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Role of knowledge in public health and health promotion policy change*

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SUMMARY

A framework of policy development is presented that identifies the role various forms of knowledge can play in the policy formation process. The framework is based upon the premise that public health and health promotion issues should be addressed within an analysis of policy change that considers concepts of interactive and critical knowledge in addition to scientific knowledge. Progress in developing meaningful health policy will require accepting the validity of these various forms of knowledge and developing frameworks that see experts and citizens working together to develop and achieve public health and health promotion goals.

Key words: health promotion; knowledge; policy change

INTRODUCTION

Policy change is important to health promotion and public health in two ways. First, the development of healthy public policy has been recognized as a cornerstone of the new public health (World Health Organization, 1986). Secondly, public health programmes are developed to reflect policy aims of local departments and units. Despite this recognition, remarkably little work has considered how different forms of knowledge contribute to policy development in these areas (Bryant, 1998).

Like many other policy fields, public health and health promotion have tended to rely on traditional forms of scientific knowledge to guide the development of both healthy public policy and local public health programmes (Williams and Popay, 1997). This knowledge has usually been associated with medical, clinical and epidemiological expertise. For the most part however, the reliance upon scientific, and usually quantitative knowledge by health promoters in North America has led to an emphasis on lifestyle issues that potentially detract attention from the political and socioeconomic issues that influence health and well-being, such as poverty and the environment (Tesh, 1990; Raphael, 2000).

There has also been a neglect of how political dynamics such as the ideology of governments and competition between medical and other health professionals influence how some forms of knowledge are accepted and others rejected in the policy formation process (Bryant, 1998). There are alternate forms of knowledge such as lay knowledge that can be used to guide the policy development process (Blaxter, 1990).

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This article presents an analytic framework of policy change that illustrates the role that various forms of knowledge can play in influencing policy development in public health and health promotion. It also illustrates—through two case studies related to housing and health care policy in Toronto, Canada—how government receptivity to knowledge is influenced by the identity of the policy advocates and the ideology of the government of the day.

THE NOTION OF POLICY CHANGE

Policy change refers to a new direction in public policy. Two patterns of policy change have been identified (Howlett and Ramesh, 1995): normal or routine policy change and paradigmatic policy change. Normal policy change refers to a continuation of existing policy with only slight variations from existing policy. Such changes are also called incremental change. Most policies and practices tend to be a continuation of past policies and practices. Paradigmatic policy change represents a fundamentally new direction in state policy, also understood as signifying the emergence of a new paradigm or way of thinking about a policy issue. Normal and paradigmatic patterns occur under different political and social conditions.

Paradigms can undergo a shift such as from a focus on hospital and diagnostic services to health promotion and disease prevention. The latter suggests a broader focus on social, political, economic and environmental conditions as contributing to human health. Such a change can be seen as a paradigm shift in the understanding of health and the causes of illness. Models of policy change are rarely discussed in the health promotion literature.

The political science literature presents a continuum of policy change models and approaches. For example, Lindblom's model of incrementalism (Lindblom, 1959) and Kingdon's policy entrepreneur model (Kingdon, 1984) in the agenda-setting literature are general models about the public policy process. Of particular interest to health promoters are Sabatier's and Hall's policy change approaches, which consider the role of knowledge, ideas and learning as key components in the process (Hall, 1993; Sabatier, 1993). Health promotion is an approach that stresses new ways of thinking about means to improve well-being. Analysis of models that consider how some ideas are accepted and others rejected should provide insights into health promotion's successes and failures in influencing policy development.

Sabatier considers long-term policy change by examining the knowledge activities of policy experts, such as social scientists, senior civil servants and politicians in what he terms advocacy coalitions (Sabatier, 1993). Sabatier's framework explains how the strategic interaction of these elites, in groups and organizations, lobby for specific policy changes. Policy communities consist of ideologically based coalitions that can include actors in the private and public sectors. Other actors can be local or regional governments that are involved in policy formulation and implementation. Members of such communities are bound by ideological and ontological beliefs about policy issues. Those subscribing to differing concepts of health and health promotion, for example, constitute various advocacy coalitions.

Policy change occurs within a social, economic and political context, and involves competition within the policy community. Policy change can also involve competition for power and conflicting activities within the community that arise to address a policy issue. Sabatier is particularly interested in the role of technical information and ideology throughout the policy process. Some of his key concepts require examination.

Belief system

All members of an advocacy coalition share a set of normative and causal beliefs or ideology. These beliefs shape policy positions, instrumental decisions, and information sources selected to support specific policy positions. The belief system consists of three structural categories: the deep normative core consists of fundamental normative and ontological beliefs; the near policy core consists of the coalition's policy positions; and there are secondary aspects related to instrumental decisions enlisted to support the policy core. The coalition's strategies in support of the policy core will involve statements about the adequacy of governmental decisions that address the perceived problem.

Change in the larger environment

A range of factors can influence an advocacy coalition and its activities as well as its success in achieving policy change. *Stable influences* such as established policy parameters and the social,

legal and resource features of the society persist over a period of several decades. These influences frame and constrain the activities of advocacy coalitions. *Dynamic influences* such as external changes or events in global socioeconomic conditions can alter the composition and resources of various coalitions. Personnel changes at senior levels within government ministries can also affect the political resources of various coalitions and the decisions that are made at the collective policy choice and operational levels.

Policy oriented learning

This concept refers to enduring changes in thought or behavioural intentions that are based on previous policy experience. Learning occurs through internal feedback mechanisms and includes perceptions of external dynamics and increased knowledge of problem parameters. Such learning is instrumental, since it is assumed that members of the various advocacy coalitions seek to improve their understanding of the world in order to further the achieving of their policy objectives.

By considering the purpose of knowledge activities of the policy community as improving participants' understanding of the world, the advocacy coalition framework espouses a rational approach to policy development. Within such a framework, decisions about which health promotion policy paradigm to pursue would be made on purely rational grounds related to effectiveness and efficiency.

Yet, Sabatier's framework does not fully appreciate the conflictual nature of politics and the favouring of certain types of actors and knowledge over others. It does not deal with what some critics have identified as the deliberate exclusion of particular holders of, and types of, knowledge from the policy process (Gamson and Wolfsfeld, 1993). This certainly is an experience many with innovative ideas in health promotion have had in regards to having their voices heard by policy makers.

Hall considers different types of policy change (Hall, 1993). Drawing from Kuhn's work on scientific paradigms (Kuhn, 1970), he delineates between normal and paradigmatic patterns of policy change. First-order change is concerned with normal or routine policy changes, such as level of fee payments to physicians. Second-order change involves the development of new policy instruments and strategic action such as the establishment of community health centres to complement existing primary care. First- and second-order changes are 'normal' in that they occur within the overall terms of the accepted policy paradigm. Third-order change is radical change from the received paradigm.

The move towards a structural emphasis in health promotion in Canada with the publication of *Achieving Health for All* (Epp, 1986) was probably a second-order shift from the broadened concept of health identified in *A New Perspective on the Health of Canadians* (Lalonde, 1974). Such a shift towards a structural approach in the USA from a lifestyle approach would even now be a major paradigmatic shift.

Concerning the role of knowledge in policy change, Hall aims to connect social science and the activities of social scientists as non-state actors to the larger political system (Hall, 1993). Hall argues that decision makers function within a framework of ideas and standards that specify policy goals and the policy instruments that can be deployed to achieve policy goals. But ideas also determine the nature of problems that will be addressed. Hall terms this interpretive framework a 'policy paradigm'.

Hall links the concept of policy paradigm to social learning. Social learning can assume different forms, depending upon the type of changes in policy that are involved. For Hall, social learning emphasizes the role of ideas in policy making, a process that is dominated by officials and highly placed experts.

While Hall considers the exchange of information and ideas among social scientists, policy makers and political interests that can bring about policy change, he privileges rational or expert knowledge creation and policy experts. It is acknowledged that the prevailing system of ideas permeates the rules and procedures of the political system and is embedded in institutions that shape the distribution of power within the political system and society. Moreover, Hall recognizes that the government of the day is not neutral, but a political actor with its own policy agenda. The government of the day uses state power to implement its policy agenda.

Traditional knowledge is seen as legitimate, with little discussion of lay or non-expert experience. The close relationship of governments with established think-tanks that may have specific ideological bents is not seen as problematic. While scientific knowledge has made important contributions to the understanding of health and

social problems, it has also been the subject of some severe critiques, especially among health promoters such as Macdonald and Davies (Macdonald and Davies, 1998). The alternative view is that diverse forms of knowledge should enter the policy change process. This is a theme taken up by Guba, Hancock and Minkler, and Raphael and Bryant in discussions on the new public health (Lincoln, 1994; Hancock and Minkler, 1997; Raphael and Bryant, 2000).

In his theory of critical knowledge, Habermas argues that people relate to the world and one another through three different forms of knowledge (Habermas, 1968). Park has defined these forms as instrumental or traditional scientific knowledge, interactive knowledge and critical knowledge (Park, 1993). Interactive knowledge is lived experience acquired through dialogue and information sharing among members of a community (Park, 1993). Critical knowledge is about the influence upon society of powerful socioeconomic and political forces.

These latter forms of knowledge are the kinds possessed by the people in whose health and well-being public health workers are concerned (Eakin *et al.*, 1996; Williams and Popay, 1997). The importance of interactive and critical knowledge is acknowledged within community-based health approaches based upon WHO concepts of health and health promotion (Williams *et al.*, 1995; Macdonald and Davies, 1998). Additionally, the importance of critical knowledge is increasingly being recognized by health researchers attempting to understand the potent societal forces influencing the health of the population (Travers, 1996; Chernomas, 1999). How can these differing forms of knowledge be conceptualized, recognizing that these forms of knowledge may be applied in various ways by those attempting to influence public policy?

AN ALTERNATIVE FRAMEWORK OF POLICY CHANGE

The framework presented here considers knowledge developed by experts, community members and politically engaged groups of civil society. The term 'professional policy analyst' is applied to those whose professional roles are focussed on such policy change activities. 'Citizen activists' refers to those who may also participate in the policy change process, but do so outside of the normal expert policy community. This framework was devised to examine how the knowledge and advocacy activities undertaken by these various groups can be applied in the health and housing policy spheres. Both professional policy analysts and citizen activists engage in knowledge creation and other activities that animate dialogue on what are perceived as key issues to be addressed in the public domain. Figure 1 identifies these two main possessors of knowledge: professional policy analysts and citizen activists.

Professional policy analysts may be university professors, health department epidemiologists or policy analysts affiliated with governments, private policy organizations or non-governmental agencies. These experts usually have a graduate education and are perceived as having specialized knowledge that enhances their credibility in the public domain. They are also seen as possessing an objectivity that allows the separation of self-interest from their knowledge creation activities. To illustrate this, professional policy analysts who conduct research in social policy areas such as homelessness are seen as engaged in research to

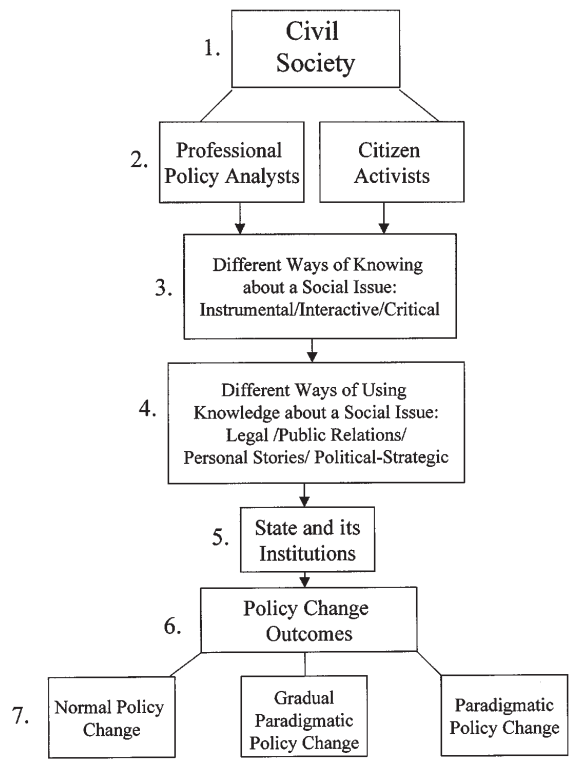

Fig. 1: Conceptual framework of the policy change process.

promote progressive social policy, and the issues they address do not affect them personally. In contrast, citizen activists tend to address issues that affect them personally and may be perceived by the public as self-interested. Yet, citizen activists may have a genuine concern about homelessness, but not be homeless or at risk of becoming homeless.

Moving down the framework, Figure 1 incorporates a typology of knowledge as 'different ways of knowing about a social issue'. *Instrumental* or expert knowledge is usually created by 'experts'. It is perceived to be, like its creators, objective, and systematically developed through 'scientific' —usually quantitative—research methods. *Interactive* or lay knowledge develops from lived experience and is exchanged among people in their daily lives. *Critical knowledge* is reflective knowledge. This knowledge considers the role of social structures and power relations in reinforcing inequalities and disempowering people. Critical knowledge considers questions of right and wrong, analyses existing social conditions, and outlines what can be done to alter social conditions to improve quality of life.

In practice, these different forms of knowledge are frequently isolated from each other. This is typically the case where governments neither consult nor consider the views of community members. Fischer writes of collaborative policy analysis in which experts mentor citizen activists and conduct research on issues of concern to the citizen activists (Fischer, 1993). Collaboration occurs when professional policy analysts and citizens carry out cooperative analyses on community-identified issues. For example, both groups, whether collaborative or isolated, can present submissions to committees of the legislature or local public health boards. Isolation occurs when these groups remain independent of each other.

An example of isolation would occur when either public policy or a local health department's strategic plan is developed solely on the basis of expert knowledge informed by a standard epidemiology-based needs assessment. In contrast, an approach that actively involved the community in identifying needs and formulating policy would be an example of collaboration. Within Toronto, the Toronto Disaster Relief Committee has seen the working together of university academics with community organizations and the homeless themselves to identify policy solutions to the homeless crisis (Toronto Disaster Relief Committee, 2000). Hancock and Minkler consider this issue in their succinctly named chapter *Community Needs Assessment: Whose Community?, Whose Needs?, Whose Assessment*? (Hancock and Minkler, 1997).

Box 4 in Figure 1 identifies 'different ways of using knowledge about a social issue'. The ways refer to approaches to presenting knowledge. These include legal, public relations, personal stories and political–strategic approaches. The legal approach consists of using legal knowledge and analysis and lawyers to make a case to policy makers (Figure 1, box 5). The public relations approach consists of marketing a political message by targeting an audience and decisions concerned with how a political message will be presented. Using personal stories is a form of narrative, whereby individuals present their stories about how particular policies have affected their well-being to policy makers. The political–strategic approach involves using the political system to achieve one's policy objectives. This approach involves knowing the political system, specifically the politicians and civil servants to meet with to present their policy perspective to, and strategizing to achieve their policy objectives. Civil society actors, including both professional policy analysts and citizen activists, have such knowledge. They may vary in their influence on the state or the government of the day.

Filters such as political ideology and the political identity of the civil society actors presenting knowledge lead to screening out information from some groups and not from others for consideration in the policy change process. Political ideology is a system of ideas or beliefs about society that guides political action. Political identity refers to the social class, ethnoracial background, and other attributes of a group or an individual.

The government of the day uses state power to make policy decisions that are based on its ideological beliefs. The framework suggests three possible policy change outcomes. Normal policy change is routine policy change involving virtually no change in the overall policy objectives. Gradual policy change consists of a series of normal policy change decisions that may add up to a shift in the policy paradigm. Paradigmatic policy change is a radical shift in the overall objectives of the policy area, such as a shift from emphasis on biomedical health care treatment to health promotion. Another type of pattern is no change in policy. Such a decision can be as

deliberate as a decision to carry out any other policy option.

CASE STUDIES OF RECENT HEALTH AND SOCIAL POLICY CHANGES IN TORONTO, ONTARIO

Two case studies focussed on social and health policy changes in Toronto, Canada, drew upon this framework (Bryant, 2001). Interviews and document review were used to learn about knowledge activities used by individuals attempting to influence the policy change process. The first case study focussed on the 1997 Tenant Protection Act. This provincial Act replaced all previous rental housing regulations in Ontario and introduced vacancy decontrol. Vacancy decontrol enables a landlord to increase rent without restriction when a tenant vacates an apartment. The tenant is protected provided s/he does not move. It also amended the Ontario Human Rights Code to allow landlords to use income criteria to evaluate potential tenants. Housing is an especially important health promotion issue in Toronto. Homelessness has skyrocketed and the city lacks the infrastructure to address the problem (Raphael, 2001). In addition, Canada is one of the few Western nations without a national housing strategy.

The second case considered the use of knowledge during the hospital restructuring process. The case focussed on Toronto's Women's College Hospital and its 1995–1998 fight against closure. In order to reduce hospital expenditures, the provincial government formed the Health Services Restructuring Commission, an independent body empowered to close and merge hospitals across Ontario. Women's College Hospital was designated by the Commission to close and merge with the larger Sunnybrook Health Sciences Centre.

Women's College Hospital was the successor to the Ontario Women's Medical College that was founded in 1911. The College was established in response to the refusal of the University of Toronto Faculty of Medicine to accept women as students in the late nineteenth century. At that time it provided an opportunity for women to practice medicine. In 1960, Women's College Hospital became a teaching hospital affiliated with the University of Toronto's Faculty of Medicine.

Of specific interest were the types of knowledge and other activities used by professional policy analysts in the two cases. The typology of knowledge in the conceptual framework was applied to identify the types of knowledge employed by the participants in each case and to understand their use of knowledge in making their case. Seven participants who work with low-income tenants in Toronto and 10 participants associated with Women's College Hospital were interviewed about their perceptions of knowledge and their use of diverse types of knowledge. Participants responded to questions about how they selected knowledge for use in their briefs to government committees and in their public advocacy campaigns.

DATA COLLECTION AND ANALYSIS METHODS

Document review and in-depth interviews with key informants explored the relationship between knowledge and the influence of civil society actors on the policy change process through the exemplars of the Tenant Protection Act and the Health Services Restructuring Commission.

The document review identified key issues in housing and health policy, and the motivations of state and civil society actors and their epistemological assumptions. Legislative transcripts of hearings on the Tenant Protection Act in Toronto held during June and August 1997 were reviewed to identify briefs that used diverse types of knowledge and identified key issues raised during the hearings. Friends of Women's College Hospital provided copies of all of the Hospital's and Friends submissions to the Health Services Restructuring Commission and access to materials on the campaign against the proposed merger with Toronto Hospital in 1989–1990. This information supplemented the data provided by in-depth interviews.

The in-depth interviews provided insights about participants' perceptions of knowledge and how they selected the information and evidence to use in their briefs. Key informants included policy analysts within the provincial civil service, municipal government, those who work directly for political representatives such as cabinet ministers and city councillors, and community activists and professional policy analysts engaged in the political change activities or organizations in health and housing policy. Interviews were recorded and transcribed. Themes and issues contained within the data were identified.

The data were organized using concepts and categories identified in the policy change model. For example, civil society actors were organized into the categories of professional policy analysts and citizens. Additional categories were created for activists who are paid employees of interest groups. The categories of 'interactive', 'rational/scientific' and 'critical' were used to classify the knowledge used by actors. Policy change patterns were identified and coded using the typology in the policy change model: normal, paradigmatic and gradual paradigmatic change. These initial concepts and categories were tested on emergent understandings. New categories were developed to fit the data.

Inductive methods of analysis were used to analyse notes taken during the document review and comments from the interviews were used to develop additional categories to reflect accurately emerging themes and patterns in the data. This approach allows consideration of alternative explanations and understandings (Marshall and Rossman, 1999).

DIFFERENT WAYS OF KNOWING ABOUT A SOCIAL ISSUE

The cases confirmed the awareness and application of different ways of knowing by these civil society actors. Participants in both cases used scientific studies (instrumental knowledge), anecdotal evidence (interactive knowledge) and presented an alternative perspective (critical knowledge) to the dominant policy paradigms in their respective policy areas. Concerning instrumental knowledge in the case of the tenants, the professional policy analysts presented their agencies' own primary research and other scientific studies to support their case against vacancy decontrol and the amendment of the Ontario Human Rights Code to allow income criteria for screening of potential tenants by landlords.

Women's College Hospital cited its own research on gender differences in health issues such as cardiology as justification for its continued independence. They also critiqued the methodology of the Health Services Restructuring Commission and the Commission's recommendation for closure of the Hospital.

In both cases as well, the professional policy analysts made extensive use of interactive knowledge. In fact, participants found that qualitative studies were more persuasive in influencing policy makers than instrumental knowledge. Both groups of participants used anecdotal evidence, a form of interactive knowledge acquired through interactions between professionals and clients. The professional policy analysts in the tenants' case used anecdotal evidence in the forms of the experiences of their clients with landlords to illustrate the negative impact of the provisions of the Tenant Protection Act. In the case of Women's College Hospital, there was considerable reliance on anecdotal evidence to demonstrate the quality of care provided by the Hospital. Evidence based on experiences with which people could identify, such as giving birth or being born at the Hospital, was used.

The cases also demonstrate different uses of interactive knowledge. In the case of low-income tenants, the professional policy analysts used interactive knowledge to outline the harmful implications of the Act such as forcing tenants who need to move to remain in their apartments to avoid high rent increases. Women's College Hospital used interactive knowledge to highlight its uniqueness.

In both case studies, communication was important for building support for the advocated policy changes. Interaction among professional policy analysts representing tenants occurred as an important means for communicating concerns about the Tenant Protection Act and its implications for low-income tenants. Through these interactions, professional policy analysts and citizen activists identified key issues to present in their briefs on the Act. The legal clinics and other organizations also built a province-wide coalition to coordinate advocacy efforts during public hearings.

In the case of Women's College Hospital, the strategists interacted with hospital staff, board members and others to build a team and mobilize its constituency. They communicated with other hospitals as they contemplated alliances with these hospitals to avoid closures.

In both cases, there was extensive interaction with the media; another form of interactive knowledge. However, the media were not responsive to the concerns of tenants, in contrast to their interest in groups acting on behalf of Women's College Hospital.

Legal arguments and analyses were used in both cases. Legal research and analysis have elements of instrumental, interactive and critical knowledge. It is developed interactively through cases and legal debate, and imbued with authority.

A judicial ruling on an issue is considered authoritative in the same way that instrumental knowledge is.

Critical knowledge was reflected in the use of legal knowledge and analysis. In the case of the tenants, critical knowledge was reflected in their interpretation of the effects of the provisions of the Tenant Protection Act on low-income populations. Women's College Hospital used gender, an element of critical knowledge, to critique the Health Services Restructuring Commission. They highlighted women's health needs as experienced by women and the failure of the Commission to recognize women's unique health needs.

DIFFERENT WAYS OF USING KNOWLEDGE ABOUT A SOCIAL ISSUE

The participants presented knowledge about their issues using legal arguments, public relations, personal stories and political–strategic approaches. Legal analysis and arguments challenged the many decontrol provisions of the Acts. The Act was presented as threatening affordability in the rental market. They targeted their message to the government and worked with citizen activists to define this message and determine how it would be presented. The personal stories approach presented the experiences of individual tenants to illustrate the effects of policy. The political–strategic approach used the political system to achieve policy objectives. Briefing notes were prepared on the Tenant Protection Act and meetings took place with the Opposition parties to assist them in their analysis of the Act.

Ultimately, the professional policy analysts were unable to influence the final form of the Act. The case demonstrated that although the tenants had knowledge and evidence to challenge the provisions of the bill, the knowledge did not have a significant role in the policy change process. The knowledge was ignored as it questioned the government's premise that a functioning market must not be burdened by regulations. Knowledge that conflicted with ideological commitments was ignored, no matter what form it took or the manner in which it was applied.

In the other case, during the hospital restructuring process the Hospital marketed itself as the 'women's hospital' to distinguish itself from other hospitals. The strategists used diverse types of knowledge and evidence to defend the interests of the Hospital and highlighted its contributions to women's health. Although they used scientific studies, the strategists found that anecdotal evidence, a form of interactive knowledge, was more persuasive in the policy change process.

The strategists also used legal arguments, public relations, personal stories and political–strategic approaches to make the case for the hospital. Of these approaches the legal and political–strategic approaches were most effective in helping the Hospital achieve its objectives. The Hospital litigated against the provincial government and the threat of legal action forced a change that allowed Women's College Hospital to reconfigure itself as an ambulatory care centre. The Hospital also legally ensured its existence in legislation.

DETERMINANTS OF GOVERNMENT RECEPTIVITY TO POLICY MESSAGES

Women's College Hospital was more successful than the tenants in realizing its political objectives. Its success and the tenants' unsuccessful attempt to retain rent control highlight the importance of the political identity of civil society actors who lobby government for change. Political identity refers to the social class, ethnocultural background, sexual orientation, and other ascriptive attributes. In the tenants' case, low-income tenants did not have the political clout that accrued to women in the hospital case. The tenants were predominantly low income and therefore likely to rent throughout their lives. Their issues and the knowledge brought to bear in their interests did not attract public attention.

In contrast, Women's College Hospital drew its influence from its institutional status. It mobilized women in Toronto and across Ontario. Women represented a significant political constituency that the provincial government did not wish to antagonize. Political identity determined which civil society actors had access to the political system and were able to influence policy change outcomes. Identity determined what constituted valid knowledge and evidence for the government in its policy process.

While it is difficult to determine the exact impact of knowledge on the policy change process, the cases demonstrate that different types of knowledge are essential to building a case to achieve particular policy change outcomes. The cases showed that the political ideology of the

government of the day and the political identity of the constituency influence the receptivity of government towards civil society actors and the ability of the actors to influence the policy change process. In the end, the government was willing only to heed knowledge and evidence that supported its ideological perspective.

DISCUSSION: IMPLICATIONS AND FUTURE DIRECTIONS

There are many lessons here for health promoters trying to influence the policy change process. These cases showed that different types of knowledge can inform the policy change process. Although the participants were not totally successful in achieving their policy objectives, they revealed that interactive knowledge in the form of anecdotal evidence can be a powerful political tool. The cases also showed that the political identity of civil society actors seeking particular types of policy change can influence their access to the political process and the receptivity of the government to the knowledge and evidence brought to bear on the policy change process. By employing diverse types of knowledge, the participants in the cases sought to be representative of larger constituencies and to bring about responsive policy change.

The cases also showed that ideology can influence the types of knowledge and evidence accepted into the political process. Such findings have serious implications for all policy fields, but particularly for newer policy perspectives such as those represented by health promotion. Health promoters should be aware of the current dominant policy paradigm and the barriers to change that it may present. For example, it may be difficult to persuade a government of the value of the social determinants of health in developing policy when the dominant paradigm in health policy is the biomedical approach. The dominant advocacy coalition in the health policy community may be institutions such as hospitals, health professions and the pharmaceutical industry, all of whom benefit from the biomedical approach and have the ears of government. Similarly, neo-liberal governments will not be receptive to knowledge concerning the important role of income inequality upon population health, whatever the empirical evidence may be.

Nonetheless, linking instrumental, interactive and critical knowledge can root policy ideas in the community within which health promotion programmes and public health policy is ultimately applied. The solicitation and use of interactive and critical knowledge is consistent with the principles of health promotion and democracy. According to the WHO (WHO, 1998), public health activities should:

- enable individuals and communities to gain more power over the personal, socioeconomic and environmental factors that affect their health;
- involve those who are concerned about an issue in all stages of project planning, implementation and evaluation; and
- be guided by a concern for equity and social justice.

Achieving such goals will require collaboration between experts and community members specifically by drawing upon community members' knowledge about their health and well-being. This knowledge should be complemented with critical analysis of how social and political structures affect health. It is also important to make explicit the various forces that influence whether different forms of knowledge are allowed to contribute to the policy development process.

The framework presented here is being used to guide a national study whereby Canadian seniors are considering how policy decisions by governments are affecting their quality of life (Raphael *et al.*, 2001). The challenges faced by health promoters in influencing public policy make such ongoing examination of factors influencing the policy process essential.

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