

Bringing research into practice

Fiona Johnstone

Introduction

It is a familiar theme, bringing research into practice. An enormous amount of time and resources are invested in research on health inequalities. This research has played an important part in both influencing and criticising policy. We see evidence of its impact in many of the current national initiatives, which include a remit to tackle inequalities in health. Many articles, and indeed many journals, address evidence-based policy and practice.

But there remains a gap between evidence and its incorporation into planning and policy, especially at local level. Those managing and implementing the new initiatives are often uninfluenced directly by inequalities research. My User Fellowship has enabled me to review findings from relevant Health Variations Programme projects concerned with the implications for social policy and for communities in partnership. The aim of the Fellowship is to highlight how such research can inform the development and evaluation of the Mersey Health Action Zone, as well as the policy and practice of Health Action Zones (HAZ) more generally. A second objective is to explore and develop effective channels for communication between Health Variations Programme researchers and the various Health Action Partners in Merseyside and Manchester, and to other HAZ initiatives nationally.

Merseyside has been awarded HAZ status. Covering four health authorities, five local authority districts and a population of 1.4 million people, it is the largest and most complex nationally. In line with the broader objectives of the HAZ programme, the two main aims of the Merseyside HAZ are to reduce health inequalities and to modernise services. In turn, the Health Variations Programme supports many projects which explore the key influences on health and their implications for policy development.



Source: Fiona Johnstone

Understanding the findings of this research will enable the stakeholders and decision-makers within the Zone to ensure that their proposed and existing interventions have the potential to influence the prevention or alleviation of inequalities in health in local communities.

Issues

Both practitioners and researchers face difficulties in bringing research into practice. Looking at the practice barriers, Mark Exworthy and Lee Berney¹ have written about how lack of communication or collaboration between different agencies (e.g. health and social services) can inhibit the effective use of evidence. Another conflict they outline is that of policy practitioners looking for 'quick fix' solutions, whereas much inequalities research implicitly acknowledges that tackling inequalities is a long-term process.

Further issues arise in identifying the potential *users* and the potential *uses* of research. In the Merseyside HAZ, for example, potential users could range across community groups, statutory agencies and the private sector. Uses of the research could be to support and strengthen the rationale for a proposed intervention (part of the process outlined within the Theories of Change model²) or to inform the evaluation and funding decisions of interventions to address local inequalities in health.

Additional barriers to using evidence include the political and financial context. Findings may be too expensive or too politically sensitive to implement. This can clearly be seen at a national level (for example, the government's response to the Black Report in 1980³). At a local level, community politics may make some findings more acceptable than others: selective adoption of research findings is likely to be directly related to their perceived support of a user's viewpoint.

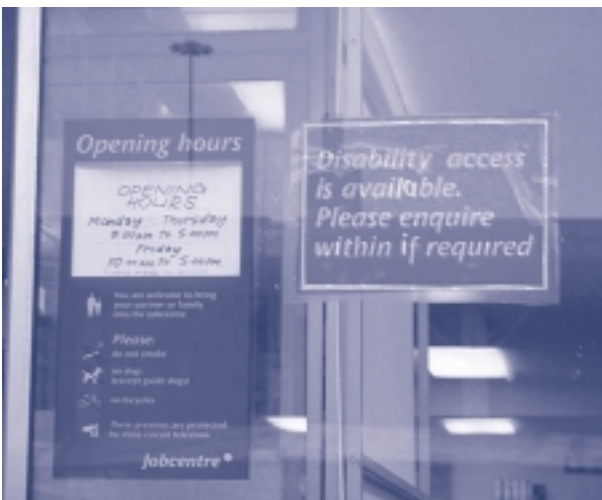
On the research side, there are important cultural barriers. Research is often not carried out in ways that are resonant with the cultures of local communities, including those of ethnic minority groups. Findings are often not available in different languages, which makes them less accessible. The language of research itself can be a further barrier. 'Research jargon' can cause misunderstanding between potential collaborators and is often impenetrable for those not working in the academic sector.

There is also the question of who researchers see as their primary users. Academic journals do not always reach practitioners, especially those who are community-based. If national policy is allegedly moving towards more 'bottom-up', community-influenced policy, how can we ensure that

those communities have the information they need to support their point of view? This is no small issue, since communities are increasingly asked for ‘evidence’ that interventions they support will work to reduce inequalities.

A key problem here is, perversely, that there are few incentives to encourage academics to publish their research anywhere other than in peer-reviewed academic journals. They get no credit for publishing beyond these journals from their employers, and it is rare to find a requirement for researchers to do so in any funding streams. Likewise, there are few incentives for academics to undertake locally funded research since there are no ‘Brownie points’ nationally for doing so. One viewpoint resulting from this is that academics are writing for other academics and it is therefore unsurprising that little evidence gets into practice. This may be unfair, but there may well be some truth to it. Statutory agencies on the other hand, rarely consider researchers or the academic sector as *partners* for change: more often they are regarded as *advisers* on evaluating interventions.

Finally, how accessible are the places one would go to find evidence? For a person with an impairment, the very structure of buildings such as libraries disable their access to information. The availability of research evidence in Braille or on tape is also rare and yet the inequities relating to disability are massive in our society.



Source: Liverpool City Council

The next stage

From reviewing the published Phase 1 Health Variations Programme research,⁴ it is clear that much of it could be of value to policy and practice. For example, Davey Smith et al⁵ provide guidance on interpreting measures of deprivation when relating to different ethnic groups. Berney et al⁶ provide examples of how health outcomes in old age can be alleviated by interventions along the lifecourse, and reinforce the need to focus interventions on children and mothers.

However, questions remain about how these findings can make their way onto the desks of those making policy and designing interventions at a local level. These users may be local politicians or community-based groups. The Merseyside HAZ has a huge range of partners including the health service, city councils, emergency services, trade unions, housing corporations, educational establishments, voluntary organisations and faith communities. Identifying these users, and equally importantly, identifying the uses of this research and the most useful ways of channelling information will be the final stage of my Fellowship.

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References

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