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# Building bridges between research, policy and practice in public health

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## ABSTRACT

The article examines core elements of the national and international discussion on the required integration between research, policy and practice in public health, and provides input for this integration. Some conceptual barriers and other barriers at different spheres that interfere with the desired integration are discussed. Evidence has shown that research, policy and practice in health are not continuous, homogenous areas but rather involve different levels and actors. Their processes develop in different grounds supported by a variety of actions, paradigms and interests that are not conflict-free. Thus, this integration is a major challenge given its complexity and multiplicity of objective and subjective aspects.

**DESCRIPTORS:** Research. Science. Public Policy. Professional Practice. Public Health.

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## INTRODUCTION

The driving motivation behind this “idea-generating” article, which is similar to recent projects that have gained attention in the national and international literature, is to emphasize the importance of integrating scientific research, policies and public (collective) health practices. This trend toward integration was discussed in the article *Public Health Science and Practice: From Fragmentation to Alignment*, by Butler-Jones,<sup>5</sup> which synthesized core elements being discussed internationally and identified issues that have challenged education, research and practice currently underway in the collective health movement in Brazil.

It would be impossible to provide a full discussion of this topic in this brief commentary. Therefore, in the interest of fostering debate and proposing alternative solutions, we will examine the elements that we consider to be essential to this debate. Four central aspects were selected for this purpose: 1) the relevance of reframing the essential connection between research, politics and professional practice; 2) the urgent need for a paradigm shift in the field of (collective) health that would enable the interconnection of these areas, known as *fields of action*, which currently display relative autonomy from each other, despite their natural interfaces; 3) the need to improve the efficacy of collective health interventions; and 4) references in the literature regarding the significance of “reflexive practices”.

## FROM CONCEPT TO REALIZATION: A NECESSARY TRANSITION

When analyzing these concepts in light of what has been discussed in countless forums and published in the public health literature, the topics of this analysis may appear to be quite evident and to have been thoroughly discussed already: how could we think about research priorities without considering the needs and demands of the user population? Who would object to establishing partnerships

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and structures that facilitate the transformation of knowledge into current practice? Who would disagree that research and evaluation are tools for the management of the health system? Even greater acceptance can be found within the principles of “learning from practice” and generating practice-based evidence as they permeate discourses and constitute a promise in countless experiences. However, if at first glance these premises appear to be self-evident, why then do they remain, paradoxically, as challenges or “promising ideas” to be realized in a future in which the completion of such projects is uncertain, if not utopian?

Understanding this scenario, we argue, requires that the complex relationships between the disciplines or fields involved be considered, along with their specific internal economies, as postulated by Bourdieu in a reference to the *scientific field*.<sup>4</sup> In other words, it is worth noting from the start that science, politics, evaluation and professional practice are not homogeneous fields, nor are they continuous. Rather, the processes that constitute these fields thrive in different arenas and are supported by equally different paradigms, interests and actions, which are not exempt from inter- and intra-field conflicts.

We do not intend to explore here the conflicts of interest prevalent in these domains. Suffice it to say that such exploration increases in complexity when attempts are made to *build bridges* between these distinct fields. In addition to technical challenges, the realm to which such analyses are often restricted, one must consider the values of each field, which requires one to move into the ethical-political dimension. Bringing up this dimension in the context of this discussion emphasizes what Butler-Jones<sup>5</sup> has called “reflexive practices”: the recognition that even the most powerful scientific evidence may have no impact if policy-makers and practitioners are unable to collaborate in a critical manner and to contextualize the evidence from various perspectives, in particular those of the users who are the targets of the interventions. In addition, the plurality of the theoretical approaches adopted by researchers results in diverse characterizations of the components of the same phenomenon. Therefore, in support of those who stake their futures on these projects, we have outlined proposed actions directed against certain obstacles that delay the completion of this urgent and promising project.

## TEARING DOWN WALLS TO ERECT BRIDGES: SECONDARY CONSIDERATIONS

Focusing on the scientific field, the first of the four core aspects refers to the predominance of traditional science as a model of “good science”. We refer here to the clear priority placed on studying results (outcomes) rather

than on analyzing the processes from which the results are obtained, processes that should be considered for use in other contexts. The scientific literature is rich in arguments that health and its challenges are phenomena that require a specific approach and, therefore, require models of research and evaluation that are integrated, multidimensional and intersectoral in nature.<sup>1,3,8,12</sup> However, by recovering the investment in research, it is possible to observe a clear dissociation between what is espoused, forming a consensus in various circles, and what occurs in the reality of the scientific practice in healthcare. This is corroborated by the predominance of biotechnology, which in some areas is nearly absolute: of quantifying and objectifying models. In addition, contemporary science is permeated by a hegemonic view of the world, in which productivity and the serialization of production are increasingly prioritized, often without regard to the intended mission.<sup>7,10,11</sup>

In the context of public health, this policy of productivity has led to the neglect of something the recognition of which has proven to be decisive: human health. If we insist on describing the object of this field of knowledge and practices, it is because we believe it is still necessary to do so because of the need for a dialog between the different paradigms that compose the field. To address the complexity inherent in health care, one must emphasize the contributions of the humanities and social sciences not by denying the importance of other centers of knowledge, but rather by complementing them and recognizing their strategic roles.<sup>2</sup>

With regard to politics, science and the daily provision of health care, we must confront human actions, in which the technical dimension is coupled with symbolic processes. This process requires the understanding that no technology, whether it is a vaccine, an MRI machine or a strategy for community empowerment, among many other examples, can be effective without subjective mediation. In other words, the operationalization of any intervention in the domain of public health depends on the process of symbolization, through which technology can be accepted or not and can be made more or less effective; i.e., it can serve or fail to serve its purpose. Therefore, defining efficacy means that we must go beyond the strict sense of the technical dimension because efficacy will always be a social construct, immersed in a culture with which technology must negotiate.<sup>1</sup>

As confirmation of these assertions, studies conducted in different countries have shown that no matter how sophisticated the technology, when scientific evidence is applied to policies or programs, it must interact with the public culture, a process by which attributed meanings gain dominance.<sup>9,a</sup> It is not useful to have artifacts

<sup>a</sup> Zaforteza C. Promoción de los cuidados dirigidos a los familiares del paciente crítico a través de una investigación-acción participativa [doctoral thesis]: Palma: Universitat de les Illes Balears; 2010.

that are not welcomed into the health-disease processes because they have several competing representations and thus will be of little or no help to the public. There are many examples of technologies that have shown gains in efficacy on the one hand but have highlighted a variety of challenges on the other hand. These challenges include the abandonment of or non-adherence to treatment; the inappropriate use of technologies; unmet needs in health care; and acceptance of or objection to the “biomedical rationale” behind the use of mammography, HIV prevention, passive smoking and the application of evidence to clinical practice, among many other varied subjects faced by professionals and managers of the system and the wider networks.<sup>6,13,14</sup>

Investment in the measurement of impacts/results is only one requirement (although an essential one) of researchers who are committed to supporting public health; an understanding of these complex processes is also necessary. Accordingly, key elements contributing to integration, the subject of this discussion, include studies that use models that are distant from traditional science yet are rigorous and refined in the exploration of solutions that require a combination of strategies. In this sense, qualitative investigations of health, particularly those based on critical approaches, become important. In this tradition, the study of outcomes does matter, but only when we understand that any outcome is generated through a specific process that should be studied; in health care, this refers to both human and collective processes.

At this point, we would like to highlight one more element: the place of the user. When speaking of the interface between research, politics and assistance, the secure positions of scientists, policy makers,

managers and evaluators can be deduced from both the discourses pertaining to this interface and the scientific literature. Surprisingly, the intended advances of even supposedly innovative proposals and critical positions rarely include users in the “task force”, although the well-established strategies that are often mentioned in articles and official papers recognize this inclusion as imperative.<sup>8</sup> Health care workers are often ignored as well. In the traditional science model, the participation of users or workers, especially those without college education, is considered unfeasible because of the complexity of the process or due to bias. The qualitative approach, however, includes participatory research as a scientific methodology that, as an ethical-political choice, democratizes the production of knowledge and affirms the importance of the understanding of processes as a form of knowledge.

To conclude this brief communication, we would like to reaffirm the importance of critically and reflectively reconsidering the proper place of the general population, particularly the users of the public health system, in the three aforementioned fields, with the goal of integrating these domains. In this regard, we cannot consider a project as innovative because it integrates politics, scientific research and health care when it marginalizes the participation of the population without considering it in its diversity, both objective and subjective. Thus, we advocate for qualitative-participative models<sup>3</sup> of research and evaluation, which are both the foundation and the tools for shared models of public health management. Such models are necessary if we are to effectively build the bridges that will eventually close the gaps that persist between research, politics, evaluation and care, as well as to advance a sustainable model for human health and well-being.

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