Community/Practice/Academic Partnerships in Public Health

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The forging of links between academia and the field of practice is a much-discussed topic. The 1988 Institute of Medicine Report on the Future of Public Health noted that public health academic institutions had become “isolated from the field of public health practice.”1 The Committee opined that neither academia nor practice can work at the desired level of excellence without the perspective and insights garnered from the other. Underlying this observation is the idea that universities are more than repositories of knowledge. In the words of Robert Zemsky: “America’s colleges and universities—both public and private—are public assets providing public services, and as such they require a public agenda.”2 Translation of theory into practice and refinement of theory through practical experience are required to fully serve the public health agenda.

In the 1995 annual supplement to this journal, Baker posed two salient questions: “Can practice/community/academic teams be created to solve urgent, practical problems in the real world of public health? Can this be done in such a way that new knowledge is generated . . . and the academic community can see tangible benefits from its participation?”3

The answers are no, according to Lancaster,4 unless schisms between research and practice are closed. He outlined four types of gaps that prevent effective collaboration: (1) a communication gap, whereby lack of shared language and different emphases prevent joint definition of research questions and identification of mutual priorities; (2) an access gap, whereby practitioners in some parts of the country have little or no access to university faculty skilled in public health; (3) a credibility gap, whereby practitioners discount the observations of academicians as unrealistic and academicians discount the observations of practitioners as simplistic; and, (4) an expectation gap, whereby the practitioners view of what it takes to operate effectively in the real world fails to meet the standards of scientific rigor demanded by the researcher.1

In many ways, the time is right to close these gaps. The conventional ways of both producing research and implementing programs and services are not achieving the potential and promise of prevention and health promotion. Alternatives are needed and some, implicitly or explicitly, require partnership. Recent public health research, for example, has emphasized multifactorial and ecologic approaches to understanding the determinants of health and disease.5 These approaches recognize that individuals with existing or potential health problems are embedded within social networks (e.g., families and friends), which are embedded within organizations (e.g., churches, schools, and work places), which are in turn subsystems of communities and of society as a whole.6 Influences on health behavior and health status occur across these layers and levels of association. Comprehensive interventions are dictated by such a view of how health and illness emerge in a population. Programs and policy strategies that attend to changes in the social and physical environment are required as well as more traditional foci on individual behavior change and medical care. In this paradigm, to achieve needed change, public health practitioners must develop, advocate for, and achieve the adoption of policies and programs that are more robust, far reaching, and complex. Researchers, on the other hand, must understand the intricate dynamics of community life and service delivery—in short, they must understand how to function within and across each layer and level of association.

As evidenced in articles in this supplement, the academic/practice connection can be successful. Both domains are recognizing the value of involving communities in the process. Three-way partnerships, comprising academic, public health practice, and community-based organizations, are seen as means to make public health practice more efficacious and university teaching and research more relevant while enhancing the capacity of communities to address their health problems.7,8 Working with the community (as opposed to working in it) may enable practitioners and researchers to work better. As both serve the public, more public participation may temper hubris and increase the skills of both.

Several incentives in the current public health environment are increasing efforts to close the gaps that Lancaster discussed. Universities no longer enjoy un-

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critical support. The public wants to know what it's getting for its money and is pressuring universities to ensure that their training and research activities contribute to the public agenda. Practitioners must operate in a dramatically changing system that has little margin for error and even less money. The programmatic and policy choices they make must be informed, and the university continues to be a rich source of information. Increasingly, funding for both domains is tied to the involvement of the people that research, programs, and policies purport to assist. Recent initiatives at NIH, CDC, and the large foundations have required community participation as a condition of funding (and have suffered no lack of applicants). Further, communication technology is connecting people in academic institutions, public health practice organizations, and communities in ways that are remarkable and unprecedented. Access has been made available in a quite unexpected way.

Many individuals and organizations will respond sooner rather than later to these incentives, and their efforts may create partnerships that will move us significantly toward the goals of public health. The closing words of an old Ashanti folk tale sum up nicely the advantage of community/practice/academic partnerships: “No one person has all the world’s wisdom. People everywhere share small pieces of it whenever they exchange ideas.”

References