If there is one thing that should be clear by now to anyone working in the area of Aboriginal and Torres Strait Islander health, it is that biomedical research carried out in isolation from the Aboriginal and Torres Strait Islander community will not significantly improve health outcomes for Australia’s Indigenous peoples.

Instead we need a holistic approach to research that includes Aboriginal and Torres Strait Islander people in every step of the way from the development of research questions and methodologies to the research itself and, importantly, through to the exchange knowledge and implementation of research outcomes in practice change and policy development.

This is the case whether the research is tackling the underlying causes of Indigenous ill health, reform of health systems or the very specific problems that require a biomedical effort – and this is reflected in the approach of the Cooperative Research Centre for Aboriginal Health (CRCAH).

As an Indigenous-led organisation with an Indigenous majority on its board, the CRCAH is unique among Australia’s peak health research organisations. This has given us the platform to break down the historical suspicion of health research in Indigenous communities, where researchers were too often seen as pursuing their own agendas, with little to show for it in terms of improved health outcomes on the ground.

The CRCAH has pioneered a ‘bottom up’ approach to health research, where Indigenous people have a big say in what the research agenda is and how it gets done. We have also put significant resources into research transfer, to ensure that our research outcomes are translated into improved practice across Australia. So how did we get here?

When I was appointed CEO of the CRCAH in 2005, the organisation had just emerged from a period where it had been involved in funding a broad spectrum of research projects. Most of these stemmed from our original incarnation as the Cooperative Research Centre for Aboriginal and Tropical Health (CRCATH), when even to have medical researchers and Indigenous health organisations sitting at the same table was a major achievement. And this in fact was one of the CRCAH’s greatest legacies – getting community healthcare providers to let go of their historical suspicion of researchers and, indeed, to become active and willing partners in the research agenda. From a biomedical perspective, having organisations such as the Queensland Institute of Medical Research, Menzies School of Health Research and the University of Melbourne at the forefront of this change as Partners in the CRCAH has helped this process immeasurably.

That broad-brush approach to research is typical of many CRCs who, in their attempt to address an area such as improving Aboriginal and Torres Strait Islander health, they try to be ‘all things to all people’ and end up finding this approach is totally impractical. The CRCAH quickly came to the realisation there was a need to refocus our effort and, shortly before I started in my role, the CRCAH board decided to implement a programmatic approach to research.

Since then the CRCAH has concentrated its funding in five specific areas:

- Comprehensive Primary Healthcare, Health Systems and Workforce.
- Chronic Conditions.
- Social Determinants of Health.
- Social and Emotional Wellbeing.
- Healthy Skin.

Of these five areas, the Healthy Skin program is where we have focused our biomedical effort because of the well-documented link between childhood infections and chronic disease later in life. The rest of our funded research is in areas which we think have generally been neglected, such as how to improve the way existing health systems function for Indigenous Australians, how to enhance opportunities for Indigenous people in the health workforce and how to build psychosocial resilience within individuals and communities.

It is obvious to anyone who looks closely enough that the high rates of renal failure suffered by Indigenous people, or the high rates of hearing impairment, or the high rates of skin infections, or the high rates of rheumatic heart disease (the list goes on and on) are in fact symptoms of a much bigger issue that needs to be addressed: the historical legacy of colonisation, dispossession and cultural collapse.

Aboriginal and Torres Strait Islander people have a higher burden of ill health than the wider community not because they are more prone to being sick, but because their living and social conditions are worse.
conditions are such that they are often caught in a trap they find difficult to escape from. You cannot deliver Western-style healthcare to people whose poor education does not allow them to understand the concepts you are using, who don’t have a fridge to store their medicines in, who live fifteen to a house with no or non-working sewerage or even running water, who don’t have access to fresh food, who suffer from the debilitating effects of institutionalised racism and who may be dealing with alcohol or drug dependency among family members.

Just as importantly, health interventions will not make any long-term difference to Aboriginal and Torres Strait Islander people unless they are embedded within the communities they are seeking to help. That is, we need to build an Indigenous health and research workforce and nurture the development of Indigenous-controlled health service delivery.

So these are the challenges we have decided to take on. Over the past 5 years we have carried out research that has the clear potential to improve the way community-controlled health services are run, the way Indigenous people are treated in hospital, the way Indigenous parents are supported in helping with their children’s education and the way in which tobacco control programs are implemented in Indigenous communities. We have also played an active role in encouraging the development of an Indigenous research workforce via the targeted use of scholarships, traineeships and workforce opportunities through projects we fund.

To give one detailed example of our work, when Australian health authorities began planning the rollout of the human papillomavirus virus (HPV) vaccine across Australia, we were concerned that Indigenous communities in remote, regional and urban locations might not understand the importance of the vaccine to the health of girls and young women. So we funded research into the attitudes of consenting parents, GPs and Aboriginal Health Workers (AHWs) in order to find the best ways to educate different communities and administer the vaccine in these communities.

This led directly to the development of education resources designed to suit the various audiences, including the translation of resources into five Central Australian Aboriginal languages and AHWs were empowered to educate their communities appropriately at the time of HPV vaccine mass immunisation. As a result, Aboriginal communities involved in this research reported high levels of vaccine uptake, equivalent to the uptake in the wider Australian community.

This work has shown us the benefit that can accrue for the Aboriginal and Torres Strait Islander community, in this case our women, when there are meaningful collaborations between Indigenous people and researchers in the biomedical arena. It shows that strategic engagement and investment can leverage great outcomes when the engagement is appropriate and built on mutual respect.

Another important area of our work is improving the systemic performance of health services dealing with Indigenous clients. In recently released results from our Overburden Project, CRC AH-funded researchers have shown the crippling impact of fragmented and short-term funding arrangements on the ability of community-controlled health services to deliver primary healthcare to their clients.

The research found that the task of managing and acquiring funding for specific programs from a variety of funding sources placed an enormous administrative burden on these health services that was well beyond the burden borne by equivalent mainstream healthcare providers. Yet these administrative arrangements did not improve accountability and acted as a barrier towards holistic healthcare. The project has resulted in recommendations to change the funding arrangements towards longer-term, more cohesive models and these recommendations have now been taken up at the highest levels of government.

This does not mean to say we have turned our back on funding biomedical research. For instance, our commitment to managing and reducing the scourge of skin infections, particularly scabies, among Indigenous Australians remains as robust as ever and is reflected in our funding for a planned trial of a new oral treatment for scabies – ivermectin – in a Northern Territory community.

Furthermore, our strong links to the world of biomedical research via our core research partners, such as the Queensland Institute of Medical Research and the Menzies School of Health Research, ensures that everything we do is informed by the very latest biomedical research outcomes.

What we are about is working the angles from the bottom up, tweaking existing systems to make them perform better for Indigenous people, improving the flow of health information into Aboriginal communities and into primary healthcare delivery.

Our successful research agenda was recognised recently when we were one of only a handful of existing CRCs to have our original 7-year terms extended for a further 5 years. This will see us continue our work through to 2014 and will allow us to focus even more tightly on those areas where we see the greatest potential for ‘closing the gap’ in health outcomes for Indigenous Australians over the medium- to long-term. Beyond 2014, we are seeking the establishment of a National Aboriginal and Torres Strait Islander Health Research Institute to continue the urgent task of finding solutions to the myriad health problems confronting our people.

We will continue to work closely with the biomedical research community and trust that our research approach will help you improve what you do for the benefit of us all.