The Use of Health Knowledge by Not-for-profit Organizations: Taking a Look at Their Policy-influencing Practices

January 2012

Briefing Note

For up-to-date knowledge relating to healthy public policy

About this Document

This short document was completed following a one-year partnership (March 2007 to March 2008) between the National Collaborating Centre for Healthy Public Policy (NCCHPP) and five not-for-profit (NFP) organizations involved in public-policy processes related to population health.

The partnership focused on two main objectives and was structured around two series of activities. The first objective was to provide support to the five organizations in their efforts to influence public policy by facilitating their adoption of a reflective stance with regard to their own practices. Over the course of the partnership, a series of collaborative thematic discussions pertaining both to their understanding of the public policy context and to their policy-influencing practices took place. The second objective was to begin to document and analyze these practices so that public health actors might be better able to develop their relationships with NFPs with a view to promoting healthy public policy.

In addition to being part of this second series of activities, this document also fits into a publication project aimed at exploring the various common issues surrounding current or future relationships between community stakeholders and public health professionals. More specifically, it deals with the way in which NFPs use health knowledge in their practices and the issues that this raises for public health professionals conducting or planning to engage in knowledge exchange processes with these stakeholders.

Introduction

Health professionals act on non-biomedical health determinants in various ways (Frankish et al., 2007). One course of action is working with not-for-profit organizations (NFP) to influence public policy. These partnerships are established mainly because the NFPs and the health professionals in question share common concerns in terms of determinants of health. Moreover, they have complementary resources (expertise, community networks, etc.) that can be put to use on both sides. For example, the Direction de la santé publique (DSP) of Montréal-Centre entered into a partnership with the Conseil régional de l'environnement de Montréal in the mid-2000s in order to reconcile the claims of resident groups requesting traffic-calming measures in their immediate surroundings with the reservations of several City of Montréal traffic engineers in this regard. The partnership was supposed to achieve its goals by way of knowledge exchange—by enabling the DSP to share the knowledge it had gained regarding the links between vehicular traffic and Montréalers' state of health and by making explicit the citizens' traffic-calming claims. It was also supposed to enable engineers to become familiar with the NFP's technical knowledge regarding traffic-calming measures in the hopes that they would incorporate these into their practices.

The purpose of the analysis proposed here is to facilitate reflection by health professionals on certain issues affecting these current or future knowledge exchange activities with NFPs. The first section is dedicated to the methodology and conceptual framework organizing the work. The next section consists of the analysis of the use of knowledge by NFPs. The last section presents a discussion of the ins and outs of the exchange of knowledge between NFPs and health care professionals with a view to promoting healthy public policy.

Methodology and Conceptual Framework

With the consent of the NFPs, we were able to use in our analyses the results of thematic discussions held as part of the project and to conduct interviews with members of these organizations. Furthermore, the NFPs gave us access to highly pertinent documents (reports presented to public audiences, press releases,

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and so on). We also consulted the organizations' Web sites. The study that follows is the result of a cross-sectional analysis of the five organizations. Given the limited number of organizations studied, this analysis obviously does not claim to be representative of all NFP practices in terms of the use of health knowledge in Canada.

For the purposes of the analysis, public policy refers to a strategic action carried out by a public authority, alone or in partnership with other public or private organizations, in order to influence certain aspects of the population that could be problematic. The public policy process therefore includes, on the one hand, activities related to the production and framing of population problems and, on the other, activities related to the actions carried out to address them, including the implementation of mechanisms, plans, strategies, policies, services, projects, and so on. By health knowledge, we mean knowledge produced by public health authorities or other researchers regarding non-biomedical determinants of health and explicitly expressed as such. The notion of knowledge refers not only to data produced through research, but also the theoretical and conceptual frameworks used.

The box below briefly presents the NFPs (they will be identified using these letters).

- A Portland Hotel Community Services Inc. Provides low-threshold services in Vancouver, British Columbia.
- B Quint Development Corporation. Develops and manages neighbourhood development initiatives using a community economic development approach in Saskatoon, Saskatchewan.
- C Partenaires pour la revitalisation des anciens quartiers. Develops and manages urban revitalization projects in Salaberry-de-Valleyfield, Québec.
- D Urban Ecology Center. Develops and manages programs and advocates for environmental projects in Montréal, Québec.
- E Équiterre. Develops and manages programs and advocates for environmental policies in Québec.

Use of Health Knowledge by NFPs

One of the underlying goals of knowledge exchange activities is that the knowledge being exchanged be used by other actors in their practices. In this case, we hope that knowledge regarding health and its determinants will be used by NFPs to direct their efforts to promote healthy public policies. It therefore seems important to ask how health knowledge becomes meaningful, important and interesting for NFPs in their work. An examination of the ways in which they use it provides possible answers to this question.[1]

Since all NFPs have already used health knowledge in one way or another, it is appropriate to begin by describing how they use it, starting with 1) the degree of systematicity and intensity of these uses, and then 2) the types of health knowledge that they turn to. We will then discuss what they "do with"[2] this knowledge. Two uses are described: 3) problem framing, and 4) justification of solutions put forward.

1. Systematicity and Intensity of the Uses

If, by systematic and intense use we mean a relatively organized and constant use in most policy-influencing practices, then it can be said that only NFP A makes such a use of health knowledge.

Most NFPs use health knowledge in a way that is not very systematic or intense. For example, NFP D explicitly used health knowledge only once in its actions to influence public policy affecting the Montréal population's state of health. NFP B has only recently begun using it fairly systematically as part of only one of its projects or programs, though it has more than fifteen in operation. This is all the more surprising given that virtually all of these projects and programs could be conceptually linked in one way or another to health and health disparities between the populations residing in the five core neighbourhoods of Saskatoon where it works and those residing in the other areas of the city.

[1] Nutley and her colleagues defend a similar argument in order to justify their examination of the ways in which the "evidence" produced by scientific research is used in public-policy processes (Nutley, Walter and Davies, 2007).

[2] Michel De Certeau used this concept to draw attention to unexpected uses of cultural products. See: De Certeau, M. (1991). *L'invention du quotidien – Art de faire. Paris : Gallimard.*

The uses also vary over time and between the NFPs' various programming priorities. For example, NFP B began using health knowledge in a fairly intense and explicit way relatively late in the process of developing one of its community building projects that was to include health care services, public housing and a "healthy" grocery store.[3] In fact, it started to use it around three years after project development began. There are also differences within individual NFPs themselves, between activity sectors or programming priorities: NFP E did not use any health knowledge as part of its actions relating to fair trade or energy efficiency, but did use it in transport (Équiterre, 2005) and in ecological agriculture (Équiterre, 2010).

2. Types of Health Knowledge Used

In general, NFPs use epidemiological knowledge, that is, knowledge characterizing the states of health of a given population and linking them or not to certain social, economic, political or environmental determinants of health. NFP C used a study that associated the state of health of the occupants of certain buildings with the level of salubrity of these buildings (Viens, Jacques, & Masson, 2003).

Another type of knowledge was also used: NFP A used knowledge about the effects of public policies on the health of the population it wants to reach. The fact that only one organization used this type of knowledge is perhaps not that surprising given the few evaluations available on the effects of public policies on health.

Lastly, it is worth noting that only NFP B used statistics showing disparities between the state of health of the population it serves and those of the populations residing in the other areas of the city, making no explicit link to what determined these differences in the state of health.

3. Problem Definition or Framing

Other than the NFP A that does it systematically, NFP C made reference, in a study conducted in partnership with the regional health authority, to several Canadian and U.S. studies to link dirt-floor cellars to health problems affecting the residents of houses that have them (Viens et al., 2003). In this study, the authors first link the occupants' health problems to excessive humidity in dwellings with dirt-floor cellars. They also propose various lines of reasoning to explain that the population residing in these dwellings, which are grouped together in specific areas of the city, is of generally low socio-economic status. The authors put forward historic reasons (workers' living conditions), socio-economic reasons (low income, income-rent ratios, unemployment rate, slowdown in economic activities, and so on) and other reasons to explain this state of affairs. The etiological framework developed in this study was subsequently used as the basis for municipal policy.

4. Justifying the Solutions

NFPs also use health knowledge to justify the solutions that they put forward. This type of use is particularly seen in NFP A, which is also the one that uses health knowledge systematically.

The other NFPs also use health knowledge to justify the solutions put forward, even in cases where the problem is not primarily defined as a health issue or is not explicitly linked to health. NFP B used two health arguments (out of a total of three main arguments) to justify its community centre project. On its Web site, under the "Why?" section, it states that the project is important because the residents of central neighbourhoods have limited access to healthy food and there are several health disparities between the populations residing in these neighbourhoods and those in other neighbourhoods of the city:

> Nearly four times as many people from low-income Saskatoon neighbourhoods wound up in hospital after attempting suicide compared to the rest of the city. The number of suicide attempts is also more than 15 times higher than the number in affluent neighbourhoods. Hospitalizations for diabetes [in 2001] were three times higher in low-income neighbourhoods than the rest of the city, and nearly 13 times higher than in the eastern suburbs [the most affluent neighbourhoods]. Only 46 per cent of inner-city children are up to date with their measles, mumps and rubella vaccinations while 95 per cent of kids in affluent areas are covered. Babies born in Saskatoon's lower income neighbourhoods are five times more likely to die than an average city baby. (Station 20 West, Community Enterprise Centre, 2010).

[3] To learn more about the process that led to this change, see this document by Val Morrison at: http://www.ncchpp.ca/162/publications.ccnpps?id_article=622.

NFP E used research conducted on environmental health to justify a program in which daycares provided organic food even though the problem was neither primarily nor predominantly formulated in terms of health (Équiterre, 2010).

In short, NFPs sometimes use health knowledge in their policy-influencing practices. The knowledge used is mostly of an epidemiological nature. Only NFP A used knowledge on the effects of public policies on health. NFPs sometimes resort to health knowledge to properly frame the problems they want to solve—they use it conceptually, as Nutley and her colleagues put it (Nutley et al., 2007, 301). They also use it to justify the solutions they propose, even if the problem is not framed as a clear or predominant health issue—that is, they use it strategically or tactically, once again as Nutley and her colleagues put it (Nutley, Walter, & Davies, 2007). They do it in a partial way, using certain elements of research and not all of it. It can also be said that they do it in a way that is non-systematic and, on the whole, not very intense. The description of these uses led to the following reflections on current or future knowledge exchange activities between NFPs and health professionals.

A Few Considerations Regarding the Exchange of Knowledge with NFPs

How may these uses affect knowledge exchange activities with NFPs? What considerations do these practices raise for health professionals? We discuss this for each of the points listed in the previous section.

1. First of all, the fact that all of the organizations have used health knowledge at one time or another and in one way or another is interesting in itself. This tends to suggest that even NFPs that have not first given themselves the mission of improving population health use conceptualizations that are compatible with health knowledge. In other words, the organizations' framework of understanding is compatible with health knowledge. This ideological compatibility has already been shown to be a determining characteristic in the use of cultural contents (Hermes, 1995).
2. The systematic and intense use of health knowledge by NFP A and the non-systematic and not very intense use by the others is a second point of interest. These two scenarios suggest that there is both a palpable desire to use it and a potential for use that can be further developed. In order to reflect on these conditions, it is useful to examine the reasons that will help us to understand these forms of use.

   First, why did NFP A use health knowledge in a systematic and intense manner? For one, this is an NFP that defines its target population using categories that come from health care practices—people suffering from serious drug addiction and mental health problems. In other words, health knowledge produced by all sorts of researchers (coroners, regional health authorities, academic researchers) on these segments of the population is highly compatible with this NFP's classification practices and its framework for understanding and addressing its situational reality. Second, and in line with this, the people working in this NFP are highly familiar with health concepts—both because several of them have a background in health and because the organization runs several programs in partnership with the regional health authority. In other words, this NFP's staff has a conceptual expertise that allows it to assimilate and use specialized knowledge in its policy-influencing practices. Moreover, funding of a major research program pertaining to the effects of one of this NFP's services has led to the publication of over 30 scientific papers.

   In contrast, the others do not always define their target population using health categories. They do not employ any staff trained in health and do not develop or deliver programs in partnership with health authorities. Furthermore, they only occasionally have health-specific research at their disposal linking social, environmental, economic or political determinants to the states of health of the populations they serve. What's more, this knowledge is not always current or organized in relation to the communities that they are seeking to help.

   In order to maximize the potential for NFPs' use of health knowledge, it therefore appears that health professionals can work to create certain enabling conditions. These NFPs can ensure that the knowledge is updated often enough for it to remain pertinent to them. They can also ensure that the population categories they use are compatible with those of the organizations with which they would like to work. Lastly, they should

probably ensure that the people working in partner NFPs can assimilate the knowledge and concepts stemming from health knowledge. The creation of venues promoting the regular and continuous exchange of knowledge (as the joint development and management of service programs seems to permit, based on what has been described above) supports the creation of all of these conditions.

3. The fact that NFPs mainly use epidemiological knowledge or population health status monitoring rather than knowledge evaluating the effects of public policy on health is not very surprising and is generally fairly easy to explain. There are, in fact, very few evaluations of the effects of public policies (other than health policies themselves) on health. For example, there is an increasing number of studies documenting the effects of vehicle emissions on various types of illnesses (cancer, cardiopulmonary diseases, and so on), but few studies have documented the effects of transport policies on polluting emissions and states of health.

4. The fact that NFPs use health knowledge to frame the problems that concern them should attract the attention of health professionals. In fact, health actors often express difficulty in getting the message out on non-biomedical determinants of health, both to other health professionals and to the general population (including the media).

   If only as a new, rather readily receptive public, NFPs already make up an interesting dissemination network for framing health problems and putting them on the political agenda. Given their networks and, in certain cases, their special access to information media, NFPs are clearly important actors with whom to engage to ensure that this framework is increasingly shared.

5. In the justification of their solutions, NFPs sometimes put forward solutions that are distinct, or even in tension with the courses of action promoted by health authorities. The use of a report by a health authority on health disparities by one NFP (B) is a good example of this. It sought to justify its multi-purpose community centre project by basing itself on data from the report, even though the report itself recommended actions aimed at early childhood development.

Conclusion

In conclusion, health authorities looking to engage in exchanges with NFPs must accept that they will not act as simple intermediaries, faithfully relaying health knowledge produced: rather, they should assume that NFPs will act as mediators of this knowledge, that is, they will use it partially and in such a way as to incorporate it into their practices and the ethical principles that guide them.

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