

Submission to McKeon Review
Aboriginal Medical Services Alliance Northern Territory

April 2012

INTRODUCTION

The Aboriginal Medical Services Alliance Northern Territory [AMSANT] represents the Aboriginal community-controlled health sector in the Northern Territory. Our emphasis is on the delivery of Comprehensive Primary Health Care to Aboriginal Territorians.

AMSANT is a member of the Northern Territory Aboriginal Health Forum [NTAHF], a tripartite body also made up of the Northern Territory and Commonwealth governments. As such, we are a major provider of policy advice on health issues to both governments.

At the heart of our work is the development of a practice—both clinical and social—that displays our strong and central commitment to Comprehensive Primary Health Care.

This model was codified at an international level at Alma Ata in 1978, and subsequently endorsed by the World Health Organisation [WHO] and the United Nations:

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.¹

Primary health care is socially and culturally appropriate, universally accessible, scientifically sound, first level care.

It is provided by health services and systems with a suitably trained workforce comprised of multidisciplinary teams supported by integrated referral systems in a way that:

- gives priority to those most in need and addresses health inequalities;
- maximises community and individual self-reliance, participation and control, and;
- involves collaboration and partnership with other sectors to promote public health.

Comprehensive Primary Health Care includes health promotion, illness prevention, treatment and care of the sick, community development, advocacy and rehabilitation services.

Comprehensive Primary Health Care prioritises dealing with health as a holistic process, which includes a strong emphasis on working with families and the communities we live in.

The attachment of the Aboriginal Community Controlled Health sector to the principles of Alma Ata is neither an accidental nor an idle one with, as AMSANT chairperson Paula Arnol has recently pointed out speaking of the importance of data in health analysis and service delivery:

Coming from 1978, the emphasis on science and technology undoubtedly referred to biomedical research and analysis, and the material technologies of health service delivery. However, public health is far more than that, which is why Aboriginal Community Controlled Health Services have embraced data collection as a fundamental tool in describing our conditions, but more importantly in advocating for improvements, as well as establishing a culture of Continuous Quality Improvement [CQI] within all our services.

¹

http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf, accessed 4 April 2012

The use of Clinical Information Systems [CIS] has provided the way forward to achieving sophisticated population health monitoring and analysis. It has also led to Aboriginal people taking up Shared Electronic Health Records to the highest level of any group within Australia.

Aboriginal health data is no longer the preserve of the “bureaucrats and researchers” of old, it is now in our hands, and controlled by our health services. And that makes an enormous difference: if anything, the Aboriginal community controlled sector is as hungry for data as anyone.²

For reasons which may not appear obvious to others, the emphasis on “scientifically sound and socially acceptable methods and technology” is at the forefront of thinking within the Aboriginal Community Controlled Health sector: research advances have the potential to help “close the gap” in health outcomes.

To this end—although the load is unevenly distributed—most Territory Aboriginal Community Controlled Health Services, along with NT Department of Health remote area clinics, are involved with external health research projects.

A number of these are “multi site” projects involving multiple health services and clinics across the Territory; a significant number of our Member services are involved with a number of different “research events” at the same time. AMSANT estimates that in the Northern Territory there are upwards of 200 “research events” taking place in the Northern Territory at any given time.³

This can lead to considerable burdens on individual clinics/services as well as individual staff members. At least one of our services had declared a moratorium on further research projects as a result, *despite* the potential benefits the research may produce.

Partly as a consequence of this overload, and the lack of capacity to analyse “incoming” research proposals—let alone manage existing projects—AMSANT’s Board developed an internal Research Policy [see attached]⁴, along with a methodology for assessing new projects through its Public Health Advisory Group [PHAG].⁵

The Policy, and related assessment template, seeks to analyse proposals from a scientific basis, as well as the use-value proposals may have for health improvements, the level to which Aboriginal people have been consulted or are involved in the project, along with other ethical considerations. AMSANT has also sought, thus far unsuccessfully, to establish a position to take on this task full time. This will be discussed further in this submission.

A key finding from the experience of PHAG, is that very, very few research projects involve Aboriginal health services at the level of research instigation, development, carriage or translation. This is despite direct recommendations outlined in as “Underlying principles” in the

² Paula Arnol, Foreword, *Northern Territory Aboriginal Health Key Performance Indicators*, Public Report, 2012, [in publication].

³ Some of our larger services are involved in at the same time in up to 30 different projects, or “research events”, at various stages of initiation, implementation and analysis/completion.

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<http://www.amsant.org.au/documents/article/147/AMSANT%20Research%20Policy%20as%20amended%20October%202010%20Final.pdf> accessed 4 April 2012.

⁵ The PHAG involves AMSANT clinical and non-clinical staff as well as external advisers in public health, research, policy and community development, among others.

NHMRC Road Map.⁶ The *Road Map*, it can fairly be said, has not lived up to its promise, and this Submission comments on the Road Map at Attachment A. While the sentiments in that 2002 document are worthy, they have not been operationalised, and the Aboriginal Community Controlled Health sector has simply not had the resources to be able to monitor it. The second version of the *Road Map*—*Road Map II*⁷—may also have a limited impact if there is not a robust review of why the first Road Map has not been effective. Furthermore, the community controlled sector had limited input into the second edition of the Road Map and the efforts to engage the sector locally were minimal. For instance, AMSANT was not even aware that a consultation for the review of the Road Map occurred in the NT.

A key task that must be undertaken is an independent review of the *Road Map*.

AMSANT's primary conclusion, and recommendation, is that adequate resources must be made available to NACCHO and its affiliates to employ a high level research analyst/broker position such as outlined in Attachment B to this Submission

There must be a word of caution offered from the Aboriginal Community Controlled Health sector about the benefits of research, and thus the support it may receive from the sector.

First, research that is aimed at merely confirming the bleeding obvious, or at only providing marginal incremental knowledge, can be expensive and time consuming for our services for little if any benefit.

Second, research that does not involve Aboriginal health organisations and services is substantially less likely to produce significant advances and therefore improvements in health outcomes.

Third, research that seeks to find a “silver bullet” for a particular condition in isolation from the broader social determinants of health, are again unlikely to achieve desired results. *There is no “killer app” in Aboriginal health.*

Fourth, failure to develop—at the earliest stages of project development—a properly resourced approach to research translation is simply unethical, no matter how prestigious published results may appear.

It should finally be noted that research advances—especially in the biomedical area—may not necessarily contribute to “closing the gap”. Such advances are likely to be taken up across the whole population. In fact, the evidence suggests that “take up” of medical advances is more likely by far in healthier sections of the population.

While it is generally accepted that access to and usage of the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS) are strong proxies for determining relative levels of *benefit* from “universally accessible health care” in Australia, this does not mean benefits are spread evenly—or indeed universally. On that basis, the Northern Territory does very poorly. Studies over 15 years have found that the Territory has consistently poor access to, and usage of, the MBS and PBS. This is not attributable to a younger population: the

⁶ National Health and Medical Research Council, *The NHMRC Road Map: A strategic Framework for Improving Aboriginal and Torres Strait Islander Health Through Research*, pp4-5, Canberra, October 2002.

⁷ NHMRC 2010. The NHMRC Road Map II: A strategic framework for improving the health of Aboriginal and Torres Strait Islander people through research.

gap between the Territory and national figures has been widening despite extra incentives being provided. The lower usage does not take into account higher levels of Aboriginal and non-Aboriginal morbidity, or the additional costs of remote area service delivery. Malyon et al.⁸ point out that:

the NT's share of total MBS and PBS benefits – 0.5 per cent and 0.3 per cent, respectively – was much less than its share of the Australian population (1.0 per cent).

They go further:

A key constraint to increasing the NT's share of MBS and PBS funding is the availability of general practitioners (GPs). The NT has about half the number of fulltime workload equivalent GPs per 100,000 people as nationally despite having a rate of disease and injury that is 1.7 times the national average.

In other words, research that leads to better drugs and/or treatment is inclined to assist the healthy rather than the unhealthy—and arguably may inadvertently widen “the gap”. As noted above, research cannot be undertaken in glorious isolation, but must take into account the broader social determinants of health that contain all the complexities of achieving universal access to far more than the immediate fruits of an individual research project.

Research must play its part in Closing the Gap but also needs to respect the expertise within the Aboriginal Primary Health Care sector and the research sector should not see itself as “the solution.”

Much of the time, researchers approach ACCHSs from a deficit model and with one intervention aiming to improve a set of complex long standing issues. Research is not developed in partnership with the sector: usually the first time a service (or AMSANT) hears about a research proposal is when they are asked to partner or participate in a fully developed /funded proposal.

How research can work in partnership with the Aboriginal community controlled sector and Aboriginal communities to play its part in Closing the Gap is the fundamental issue the current Inquiry should address.

⁸ Malyon R, Zhao Y, Guthridge S. *Medicare Benefits Schedule and Pharmaceutical Benefits Scheme utilisation in the Northern Territory 1993-94 to 2008-09*. Department of Health and Families, Darwin, 2010

Why is it in Australia's interest to have a viable, internationally competitive health and medical research sector? (Terms of Reference 1 and 6)

A number of other submissions to the McKeon Review discuss this issue at length, and we do not seek to comment on them other than to say, from an Aboriginal perspective, that *any* consolidation and enhancement of the health and medical research sector has the potential, at least, to contribute to better health outcomes for our people. Conversely, if the sector was not viable and in decline, the consequences could be catastrophic.

It is for this reason we joined national campaigns over threats to health and medical research funding last year. As far as we are aware, AMSANT was the only Aboriginal peak organisation to publically comment:

Threatened cuts to the nation's health research effort may be the unkindest cuts of all Aboriginal Medical Services Alliance Northern Territory [AMSANT] CEO John Paterson said today.

"We all acknowledge that efforts towards Closing the gap is a generational project," said Mr Paterson.

"In the same way, the research that informs the evidence base we need to develop our social and clinical practice, is generational: you just can't turn the tap of research on and off at whim.

"The cuts threaten health research that benefits all Australians.

"These broad research investments can be particularly relevant to Aboriginal Australians, who experience the greatest disparities in health outcomes of any other group in the nation.

"Research that has a particular focus on our people has the potential to provide enormous benefits.

"Let's face it, the talented scientists and researchers that may be forced offshore are hardly likely to be funded for research into Australian Aboriginal health in foreign labs and overseas projects.

"Furthermore, Aboriginal health research is highly unlikely to be filled by commercial research bodies.

"We run the real risk of creating a research gap in Aboriginal health."⁹

In this, and with provisos noted in the Introduction, we acknowledge the critical importance of research in Closing the Gap—and the threat to that historic task if research were to be reduced or curtailed. We also noted the unlikelihood of overseas research institutions taking up Aboriginal health as a key project.

Yet there are other fundamental reasons why a viable and thriving research industry can benefit our people on the one hand—and keep Australian researchers at the forefront.

Aboriginal health has developed a model closer to the Alma Ata ideal than any other health sector in Australia and can therefore, in microcosm, provide learnings about health access and service delivery to the broader population. It has been noted, for example, that the Aboriginal sector, for example, "has pioneered the development of locally relevant performance indicators" and "learning from the Aboriginal community-controlled sector will help integrate clinical governance into primary care." In other words, research in and with Aboriginal Community Controlled Health Services can benefit all Australians.¹⁰

⁹ For full text see <http://www.amsant.org.au/documents/article/83/110415-MR-JP-Cuts%20will%20not%20close%20the%20research%20gap.pdf>, accessed 4 April 2012.

¹⁰ Christine B Phillips, Christopher M Pearce, Sally Hall, Joanne Travaglia, Simon de Lusignan, Tom

Therefore Aboriginal health research is a unique opportunity to undertake research:

- With communities, and in the community controlled sector
- In a system that is leading in use of clinical data, Clinical Information Systems and Continuous Quality Improvement.
- In holistic comprehensive Primary Health Care.

How might health and medical research be best managed and funded in Australia? (Terms of Reference 2, 3 and 7)

There should be a far greater emphasis on partnerships with the community controlled sector nationally, at affiliate level and at service level. Research should be judged on the depth of their consultation and engagement and this judgement should be undertaken by experts in Aboriginal culture, health policy and Aboriginal primary health care clinicians as well as the research community.

Intervention research in Aboriginal Primary Health Care should not be funded unless there is good evidence of real partnership. We do not agree with the *Road Map* that there is a place for research that is totally researcher driven in this area (*Road Map*, 2002:5).

The model of partnership grants that has been developed by the NHMRC aims to increase translation of the research into policy and practice by involving non research partners at the start. However, these grants each ask for a significant contribution in kind from AMSANT, (and many of our members) and we are now a partner in several of these grants thus leading to a significant load on AMSANT. We need a different model of partnership grant which builds the capacity of the sector instead of draining it.

To this end, AMSANT at the direction of its Board, has developed a proposal for a full time Research Broker Analyst position {see Attachment B}. Thus far, although there is support in principle from groups such as Baker IDI, Menzies and the Centre for Remote Health, AMSANT has had no success in establishing this position—indeed a request for support from the NHMRC was not even answered.

AMSANT has often been put in the difficult situation of responding to a request to be a partner in a grant with:

- a) not enough time to consult our board or review the proposal thoroughly, and
- b) no time to contribute to the actual research proposal which has often been finalised by the time we see it.

We have in the past reluctantly agreed to partner in this situation if we believe this will benefit the sector. We see grants where fairly minimal consultation has occurred but recognise that, particularly in remote areas, proper consultation is time consuming and expensive. However, the processes and systems should support researchers to undertake much more consultation and engagement with partners, health services and communities (where appropriate) in the development of a research grant.

We believe that there should be a two step phase for approval for larger intervention research grants. The first phase should be the development of an initial research plan which will be further developed through a funded consultation process once it has received a favourable initial assessment from a research funding body. People with particular expertise in community consultation and cultural knowledge should be involved in both undertaking the consultation (as part of the research team) and in assessing the consultation process on behalf of the research funding body in the second phase of research assessment. The final assessment should give considerable weight to the assessment of the consultation process alongside a more conventional research assessment. Large scale primary health care research which may be technically feasible but which cannot demonstrate good support from the Aboriginal primary health care sector should not be funded.

Other useful ways of increasing productivity of Aboriginal health research include continuing efforts to support Aboriginal researchers but also improving the capacity of managers/clinicians in Aboriginal health services to engage with research. This could be through paid cadetships in a research organisation or allocating researcher time to training staff at ACCHSs in research methods as a part of a grant. The aim would not necessarily be to entice people out of the primary health sector into research but to increase the capacity of the primary health sector to deal with research knowledgeably. This will hopefully increase engagement with researchers and participation in research.

What are the health and medical research strategic directions and priorities and how might we meet them? Terms of Reference 5, 12 and 13

The 2002 *Road Map* contains useful principles and guidelines but was not developed in genuine partnership with our sector and in any case has not been implemented. *Road Map II* does not acknowledge this failure.

We feel it was important to independently review the original NHMRC *Road Map* for Aboriginal health as a key document in setting out strategic directions for the future (notwithstanding there was a remarkably cursory internal review). It is difficult to look at the on going directions without reviewing the implementation of the previous strategic plan. Overall, we believe that the *Road Map* and subsequent reforms have not changed how Aboriginal research is prioritised, funded and implemented as much as needed. The conventional process for research funding has largely continued and the frustrations in our sector are increasing rather than diminishing.

The process for reviewing, prioritising and judging Aboriginal health research for funding needs review.

The *Road Map* says that there should be a considerable investment in community driven research and the second version emphasised partnership with the community controlled sector (although there was clearly a failure of partnership in the review of the *Road Map*). We see little evidence of community driven research in the NT.

We agree with NACCHO that there should be a significant proportion of research which is driven from the community controlled sector as has occurred successfully in the past. The revised *Road Map* has developed a list of areas in which priority driven research could occur without any mechanism for recognising the need to fund bottom up locally developed research. The Lowitja Institute needs to be strengthened and have on going secure funding as they do essential work in priority setting and translation. However, this should not be at the expense of funding the community controlled sector to undertake translation—or indeed initial research.

There should be research in the effects of government health policy on Aboriginal health as it is obviously a dominant factor in Aboriginal health service delivery yet it is largely neglected by researchers.

How can we optimise translation of health and medical research into better health and wellbeing? Terms of Reference 4

One of the key drivers of translation is doing the right research in the right way in the first place. The right way is partnership with the community controlled sector in Aboriginal Primary Health Care sector.

Therefore, how research is selected for funding by research funding agencies is critical to doing the right research in the first place.

Some changes in how research is selected for funding that are likely to lead to improved translation are detailed below;

- Include practitioners (especially Aboriginal practitioners such as Aboriginal Health Workers) in assessment panels for research and support these practitioners with training.
- Publication assessment should be reviewed so that publications targeting people who work in Aboriginal health are rated higher than they would be under the current system (Aboriginal Health Worker Journal or the MJA for instance are better targeted towards dissemination to ACCHSs than an international journal with a higher impact factor).
- Develop objective criteria for assessing a researcher's record in addition to the conventional assessment of publications. These should include criteria about working successfully with the community controlled sector, and dissemination into policy and practice.
- Prioritize research that invests, as part of the proposal, in systems (PIRS, clinical system development) that will stay in place once the research project is over and facilitate ongoing changes to practice
- Reward research projects that include Aboriginal Primary Health Care staff in the research process with special attention to Aboriginal people (Aboriginal Health Workers, board members etc).
- Reward researchers for dissemination to the sector with greater reward for dissemination that is most likely to lead to translation (e.g. articles in practitioner rather than research journals, presenting to boards, affiliate meetings, etc
- Resource and support the sector to critically appraise research to see if it should result in changes to practice/system. It is not a given that all research should be translated, it does not all fit into the context or the evidence might not yet be strong enough.
- Resource the Aboriginal community controlled primary health sector for a translation function as outlined in our analyst and broker submission. This requires a funded position to work with other relevant staff such as Public Health medical staff and policy officers on translation to the sector.

References:

Josée Gabrielle Lavoie a,* , Evelyn L. Forget b, Tara Prakash b, Matt Dahl c, Patricia Martens b, John D. O'Neil (2010 , 717-724.. Social Science and Medicine.)

Assessing cost effectiveness in Prevention (2010). Vos, T, Carter R et al, university of Queensland, Deakin University.

Brimblecombe JK, McDonnell J, Barnes A, Dhurrkay JG, Thomas DP, Bailie RS. Impact of income management on store sales in the Northern Territory.MJA 2010 May 17;192(10):549-54.

Attachment A

Below are some brief comments on the priorities in the original Road Map which still seem to be largely appropriate apart from a lack of attention to policy on health outcomes. However, it is disappointing that much of what was recommended has been only partially implemented—if at all.

Priority 1: Descriptive and biomedical research

We agree that there is now only a place for targeted descriptive research. In particular, research shouldn't be used to justify whether money should be spent on investment in basic human services. For instance, we don't need research to justify (or not) reducing extreme overcrowding in housing in remote communities.

Similarly we don't need research looking at in depth biomedical explanations for illness which has disappeared from the rest of Australia as living conditions have improved over the last fifty years. An example would be a grant awarded to Menzies Research Institute looking at genetic basis for rheumatic heart disease (one million dollar grant). It is hard to justify genetic testing for RHD when people in remote communities are still living twenty to a house.

Priority 2: Resilience

There is a significant body of work undertaken in Canada on the effect of community control of service delivery not just in health but in a range of basic services as well as ownership of land. There has been little research done in this sphere in Australia partly because of the extent of community control in Australia is not as wide. However, we believe that it would be useful to look at the benefits of community controlled models on the resilience of communities and individuals.

Priority 3: Health service delivery

The initial comments in the Road Map about the lack of impact of health service delivery on health outcomes is negative, ignores evidence of improved morbidity and mortality in the NT and other states as well as the decades of under investment in Aboriginal Health.

We agree that there needs to be research on the effectiveness of mainstream spending on Aboriginal health as the focus on mainstream delivery for Aboriginal people has increased since the Road Map was developed (particularly with the COAG Close the Gap investment) yet there is little strong evidence for its effectiveness. Mainstream programs are often evaluated through a competitive tendering process with the scope and timelines of the evaluation being determined by government. This clearly limits the rigour of many of these evaluations. Peer reviewed research that examined aspects of mainstream funding packages in depth would add greatly to the evidence base for policy makers. It is disappointing that there is almost no emphasis on policy research in the revised Road Map.

Crucially, there has been limited research about the benefits of community controlled health services in contrast to the work done in Canada (Lavoie et al, 2010). This research was done in partnership with Indigenous leadership in Canada and has shown very strong health benefits (and health savings) from community controlled health services. Research on benefits of community control needs a priority driven research program conducted in partnership with NACCHO.

There is increasing intervention research which is largely a positive development except that it is frequently not developed in partnership with the sector. However, there is not enough research on prevention/health promotion in Aboriginal health. There has been some health economic work on preventative program including cost effectiveness in ACCHSs (Carter et al, 2010). This was a largely theoretical project which used modelling to come to most of its conclusions given a weak evidence base for prevention in Aboriginal communities. Clearly the evidence base of prevention in practice needs to be further developed and this should occur in partnership with the community controlled sector so that the research is both relevant and likely to lead to translation.

There is little recognition of the growing capacity of ACCHSs around data and data quality in either the first or revised Road map. The capacity is varied across the nation but some ACCHSs (including many in the NT) have high levels of capacity around data quality. There needs to be 1) support for all ACCHSs around improving data quality and 2) research developed with the sector on using health data for health services research and in data linkages projects looking at health in relation to other sectors.

Priority 4: Social determinants.

There is not enough useful research on many areas of social determinants including environmental health, housing and other key areas. There is also little research on intersectoral programs between health and other sectors. Data linkage programs between sectors are being developed but in the NT, there has been poor engagement with the ACCHS sector with the ACCHS sector having little influence on how any proposed data linkages would work in practice.

Again there needs to be priority driven research on the evidence base of government policies and why the known evidence base is not influencing policy in the area of housing, for example.

A recent example of timely research on the health impact of government policies is the study by Brimblecombe et al on effects of income quarantining and store policies on healthy vs. un healthy food consumption(Brimblecombe et al , 2010). There needs to be high quality peer reviewed evidence on the health impacts of other major policies affecting Aboriginal people in the NT and nationally. This is crucial given that government consultations are often superficial as evidenced by the concerns about the consultations for the Stronger Futures legislation in the NT. The effect of government policies on community and individual wellbeing and perceptions of racism should also be critically reviewed. It is disappointing indeed to see that the second road map has not emphasised at all a need to research the effects on health of government policy.

Priority 5: Relationship with under researched communities

Neglected areas still remain neglected which indicates a partial failure of the road map approach and a lack of prioritised research funding.

Even in remote areas which are often thought to be well researched, there are some services that are approached repeatedly and are overloaded whilst other services are rarely approached. It is important to consider equity in determining how health service intervention research is conducted given that health services research now amounts to millions of dollars in the NT per annum.

Mental health and AOD intervention research is still poorly funded and what occurs in the NT is not done in partnership with the sector. The community controlled sector has been a leader in the integration of mental health and alcohol and other drug services into comprehensive primary health care. However, in the NT, this model is threatened by the continuing funding of

mainstream providers with little experience of Aboriginal health service delivery in preference to funding ACCHSs particularly in remote regions. We need a partnership with researchers that facilitates the further development of an evidence base for a holistic model of Social and Emotional Well being services in ACCHSs including a model that works in remote locations.

Many of the other under researched areas (justice and incarceration, male health, child abuse) remains under researched. The community controlled sector is doing innovative work in male health, including work on linking health services to other sectors such as employment. However, male health programs need rigorous evaluation to provide an evidence base that will justify further funding and development. Child abuse is clearly a very difficult area to research safely but we (AMSANT) are very concerned at the rolling out of programs with very little evidence in remote areas of the NT as part of the NTER. It remains a neglected area.

Priority 6: Capacity building

The *Road Map* should have influenced capacity building much more than it has. There needs to be an emphasis not just on capacity building of researchers but on capacity building of the ACCHS sector to participate in research as equal partners. This will need funding and skill development within the Aboriginal primary health care sector focusing on Aboriginal people where possible. Too much of the research employment targeting Aboriginal people is part time, and low wage. This type of employment has minimal effect on people's incomes (which is a problem since most people are poor) and it is not a stepping stone to further employment.

Measurable impacts of the *Road Map*?

We are not aware of any formal evaluation of the road map or reporting on indicators apart from a series of workshops reported in the *Road Map II* document. A formal evaluation of where we have got to with Aboriginal health research is well overdue.

There should definitely be measures around increase in capacity of the ACCHS sector to participate in research as equal partners, to improve research and research translation skills within the sector. These should be reported on regularly by research bodies such as the NHMRC that allocate large sums of funding to Aboriginal health. The move for a triennial review of the *Road Map* is a welcome development.

Improved dissemination of research to practitioners in Aboriginal health should be a key measure of the success of the *Road Map*.

Attachment B

Proposal for an Aboriginal Health Research Analyst/Broker to be located within the AMSANT Secretariat

Proposal

AMSANT to engage an Aboriginal Health Research Analyst/Broker with the aim of increasing the capacity of AMSANT and member services to actively engage with the research process. A more active engagement between the Aboriginal community controlled primary health care and research sectors will assist with optimising the contribution research makes to improving Aboriginal Comprehensive Primary Health Care.

Issues with current system

Current capacity to deal with research

ACCHSs are frequently approached by researchers with requests to participate in research. ACCHSs have variable capacity to assess and respond to researchers' requests. Even large ACCHSs that have a public health doctor or other public health specialists find it difficult to give research proposals the attention they require given the many other public health challenges they are facing. Indeed two of our services have instituted temporary moratoriums on new proposals. Many smaller ACCHSs do not employ staff with research expertise. When ACCHSs agree to participate in research proposals, they have limited time to actively engage with the research process so that it can be shaped to their needs.

ACCHSs would benefit from an active engagement with research once they have decided to participate in a research project but they often lack the staff time and capacity to drive this engagement. Active engagement with research could include the following:

- monitoring the research undertaken in their service to ensure that it is beneficial to their service and community and that it is not having unforeseen negative consequences, such as impacting on staff members core duties;
- ensuring that staff knowledge and capacity is increased through being involved in research proposals;
- facilitating the involvement of Aboriginal staff, board members and community members in research so that local Aboriginal expertise in dealing with research issues is increased;
- enhancing the potential for Aboriginal people to be employed within research projects;
- generating of research proposals *from* ACCHs through brokering of appropriate researchers and funding;
- independent assessment of research findings to enable ACCHSs to translate research into practice where appropriate;
- ensuring that their intellectual property in the research is valued appropriately; and
- dissemination of research findings to ACCHSs boards and communities.

Research priorities

ACCHSs have limited time or capacity to engage with research institutions in formulating research questions that are of most importance to their service. The current approach of ACCHSs being approached by researchers means that important areas may be neglected. A

common concern is that research does not help ACCHSS to undertake core primary health care service delivery and improve their systems and processes. There is limited health service research and/or intervention research in Aboriginal health: research describing problems is much more common than research looking at solutions (Sanson Fisher et al, 2006). A more active process would bring ACCHSSs and researchers together to jointly develop research proposals.

Dissemination

Dissemination in research is largely via peer reviewed journal articles. This can be of limited usefulness to the staff and boards of ACCHSSs who may not have the time or capacity to read technical journal articles. Also, the results from their own service will not be published in a journal in order to protect their confidentiality.

The NHRMC policy on Aboriginal research has recognized the importance of researchers feeding back the results of research to communities. Researchers also need to actively disseminate their work to boards, managers and clinicians in ACCHSSs and other stakeholders such as policy makers in Aboriginal Health. This can be challenging for researchers who are either new to Aboriginal health research and/or who are located interstate and do not have the necessary contextual knowledge and networks to undertake this type of dissemination. Researchers may neglect this important area of dissemination because in the research world, they are largely assessed by publications rather than other methods of dissemination.

AMSANT's role in research

AMSANT's role in research includes:

- providing input to a developed research proposal prior to submission to funding bodies;
- providing letters of support for ethics committees (usually required in Aboriginal PHC research affecting multiple communities) and funding bodies;
- collaboration with researchers to design research proposals to answer particular questions; and
- being an active partner in research trials (i.e. being on an executive management group of a trial).

AMSANT has developed a research policy to guide AMSANT's work in research.

A subcommittee of the board oversees this policy, along with the Public Health Advisory Group [PHAG]. Researchers who wish to work in region or with a limited number of ACCHSSs do not always approach AMSANT for assistance. However, Aboriginal PHC research with a regional or NT wide scope usually requires AMSANT's input. Of note, active collaboration with researchers occurs less frequently than the other activities: AMSANT is usually asked to support research proposals that are well developed. Also, when AMSANT has been approached to be an active collaborator in developing a research proposal, it has been difficult for existing AMSANT staff to find the time to provide the input required.

All research proposals which require input from AMSANT are assessed according to a research template (Appendix 1). Key aspects of this assessment include whether Aboriginal people are involved and benefits of the research to the communities being researched. The assessment is undertaken by one of the members of PHAG which meets weekly. Members of the group include the CEO, Public Health Medical Officers and two senior medical advisors (who both work in large regional ACCHS with considerable experience of research), the program manager

and the policy/strategy manager. The research template is the assessed by the research subcommittee. Proposals which have NT-wide significance or where AMSANT is asked to be a partner are referred to the AMSANT board.

However, AMSANT is also dealing with a large workload and has limited capacity to provide individual assistance to ACCHSs or to work with research institutions and researchers so that Aboriginal PHC research meets the needs of the sector at the NT, regional and local level. This is despite the collective experience and knowledge within the AMSANT secretariat membership about research and research priorities.

Specific functions of the Aboriginal Health Research Analyst/Broker

Working with individual ACCHSs

The Aboriginal Health Research Analyst/Broker will assist ACCHSs to assess research proposals. The AMSANT Aboriginal Health Research Analyst/Broker will ascertain from each ACCHS whether they want research proposals to be assessed initially by AMSANT. If this is the case, the Aboriginal Health Research Analyst/Broker will assess research proposals received by ACCHS according to the AMSANT template and any criteria set by the service or by the services own assessment procedures. The Aboriginal Health Research Analyst/Broker could use expertise within the AMSANT secretariat (e.g. through the input of public health medical officers) to complete this task as required. Once this is completed, the researchers will discuss with the service the results of the assessment and assist the ACCHS to engage with the researchers if they are interested in pursuing the research. The Aboriginal Health Research Analyst/Broker will assist services to obtain any additional information they require prior to deciding whether to engage in the research.

The Aboriginal Health Research Analyst/Broker would also assist ACCHSs to engage with research projects they are currently participating in, including assisting researchers to work with staff and managers in services so that they gain skills and knowledge but are not overloaded. They would also work with researchers to ensure that the results of the research are fed back in a way that is most useful and appropriate to the ACCHS and the community.

As discussed later, the Aboriginal Health Research Analyst/Broker would also work with ACCHSs on formulating research questions that are a priority for their community and then work with research organisations, philanthropic bodies and government to seek out appropriate expertise and funding.

Research proposals submitted to AMSANT

Similarly, the Aboriginal Health Research Analyst/Broker will assess research proposals submitted to AMSANT by researchers for input (letter of support, intellectual input. request for partnership etc.). The Aboriginal Health Research Analyst/Broker will submit the assessment to the Public Health Advisory Group and again will work with the researcher to ensure that AMSANT has the necessary information to fully assess the proposal. Once the research has been assessed by the Public Health Advisory Group, the Aboriginal Health Research Analyst/Broker will work with the Research Subcommittee of the Board and/or the AMSANT board in order that they can provide informed comment on the research. A more active process of engagement with researchers will assist with providing more in depth input to research which in turn should improve the quality of the research proposal.

The Aboriginal Health Research Analyst/Broker would also work with researchers to ensure that researchers continued to engage with AMSANT during the research process and that research

with regional and/or NT wide implications is disseminated appropriately e.g. by presentations at AMSANT general or board meetings, AMSANT newsletters and through clinical networks.

Research priority setting

The Aboriginal Health Research Analyst/Broker will work with the AMSANT membership and board to ascertain research priorities at a local, regional and NT wide level. The Aboriginal Health Research Analyst/Broker will work with research organizations to negotiate potential partnerships between ACCHS and or/AMSANT and researchers in developing research proposals which will address these research priorities. The Aboriginal Health Research Analyst/Broker will also assist with obtaining funding through research organisations, philanthropic bodies, governments and other funding agencies.

Research translation

The Aboriginal Health Research Analyst/Broker would work with a range of relevant organizations on assisting with research translation into the Aboriginal comprehensive primary health care sector. This would include seeking out relevant research (even if that research is done outside the NT), assessing its relevance and disseminating it through AMSANT networks such as clinician networks, AMSANT meetings and other forums. The Aboriginal Health Research Analyst/Broker would work with the public health medical officers to achieve this task (i.e. it would not be their sole responsibility).

Support for the Aboriginal Health Research Analyst/Broker

The job as described here has a broad scope and a large potential workload. The Aboriginal Health Research Analyst/Broker would work closely with the two AMSANT public health medical officers, the programs manager and the policy officer at AMSANT. One of the full time public health medical officers now has a particular focus on research and policy related to public health so would be able to support the position and share the workload.

The Aboriginal Health Research Analyst/Broker would be able to share some of the responsibilities with others in the organisation with public health expertise and so would be well supported. They would also be invited to attend the weekly PHAG meetings when research or other relevant issues such as knowledge translation are discussed (which would mean that they are likely to attend as often as fortnightly). The job would be suitable for someone with experience of research processes and research translation, a commitment to the philosophy of community control as well as some knowledge (or interest in obtaining knowledge) about Aboriginal comprehensive primary health care.

References

Robert W Sanson-Fisher, Elizabeth M Campbell, Janice J Perkins, Steve V Blunden and Bob B Davis (2006): Indigenous health research: a critical review of outputs over time. *MJA*; 184 (10): 502-505