Research Priorities and Policy-Research Interface

Views of Selected Senior Aboriginal Health Policy Makers

Report for the Cooperative Research Centre for Aboriginal Health

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Introduction

The Cooperative Research Centre for Aboriginal Health (CRCAH) plans to submit a proposal to the Commonwealth CRC Program for an extension of funding. This report is intended to support the development of that proposal. It is based on a rapid appraisal of government documents and telephone interviews with senior Aboriginal health policy makers.

At the time this work was carried out (September 2008), consideration was being given to alternative futures for the CRCAH and this influenced the framing of the investigation and an initial analysis. A considerable amount of the information obtained has bearing on a research agenda for the extension proposal, and also to a lesser extent on potential ways to maximise the impact of the CRCAH in an extension phase. It is this information that is presented here.

The draft research agenda for the extension phase that has been developed, based on this and other work, has three proposed programs:

Health, Social and Physical Environmental Systems
Healthy Communities and Institutions
Reducing the Burden of Chronic Ill-health:

Ranking of importance and commentary on policy areas related to these three programs are the focus of this report.

Method and Caveats

A rapid appraisal of Australian Government and state/territory health department strategies and policies was undertaken. From this, twelve areas either explicitly or implicitly of importance to policy makers were identified. These formed the basis of a questionnaire that explored the views of senior Aboriginal health policy makers from these jurisdictions about the twelve policy priorities, priorities that did not appear on the list of twelve and how a national research institute could maximise its impact.

Thirteen people were asked to participate. They were selected on the basis of being known to the CRCAH as having substantial Aboriginal health policy knowledge and experience in Australian Government and state/territory health departments. They were assured of confidentiality.

The questionnaire was emailed to respondents for completion prior to a follow-up telephone interview. It was completed and returned prior to interview by 12/13 respondents. The telephone interview provided an opportunity for respondents to expand on their answers and for follow-up questions to be asked. The interviews ranged in length from 30 minutes to 1 hour.

Respondents were asked to rank the importance – high, medium or low - of research to policy in each of the 12 policy priorities at 5 years and 10 years. In order to summarise the information in some way, each rank was assigned a numeric value (high=3, medium=2, low=1) and a mean rank was created. A synthesis of the commentary was also developed. The mean ranks should be interpreted with caution because in assigning the ranks, respondents took a range of factors into account (see below) which makes the information somewhat difficult to interpret. A synthesis was also developed of relevant commentary relating to other policy priorities and to maximisation of impact.

Key Findings

Research-Policy Interface

Respondents were energised by the issue of the research-policy interface and had lots of very informed and insightful things to say about the subject. The predominant view was that research-policy translation is improving, but remains patchy, with some very significant gaps in useful evidence.

Respondents generally looked to a brighter future when there was more evidence available to inform policy. Many departments are taking a quite active role in making research evidence address issues of importance to them, and better meet their needs.

There was a widely and strongly held view that as a general rule research has to be practical and shed light on possibilities for action in order to inform policy. More 'esoteric' sociological work does not satisfy this requirement. There are however, some exceptions to the latter, where problem descriptions result in a fundamental reframing of policy problems. An outstanding example of this is the work on 'burden of disease'. More research evidence on burden of disease was rated highly by everyone. The overwhelming need is for increased sophistication of the methods so that more finely nuanced understandings of burden of disease can be generated to support regional agendas that are everywhere seen as the way of the future – and are already quite advanced in some jurisdictions.

Related to this is the need for improved capacity to monitor achievements against indicators, particularly the COAG indicators of Indigenous Disadvantage (and to a much lesser extent the NATSIHPF indicators). This was partly about an acknowledgement that achievement against these indicators will be uneven, and it will be important to be able to demonstrate to the Parliament successes, as well as where challenges remain to be addressed.

Twelve Policy Priorities and the Draft Research Agenda

Of the twelve policy priorities explored with respondents, the following are directly relevant to the three research programs in the CRCAH extension draft research agenda. The rankings and commentary for each are shown in the Table.

Health and Social and Physical Environmental Systems

the effectiveness of policy instruments such as regional agreements;
the effectiveness and sustainability of community controlled service delivery;
contribution of mainstream primary health care services;
burden of disease; and
workforce

Healthy Communities and Institutions

community-based health promotion

Chronic ill-health

effective strategies to reduce risk behaviours
effective interventions for health priority areas – maternal and child health and chronic disease

Other Policy Priorities

Respondents also identified other policy priorities, some of which have relevance to the proposed research program. They commented on:

the need for evidence about sustainable, intersectoral interventions that can make a difference in the long term around the interactions between health and education, health and employment, and health and housing;
the increasing importance of injury, which is often seen by governments as a low priority and for which there is little good evidence of effective interventions;
the importance of the early years of life and the interaction of health in the early years and school success;

the increasing importance of men's health in the context of early high mortality among Indigenous men, and recognition of the importance of loss of social roles, and the importance of the family unit to child health;
the importance of sexual health; and
environmental health including the impact of climate change, food security, water availability and the economic viability of some communities.

One respondent expanded on the policy questions raised by regional models, if they are to be based around community control. What needs to be done by governments to transfer power to community control? What does the government hang on to and what does it hand over, including buildings and other infrastructure? How does this get into capital works program, including tendering and procurement issues? How do we establish culturally appropriate integrated delivery of core services? How do we overcome barriers to access? How do we enhance the role or mainstream; attract and retain health parishioners? Need functioning complaints mechanisms.

Maximising Impact of the CRCAH Research Agenda

Respondents suggested a range of strategies, including:

active engagement with policy makers in research processes, including in defining the policy problem and research questions, and determining study design etc;

emphasis on intervention research and active engagement in translation of evidence into practice;

direct engagement in policy processes; researcher membership of committees

a regular research bulletin that synthesises research evidence and draws out the policy implications, the latter from an authoritative voice.

more events such as the effective CRC showcase, tailored as policy briefings; Think Tanks that explore policy options based on research evidence

research seminars accessible to bureaucrats;

one-on-one meetings with policy-makers;

paying attention to emerging issues;

One respondent argued as follows: "I don't think you need planned, long-term engagement to get 'research transfer'. I think it looks more like guerilla tactics, opportunistic engagement, social networking. I think researchers need at times to lead the policy debate rather than second guess the policy makers. This is an incredibly difficult role to play as advocates for particular points of view can get trapped in that role… (she's the one who thinks blah...). But it can also be very powerful if the research is credible and the researcher sticks to the research message."

Another argued that engagement with researchers would depend on the priorities of the organisation at the time. [In response to a follow-up question about how a research body can plan around that] … some problems are perennial and the trick is to define the problem in broad enough terms that the research can contribute to policy in spite of the particularities of a given 'policy moment'; sometimes it's just the language that's the problem [in the mismatch between research and policy].

Table: Summary of respondents' rankings of importance of research evidence in different policy areas (n-12*)

These data need to be interpreted in the understanding that respondents may have ranked an area as low or moderate for one or more of the following reasons:

1. It is not a high priority policy area;
2. It is not a policy area that is particularly amenable to research;
3. It is a policy area amenable to research, but current research methods/capacity are inadequate to address it more effectively at this time;
4. There is already a fair amount of research evidence; and/or
5. Evidence/experience accumulated in the next five years will have diminished the need for and/or importance of research evidence in subsequent years.

Policy Area	Period	Mean Rank	Summary of Commentary
Health and Social and Physical Environmental Systems			
Effectiveness of key policy instruments, such as Framework Agreements, Regional Plans etc	5yr	2.3	Mixed ranking of importance; seen as one of the few tools bureaucrats have to effect change; some ambivalence expressed about the effectiveness of these instruments; seen as relevant to regionalisation but this is going to be more about whole of government, rather than just health; existing Aboriginal health forums could morph into something more significant; considerable ambivalence expressed about research evidence as appropriate mechanism for informing policy in this area.
	10yr	2.0	
Effectiveness and sustainability of community controlled health services	5yr	2.7	Views ranged from this being ideological territory and an 'old agenda' to a question of contemporary importance through which there is a need to 'cut through the politics'. Relatively high ranking of importance particularly for the next five years, but for the majority this is part of a broader, important agenda about the delivery of effective primary health care, in which the community controlled sector is seen to play a vital role. Conceptual work seen as needing to be done to understand their role in a rapidly changing environment – regional models, for example, need more than just ramping up of community controlled health centres.
	10yr	2.4	
Contribution of mainstream primary health care services	5yr	2.7	Mostly ranked of high importance, and as for area 6, largely seen as part of a broader agenda about the delivery of effective primary health care, in which mainstream services are also seen to play a vital role. Appropriate models for the mix or community controlled and mainstream were seen as highly influenced by state/territory and regional service delivery contexts.
	10yr	2.8	
Burden of disease, morbidity and mortality – patterns and causes etc	5yr	2.8	Most respondents ranked this of high importance; great need expressed for regional data; realisation of full potential seen as currently constrained by methodological limitations; finer segmentation needed both to demonstrate progress in 'Closing the Gap' and show where more work is needed; will become increasingly important to distinguish between remote, regional and urban populations as well as between age groups and sexes. The importance of having contemporary data rather than data that is 5-10 years old to assess impact was seen becoming of increasing importance to policy makers.
	10yr	2.8	
Workforce	5yr	2.7	The majority ranked this of high importance. Universally this was about different models for the make-up of the workforce and more effective and efficient ways of deploying them. Information is needed to support the development of multi-disciplinary teams, creative solutions to doctor
	10yr	2.8	

			shortages, new professional roles (e.g. community health promotion workers), redefinition of existing roles and competencies, expansion in the use of IT, increased self-management and improved education pathways. While most saw research as having a role to play in the production of evidence, two felt sceptical about what it could contribute. Struggles over professional turf were seen as continuing to impede reform.
Healthy Communities and Institutions			
Effective and (efficient) interventions in community-based health promotion	5yr	2.8	While this was universally seen as an area of high importance in terms of Aboriginal health, and one with a big evidence gap, limits to the generalisability of research evidence in health promotion were seen as a limiting factor. Community capacity to benefit from health promotion was seen as an important - community development, social participation, leadership etc are seen as being important but poorly understood. The importance of social determinants in the health promotion agenda was raised repeatedly in different contexts. There was seen to be a great need for research that focused on the trialling of effective interventions rather than descriptions of issues and problems.
	10yr	2.8	
Chronic ill-health			
Effective (and efficient) strategies to reduce risk behaviours	5yr	2.9	Almost all respondents ranked this of high importance. Where importance was seen to diminish over time, it was about the increased availability over time of evidence that would inform policy. Need was expressed for improved understanding of individual and community constructions/understandings of risk and the community dynamics that increase capacity to benefit from interventions.
	10yr	2.7	
Effective and (efficient) interventions in health priority areas (e.g. chronic disease, maternal health)	5yr	2.9	All but one respondent ranked this of high importance for the next five years. Again diminishing importance was seen to result from knowing more in subsequent years. The one respondent who ranked this as moderate for the next five years felt that medical interventions are only a part of the story, particularly since there will never be any doctors in some areas, or enough doctors in some other areas.
	10yr	2.5	
Other			
Primary health care expenditures	5yr	2.5	Very mixed ranking of importance for areas 3, 4 and 5 and the issues raised about the three are inter-woven. These policy areas are seen as only moderately amenable to research for a range of reasons including the shift to an outcomes focus, the way expenditure and need are assessed by governments, the way resource allocation decisions are made, the importance of state/territory (and regional) context, differences in capacity to benefit, the tendency for research to be 'academic' and fail to take account of whole-of-health-system need/expenditure, the very specific nature of the information required to inform policy decisions, and the shifting nature of the policy problems and evidence needs over time. Need information on where PHC funds are being directed and where the gaps are.
	10yr	2.1	
Methods for assessment of health care need	5yr	2.1	
	10yr	2.1	
Health care funding models	5yr	2.3	
	10yr	1.7	
Primary health care's contribution to mental health and resilience	5yr	2.4	Mixed ranking of importance for a mix of reasons including not a current Australian Government priority, resources will flow with or without research, PHC is not the main player, and resilience is a bad way of looking at mental health.
	10yr	2.4	

One respondent no longer working *directly* in Aboriginal health policy did not rank areas in importance but provided commentary on key emergent policy issues.