

# Getting the most from Indigenous health research

David P Thomas and Ian P Anderson

*Each Indigenous health problem calls for its own unique mix of descriptive and intervention research in both clinical and public health fields*

The Aboriginal and Torres Strait Islander Social Justice Commissioner, Tom Calma, has challenged all governments to commit to achieving Indigenous health outcomes equal to those of non-Indigenous Australian people within 25 years.<sup>1</sup> Governments have set similar goals in the past, but have avoided such clear deadlines.

What role should research play in a properly funded program for Aboriginal and Torres Strait Islander health equality? Research can provide useful evidence to better target health policy and strategy, and to guide more effective health services. Researchers can also intervene with empirically-based good sense when the debate gets sidetracked by slogans from all points in the political spectrum. The debate will not be depoliticised, but researchers may help in moving it along. In fact, researchers would be wise to be humble about their impact. They only act as small — if sometimes crucial — wheels in the complex social and political machinery that drives the necessary changes to health services and to the broader social determinants of health. They also must bear the legacy of unhelpful or damaging past health research that fuels Indigenous distrust of research and researchers today.<sup>2</sup>

Since the social changes of the late 1960s, Australian researchers have increasingly turned their attention to the health of Aboriginal and Torres Strait Islander peoples. Indigenous health publications occupied less than one per cent of the pages of the *Medical Journal of Australia* in the years before 1970, but by the 1990s this had risen to more than four per cent.<sup>3</sup> In this issue of the Journal, Sanson-Fisher and colleagues describe the trends in the numbers of Indigenous health publications in Australia, New Zealand, Canada and the United States since 1987 (page 502).<sup>4</sup> They do not tell us who wrote these publications, nor do they tell us much about what was written. Nevertheless, they report that the greatest increase in the number of Indigenous health publications was in Australia, where the total number rose from 28 in 1987–1988 to 167 in 1997–1998 then fell to 147 in 2001–2003. Original research publications were dominated by descriptive research. We agree with their concern about the much smaller (albeit increasing) number of publications assessing health interventions, and the consistently low number assessing measurement tools.

How do we find the right balance between these different types of research? We need research that assesses new interventions for diseases or clinical syndromes, such as chronic suppurative otitis media, that are common among Aboriginal and Torres Strait Islander peoples, but relatively uncommon in other Australians. We may also need to evaluate the transferability of some well tested interventions when we suspect that they will work differently in an Indigenous health setting, which is the case for chronic disease programs. Often, however, we can readily apply research from other settings without the need for new research. Some descriptive research can still be necessary when it fills gaps in knowledge that undermine the capacity to make good policy decisions.

Different problems will require research programs with different mixes of descriptive and intervention research, and different research methods. Health-service providers, policy makers and Indigenous communities can tell us which uncertainties are impeding action to improve Indigenous health, and so need answers from new research programs. The “road map” produced by the National Health and Medical Research Council (NHMRC) describes what areas of new research are agreed to be most useful: from patterns of risk factors to researching resilience and well-being.<sup>5</sup> The NHMRC has also produced guidelines to help non-Indigenous researchers build more ethical relationships with Aboriginal and Torres Strait Islander communities.<sup>6</sup>

The Journal has not just been a passive recipient and publisher of an increasing number of manuscripts about Aboriginal and Torres Strait Islander health. The first of many special supplements on Aboriginal health was published in 1975.<sup>7</sup> This issue, like several earlier issues, is devoted to Aboriginal and Torres Strait Islander health. There are other less visible changes at the Journal: editors can now usually recruit at least one Indigenous reviewer for every Indigenous health manuscript. No longer is Indigenous health research only a matter of white researchers writing about Aboriginal people for a white readership:<sup>8</sup> there are slowly more and more Indigenous people involved in all stages of the research process — from setting the research question, to doing the research, to writing, reviewing and reading the final publication.

There have been changes in how Indigenous health problems are framed in the Journal. Sixty years ago, the Journal reported a conference paper which compared the falling Australian Aboriginal population with the increasing indigenous populations of the United States, Canada and New Zealand.<sup>9</sup> The author did not call for more research on health interventions but for more scientific research on “hybrid vigour”, reflecting the prevalent but misguided political obsession with the “half-caste problem”. However, he then moved to a more familiar issue. He linked the unfavourable international comparisons to the “outstandingly mean, neglectful and backward” approach of Australian governments to Aboriginal people: the 63 shillings of Australian government annual spending per Aboriginal person compared with much higher spending in the United States (£23) and Canada (£10).

Recent research has documented that Australia now spends only 18% more on health services for each Aboriginal and Torres Strait Islander person than for each non-Indigenous person, in spite of the much greater burden of illness among Indigenous people, and the higher costs of providing services to them, especially in remote areas.<sup>10</sup> This descriptive research on expenditure has been invaluable in cutting across polemical argument about the “buckets of money” that are “thrown” at Indigenous health. This descriptive work now needs to be complemented by research that will evaluate financial and administrative interventions in Indigenous health against progress towards the other goal set by the Social Justice Commissioner: equal access to primary health care and health infrastructure within 10 years.

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