Is It Working … Together?

Linking research, policy and practice in relation to children and health inequalities in South Australia

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Occasional Paper Series No. 3

Public Health Information Development Unit

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National Library of Australia Cataloguing in Publication entry

Hetzel, Diana.
Is it working -- together? : linking research, policy and practice
in relation to children and health inequalities in Australia.

Bibliography.
ISBN 0 7308 9234 4.

1. Children - Health and hygiene - South Australia. 2. Children - Medical care - South Australia. I. Glover, John, 1945- . II. Public Health Information Development Unit (Australia). III. Australia. Dept. of Health and Ageing. IV. Title. (Series : Occasional paper series (Public Health Information Development Unit (Australia)) ; no. 3).

362.198920009423

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This research was produced by the Public Health Information Development Unit (PHIDU), The University of Adelaide, South Australia in August 2002. The research was funded under a grant from the Australian Government Department of Health and Ageing. The views expressed in this paper are solely those of the authors and should not be attributed to the Department of Health and Ageing or the Minister for Health and Ageing.

Suggested citation:

Hetzel D and Glover J. (2003) *Is it working … together? Linking research, policy and practice in relation to children and health inequalities in Australia.* Occasional Paper Series No. 3. Public Health Information Development Unit, Adelaide.

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ISSN 1447-8803 Occasional Paper Series

Published by Public Health Information Development Unit, The University of Adelaide

Abstract

Despite an increasing interest in the extent of child health inequalities in Australia and effective strategies to address them, there remains a significant gap between existing research evidence and its incorporation into planning, policy and practice. Researchers, policy-makers and practitioners face difficulties in bringing research into practice effectively, and local communities are often neglected in the processes.

This paper presents a summary of data on child health inequalities in South Australia over the last decade. It then reviews the extent to which research findings have been incorporated into the State's human services' policy and practice. Particular barriers for researchers, policy-makers, planners, practitioners and communities are discussed, drawing on local and overseas experience, and possible strategies for addressing some of the barriers are outlined.

Preface

The views and opinions expressed in this paper are solely those of the authors. Therefore, they should not be attributed elsewhere, and particularly not to the Australian Government Department of Health and Ageing nor to the Minister for Health and Ageing.

Introduction

Despite an increasing interest in the extent of child health inequalities in Australia and some evidence of effective strategies to address them, there remains a significant gap between current research evidence and its incorporation into planning, policy and practice in Australia.

The existence of child health inequalities in Australia has been recognised for decades as evidenced by numerous historical documents and the diverse efforts of governments, other organisations and individuals over many years to improve outcomes for children and their families. Some interventions to assist children and their families have been effective in reducing overall mortality and morbidity and increasing life expectancy, but in spite of these gains, the health and wellbeing of certain groups remains poor. Of particular concern is the health of Aboriginal and Torres Strait Islander peoples whose life expectancy at birth in the late 1990s was estimated to be 20 years less than that of the general population, placing their life expectancies a hundred years behind those for non-Indigenous people (AIHW 2000). Mortality differentials are also still evident across different socioeconomic groups in Australia (Turrell & Mathers 2001).

The poorer health of certain groups in the population, particularly Indigenous people and those who are socio-economically disadvantaged, shows that there is much in the social environment that contributes to poor health outcomes. However, these substantial health disparities are under-recognised and come as a surprise to many Australians who tend to regard their society as relatively egalitarian. Some believe that solutions lie solely in making people responsible for their own health. However, considerable evidence now indicates that many factors that determine health are beyond the control of individuals, and beyond the scope of the health care system.

Evidence about the extent of health inequalities among Australian children has increased considerably over the last ten years or so, as interest in this area of research has grown elsewhere around the world. There is a wide range of studies from many disciplines that point to disparities in health and wellbeing outcomes across the population of Australian children. Australian researchers have contributed substantially to the international and health evidence base, and have also developed an improved understanding of the ways in which socioeconomic groups differ in their health status within Australia (Turrell et al. 1999). In a recent review of socioeconomic determinants of health, 41% of the 202 published empirical studies related to infants, children and adolescents (Turrell et al. 1999).

However, evidence from Australia and overseas also indicates that childhood, especially pregnancy and the earlier years of childhood, is a period in the life course when certain evaluated interventions can be effective in reducing health and social inequalities (Roberts 2000).

Summary of recent data on child health inequalities in South Australia

A brief examination of the changes in demographic and socioeconomic variables in Australia over the last ten to fifteen years indicates change in the social and economic structure of society. There has been a growth in single parent families, low-income families, and a significant increase in those receiving some form of income support. There has been a consistent decline in both the numbers and proportions of unskilled and semi-skilled workers nation-wide in the decade since 1986. These changes are evident in all capital cities as well as across non-metropolitan areas (see Table 1).

Table 1: Changes in Demographic and SES variables (Australia)
(per cent change)

Variable	All capital cities	Non-metropolitan Australia
1986 to 1996		
Single parent families	39.5	43.3
Low income families	41.1	30.2
Unskilled and semi-skilled workers	-12.4	-4.8
Managers and administrators, and professionals	42.2	9.0
Aboriginal and Torres Strait Islander people	79.0	44.4
1989 to 1996		
Disability support pensioners	90.6	89.1
Female sole parent pensioners	42.7	35.9
Unemployment beneficiaries	142.9	85.5
Dependent children of selected pensioners and beneficiaries	75.3	50.1

Source: A Social Health Atlas of Australia (1999)

In South Australia, there is evidence of growing inequalities in health over the last ten or so years (Glover & Tennant 1999). This trend has been documented for children and young people in the Social Health Atlas for Young South Australians, a new edition of which is currently being produced (Ambagtsheer & Glover 1998; Glover & Tennant 1999).

The level of disadvantage among South Australian children and their families is exemplified by some of the following tables and graphs.

Table 2: Dependent children of selected pensioners and beneficiaries, State/Territory

Per cent

	NSW	Vic	Qld	SA	WA	Tas	NT	ACT	Total[1]
1996									
Capital city	37.2	38.0	43.7	45.6	39.4	45.5	40.3	28.1[2]	39.2
Other major urban centres[3]	41.4	43.4	48.4	..	..	..	..	..	44.0
Rest of State/Territory	54.1	49.1	52.5	51.5	43.7	53.2	52.9	–[4]	51.4
Whole of State/Territory	42.6	41.3	48.2	47.3	40.7	50.1	47.8	27.4	43.5
1989									
Rest of State/Territory	41.4	31.3	41.0	38.8	31.9	38.3	42.6	–[4]	37.8

[1] Total for *Whole of State/Territory* includes 'Other Territories' (Jervis Bay, Christmas Island and Cocos Islands)

[2] Includes Queanbeyan (C)

[3] Includes Newcastle and Wollongong (NSW); Geelong (Vic); and Gold Coast-Tweed Heads and Townsville-Thuringowa (Qld)

[4] Data unreliable: included with ACT total

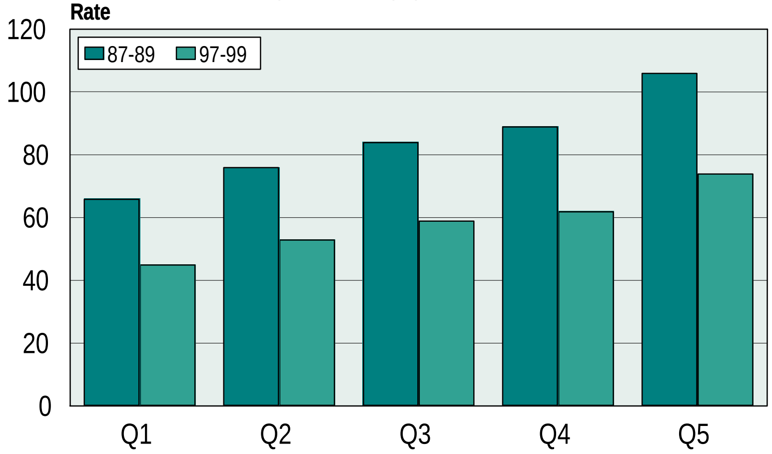
Source: A Social Health Atlas of Australia (1999)

Both the number and proportion of dependent children aged less than 16 years in Adelaide and living in families receiving an income support payment have increased since 1989. While the percentages rose from 31.2 per cent in 1989 to 45.6 percent in 1996, the numbers have also increased substantially, from 64,241 in 1989 to 99,880 in 1996.

Differentials in mortality rates for children and young people across income quintiles are also evident in South Australia. Between the two periods, 1987-89 and 1997-99, there was a decrease in the mortality rates for all quintiles. The decrease was 31.7 percent for Quintile 1 (most advantaged) and 30.1 percent decrease for Quintile 5 (least advantaged). The differential between Quintile 1 and 5 was 1.61 for the period 1987-89, and 1.64 for the later period 1997-9.

Figure 1: Deaths of people aged 0 to 24 years in SA

Deaths per 100,000 population



Source: A Social Health Atlas of Australia (Glover et al. 1999).

To what extent have these findings on child health inequalities been incorporated into health policy in South Australia?

A brief review was undertaken of relevant South Australian health policy documents published from 1990 to 2000.
The criteria for the review were: -

1. Was there explicit evidence that research on inequalities had contributed to the development of the policy? (Research cited, data included to support policy or as background information).
2. Were equity objectives explicit, clearly articulated, comprehensive and consistent over time within the policy documents? (Criteria adapted from Exworthy et al. 2000).

It is clear from the review that research findings on child health inequalities have underpinned some of the policy development processes in the areas of child and youth health in South Australia over the period. From 1990 to early 1999, the Policy Division of the South Australian Health Commission published the Social Health Atlas series for South Australia, and a Social Health Atlas of Young South Australians. Thus, there was significant research capability within the Division to underpin policy development. During this time, policy development processes were relatively transparent, and significant consultation with stakeholders was undertaken. The policy development process for the Youth Health policy also involved the participation of a group of young people from a variety of backgrounds and experiences.

However, implementation of the Child and Youth Health Policies proved to be problematic in some areas. For the Child Health Policy, a number of the identified strategies were implemented. However, others were too broad to be practical, and only some of the strategies were adequately resourced. The Policy failed to guide resource allocation decisions for children across the wider health care system. There was no clear responsibility for its overall implementation within the Division, no funding for an implementation process was available, there were no levers to ensure action occurred and no evaluation was undertaken of either the policy development or the policy implementation processes.

The responsibility for the coordination and planning of child health services at a statewide level was given to a newly established body, the Child Health Council of SA, which was unable to fulfill its purpose fully, as it had no authority to do so, and was under-resourced. Its youth health equivalent, the Youth Health Council, never gained Ministerial approval to be established. There was no implementation plan for the Youth Health Policy, although a number of the initiatives were implemented, and again, there was no formal monitoring of progress with its implementation. However, there was a process for establishing targets and data monitoring requirements, and an attempt was made to review the policies, although these were not undertaken because of limited resources.

A process of re-structuring occurred across the SA Government in October 1997. This resulted in the formation of the Department of Human Services (DHS), incorporating an amalgamation of health, housing, community services and ageing and disability services. There was a further period of organisational restructuring which was partially completed early in 2001.

A significant change of culture within parts of the new organisation became apparent. There was a move away from the language of 'health' towards broader statements about 'quality of life' and a concomitant change of focus from health to human services more broadly. Many health research functions within the former SA Health Commission were eroded and a number of experienced staff with research skills left the organisation. Access to sources of research information became more difficult with the physical relocation of the DHS Library away from the Central office to another building nearby and with a significant reduction in its budget.

It was not therefore surprising perhaps, that research was not cited in the policy documents published after 1997. The Department retained a research function but policy development processes altered significantly. Consultation processes were far more limited, advisory bodies with expertise were less valued and greater control on policy content was exercised centrally. Government policies became more explicit and there was a shift towards encouraging individuals, families and communities to take responsibility for their own health and wellbeing. A focus on 'priority support for those in greatest need' appeared in some areas to be a gate-keeping strategy to limit service provision, rather than a resourced strategy to target services to those in need, within a system of universal service delivery.

Thus, from a brief examination of the South Australian experience, it appears that the process of getting research findings about child health inequalities into policy, and then implemented as interventions for the groups to whom it is aimed is a complex and difficult one. This situation is by no means unique (Lomas 2000).

Changes in the nature of policy development

Policymaking has undergone a substantial transition over the last century, and the process itself deserves some examination. Most frameworks for thinking about policy development have historically followed two main patterns, with a third now apparent (Glouberman 2001).

The first stressed the hierarchical structure of bureaucracies and the ‘top down’ nature of power and public policy-making. These frameworks followed a mechanistic view of organisations generally and were evident until World War II. The second developed following World War II, when there was a rise of staged, rational planning frameworks for policy development using new scientific methods and expert stakeholders. Decisions about public policy were viewed as a function of scientifically valid evidence and differing vested interests. Approaches evolved which recognised the need to include more stakeholders and policy outcomes began to be seen as the confluence of multiple forces (Glouberman 2001).

Many researchers outside the policy arena still regard policy development as linear or cyclical, with discrete stages - problem identification and agenda-setting, formal decision-making, policy implementation and evaluation (Stone et al. 2001) - with research contributing to any or all of these stages. However, there is now a third body of literature that describes policy as being developed in a non-linear way, as in the functioning of complex systems (Stone et al. 2001; Glouberman 2001; Black 2001). The component elements interact in ways that mean small changes can have very large effects, and the process is in a constant state of evolution, adapting to changing circumstances and in many ways, self-organising. In this reality, policy development is messy and chaotic, and characterised by opportunism, time constraints, and limitations on the use of research, and confused by the fragmented activities of policy makers and others (Kingdon 1984).

This perspective goes some of the way to explaining the difficulties of bridging the research and policy arenas. The relationship of researchers to policy makers has been likened to “a marriage where both parties believe something is left to be desired and both agree that something can be improved” (Global Development Network 2001). On the surface, the relationship between research and policy appears straightforward: a rational process with good research, designed to be relevant to policy, and its results delivered in a timely and accessible form to policymakers who utilise it as the basis for their decision-making. In fact, as with all relationships, this is far from the case.

Barriers to linking health inequalities’ research with policy

Researchers, policy-makers, planners, practitioners and communities all face significant barriers to the linking of research into child health inequalities with effective interventions to address them. Some of these challenges relate to the nature of health inequalities per se and the lack of strong evidence for successful policy interventions. Others pertain to the general difficulties faced by any one of these groups in linking effectively with the others. In spite of the fact that there are often good relationships between people working with children in different sectors across South Australia, effective links between research, policy and practice have been limited.

Issues for researchers and policy makers

The relationship between policy and research in general is poorly understood. This observation is apparent across many disciplines and in many sectors and organisations. Yet we still need to work at improving the relationship and strengthening it, in order to achieve the desired outcomes for society as a whole.

Four types of barriers to the use of health research by policy makers have been identified – related to context, content, stakeholders and process - (Bronfman et al. 2000), and these obstacles are relevant in the area of health inequalities. Centralised power structures, lack of continuity in planning and policy making, and lack of financial resources are contextual factors that are problematic. Content aspects are exemplified by differences between researchers and policy makers in their use of language, in their pace of work and in their understandings of each others' work. There may be a lack of consensus about the research evidence because of its complexity, incompleteness or differing interpretations. In many situations, research is not initially designed to be relevant to policy. Sometimes it is so designed, but fails to make an impact because of problems with timeliness for the policy process, the format of results or the manner of communicating those results.

Many policy makers do not see research findings as fundamental to their decision-making, in spite of rhetoric about the need to be 'evidence-based'. Other difficulties are the lack of scientific education among many decision makers, the common practice of making policy without using evidence, the existing entrenched beliefs of policy makers, the often rapid turnover of policy staff, and the pressures exerted by interest groups and lobbyists. Another challenge is that of policy makers looking for 'quick fix solutions', whereas much inequalities' research implicitly acknowledges that tackling inequalities must be a longer-term process.

Some believe that research findings into health inequalities are low down the list of factors that influence government policies (Barker & Chalmers 2000). Political elements, financial stringency, pressure groups, the media and local issues are often perceived to be more relevant. Research findings may be seen as too expensive or too politically sensitive, or they may be ideologically opposed at a state or national level, or too difficult at a community level to implement. Research evidence can be an embarrassment to governments, indicating or highlighting an unmet need, a worsening situation or a growing area of demand. Selective adoption of research findings is more likely (Johnstone 2001), and there are also numerous examples where research findings have been deliberately ignored (Barker & Chalmers 2000).

Little is known about how policies to tackle child health inequalities, or indeed any inequalities, are implemented (Philip 2001). Those who are responsible for developing policy do not usually implement the policies themselves and so, lack control of the process. Issues of bureaucratic incompetence or resistance, and inadequate resources, time, infrastructure or expertise can hamper the process. This leads to inevitable modifications of policy in the implementation phase, particularly when a failure to plan for implementation creates space for bargaining between advocates and interest groups, and bureaucrats over the details. Variations may occur within sectors or organisations or at a local level between agencies and practitioners (Exworthy et al. 2000). As there are rarely any evaluations of the process of implementation, failures and successes are seldom documented and the lessons are therefore never learned. These factors are part of the realities of the policy development process and need to be identified and addressed.

Issues for local planners and practitioners

For practitioners and local service planners, barriers to linking health inequalities' research with policy are also substantial. Practitioners working in the area of child health represent a diverse set of audiences. Fieldworkers, researchers and policy makers, for example, may have different models of health, and various conceptual frameworks of inequalities may influence their practice. In addition, groups differ in their opportunities to shape agendas and to implement research. A clear need exists to take account of such differences and disseminate strategies to engage with the challenges that practitioners and others face.

Research may have limited application for some practitioners who may have scant regard for 'expert opinion'. Other practitioners may consider that theoretical research uses needlessly technical language, prefers publication in inaccessible journals at the expense of other outlets, and that results take too long to reach the field (Kernick et al. 1999; Philip 2001) or neglect the realities of working in community settings. For yet other practitioners experiencing an already heavy workload, research information may become an additional, unwelcome burden (Philip 2001).

Some researchers complain about reluctance or defensiveness on the part of service providers to change their practice in the light of new evidence. These issues are complex and not easily resolved. Solutions lie in developing trusting relationships and in sharing knowledge and information more freely. However, obstacles remain for many practitioners to share in the knowledge of health inequalities, as conferences are expensive to attend, and academic journals do not often reach those who are primarily community-based.

It is difficult to find many current Australian examples of current policy-related practice that have been based on the best available evidence in the area of health inequalities. There are a number of reasons for this. Firstly, the daily pressures on agency managers and practitioners to “get on with the job” are significant. Secondly, there is also a desire for innovation in providing services (funding may depend on the development of “new initiatives”), which can be a disincentive to using the best of what is already known. Lastly, some practitioners do not necessarily have the time or the interest in presenting or publishing their work, and there is an urgent need to improve this situation.

Effective interventions in the area of child health inequalities often require an intersectoral approach. In the UK, a lack of communication and poor collaboration were identified between local agencies from different sectors in the area of health inequalities’ work (Exworthy et al. 2000). Research found that effective use of evidence could be hampered by inherent competition for funds or other resources, or by disparate organisational goals and structures. Outcome measures were seen as problematic, process measures dominated and data could not often be shared by agencies. There were few signs of integration of policy streams at local or national levels and policy objectives remained confused (Exworthy et al. 2000). Intersectoral partnerships have long been recognised as challenging, given differing goals, structures and resource pools. The term ‘health’ inequalities and its broad public health focus may be detrimental to developing a wider ownership of the issues, especially among non-health agencies that may perceive this as ‘yet another example of health imperialism’.

However, in South Australia and elsewhere, there have been significant attempts to develop a common understanding of inequality and a commitment to doing something about the issue. There are local examples of where opposition has been overcome, mainly as a result of the trust and the existing relationships between local practitioners, and an acknowledgement that many marginalised families with children are ‘clients-in–common’. However, policy makers may also undermine these opportunities: inadvertently, if they do not have a detailed knowledge of the problems or are too isolated from the community to contribute to the process of collaboration, or on occasions, more deliberately.

Issues for communities

In many cases, the participation of interested parties, such as community members, often occurs only after research results are published. This excludes proactive involvement by them at the beginning of the research process, in the identification of priority problems and the definition of themes to be studied (Campbell & Jovchelovitch 2000). It also excludes the participation of those whose voices are often not heard, the populations who are studied. This is particularly the case for children.

Research aimed at understanding why individual health and health-related behaviour is so strongly patterned by socioeconomic status should be centrally concerned with how people experience and seek to act against the constraints of their daily lives. There is a need for a new emphasis on assisting people, both materially and through other community-based initiatives to exercise their agency in favour of a better quality of life (Thomas 1999). This means investing resources in improving people's living conditions and listening to what local people have to say about their barriers to the achievement of good health. Lay knowledge of health inequalities, and how to overcome them should be valued and acted upon (Thomas 1999).

The relationship of children and their families to health inequalities' researchers is also complicated. Some do not wish to take part in studies or evaluations where they are not acknowledged as active participants – they may already have experienced 'being done to' rather than 'doing with'. This has led some communities to resist being cast as 'research subjects under the scrutiny of others', when there is already substantial description of the challenges they face and a shortage of resources for interventions that would help (Philip 2001). Such communities rightly are wary of researchers and evaluators with yet another 'study' of them in mind.

Researchers and policy makers are often reluctant to engage in participatory research directly with children and young people. Structures are emerging for the involvement of young people from some sectors (e.g. children in or ex state care), but there is reluctance on the part of many to work with young people, with younger children or with those adults who could represent the interests of infants and toddlers. Many attempts at involvement are misguided and tokenistic, rather than participatory (Hart 1992). For many young people without incomes, and for parents struggling with expenses of daily living, opportunities to attend and present views or their own research are generally beyond reach. There is an urgent need to develop alternative venues to disseminate research findings, to engage people from diverse communities and to encourage greater partnerships around these issues.

Strategies to address barriers and move forward

Many people working in the area of health inequalities have identified these and other challenges, and have applied a range of different strategies.

Internationally, considerable effort has been made to improve the quality of the research evidence and its accessibility. The Cochrane and Campbell Collaborations, particularly the latter, have relevance for policies related to child health inequalities. The Campbell Collaboration serves to remind us that sectors other than health have also had to confront major challenges in identifying relevant evidence and getting the information to policy makers in a timely fashion (Boruch 2001). Public Health Observatories in the UK and Bolivia have been established to monitor the effects of health reform and other public health interventions on health equity, thereby enabling some evaluation of health policy interventions (PAHO 2001). In England, there are eight regional Public Health Observatories that operate independently, usually supported by a network of universities and public health agencies. Their goal is not only to provide regular, high quality public health information for decision-makers but also to facilitate its use to improve health at a local level. These bodies also consider the development of specific projects required by policy makers and representatives of the community (PAHO 2001).

The ESRC Health Variations Programme in the UK has also made a number of contributions to our understanding of the challenges in health inequalities' work, and has used a number of different methods to bridge the interest of researchers and those in the policy and practice communities as users. The Netherlands have mounted a research program on interventions to reduce socioeconomic inequalities in health, with a particular focus on children in poverty, with interventions aimed at four levels: reducing poverty, reducing the effects of poverty on health, attacking the tendency for poor health to lead back to poverty and providing extra services for those whose health has already been damaged by poverty (Smith 2001). Research programs have been established in other countries in Europe, Canada and the Americas and many are collaborative international networks with participants from a range of backgrounds.

Here in Australia, there is considerable attention being given to research agendas at a national and state level (Oldenburg et al. 2000), and increasing interest in cooperative relationships between researchers, policy makers, practitioners and occasionally, communities. This is indeed encouraging, although the field of health inequalities here is still evolving and is not yet well resourced. The recently established Health Inequalities Research Collaboration (HIRC) Board has responsibility for influencing these processes.

Current evidence suggests that changes in social policy are likely to have a far greater impact on health inequalities than direct health interventions (Ben-Shlomo & Davey Smith 1997). The area of health equity research therefore requires the involvement of many sectors other than health, but to date there appears to have been limited intersectoral collaboration in setting the research agenda in Australia at a national level. To work well, this approach implies collaboration rather than competition, power sharing and access to information, and a mutual desire to move forward (PAHO 2001). One benefit is that it allows the research community to share with other stakeholders the burden of advocating for specific research agendas and funding resources. These stakeholders are also likely to bring new networks of funders.

We should start to engage our colleagues in other sectors, at least in monitoring the extent of child health inequalities in Australia more closely. To this end, the New Zealand government has developed a set of cross-sectoral outcome measures for children to assess the Strengthening Families Initiative. The lead roles are with the Ministries of Social Policy, Education and Health. The other contributing agencies are Ministry of Justice, The Department of Children, Youth and Family Services, Ministry of Maori Affairs, Ministry for Pacific Island Affairs and the Ministry of Women's Affairs (NZ MOH 2001). Innovative work in Canada following the publication of the Early Years Study has been undertaken, and lessons in policy change and implementation are emerging (Mustard et al. 2000). The significant role of policy entrepreneurs (specialists who promote change or shifts in policy to policy-makers) in linkage and exchange between researchers and decision-makers has also been identified (Lomas 2000).

Finally, any discussion of health inequalities contains an inherent ethical dimension that has not been broadly debated in Australia. We need to assess the distribution of health status among different groups in Australia, because it reflects the degree to which social injustices prevail in this society and it reveals unfair and avoidable suffering (Peter & Evans 2001). We need to seek the views of the wider community, and the diverse views of justice that will determine what distribution of resources across the population is acceptable. There are also the ethical dimensions of waiting for more conclusive evidence about which intervention to implement – the issue of 'how much evidence is enough?' Questions such as these demand explicit attention to the various competing values and the way in which they affect choices about research designs, identifying outcome measures, determining the appropriate standard of proof, assigning the burden of proof and selecting an appropriate policy intervention (Schrecker et al. 2001). Even when the effectiveness of policy interventions can be demonstrated, the desirability of undertaking them is not self-evident to all.

The development of a knowledge base for effective services to address child health inequalities is also an issue of rights. Children and families are entitled to expect that those of us offering them services are doing so on the basis of the best of what is already known (Roberts 2000). The next appropriate step is rigorous evaluation rather than widespread replication, as some of our well-meaning interventions may cause harm. It is also likely that a number of interventions may actually increase inequalities, as a result of differential access or uptake (Macintyre et al. 2001). We must try to ensure that we reflect on the ethical aspects of our activities and encourage others into the debate.

Conclusion

There is research evidence in Australia and elsewhere that early intervention makes a difference to health outcomes in children, and that implementing evidence-based policies to promote health and wellbeing in children, young people and their families can help to reduce inequalities in health. However, research and policy development are value-laden, for they are conducted within a social, cultural and economic context and powerful interests shape their directions. Convincing arguments and scientific consensus from researchers are not enough to shift policy. The rational linear approach to policy processes does not conform to reality; it resembles more, the nature of chaos in complex systems and there is much still to be learned.

There is also a need in Australia to target public agendas in addition to official decision makers, and to build support and learn from communities themselves in order to contribute to public opinion, for wider debate adds to the legitimacy of the research agenda regarding child health inequalities. Evaluations of how research connects effectively to policy are part of the learning process and can identify barriers, offer opportunities for collaboration and may lead to the development of innovative solutions. The involvement of many sectors in addition to health is essential in coming to a shared understanding of the extent and impact of health inequalities in Australia and in finding effective policy solutions.

So, is it working … together?

In our view, not yet.

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