forming relationships at the appropriate administrative level of government (n = 2; 15.38%); and maintaining highly regarded centre leadership and affiliated investigators (n = 2; 15.38%). In terms of funding, some centres stressed avoiding industry funding (n = 2; 15.38%) and seeking funding through competitive grant competitions (n = 2; 15.38%). Avoidance of proprietary projects and projects with little policy relevance (n = 3; 23.08%), utilizing external reviewers to critique projects prior to release (n = 2; 15.38%), and ensuring academic excellence and integrity in centre research (n = 2; 15.38%) constitute the most widely used research mechanisms. Finally, the dissemination tools commonly employed to support objectivity are publication of research results in peer-reviewed journals (n = 3; 23.08%), defining positions based on research results (n = 2; 15.38%), remaining apolitical (n = 2; 15.38%), and ensuring all results are publicly released (n = 2; 15.38%).

With regard to objectivity, both in terms of its importance and the variety of tools centres apply to maintain it, the Canadian findings mirror those from the United States. Likewise, the challenges are universal. A 1998 study by Coburn on the role of academic-based health services and policy research entities in the United States identifies American centers’ struggle with “the need to maintain a strong link to policymakers and agencies and the need to remain sufficiently independent so as not to be (or to be perceived as) agents of government.” This study also makes clear that centers’ vigilance in maintaining their reputation for objectivity is well placed as governmental policy makers are inclined to question it due to a pervasive perception that academic investigators are ideologically biased.

2. **Staffing & Collaboration**
   
a. **Centre Staffing**

All participating centres have a director and paid staff. At the time of the interviews, centre staffing ranged from a reported high of 107 full-time equivalents (FTEs) to a reported low of five FTEs, and the concentrations were as follows:

- five centres (38.46%) had fewer than ten FTEs;
- two centres (15.38%) had approximately 20 FTEs;
- three centres (23.08%) had between 40 and 55 FTEs;
- one centre (7.69%) had between 60 and 80 FTEs; and
- two centres (15.38%) had more than 100 FTEs.

It should be noted that these data are relative as centre staffing tends to fluctuate over time according to funding. The most common centre positions, aside from the directorship and
investigators, are administrative staff, research associates, and communications/knowledge-transfer personnel. Data centres, due to their unique functions, generally tend to have additional positions, including programmers, data base managers, systems analysts, and security coordinators.

b. Affiliated Investigators & Collaborative Partners
To augment their core research resources, all centres reported having affiliated investigators and other collaborative partners. With regard to affiliated investigators, most affiliations commence with a joint research project and then are self-driven by the non-affiliated investigators seeking a permanent connection with the centre. To that end, the majority of centres (n = 9; 69.23%) have formal affiliation processes in place, which generally require that a letter of interest and curriculum vitae be submitted by the interested investigator (n = 4; 30.77%). The application is then presented for review and approval by the centre’s core and affiliated investigators (n = 3; 23.08%). A few centres formalize the relationship further with a written agreement that enumerates the benefits that accrue to the investigator and the obligations owed to the centre. During centre start-up, however, two centres (15.38%) reported actively recruiting affiliated investigators through faculty-wide calls for membership and by targeting specific faculty with needed expertise. As an alternative to formal membership, some centres (n = 2; 15.38%) contract with investigators or university departments to buy time on a per-project basis.

To maintain and bolster their base of affiliated investigators, centres rely on several factors:

- the centre’s reputation and track record for success (n = 4; 30.77%);
- the ability to provide investigators with support services, project funding, and collaborative opportunities (n = 4; 30.77%);
- an interdisciplinary, collaborative environment (n = 3; 23.08%); and
- co-location of investigators within the centre (n = 2; 15.38%).

Those centres functioning as data centres have additional enticements to offer affiliated investigators – data access and data-analysis services. Nevertheless, the data centre function also places some serious restrictions on affiliation due to data privacy and confidentiality concerns.

Centres frequently stressed the importance of having a multidisciplinary base of investigators given the complexities of modern health services research. And almost all have achieved this as investigator rosters reflect a nearly endless range of disciplines. The most commonly represented fields are: economics, medicine, epidemiology, health services research, statistics, sociology, nursing, anthropology, education, pharmacology, geography, political science, history, psychology, gerontology, information technology, and engineering.

Due to their multidisciplinary nature, centres must work across numerous university faculties and departments, creating a matrix structure. While enabling the necessary linkages, this operational model also creates unique challenges for centre management. Because
investigators report to their respective departments rather than to the centre, centres tend to have little formal control over affiliated investigators. This structure also encourages disputes over shares in research revenue generated by individuals between home departments and centres. Additionally, centres hold little sway over departmental reviews of affiliated investigators. Six centres (46.15%) reported that this was of particular concern because their associated universities fail to reward applied research and knowledge-transfer activities on par with traditional research, peer-reviewed publications, and teaching.

In addition to relying on affiliated investigators, centres also embrace other collaborative partners, including other research organizations, governmental entities, clinicians and provider organizations, other health care organizations, and private-sector entities. These partnerships take numerous forms, including: specific projects conducted on an ad hoc basis (n = 13; 100%); formal, long-term, renewable core funding contracts (n = 5; 38.46%); and joint funding of research positions (n = 3; 23.08%).

Regardless of the type of alliance, centres shared some generally applicable strategies for success. The most frequently cited strategy was linking partners to the centre (n = 5; 38.46%) through projects, regular meetings, or advisory board representation. Building interpersonal trust and rapport over time through the types of face-to-face interactions discussed previously with regard to audience outreach constitute another core strategy employed by centres (n = 2; 15.38%). Additionally, centres boost their partnership capacity by being an “attractive” research collaborator, which is achieved by maintaining a university linkage (n = 2; 15.38%), as also noted earlier. Finally, steering clear of turf issues and the politicization of research issues (n = 2; 15.38%) is critical to maintaining viable partnerships.

Again, Canadian and American centres are virtually identical with regard to their use of affiliated investigators and collaborative partners. The same types of individuals and entities are selected, and the same mechanisms for ensuring the viability of these relationships are employed. In addition, they experience the same challenges in operating multidisciplinary matrix organizations – especially in the area of ensuring affiliated faculty investigators are rewarded for interdisciplinary, applied research within the rubric of a departmentalized, traditional academic environment.

3. Structure
In terms of physical structure, most centres (n = 9; 69.23%) are “centralized,” meaning that they have a single location. Four centres (30.77%), however, are “decentralized” in that they have multiple offices. This decentralization takes a few different forms among Canadian health policy centres. Two of the decentralized centres (15.38%) are “dual centres” with autonomously functioning centre locations on two university campuses that operate under the umbrella of a single centre name. These dual centres have separate directors at each location and manage their own budgets and research, but they often collaborate on projects and maintain regular communication. Another decentralized centre also has offices on two different university campuses, which function under a single centre name, but these locations are overseen by a single director and operate under a unified budget and shared research agenda. The fourth decentralized centre is located on a single university campus, but it has multiple sites dispersed across the campus.
Managing across multiple sites – whether on the same campus or on different campuses – presents additional difficulties. Decentralized centres shared the following success strategies for overcoming these challenges:

- organize sites around functional domains or research themes;
- establish complementary, rather than duplicative, competencies at the various sites;
- adopt a broad, overarching centre focus/area of study;
- offer core administrative and research support services at all sites;
- designate an operations manager for each site; and
- maintain strong communications between sites at all levels to instill a sense of unity and to build relationships between geographically separated investigators and staff.

While it is important to highlight the structural differences among centres, especially as 30.77% of participating centres are decentralized, this centralized-decentralized dichotomy should not be overemphasized as all centres are decentralized to some extent due to their matrix design, as previously discussed.

4. Funding
a. Present Centre Funding Levels & Key Funding Sources
Present centre funding varies from a reported annual high of approximately $8 million to a reported annual low of $325,000. The concentration ranges for those centres that responded (n = 12; 91.31%) are as follows:

- four centres (30.77%) reported less than $1 million in annual revenues;
- four centres (30.77%) reported between $1 million and $3 million in annual revenues;
- two centres (15.38%) reported between $4 million and $5 million in annual revenues; and
- two centres (15.38%) reported approximately $8 million in annual revenues.

The main funding sources cited by centres are depicted below in Figure 4. Reflective of the previously explored linkage between provincial ministries/departments of health and Canadian health policy centres, ministries were not only the most commonly cited source of funding (n = 11; 84.62%) but also the primary source of funding for six centres (46.15%), including three of the four data centres. For many centres, ministry funding, which supports infrastructure, is provided under multi-year, renewable contracts. One centre, however, reported being a budget line item with its department of health.
Grants were the next most heavily reported funding source (n = 9; 69.23%) – serving as the primary revenue resource for five centres (38.46%). The most frequently identified granting agencies are: Health Canada, CIHR, CHSRF, and various provincial foundations.

Following grants were universities, which provided monetary support to eight centres (61.54%). Nevertheless, universities did not serve as a primary funder for any centre. In fact, three university-based centres (23.08%) reported that their university provided no operational funding, and those centres receiving university support shared concerns over the continuation of such funding.

Contracts and cost-recovery fees were relied upon by six centres (46.15%). Cost-recovery fees, however, tended to be primarily utilized by data centres in an effort to recoup overhead related to the provision of data access and data analysis services.

Industry provided funding to three centres (23.08%), but in no case was this funding the centres’ primary financial support. Nevertheless, other centres (n = 2; 15.38%) strongly expressed that they do not and would not accept industry funding out of concern for their reputation for objectivity.

Finally, regional health authorities (RHAs) were cited as key funders by two centres (15.38%).

Overall, American centers were reticent to disclose funding-related information. This reticence was due to the highly competitive environment in which they operate. They were, however, quick to point out the need to avoid funding sources that could potentially compromise the center’s perceived objectivity.
b. Funding Challenges
Funding emerged as the predominant challenge faced by centres. Of particular concern is stagnant and, in some cases, shrinking infrastructure funding supplied by ministries of health and affiliated universities (n = 7; 53.85%), coupled with escalating staffing and operational costs. This coalition of forces can be crippling if the centre relies on a single source for financial support. To survive, centres have been forced to do more with less. Centre growth is constrained, and new services are curtailed because centre infrastructure is often already stretched to capacity. Data centres seem especially vulnerable because they tend to rely primarily on their ministry of health for funding and because their operations require that they maintain a cadre of highly skilled, technical staff.

Another major anxiety voiced by centres surrounds the instability and sustainability of funding (n = 5; 38.46%). This issue stems from the cyclical nature of grants and contracts, which are key centre funding sources. Such term-limited funding requires that intensive effort be focused on applying for grants and on ensuring contract renewals – ultimately reducing the resources available for centres’ core research and knowledge-transfer functions.

A final point of mutually shared, funding-related distress among centres is the lack of grant support for investigator salaries (n = 3; 23.08%). This makes assembling and maintaining the requisite core of multidisciplinary investigators difficult in an era in which universities are suffering financial hardship and, as a result, capping or reducing tenure-track faculty positions.

Despite their hesitance to share funding levels and sources, American centers were open about funding challenges, and they shared many of the concerns articulated by Canadian centres, including those addressing sustainability due to the cyclical nature of project-based funding, resource-intensive funding acquisition efforts, single-source dependence, and the lack of core funding necessary to support knowledge-transfer and relationship-building activities. In the United States, however, grant funding generally covers investigators’ salaries. In his study recommendations, Coburn promotes adequate core funding as the solution to both the service provision issues and the objectivity concerns cited above: “Core funding . . . may contribute to enhancing . . . independence, to the extent that faculty and staff do not feel as constrained in their analysis and conclusions by the agenda or concerns of specific agencies or programs.”

c. Funding Solutions & Success Strategies
To cope with these financial difficulties, Canadian centres suggested a number of creative solutions, including:

- applying for team-building infrastructure grants;
- seeking out endowments for centre-based faculty chairs;
- negotiating budget line item status with ministries of health; and
- establishing a top-level university centre advisory board to enhance visibility and support within the institution.
In addition, centres employed numerous strategies geared toward obtaining funding, and the success of these measures is evident from participating centres’ continued existence over the long term. Among those strategies are the following:

- developing and maintaining a critical mass of well-respected, high-caliber, committed investigators (n = 8; 61.54%);
- building relationships with and getting buy-in from key funders (n = 3; 23.08%);
- working in a booming research domain, where project funding has become increasingly available (n = 3; 23.08%);
- having centre name recognition and a positive centre reputation (n = 2; 15.38%);
- producing quality work (n = 2; 15.38%); and
- retaining a well-respected, connected director (n = 2; 15.38%).

Data centres noted their role as data custodians as an additional, fundamental success strategy (n = 3; 23.08%). This role assists such centres in attracting funding because their affiliated investigators have easy access to the data required for research, and, in many cases, this unique function generates revenue streams through the cost-recovery fees charged for data access and analysis services.

Once again, there is significant overlap between Canadian and American centres. Due to their highly competitive environment, American centers further stressed the importance of maintaining center personnel specifically dedicated to grant writing and management functions. They also underscored the need for diversification of funding sources.\(^1\)

Of additional interest is the state of health services research funding versus clinical research funding. Centres in both nations operate under a system where the amount of funding dedicated to health services research tends to be far less than that devoted to clinical research.\(^4,6\)

d. **Theme-based Funding**

To meet the participation criteria, centres had to have a general focus on health services and health policy research. Within this broad scope, however, some centres have chosen to adopt specific themes upon which to focus their research efforts. As a result, five centres (38.46%) explained that their decisions to apply for grants and respond to requests for proposal (RFPs) are heavily guided by whether or not the funding opportunity in question fits within their adopted research themes. Three centres (23.08%) reported taking a somewhat looser approach by only applying for grants and responding to RFPs if the topic fits within the centre’s general areas of expertise and is of interest to affiliated investigators. Two centres (15.38%), however, noted taking a more opportunistic approach in applying for funding even if the particular grant or contract area is not among the centre’s existing core competencies.
Osterweis and Evans identified two funding approaches employed by American centers: (1) a “follow the money” strategy under which the center’s research focus is guided by funding opportunities; and (2) a center-generated, mission-based strategy under which the center seeks out funding that is in line with its predetermined themes. The authors then went on to set out the advantages and disadvantages of both methods. The first, opportunistic strategy can ease center struggles to obtain financing and aid in expanding center expertise, but it “can lead to fragmentation rather than a unified focus,” as well as impede strategic planning. The theme-based strategy, on the other hand, may exacerbate funding issues, but it enables strategic planning and aids the center in creating strong, well-defined core competencies.

5. Performance Measurement & External Resources

a. Performance Metrics, Benchmarking & External Review

Tied directly to funding issues is the need for and utilization of performance measures. As noted earlier, funders, especially ministries of health, increasingly emphasize the necessity for centres to show accountability for the funding they receive. As a result, both funders and centres have begun to look to metrics and benchmarks as a means of quantifying performance. Nevertheless, both are struck by the dearth of systematic, centre-specific performance measures. Thus, those centres wishing to employ metrics must create their own and compare their performance internally over time. Six centres (46.15%) have taken this approach and measure things such as the:

- number of peer-reviewed publications;
- ratio of core funding to other research dollars generated;
- research dollars per researcher;
- overall annual funding; and
- number of graduate students overseen.

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1 The authors engaged in a futile search for a standardized core funding leverage ratio, which measures the number of times a centre is able to leverage its core funding to generate other funds. This investigation included a literature search, an internet search, and contacting other centres and health care organizations on both sides of the border. Recognizing the lack of metrics, the Network recently established a task force charged with identifying and developing centre-specific performance measures.
Another method of performance measurement engaged in by a slight majority of centres (n = 8; 61.54%) is “best-in-class” benchmarking, whereby centres informally compare themselves to other centres that they view as leaders in the field. The centres most commonly cited as best-in-class benchmarks are the Centre for Health Services and Policy Research at the University of British Columbia, the Institute for Clinical Evaluative Sciences, and the Manitoba Centre for Health Policy at the University of Manitoba. Interestingly, all of these centres are long-established data centres. And, while such comparisons are a nearly perfect fit for data centres, the general applicability of these best-in-class benchmarks to centres that do not play a data repository role is debatable due to significant functional differences. Given the small number of centres and the variability among centres in terms of size and focus, however, finding a best-in-class centre to benchmark against overall is difficult to impossible.

A final way centres (n = 2; 15.38%) reported assessing their performance was through external reviews. These audits, conducted every few years, assess centre performance and operations in all areas, and, in some instances, are required by core funders as part of the funding contract.

Similarly, American centers failed to cite any systematic, center-specific performance measures and, instead, engaged in informal benchmarking as a way to assess performance.(1)

b. External Resources
Centres regularly tap external resources for financial, informational, networking, and research purposes.

In line with their concerns surrounding funding, funding sources came in as one of the top two most frequently accessed external resources (n = 8; 61.54%). The other most regularly utilized external resource was networking opportunities (n = 8; 61.54%). Among these networking resources, centres listed other centres and researchers, meetings and seminars, and peer-group organizations such as the Network of Applied Health Services Research Centre Directors and the National Alliance of Provincial Health Research Organizations.

Informational resources were cited as the next most commonly used external resource (n = 5; 38.46%). These resources, which enable centres to scan their environment, include peer-reviewed and gray literature, and electronic resources (i.e., web sites, electronic newsletters, and e-mail services).

As data sources are critical for much health services research, centres also spent significant effort gathering data resources (n = 4; 30.77%).

Another resource cited by centres (n = 2; 15.38%) as highly valuable is the centre’s advisory board, a quasi-internal, quasi-external entity. These boards tend to consist of representatives from the centre’s key audiences. In addition, they often include the director from another health policy centre. Such boards were cited as particularly helpful in providing guidance and setting direction.
These findings are akin to those reported by centers in the United States. American centers have a peer group analogous to the Network or Applied Health Services Research Centre Directors, as well.(1)

V. Conclusions & Next Steps

A. Summary of Principle Findings

1. Major Challenges

The major challenges faced by Canadian health policy centres revolve around three primary areas: funding, performance measurement, and university faculty promotion criteria. As to funding, the challenges are:

- stagnant and shrinking infrastructure funding in the face of rising operational costs;
- single source dependence, especially for data centres;
- stability and sustainability given the term-limited nature of most funding opportunities;
- lack of grant-based investigator salary support; and
- university financial conditions that threaten institutional centre support and tenure-track faculty positions.

With regard to performance measurement, the concerns are:

- a lack of systematic, centre-specific performance metrics; and
- an absence of meaningful benchmarks for centres that do not serve as data custodians.

The third and final category of centre challenges surrounds the failure of universities to recognize and reward centres’ core activities – multidisciplinary applied research and knowledge-transfer activities – on par with traditional academic endeavors.

2. Key Strategies for Success

Overcoming these tripartite issues is no small feat. In sharing key factors for successful development and ongoing operations, however, Canadian health policy centres enumerated multiple requirements. Recurrent factors are:

- having university buy-in at a significant administrative level (n = 8; 61.54%);
- developing a critical mass of high-quality investigators with the “right” mix of expertise (n = 7; 53.85%);
• attracting and maintaining funding, especially for infrastructure support \((n = 5; 38.46\%)\);

• building relationships with national and provincial health care decision makers \((n = 5; 38.46\%)\);

• producing excellent, policy-relevant work \((n = 4; 30.77\%)\);

• maintaining a university affiliation \((n = 3; 23.08\%)\);

• providing tenure-track, funded salary positions \((n = 3; 23.08\%)\);

• creating a stimulating, multidisciplinary environment for exchange and innovation \((n = 2; 15.38\%)\); and

• avoiding overselling the centre \((n = 2; 15.38\%)\).

Interestingly, some of these factors present a chicken-and-egg conundrum. This is particularly true of the need to develop a critical mass of investigators and the necessity of attracting funding: recruiting and maintaining a core of investigators becomes an intractable task without sufficient, stable funding, and it is equally difficult to attract funding without having that cadre of respected researchers already in place.

The vast majority of the above-noted success factors shared by Canadian centres were also expressed by their American counterparts.\(^{1,3,4}\) U.S. centers also reiterated key center staffing issues – specifically the necessity of in-house grant writing, grant management, and knowledge-transfer capacity, and the importance of visible, connected, and respected leadership.\(^{1}\) Finally, American centers circled back to funding issues by emphasizing the need to develop efficient methods of trolling and applying for funding.\(^{1}\)

**B. Emergent Themes Regarding Canadian Academic Health Policy Research Centres**

While each of the 13 participating centres is unique, a number of universal themes emerged from the study. Moreover, these themes build upon one another.

First and foremost, Canadian health policy centres and ministries of health have a symbiotic relationship. Nearly all of the participating centres depend heavily on their respective ministry for core funding. As a result, these centres generally focus a portion of their research efforts on provincial health care issues and view their ministry as a key audience for centre research and knowledge transfer. By funding centres, ministries not only acquire a reputable source for project-specific research and consulting services, but they also ensure the existence of independent health services and policy research capacity within the province. Presently, however, centres and ministries are at crossroads; they must work together to develop more appropriate core funding mechanisms and institute mutually agreed upon performance measures to demonstrate accountability.
The first theme dovetails with the second – core funding. While project funding is on the increase, core funding is failing to keep pace. This financial support typically comes from ministries of health and centre-affiliated universities. Such funding enables centres to provide a basic research infrastructure that, in turn, attracts the requisite core of affiliated investigators. Maintaining a core of high-caliber investigators, in turn, enables centres to leverage their infrastructure resources to draw additional funding. Such funding allows centres to enhance their contributions to health services and policy research and knowledge transfer regionally, provincially, nationally, and internationally.

The third theme addresses centre relations with their affiliated universities. Centres not only rely on their ministry of health but they also depend on their affiliated university for buy-in. Such buy-in may take the form of financial and/or philosophical support through formal recognition of the centre as part of the institution or as an institutional partner. Such recognition provides centres with an aura of credibility and integrity that makes them attractive to investigators, funding agencies, and key audiences. In many cases, however, universities and centres are also at crossroads. First, university funding of centre operations is stagnant, declining, or entirely non-existent for some centres due to the state of higher education financing in Canada. As a result, centres and their affiliated universities must jointly develop innovative ways to attract and support faculty. Second, the traditional faculty review-and-reward system, in many cases, devalues centres’ core functions of applied research and knowledge transfer. Thus, centres must educate universities on the importance of these activities and the need to recognize and reward faculty for engaging in multidisciplinary, applied research and knowledge-transfer efforts on par with more traditional activities, such as publishing and teaching.

C. Comparative Results
1. Similarities Between Canadian & U.S. Findings
As can be seen from the findings section above, centres on both sides of the border share numerous similarities with regard to structure and function, and even in terms of the challenges they face. These commonalities include:

- governmental policy makers as key audiences;
- the importance of maintaining a university-affiliation and a reputation for objectivity;
- significant concerns over the availability and stability of infrastructure funding;
- utilization of affiliated investigators and collaborative partners in research initiatives;
- the challenges associated with operating a matrix organization within a traditional, departmentalized institution of higher education; and
- a dearth of systematic, centre-specific performance measurement tools.

2. Differences Between Canadian & U.S. Findings
Despite the numerous similarities among Canadian and American centres, some noteworthy differences also surfaced, such as:
• Canadian centres’ greater overall focus on provincial issues than that devoted by their American counterparts to state issues;

• Canadian centres’ reticence to engage legislative policy makers;

• Canadian centre differentiation based on health care data oversight (i.e., whether the centre served as a delegated repository for provincial health care data) compared with differentiation among American centers based on the type of research undertaken; and

• an overall more collaborative, open, and less competitive environment among Canadian centres than among centers south of the border.

As highlighted in the findings section above, where Canadian and American centres differ, these divergences are primarily attributable to the governmental structures and health care systems under which these centres operate.

D. Final Reflections

While the sample sizes of the Canadian study and the various American studies were small, the results are important because they allow health policy centres to identify, explore, and adopt success strategies that are particularly suited to their operational model. On the national level, Canadian centres have the opportunity to jointly address their common concerns. Finally, the identification of challenges shared by both Canadian and American centres presents a prime opportunity for international collaboration.
VI. REFERENCES & BIBLIOGRAPHY


2. Coburn AF. The role of health services research in developing state health policy. Health Affairs 1998;17(1):139-51.


APPENDIX A: 
PUBLISHED U.S. STUDIES ON HEALTH POLICY CENTERS


The report details findings on center functionality derived from six center site visits. Key findings include:

- there are approximately 70 academic health center-based health policy and health services research centers in the United States;

- “centers are preferable to a loose confederation of researchers because they can command resources, provide technical assistance, signal the importance of the issues they deal with, attract faculty, and provide an intellectual gathering place for consideration of issues”;

- there is no single correct approach to structuring a successful center, and centers vary widely in terms of mission and focus – with “some centers aspir[ing] to be rigorously academic” and “others being more oriented toward service and technical assistance”;

- funding sources have a tremendous impact on center focus, and centers tend to gravitate toward one of two funding approaches: (1) opportunistic, or (2) mission driven;

- the smaller the academic unit within which the center is housed, the narrower its scope is likely to be and the more difficult it will be to attract investigators from multiple disciplines, although an interdisciplinary approach is critical to center success;

- being perceived as objective is imperative for centers that engage in research; and

- having well-connect center leadership that is skilled at relationship building is a lynchpin to center success.


This report summarizes the discourse at an expert meeting geared toward enabling academic health services research and policy analysis centers to share their expertise and experiences.

The authors distill information obtained through interviews with university-based, center-affiliated health services researchers and directors of health services research training programs. Applicable results are as follows:

- health services research is increasingly “organized under the auspices of health services research centers or institutes” due to the interdisciplinary nature of such research;

- “core funding and support from the parent institution . . . is essential for providing research infrastructure elements that, typically, may not be fundable under soft-money grants or contracts”;

- “[a] centralized structure is an important way to support interdisciplinary collaboration, training, and information-sharing for extending and leveraging funding and for providing the environmental support researchers may need to be successful”;

- “a critical mass of affiliated researchers is essential to making a health services research enterprise viable”; and

- “a great deal of tension between interdisciplinary and applied emphasis of health services research and the disciplinary values of academic departments” exists and concern also surrounds how equitably applied research is assessed for tenure and promotion determinations.

Coburn AF. The role of health services research in developing state health policy. Health Affairs 1998;17(1):139-51.

The author presents information gathered through five case studies of health services research and policy programs, and interviews with legislative- and executive-branch state policy makers and university-based health services researchers. Relevant results follow:

- the devolution of health care responsibility from the federal level to the states coupled with pressures to downsize government has resulted in states looking to health policy centers for “consultation, analytical support, and technical assistance”;

- there is no single model for organizing such entities, but “models that provide for a distinct organizational unity for . . . health services research and applied policy analysis have certain advantages,” including the ability to assemble the requisite faculty and staff, and leveraging core funding;
• policy makers expect “academics to bring a ‘broader perspective’” to the issues, but policy makers are still suspicious of academics’ objectivity because they suspect academics frequently have ideological or political biases;

• working with policy makers requires a special skill set, including timeliness, and familiarity with the policy-making process, history and players;

• universities, nevertheless, tend to give short shrift to such applied research and public service activities in faculty promotion, tenure and compensation decisions;

• “[a] tension exists between the need to maintain a strong link to policy makers and agencies and the need to remain sufficiently independent so as not to be (or to be perceived as) agents of government”; 

• formal contractual agreements with core funders, especially state agencies, “may provide a structure and procedures for addressing . . . issues such as independence and accountability”;

• much of the policy-related work engaged in by such centers tends to be for the executive branch due to a multitude of reasons, including the availability of funding; and

• reliance on project funding is pervasive among centers, and such reliance may preclude mission-critical, unfunded activities.
APPENDIX B:

QUESTIONS FOR SEMI-STRUCTURED INTERVIEWS
WITH SELECTED CANADIAN ACADEMIC HEALTH POLICY RESEARCH CENTRES

A. General Information

1. Name of Health Policy Centre (“Centre”):

2. a. Name of University with which the Centre is affiliated (if applicable):

   b. If the Centre is university-affiliated, is it housed within (a) specific school(s)/department(s), or is it a stand-alone entity?
     i. One School/Department  ii. More Than One School/Department  iii. Stand-alone

   c. If located within (a) specific school(s)/department(s), please list the school(s)/department(s), and the reason(s) for and/or the history behind such affiliation.

3. Year Centre Founded:

4. Name and Title of Interviewee:

5. Centre’s Mission and Vision:

6. a. Please describe the original impetus for founding the Centre.

   b. How long was the process of founding the Centre in terms of months/years?

   c. Please list the key factors that contributed to the successful founding of the Centre.

B. Audience(s)

1. On which of the following is/are the Centre’s efforts primarily focused?
   i. Provincial  ii. National  iii. Both i. and ii.  iv. International  v. Other

   aa. Describe:

2. Please list in ranked order from most critical to least critical the Centre’s target audiences.

3. a. Please describe how the Centre works to maintain a non-partisan position and reputation.

   b. Have these efforts been effective?
     i. Very Effective  ii. Somewhat Effective  iii. Not Effective
c. Please describe the challenges to maintaining a non-partisan position and reputation for the Centre.

4. a. Please describe in detail how the Centre tracks its interactions with its key audience(s).

b. Has/have this/these tracking mechanism(s) been effective?
   i. Very Effective ii. Somewhat Effective iii. Not Effective

5. Please list in ranked order from most effective to least effective the tools/methods/activities used in responding to the needs of the Centre's key audience(s).

6. Please list in ranked order from most beneficial to least beneficial any events regularly sponsored by the Centre for its key audience(s).

**C. Staffing and Collaboration**

1. Does the Centre have a single, designated chair/director?
   i. Yes ii. No
   aa. Describe

2. a. Does the Centre have any paid employees (including staff and core investigators)?
   i. Yes ii. No

   b. If yes to C.2.a., how many full-time equivalent employees?

   c. If yes to C.2.a., what positions exist presently (as represented by staff and core investigators)?

   d. If yes to C.2.a., what positions existed within two years of the Centre's founding?

   e. If no to C.2.a., please describe in detail how the Centre is staffed presently.

3. a. Does the Centre have any affiliated investigators (“affiliates”) and/or collaborative partners?
   i. Yes ii. No

   b. If yes to C.3.a., please describe how the Centre’s affiliation and/or collaborative partnership process(es) operate(s), and how such affiliates and/or partners are selected.

   c. If yes to C.3.a., please list the success factors and the practices that have proven to be key to developing and maintaining the Centre’s affiliate and/or partner base(s).
d. If yes to C.3.a., please list pitfalls to be avoided in developing and maintaining such affiliations and/or partnerships.

e. If yes to C.3.a., please list the entities and areas of expertise represented by the Centre’s affiliates and/or collaborative partners.

f. If yes to C.3.a., please describe in detail how the Centre has been successful in keeping its affiliates and/or partners actively engaged in Centre activities.

4. Please list the various disciplines/professions represented by the Centre’s staff, core investigators, affiliates, and collaborative partners.

5. If the Centre is university-affiliated, please address how the Centre and its affiliated University recognize, evaluate, and reward the efforts of tenure-track core and affiliated investigators in applied health services and policy research projects.

D. Structure

1. Are Centre activities located within a centralized office, or are they decentralized?
   i. Centralized    ii. Decentralized

2. a. If decentralized, please describe in detail how the Centre manages and coordinates its activities.

b. If decentralized, please list the key factors in managing and coordinating the activities of a decentralized Centre.

c. If decentralized, please list the pitfalls to be avoided in managing a decentralized Centre.

E. Funding

1. a. What level of funding, in terms of dollars, did the Centre have annually when it was initially founded?

b. Please list in ranked order from largest to smallest the sources of initial funding for the Centre.

c. At present, what level of funding, in terms of dollars, does the Centre have annually?

   d. Please list in ranked order from largest to smallest the sources of present funding for the Centre.

2. a. Please list the funding challenges faced by the Centre.
b. Please list the key factors contributing to the Centre’s success in obtaining funding.

c. If the Centre relies predominantly on grant funding, please list the key factors, strategies for success, and/or core competencies required for optimizing grant management capacity.

d. Please address if and how theme-based funding opportunities guide the Centre’s activities.

F. Resources, Benchmarking, and Miscellaneous
1. Please list in ranked order the top-five most valuable external resources (i.e., informational, funding, networking, etc.) regularly tapped by the Centre.

2. Please list the health policy centres or other institutions against which the Centre benchmarks its performance or the health policy centres or other institutions looked to as leaders in the field by the Centre.

3. Please add anything else you feel to be key to the successful development and operation of a top-notch (university-based, if applicable) health policy centre.

4. Please add anything else you feel to be a pitfall to be avoided in the successful development and operation of a top-notch (university-based, if applicable) health
## APPENDIX C:
### TABLE 1: CANADIAN ACADEMIC HEALTH POLICY RESEARCH CENTRES INVITED TO PARTICIPATE IN STUDY

<table>
<thead>
<tr>
<th>Centre Name</th>
<th>Affiliated University</th>
<th>Centre Location</th>
<th>Centre Web Site</th>
<th>Centre Participation</th>
</tr>
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<tbody>
<tr>
<td>Centre for Health Economics and Policy Analysis</td>
<td>McMaster University</td>
<td>Hamilton, ON</td>
<td><a href="http://www.chepa.org">http://www.chepa.org</a></td>
<td>Yes</td>
</tr>
<tr>
<td>Centre for Health and Policy Studies</td>
<td>University of Calgary</td>
<td>Calgary, AB</td>
<td><a href="http://www.chaps.ucalgary.ca">http://www.chaps.ucalgary.ca</a></td>
<td>Yes</td>
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<td>Centre for Health Services and Policy Research</td>
<td>Queen’s University</td>
<td>Kingston, ON</td>
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<td>University of British Columbia</td>
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<td><a href="http://www.chspr.ubc.ca">http://www.chspr.ubc.ca</a></td>
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<td>Centre for Rural and Northern Health Research</td>
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<td>Thunder Bay, ON</td>
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<td>Department of Health Policy, Management and Evaluation</td>
<td>University of Toronto</td>
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<td>University of Alberta</td>
<td>Edmonton, AB</td>
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<td>University of Ottawa</td>
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<td>University of Toronto*</td>
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<td>Dalhousie University</td>
<td>Halifax, NS</td>
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<td>School of Health Policy &amp; Management</td>
<td>York University</td>
<td>Toronto, ON</td>
<td><a href="http://www.atkinson.yorku.ca/SHPM/">http://www.atkinson.yorku.ca/SHPM/</a></td>
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* Note: For these dual-site, multi-university centres, only the site marked with an asterisk (*) participated.
** Note: This site was not invited to participate.
*** Note: The Institute for Clinical and Evaluative Sciences has no formal university affiliation, but it is located on the campus of a teaching hospital and draws its affiliated investigators from university faculty, largely the University of Toronto.
**APPENDIX D:**

**BACKGROUND INFORMATION ON**

**U.S. ACADEMIC-BASED HEALTH POLICY CENTERS STUDY**

Conducted: 2002-2003

Investigator: Michele Mekel, J.D., MHA, MBA

Objective: To identify the structural organization and operational success factors of U.S.-based academic-affiliated health policy centers

**Inclusion Criteria:**
1. Designation of “health policy” in entity name
2. Designation in name as “center,” “institute,” “program,” or equivalent
3. University affiliation
4. U.S. situs

Study Design: Same as in Canadian study

Response Rate: Twelve (48%) of 25 identified centers participated.