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Editorial

Research and development: what is the difference?

The declaration of Alma-Ata (World Health Organization, 1978) described primary health care as essential health care based on practical, scientifically sound and socially acceptable methods. The evidence base for such methods may include a range of technologies as diverse as drug trials and community development programmes. The terms 'research' and 'development' and their synonyms are often used co-terminously when referring to these activities in the context of health care and, especially since the publication of *Primary Care: the Future* in 1996 in the UK (Department of Health, 1996), almost as interchangeable terms in primary health care. Terms used in such close proximity to one another merit a closer semantic appraisal and should also invite interrogation from the professional disciplines involved with regard to both their relationship to each other and their individual value to the health practitioner in relation to the quality of evidence that each provides. It is also worth considering, in the light of such an appraisal, what this apparent union says about the health disciplines. Is it the case that development is perceived as a 'weaker' option than research? Or is it actually a stronger message about the need to be more cautious and exploratory before going pell-mell down the path of primary health care research?

Research has been variously and frequently defined. In 1993, the Department of Health for England defined research as 'rigorous and systematic enquiry, conducted on a scale and using methods commensurate with the issue to be investigated, and designed to lead to generalizable contributions to knowledge'.

This is a helpful start to understanding research. However, the assumption of generalizability is a contentious issue. Whilst it offers the potential to differentiate research from development (development often being seen as a local activity with little generalizable result), it fails to recognize that some research is underpinned by methodologies which are theory-building, rather than producing findings which are generalizable from one context to another.

Development, on the other hand, has been described by the Department of Health (1991) as an activity in which the emphasis is on the results of research – getting evidence into practice. Three stages were described, namely the development of new methods of care, the experimental introduction of these methods into services, and the establishment of their use throughout the NHS. In 1997, Wilkin *et al*. suggested that development 'will focus on new methods of commissioning and organizing comprehensive primary care, including the experimental introduction of these approaches into service and their evaluation by qualitative and quantitative research' (Wilkin *et al*., 1997: 4). These expressions of development provide a helpful insight into the policy context of development, but do not allow for wider definitions from a more global perspective. Development of primary health care in rural Kenya, where women still have to walk 20 km for antenatal care, is likely to be very different to development in Western Europe.

In 1996, the UK government laid out its intentions to improve primary care and within its emerging agenda for debate was the statement that 'the development of a good research base in primary care should also be encouraged. This would provide more information on effective treatments and interventions in primary care, as well as offering wider career opportunities' (Department of Health, 1996, paragraph 22). However, this document did not expand on what it meant by the research base. The subsequent publication of the Mant Report, *Research and Development in Primary Care* (Department of Health, 1997), provided three key areas of relevance for primary care. These were the need for more research and development in primary care, the need for research and development

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to impact on health, and the importance of managing the expansion of research and development carefully. Whilst these areas continue to be relevant to the evolution of research and development in primary care, the emphasis seemed to be more on research than on development, and there was little in the report to aid understanding of the meaning of either of these terms.

Why should this be of concern? First, there does appear to be an issue of hierarchy which not only infiltrates the discourse on research and development activity, but also affects would-be activists in primary health care. Those practitioners who are not currently research active may feel, by implication, that development is a less prestigious or valuable activity. For example, McKinnell *et al*. (1999) describe a classification of the strength of evidence, ranging from randomized controlled trials as the preferred 'gold standard' (level 1) down to cases of 'someone once told me' (level 6). Somewhere within level 5 evidence there might be scope for development studies. Certainly there is less emphasis on the funding of development, its recognition as a bona fide activity, or its right to be peer-reviewed and disseminated for the purposes of widening the debate and opening up the possibilities for new research questions. In contrast, the Department of Health for England funds research support in the NHS through a dedicated budget, and in order to qualify for this funding health trusts and primary care groups must demonstrate that rigorous criteria have been fulfilled. This question of hierarchy and value labels may jeopardize work which lays the foundations for some of the best research. Synonyms for development include progress, expansion, evolution and growth. If primary health care is to achieve any of these objectives, then the model of development discussed by Wilkin *et al*. (1997) should be carefully considered. It takes into account the inextricable relationship between development and research through the helical model, which includes providing an evidence base for new innovations, as well as the need for continuous feedback from the development to ensure that the right research questions are being asked.

Peile's paper in this issue (Peile, 2000) provides an example of how development around an intervention can lead to clarification of potential research questions. In Peile's practice, questions were raised with regard to counselling older people about loss, and how this might lead to more harm than good being done if it was not handled appropriately. The need of the practice team to reflect critically on issues of empathy and intuition is raised, and also the need to search for the evidence base for an effective intervention. In addition, it raises potential research questions. For example, what are the psychological problems of older people following loss? And what are the most effective interventions for supporting older people through times of loss? Such a model of development ensures that there is evolution and expansion of the quality of care provided. This issue also includes three research papers from community nursing. Arguably, none of these meet the criteria for providing evidence at level 1 as described by McKinnell *et al*. (1999), but they all contribute to our understanding of the theoretical base and the evolution of primary health care nursing.

Ultimately, the need for development and research has to be about the impact on quality of care. The clinical governance agenda creates an environment for individual practitioners, primary care groups and trusts in which development, evidence-based practice and the search for new knowledge will all contribute to clinical effectiveness and health improvement. For the majority of practitioners in primary health care, the need to address clinical governance through new ideas and the development of projects locally is likely to be of greater significance than primary research. What is certain is that published research and other evidence at all levels should feed into this process, in order to maintain the double helix of innovation and generalizability. To isolate research from development would be a mistake for primary health care, and an injustice to the patient populations for whom primary health care is responsible.

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