CONTRACTING CARE

Evaluating the effects of the 'Second Generation Health System Strategy' on the contracting environment for community organizations in the Downtown Eastside of Vancouver

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A Research Paper submitted to the Graduate Program in Health in partial fulfilment of the requirements for the degree of

Master of Arts

Graduate Program in Health
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April 2019

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ABSTRACT

This paper examines the impacts of the Downtown Eastside 'Second Generation Health System Strategy' (2GHSS) on the contracting environment for community organizations and programs receiving funding from the regional health authority, Vancouver Coastal Health (VCH). The 2GHSS was designed by VCH and implemented in 2015 with the aim of removing siloed services and providing a more integrated and responsive health system in the Downtown Eastside (DTES). The 2GHSS represents a significant reorientation of government priorities in the community and the accompanying funding shuffles and cuts – primarily directed at non-clinical programs and organizations – have shifted the landscape of the DTES third sector. Informed by the theoretical framework of feminist political economy, and through the use of thematic analysis, this paper identifies trends in the DTES contracting environment between 2015 and 2019 that reflect the intensification of medical dominance and indirect neoliberal governance, including: funding cuts to organizations without links to the formal health system; use of market-based competitive tendering; valuing health services for their clinical rather than their social components; and contributing to an environment of fiscal precarity. It is concluded the 2GHSS is an extension of the neoliberal ideological orientation that has long directed the priorities of the BC health sector.

LIST OF ABBREVIATIONS

2GHSS	Second Generation Health System Strategy
CBO	Community-Based Organization
DTES	Downtown Eastside
DURC	Drug User Resource Centre
EBM	Evidence-Based Medicine
FPE	Feminist Political Economy
LGBTQ2	Lesbian, Gay, Bisexual, Trans, Queer, Two-Spirit
Lookout	Lookout Housing and Health Society
NPM	New Public Management
POP	Positive Outlook Program
RFP	Request for Proposal
RHA	Regional Health Authority
UIHHC	Urban Indigenous Health and Healing Cooperative
VANDU	Vancouver Area Network of Drug Users
VCH	Vancouver Coastal Health
VNHS	Vancouver Native Health Society

Acknowledgements

Thank you to my professors at York University whose teaching inspired and introduced me to new perspectives and fields of inquiry. A special thank you to my supervisor, Dr. Tamara Daly and my advisor, Dr. Pat Armstrong. I have valued your constructive feedback, and am grateful for your guidance and support throughout the writing of this paper.

To my family and friends, I am grateful for the words of encouragement.

Lastly, thank you to Adrian for being a pillar of unwavering support and encouragement throughout my years of study, and through the research and writing of this paper.

INTRODUCTION

On February 24, 2015 the Vancouver Coastal Health Authority (VCH) began implementation of the *Downtown Eastside Second Generation Health System Strategy* (2GHSS), marking a shift in the governance, organization and delivery of health services in Vancouver's Downtown Eastside (DTES) community. The health system in the DTES has historically operated as a fragmented mix of public, private, and third sectors, including private charities, direct VCH-run health services, and service provision via VCH contracts with non-profit, community-based organizations (CBOs). In response to critiques over incongruities in the local system, and historically strained relations between VCH and DTES community partners, the 2GHSS was developed with the aim of reorganizing health services to become more integrated and responsive to the unique health needs of the DTES community (VCH, 2015a). The 2GHSS is a reorientation of government priorities in the DTES and the accompanying funding shuffles and cuts have altered the health landscape of the community, particularly for organizations that rely on annual funding from VCH. This Major Research Paper examines the impact of the 2GHSS on the contracting environment for health CBOs operating in the DTES following its implementation in 2015. The "contracting environment" is defined here as the conditions within which organizations that enter into contracting relationships with VCH operate, and particularly, the complex of expectations, requirements, funding priorities, and expressions of power that structure VCH's funding relations with contracted organizations.

The 2GHSS was designed and implemented by VCH – the regional health authority responsible for the delivery of health services to over one million British Columbians along the west coast of the province, including the approximately 18,477 residents of the DTES (City of Vancouver, 2015, p. 17). The DTES is located only minutes away from Vancouver's affluent urban core, and while far from homogenous, DTES residents disproportionately face severe health challenges and intersecting experiences of marginalization. The long history of social and health inequity in the DTES has both made the community a frequent target of biomedical intervention and, where formal health services have fallen short, fostered a vibrant community of grassroots advocacy and community health organizing (Jozaghi, 2014). Local, resident-run community organizations have been especially instrumental in advocating on behalf of DTES residents, and have filled critical health service gaps left open by the narrowing and increasingly clinical purview of VCH. Since the implementation of the 2GHSS in 2015, however, several CBOs have lost their funding contracts with VCH and there remains much concern over what kinds of organizations and contracted programs will be prioritised within the new contracting environment.

To date, the only academic article published on the 2GHSS is a critical commentary by Masuda and Chan (2016). In the article, the authors frame the strategy as a reflection of the neoliberalization of the Canadian health sector, and suggest the accompanying funding cuts to CBOs may signal a shift towards an increasingly clientelistic and biomedical model of health in the DTES. Taking the concerns of Masuda and Chan (2016) as a starting point, this paper examines the extent to which broad trends

of medical dominance and neoliberal governance in the health field shape the contracting environment for community organizations in the DTES following the implementation of the 2GHSS. Drawing on the theoretical framework of feminist political economy (FPE), I consider the ideological and epistemological dynamics that exacerbate contracting precarity for certain community organizations while providing new opportunities for other organizations. Through thematic analysis of VCH media statements, VCH financial statements, local media reports, organizations' press releases, websites, and annual reports, I explore how tenets of neoliberalism are enacted in the DTES third sector through VCH's deference to the biomedical paradigm, and funding shuffles that favour organizations aligning with the 2GHSS. Finally, I outline potential long-term implications for the DTES third sector if these trends continue to intensify, and offer future directions for research in this area.

Theoretical Orientation: Feminist Political Economy

In order to assess the effects of the 2GHSS on the contracting environment for DTES CBOs, this paper draws on the analytical framework of feminist political economy (FPE). Central to the FPE framework is an interrogation of who benefits and who is left out of dominant political, economic and cultural structures (P. Armstrong, Armstrong, & Scott-Dixon, 2008), and by extension, a consideration of how certain types of knowledge and work become legitimized and elevated within these systems (Laxer, 2015). As FPE approaches examine both structures and relations in the organization of systems (P. Armstrong et al., 2008), an FPE framework situates the 2GHSS at the nexus of an *interrelated* set of institutions – economic, political, historical, and ideological – that

together foster hierarchies of epistemology, and contribute to a narrowing definition of health.

FPE is a theoretical tradition borne of critical theory paradigm. Paradigms, as Weaver and Olson (2006) explain, are the frames through which inquiry is regulated, values are held, theories are developed, and significance is interpreted. Paradigmatic orientations inform every level of research and analysis from conceptualization to dissemination. Research produced from within the critical theory paradigm is typically premised on certain key assumptions concerning the distribution of power, the potential for emancipation, and the centrality of social structures in shaping domination (Lincoln & Guba, 2003). The oppressive aspects of power and the hegemonic expressions of ideology are central to a critical analysis (Ho, 2015; Kincheloe & McLaren, 2003).

While FPE shares central assumptions and a paradigmatic foundation with other disciplines of critical research, the FPE framework provides a method of analysis for identifying component parts of the political economy, or, the "forces, relations and structures that shape our worlds" (P. Armstrong et al., 2008, p. 63). P. Armstrong and colleagues (2008) explain that a core legacy of the political economy approach is understanding the political and the economic to be intrinsically related, and importantly, that "states, markets, ideas, discourses, and civil society" are not viewed as isolated institutions, but rather conceived of as constituent parts of the same whole (p. 63). With philosophical roots in Marxist thought, FPE approaches emphasize material relations, structures, and the implications of modes of production at micro, meso, and macro levels (Jackson, 2012). In a critical departure from Marxist orthodoxy, however, feminist

political economists have connected social reproduction with production, illuminating critical facets of the economy – households, communities, unpaid work – otherwise rendered invisible in traditional discourse (P. Armstrong et al., 2008; Bezanson & Luxton, 2006; Laxer, 2015). Underlining the contributions of intersectionality scholars, FPE literature increasingly considers intersecting systems of oppression when analysing power relations within the capitalist state (Vosko, 2003). In moving away from assumptions of homogeneity in experiences of oppression, FPE analyses grapple not just with relations of gender and class, but also explore how a range of social identities relate to distributions of power within and between welfare states (Jackson, 2012).

In their discussion of FPE, P. Armstrong and H. Armstrong (1983) frame the FPE method as being at once materialist, historical and dialectical. A materialist approach, P. Armstrong and H. Armstrong (1983) explain, acknowledges the existence of real, material conditions that underlie "the social, political and intellectual processes" (p. 9) of the world. As feminist thought has long focused on identifying axes of oppression in social and political systems, the FPE approach is particularly attuned to illuminating relationships of domination via material structures (Delphy, 1997). P. Armstrong and H. Armstrong (1983) make clear, however, FPE is not a determinist framework or one that fails to acknowledge agency within the context of constraint. Rather, a FPE perspective contends that while we are born into a particular set of existing conditions, individuals and groups can actively uphold structures of inequity, or in challenging them, work to create change (P. Armstrong et al., 2008).

FPE perspectives are also historical. This is significant when considering the implications of dominant modes of production: FPE analyses point not just to capitalism broadly, but rather identify *historically specific* manifestations of modes of production that are linked in time to structures and relations of the material world (P. Armstrong & Armstrong, 1983). The modern embrace of neoliberalism, and the ideological shift towards market-oriented social policy and metric-based public management is one such manifestation of the capitalist mode of production. The third defining characteristic of FPE is that as an analytical approach it is dialectical (P. Armstrong & Armstrong, 1983). FPE perspectives acknowledge the inherent tensions and contractions produced within systems, social processes and social relations (P. Armstrong & Armstrong, 1983).

In being materialist, historical, dialectical, and increasingly, intersectional, an FPE approach is particularly suited to analysing ideological and epistemological shifts in the DTES contracting environment. Specifically, FPE allows me a framework for considering: how the ideological context informs which knowledge paradigms become elevated, in what ways neoliberal governing practices are subtly enacted, and who benefits and who is left out of the DTES' reorganized health landscape.

BACKGROUND AND CONTEXT

Situating the Downtown Eastside

The DTES is one of Vancouver's oldest and most diverse neighbourhoods. The community is home to students, families, single persons, seniors, recent immigrants, and long-term residents of varying socioeconomic, ethnic, linguistic, and racialized backgrounds (Kumagi & McGuire, 2015). A majority of residents in the DTES are low

income (Census Mapper, 2016), and the community remains one of the few affordable regions within one of Canada's most expensive and increasingly inaccessible housing and rental markets (Canadian Rental Housing Index Coalition, 2015). While the geographic boundaries of the DTES are fluid, the neighbourhoods of Chinatown, Gastown, Strathcona, Victory Square, Oppenheimer District (former Japantown), Industrial Area, Thorton Park, and the Hastings Corridor are collectively considered to make up the DTES community (see Appendix A). Along with the rest of the city of Vancouver, the DTES neighbourhoods sit on the unceded territories of the Coast Salish Musqueam, Squamish, and Tsleil-Wauthuth First Nations.

Since the 19th century, inhabitants of the region now designated "the DTES" have been directly impacted by a series of systematic displacement policies, including BC residential schools and the dislocation of Indigenous peoples from ancestral lands (Barman, 2007), the Chinese head tax of 1885 (Anderson, 1988), the forced internment of Japanese Canadians during WWII (Masuda & Crabtree, 2010), and decades of deinstitutionalization, which has led many formerly institutionalized people with unsupported mental illness to the DTES streets, or to derelict, low-cost rental units in the community (Kumagi & McGuire, 2015). Today, encroaching gentrification and rising rental rates, or what Masuda and Crabtree (2010) call the "re-colonization of the neighbourhood by the middle class" (p. 661), represent one of the latest iterations of structural displacement disproportionately impacting residents of the DTES. Intersecting experiences of gender and racial oppression, and the ongoing impacts of settler colonialism are reflected across the community (Culhane, 2003). Women in the DTES,

particularly Indigenous women, have experienced staggering rates of violence, with a 2014 safety audit conducted by women-serving organizations in the DTES finding 48 percent of the 157 surveyed women had experienced gendered violence within the last two years (Women's Coalition, 2014). With these legacies of disenfranchisement, and the continued erosion of the Canadian welfare state, a number of marginalized populations are over-represented in the DTES, including: Indigenous people, Indigenous women, women, LGBTQ2 people, children, youth, the homeless, people at risk of homelessness, people who use drugs, people with mental illness, people with disabilities, seniors, and survival sex workers (City of Vancouver, 2015).

Health Organizing in the Downtown Eastside

Conventional depictions of the DTES frame the community as a place of destitution, and community struggles such as the prevalence of drug abuse, infectious disease, and crime have long occupied both academic literature (Linden, Mar, Werker, Jang, & Krausz, 2012) and mainstream news (Liu & Blomley, 2013; Woolford, 2001). While the severity of social, gender, economic, and health inequities that persists in the DTES cannot be minimized, one-dimensional narratives focused solely on community tragedies belie a strong tradition of grassroots activism and organizing that is central to the neighbourhood. As Culhane (2003) articulates, in contrast to pejorative media depictions, the DTES is "an active and activist neighbourhood" (p. 599), with a history of community mobilization against social and political injustice.

Organizing around issues of health has long been at the forefront of community-based advocacy in the DTES, and in the absence of adequate resources from formal

governing health bodies, grassroots CBOs have been the first responders to health crises across the community (Boyd & Boyd, 2014; Jozaghi, 2014; Lupick, 2017). During the mid-1990s, for example, injection drug related overdose deaths and transmission rates of HIV and hepatitis C reached epidemic proportions in the DTES (Kumagi & McGuire, 2015). Although local health authorities had declared a public health emergency by 1997, peer-run, grassroots organizations like the Vancouver Area Network of Drug Users (VANDU) – a prominent, user-run, advocacy group for people who use drugs – were the vanguards of advocacy for community members typically overlooked by regional health policies. In response to urgent and unmet community need, VANDU and other CBOs mobilized to heighten pressure on local and federal policy makers and demand the legalization of supervised-injection sites (Jozaghi, 2014; Kerr et al., 2006). As a result of their advocacy, and the coordinated lobbying efforts of DTES community members, professional advocates, and eventually VCH, the first federally sanctioned supervised-injection site in Canada – named "Insite" – opened in the DTES in 2003 (Small, Palepu, & Tyndall, 2006). In 2016, the Government of BC declared another public health emergency due to the arrival of fentanyl in the province – a powerful, synthetic opioid responsible for an unprecedented rise in opioid-related overdose deaths in the DTES and across North America (Karamouzian et al., 2018). Community activists and peer-run CBOs continue to be on the front lines of this health crisis, filling critical service gaps in advance of coordinated responses from formal governing bodies (Eagland, 2017; Kerr, Mitra, Kennedy, & McNeil, 2017; Wong, 2017).

As well as their capacity for political advocacy and crisis management, grassroots CBOs in the DTES provide critical respite for a population that carries, as Masuda and Chan (2016) describe, "a long legacy of distrust toward governments and health care professionals" (p. 591). Many communities within the DTES, including women drug users (VANDU Women CARE Team, 2009), Indigenous women (Benoit, Carroll, & Chaudhry, 2003), and Indigenous people (Goodman et al., 2017), among others, have reported encounters of discrimination, racism, judgment, and dismissal when interacting with the formal health system. CBOs often provide health supports beyond the clinical spectrum, with many in the DTES offering non-medical, health interventions such as welcoming spaces, access to arts, advocacy, social assistance, peer education, employment, and supportive community. Given the climate of fear and suspicion that permeates local perceptions of the health, policy, and policing systems, community organizations in the DTES, particularly peer-run and governed organizations, act both as providers of social and health support, and as vital spaces of belonging for community members subjected to daily encounters of systemic discrimination.

There is a complex landscape of public and third sector service provision in the DTES. A 2015 investigation by a local newspaper, *The Vancouver Sun,* found there are as many as 260 CBOs, non-profits, charities, and governmental agencies providing social and health services across the DTES (Culbert & McMartin, 2015). As the regional health authority for the coastal region of BC, VCH is responsible for funding DTES health services both directly, through VCH-run health programs, and indirectly, through funding contracts with local organizations. Given their consistent support of harm reduction

initiatives, VCH is often considered a progressive leader in Canadian public health and harm reduction communities (Prangnell et al., 2017; Small et al., 2006).

Despite their laudable commitment to innovation in harm reduction, however, VCH's adherence to a predominantly biomedical view of health has been subject to criticism, particularly among community activists in the DTES. The steep funding cuts to all non-clinical services at the DTES' first women's-only supportive housing and drug treatment centre in 2012 – The Rainier Women's Treatment Centre – is a stark example of the dissonance that can exist between the health priorities of VCH and those using their services. The Rainier opened in 2009 with a three-year pilot grant from Health Canada. If the model proved successful after three years, VCH was to assume the long-term operation costs of the centre in 2012 (Lupick, 2017). The program was intended to reach women at the nexus of intersecting extremes in marginalization – women struggling with addictions, former sex workers, women with untreated mental health illness, victims of physical, domestic and sexual abuse, and those facing severe poverty (BC-CfE & PHS, 2012). As traditional, mixed gender detox programs in the DTES repeatedly failed to address accessibility and retention barriers experienced by marginalized women seeking treatment (BC-CfE & PHS, 2012), the Rainier filled a critical gap in the DTES treatment sphere.

The philosophy of the Rainier program was unique in having a holistic, inclusive and non-punitive approach to recovery: as well as being involved in the design of treatment programs, women were able to build community with other residents, had access to onsite clinical personnel, were supported through transitional housing options,

and were able to participate in non-clinical programs like meditation, acupuncture, vocational training, and writing workshops (Lupick, 2017). When the federal grant ended in 2012, however, VCH concluded Rainier's holistic care model did not provide added clinical value and decided against funding the full spectrum of Rainier services (Lupick, 2017). Despite passionate resident testimony and community protests in support of the Rainier (Cole, 2012; Sandborn, 2011), VCH replaced all non-clinical programs and onsite staff with a wider range of *offsite clinical services*.

In a 2012 op-ed to a local newspaper, the executive director and senior medical director of VCH defended the Rainier's funding adjustments through calls to fiscal responsibility and evidence-based assessment metrics:

> On-site staff will be replaced by a wider range of *outside clinical staff* such as counsellors, case managers, nurses and doctors operating from centres in the broader community that offer more *evidence-based care – that is, managing health problems with proven approaches.* … It is our responsibility to make thorough decisions about the *use of limited tax dollars* for programs like the Rainier. As this pilot project ends, the evaluation indicates that the benefits are inconclusive. [Emphases added] (Bessubetz & Barrios, 2012)

In closing the Rainier, VCH made apparent the degree to which measurable, clinical, and fiscally efficient services are prioritised within their contracted health programs.

Provincial Policy Context: Neoliberal Reforms in BC's Health Sector

The VCH's prioritization of clinical programming, outcome metrics, and conservative spending parallels the agenda of the BC Ministry of Health under the

ideologically conservative, provincial BC Liberal Party, and more broadly aligns with the tenor of post-1980s neoliberal federal policy. Connell (2010) defines neoliberalism as "the agenda of economic and social transformation under the sign of the free market that has come to dominate global politics in the last quarter-century" (p. 22). It is the global economic paradigm that has supplanted Keynesianism, and as H. Armstrong (2013) describes, is manifest as ideology, policy, and governance (p. 188). Neoliberal thought, Braedley and Luxton (2010) explain, is historically rooted, developing out of staunch opposition to early twentieth century socialism and a vehement repudiation of collectivist policies thought to restrict market competition. In practice, neoliberal policies centre on eroding state regulations, promoting global economic participation, cutting taxes for the wealthy, dismantling unions and labour protections, privatizing public institutions, and importantly for the context of the DTES, "the co-opt[ing] and taming of non-governmental organizations (NGOs) to deliver social services" (H. Armstrong, 2013, p. 189).

In the Keynesian postwar period (1945-1970s), Canadian social policy was broadly premised on notions of shared risk and regulated capitalism. With the entrenchment of neoliberalism in the 1980s, however, social risk effectively shifted to the level of the individual, and welfare state policies became primary targets for reform (P. Armstrong, 2010). In British Columbia, the BC Liberals implemented a series of sweeping health and social reforms throughout their 16-year tenure (2001-2017) that solidified the ideals of neoliberalism across the province's health, labour, and social service sectors. While the tacit introduction of neoliberal policies in the province began in the 1990s under the

socially democratic New Democratic Party, the election of the BC Liberals in 2001 marked the beginning of a concerted effort to dismantle the welfare state through dramatic reductions to social service spending, tax cuts for the wealthy, attacks on collective bargaining, reductions to welfare eligibility, and an expansion of private sector investment (Mcbride & Mcnutt, 2007; Morrow, Hankivsky, & Varcoe, 2004; Teghtsoonian, 2009).

Under the BC Liberals' "New Era" reforms, the health care sector became a primary target for neoliberal restructuring. In 2001, the province's health authorities were reduced from 52 to six: one provincial-level coordinating authority, and five regional health authorities (RHAs), of which the VCH is one. As Whiteside (2015) describes, along with restructuring came a reorientation in health authorities' focus from service provision to *fiscal performance management* (p.75). First, as provincial health budgets were constricting, responsibility for hospital infrastructure and planning transferred to the RHAs (Whiteside, 2015). As such, Whiteside (2015) explains, RHAs were tasked with implementing cost-cutting measures to align with the new austerity-driven agenda. Second, the Ministry of Health introduced mandatory three-year performance agreements, which outlined RHAs' expected performance deliverables (Whiteside, 2015). Fiscal conservativism – a feature of neoliberal economic policy – was the foundation of the new performance agreements, which according to the Ministry of Health Services' 2001/02 Annual Report held "health authorities across BC accountable for dollars spent and the effectiveness of health service delivery" (BC MoHS, 2002, p. 11). Third, the Minister of Health appointed new board members to the RHAs, and

prioritized those not just with backgrounds in healthcare, but those with expertise in business management (Whiteside, 2015), and a "willingness to be accountable through performance agreements" (BC MoHS, 2002, p. 6). These shifts, according to Whiteside (2015), opened the gates to private sector investment in BC's health sector and reoriented RHAs – including VCH – towards private sector models of governance.

In the 2003/04 fiscal year, the BC Ministry of Health Services' Annual Service Plan Report articulated a strategy to "Embed sound business practices and a business management culture within the Ministry of Health" (BC MoHS, 2004, p. 75). The report elaborates, "The ministry is undergoing a culture shift … [that] emphasizes *structured business planning and performance monitoring* as the new standard" (BC MoHS, 2004, p. 75, emphasis added). Twelve years later, in the BC Ministry of Health Service Plan Report for 2015/16-2017/18, neoliberal goals of fiscal efficiency and performance monitoring continued to direct the policy priorities of the BC health authorities. As stated in the report under Goal Three, "Ensure Value for Money":

> A focus on performance and budget management and efficiency, along with collaboration and quality improvement, must be continually pursued in partnership with health authorities and other stakeholders to ensure our publicly funded health system is effective and affordable. (MoH, 2015, p. 13)

Although in the 2017 provincial election the New Democratic Party won a minority government – marking a potential shift in the ideological orientation of the province for the first time in 16 years – it was under the BC Liberals, and with over a decade of institutionalized neoliberal policy that the 2GHSS was developed.

THE SECOND GENERATION HEALTH SYSTEM STRATEGY

In response to the disjointed landscape of health service provision in the DTES, the 2GHSS design paper was released in 2015, laying the foundation for a series of changes to funding priorities and service delivery in the DTES health system. In planning for a "new generation" of DTES health services, VCH engaged in two-years of community consultations. Three "Discussion Papers" were commissioned through this process, which reported feedback from community health organizations (Campbell, 2012), VCH staff (Campbell, 2013), and DTES "clients" (Karp & Livingston, 2014). All three papers critiqued VCH in their role as a funder, service provider, and partner, and highlighted, for example: frustration over a lack of a coordinated vision for the DTES (Campbell, 2012, 2013; Karp & Livingston, 2014); the need for significant contract reform (Campbell, 2012, 2013); a culture of top-down governing (Campbell, 2012); lack of transparency (Campbell, 2013); lack of community inclusion in decision-making (Karp & Livingston, 2014); and insufficient services for women (Campbell, 2012) and Indigenous people (Karp & Livingston, 2014), among other concerns. Community agencies and organizations were particularly critical of VCH, faulting the health authority for being too "too distant and bureaucratic, … failing to adequately engage the community as equal and respected partners. … [And] contributing to a precarious funding environment" (Ostrow, 2013, pp. 1–2).

In response to the feedback, VCH detailed five new approaches to guide the delivery of health care in the DTES through the 2GHSS. As articulated in the design paper, the new priority areas are: [1] to strengthen relationships – with Indigenous

stakeholders, DTES clients, and government partners; [2] to expand care teams and competencies – through peer-based supports, standardized competency training, and interconnected services; [3] integrate services to provide better-coordinated care – through integrated community health centres, services, and clinics, treatment continuums, and a common client database; [4] align services with client demand – by implementing a series of new harm reduction initiatives, a housing continuum, and improved services for families and children; and [5] achieve performance excellence – by providing opportunities for client feedback, and standardizing service definitions and outcome measures across direct and contracted services (VCH, 2015a). Although the priority areas are broad in focus, the unifying themes throughout the policy paper are enhancing access to (clinical) health services, reducing silos in care, and developing a more coordinated health system in the DTES.

In 2016, after women-centred organizations critiqued the 2GHSS for failing to address the health needs of DTES women (VCH, 2016b), VCH released a companion paper focused on women's health and safety in the DTES. The paper outlines seven priority areas to address the lack of supports for women's health services in the DTES: [1] develop clinical health services that respond to the unique needs of women; [2] ensure safe, welcoming and relevant services and programs for women; [3] recognize violence against women as a systemic and urgent priority; [4] use an Indigenous cultural safety lens across DTES services; [5] address gaps amongst hardest to reach women in the DTES, including sex workers, LGBTQ2 people, and elders; [6] keep families together and support women's reproductive health; and [7] provide leadership and collaboration

within VCH and across sectors (VCH, 2016b). In contrast to the 2GHSS, the companion paper uses a gender lens to assess the DTES health landscape, and acknowledges that systemic gender and racial oppression, and histories of violence, inform the ways many women experience care in the community (VCH, 2016b). The paper also highlights the dramatic inequity in funded services available for women in the DTES, and emphasizes the need for more women's only services (that are inclusive of all women-identified people). Despite the more critical tenor of the women's paper as compared to the 2GHSS – perhaps a product of the report being drafted not only by VCH personnel, but also by DTES women's organizations, and Dr. Kate Shannon, Director of the Gender and Sexual Health Initiative at the BC Centre for Excellence in HIV/AIDS – the key action areas remain located primarily within the clinical sphere.

LITERATURE REVIEW

A considerable body of interdisciplinary, critical health, and social sciences scholarship has examined the manifold manifestations of neoliberalism within Canadian health policy and practice. From this literature, two central and interconnected themes are particularly relevant for an analysis of the DTES third sector contracting environment following the implementation of the 2GHSS: [1] medical dominance, or the prioritization of the biomedical paradigm within health policy, research, and practice, and [2] the ways in which neoliberalism indirectly governs through contract relations with the third sector.

Medical Dominance in Health Policy

The biomedical paradigm dominates conventional conceptions of health across research, policy, and practice. Fundamental to the biomedical paradigm, as Clarke and

colleagues (2003) explain, is the "extension of medical jurisdiction… over health itself and the commodification of health (p. 162). Within biomedical approaches, the medical model is paramount and health and illness are primarily understood as biological phenomena – isolated from social and physical contexts – and located at the level of the individual body (P. Armstrong & Armstrong, 2002; Raphael, 2000). The doctor and the trained medical professional hold privileged positions in the medical model, and expert knowledge is prioritised at the expense of other forms of knowledge and experience (Popay & Williams, 1996; Raphael & Bryant, 2002). As biomedical perspectives are rooted in positivist thought, research and evaluation methods tend to focus on "the concrete and the observable" (Raphael, 2008, p. 407), and quantitative, evidence-based analysis heavily informs the orientations of health policy and practice (Raphael, 2000).

The evidence-based movement is a cornerstone of the contemporary medical model. In 1991, clinical epidemiologists working at McMaster University coined the term "evidence-based medicine" (EBM) (Mykhalovskiy & Weir, 2004). By 2007, the *British Medical Journal* listed EBM as one of the 15 most important medical milestones since the journal's inception in 1840 (Dickersin, Straus, & Bero, 2007; Godlee, 2007). Rosenberg and Donald (1995) define EBM as "the process of systematically finding, appraising, and using contemporaneous research findings as the basis for clinical decisions" (p. 1122). Since the 1990s, EBM has experienced a "meteoric rise in popularity" (Zimerman, 2013, p. 71), and as Mykhalovskiy and Weir (2004) explain, evidence-based principles have permeated beyond the bounds of medical practice into health administration, biomedical research, editorial policies, the allied health

professions, and beyond. In the health policy context, evidence-based decision-making – an extension of EBM – has become central to the processes of both health policy development and healthcare reform (P. Armstrong et al., 2008).

Critical perspectives

The hegemony of the biomedical model and accompanying evidence-based methods has been subject to extensive critique and analysis across critical research disciplines. Feminist health scholars have long troubled traditional knowledge hierarchies in health, and have been central in challenging narratives of "objectivity" and "neutrality" within positivist health research. A significant contribution of feminist health scholarship has been making visible the continued exclusions of women and gender from scientific inquiry and discourse (Wylie, Okruhlik, Thielen-Wilson, & Morton, 1989). Gendered exclusions have been well documented across the academic health landscape, including in clinical research design and funding structures (Sen, Ostlin, & George, 2007), occupational health (Messing & Mager Stellman, 2006; Rochon Ford & Sweeney, 2015), and health policy development (Hankivsky, 2007; Tudiver, 2015). In illuminating the persistent absence of gender-based analyses within traditional health research and policy, feminist perspectives have destabilized normative assumptions about the objectivity of the scientific method and the impartiality of the evidence-based approach.

In their paper reviewing women's occupational health, P. Armstrong and Messing (2014) identify a number of epistemological tensions that hinder the acknowledgement of women's experiences in health research. While their discussion is grounded in an analysis of gender and occupational health, several of the tensions identified speak to

broader paradigmatic clashes between scientific and critical approaches, and help illuminate why certain types of evidence and knowledge continue to be excluded from biomedical research and policy. One such tension is the divide between qualitative and quantitative research methods. In the health context, qualitative research frequently generates detailed, descriptive data focused on "how people experience health and illness, and the context in which people have these experiences" (Morrow & Hankivsky, 2007, p. 107). As J. Eakin (2016) explains, however, qualitative methodology has a history of being perceived as anecdotal and is oftentimes relegated to the periphery of health research in favour of quantitative methods. Critical health researchers have been vocal in opposing characterizations of quantitative methods as inherently objective, pointing out, as H. Armstrong, Daly and Choiniere (2016) do, that whether quantitative or qualitative "the evidence depends on what the researcher (or the provider or the manager) deems to be relevant and significant" (p. 351). Nonetheless, examples of qualitative research being marginalized persist across the spectrum of health policy and research, including in the dominance of quantitative teaching paradigms within the university (J. Eakin, 2016), the resistance of formal health bodies to engage with the findings of critical, qualitative research (Mykhalovskiy et al., 2008), and the marginal use of qualitative knowledge in the production of health policy (Tudiver, 2015).

In the context of health policy development, Jackson and Haworth-Brockman (2007) posit that policy analysts' resistance to incorporating qualitative research stems not just from incongruities in methodological ideology, but also from a lack of practical application capacity. The process of "context stripping" (Raphael & Bryant, 2002) in the

positivist health sciences – where the research design controls for factors such as socioeconomic status, class, gender, socio-political structures, and social location – is employed to help yield evidence that is presumed reliable, factual and universal. For critical researchers, however, the particular physical, material, social, political, and historical structures within which health and care are located are not viewed as "contextual 'noise'", but rather considered essential to understanding the complex relational dynamics that permeate experiences of health (P. Armstrong & Messing, 2014, pp. 5–6). Despite a general acknowledgment that more diverse forms of research are needed within health policy development, policy analysts are not typically trained in the interpretation of qualitative data, and rarely does qualitative research actually factor into the evidence-based, decision-making process (Jackson & Haworth-Brockman, 2007).

The authority of positivist approaches extends beyond the confines of research, and critical scholars across health disciplines have problematized the hegemony of top-down, expert knowledge in health practice. Much of the literature questioning the dominant role of the medical expert highlights the exclusions of "lay knowledge", – or knowledge "derived from lived experience" (Raphael & Bryant, 2002, p. 195) – and emphasizes the critical value these perspectives bring to health policy and practice (Popay & Williams, 1996; K. E. Smith & Anderson, 2018). Despite increasing attention towards "community engagement" strategies within health policy and promotion literature (De Weger, Van Vooren, Luijkx, Baan, & Drewes, 2018; Milton et al., 2012), research like Warr, Mann, and Kelaher's (2013) illuminates how trends of professionalization and the declining influence of "social action ideologies" (p. 96)

stymie the capacity of formal health organizations to understand local health contexts and engage with knowledge outside the professional sphere. Beyond the problematic exclusions of lay and experiential knowledge from health practice and policy, critical feminist researchers have illuminated how certain types of work and skills *within* the health and care sector are similarly dismissed and deemed "ancillary" to more "legitimate", professionalized roles (P. Armstrong et al., 2008). As P. Armstrong (2013) explains, many essential skills of care – particularly the relational and social components of care – are not measurable or immediately visible, and therefore not deemed of value within the formal health system. P. Armstrong (2013) argues there is a need to trouble the distinction between the celebrated "hard skills", and the dismissed "soft skills" in health research, and recognize that "skills are not exclusively about readily observable capacities, job descriptions, or credentials" (p. 102), rather, they are social constructions that reflect dominant value assumptions as well as relations of power.

Intersections with neoliberalism

The authoritative rise of the biomedical paradigm, EBM, and positivist methodologies have not occurred in a vacuum, and critical researchers have made visible the connections between epistemological hierarchies and the encompassing reach of neoliberal ideology and governance. As J. Eakin (2016) describes, in a research and policy environment where funding is largely tied to the priorities of policy makers, qualitative inquiry – which explores contextually specific (and in some cases politically inconvenient) phenomena like relations of power – continues to be considerably less competitive in traditional funding than quantitative research (p.110). In contrast, evidence

derived from positivist methods, which is removed from the social, political, and relational factors of health, can at times be used as "evidence-based" justification for neoliberal policies aimed at reducing social spending. As Denny (1999) explains, in health policy discourse EBM has become synonymous with cost-effectiveness and cost-efficiency:

> the unquestioned assumptions in EBM that health care is too expensive and that spending needs to be reduced, along with the related failure to consider who has a stake in perpetuating these assumptions, closes down broader debates on social spending and the ways in which working to reduce inequalities in the distribution of wealth might be a viable alternative to unremitting cost-cutting. (p. 259)

While efforts to reduce health expenditures may on the surface seem innocuous, Denny (1999) argues these assumptions are often located within an ideologically-charged environment that draws on positivist tools to support policies of austerity.

Critical health research, particularly from the FPE perspective, has made visible the damaging impact policies developed out of positivist principles and neoliberal ideologies can have for people working within the health and care sectors. In their study of carework in Canadian residential care facilities, Banerjee and colleagues (2015) illuminate how "epistemic marginalization" (p. 34), or the "disconnect between those who have knowledge of carework and those who design policy" (p. 34), results in significant information gaps that impact care quality at organizational and policy levels. Drawing on Shiva's (1988) concept of "epistemological violence", Banerjee et al. (2015) frame the dismissal of careworkers' knowledge as a form of violence that is borne of the

"reductionist worldview" (p.34). In Banerjee et al.'s (2015) discussion, "epistemological violence", which sits at the nexus of reductionist science and the particular economic organization of modern capitalism (Shiva, 1988), reveals that violence in the health sector can be enacted not just through physical means, but also through reductionist and hegemonic ways of knowing.

Neoliberal Governance in the Third Sector

The "third sector" refers to the range of organizations that operate outside of the public and private sectors, and is often used interchangeably with the terms "non-profit sector", "voluntary sector", and "community sector" (Lyons, 2001). While there is considerable variety in the sizes and capacities of organizations that make up this sector, third sector organizations have historically had a central role in the advocacy of marginalized populations otherwise overlooked by mainstream government initiatives (Carey, Braunack-Mayer, & Barraket, 2009; Lyons, 2001). As Evans, Richmond, and Shields (2005) explain, in the post-war, Keynesian era, non-profit organizations were not viewed as a replacement to public services; rather, they functioned as an extension of the public sector and filled gaps missed in the uniform service provision of the state. With the entrenchment of the neoliberal agenda in the 1980s, however, governments in search of "cost-effective" service provision have increasingly offloaded the delivery of public services onto organizations of the third sector (Baines, Cunningham, & Fraser, 2011; Carey et al., 2009). This shift has resulted in the institutionalization of indirect forms of governance, New Public Management, and the fundamental restructuring of public-third sector relations.

In his typology of welfare state regimes, Esping-Anderson (1990) groups nation-states according to their relative "de-commodification", or the degree to which individuals and families are not reliant upon the market to provide the basic necessities of life. The most "de-commodified" countries are the social-democratic welfare states – the Scandinavian countries, for example – while on the opposite end of the spectrum are the liberal welfare states, countries like Canada, the United States, and Australia, where the political economy is governed by logics of the free market (Esping-Andersen, 1990). Informed by doctrines of neoliberalism, liberal welfare states have increasingly relied upon competitive contracting to out-source public service provision to third and private sector organizations. H. Armstrong (2013) elaborates:

> Neoliberalism encourages states to restrict themselves to steering but not rowing the ship of state, leaving outsourced service delivery to those private establishments that win time-limited contracts that emphasize outcomes, not inputs and processes. NGOs and even existing government departments are usually welcome to compete for these contracts, on the condition that they follow marketplace logic. (p. 191)

Within these neoliberal arrangements, punitive and compliance-based systems of contract funding act as the mechanism to extend the reach of the state into the third sector, and in so doing, facilitate the transfer of private sector organizational models into the management of the voluntary sector (Baines, Charlesworth, Turner, & O'Neill, 2014). As a result, new decentralized modes of control – or third sector "shadow states" (Wolch, 1990) – have come to define governance within liberal welfare states (Evans et al., 2005).

Contract governance

According to H. Armstrong (2013), the concept of "governance" recognizes that state power can be wielded beyond the bounds of the state sector. Within neoliberal governance regimes, as Evans et al. (2005) explain, there is a prevailing assumption that multiple bodies outside the public sector should be involved in the delivery of public services, and that the role of the state lies not in service provision but rather in the co-ordination and restructuring of public policy. To realize the goal of "maximal governance with a minimal state" (Ilcan, O'Connor, & Oliver, 2003, p. 623), neoliberal governments have engaged in contract funding relations with the third sector that shift the accountability of community organizations from that of their communities to that of the state (Evans et al., 2005). Ilcan and colleagues (2003) name this particular expression of neoliberal governing through the third sector "contract governance".

Funding through contracts marks a significant shift in the delivery of public funds to the third sector: prior to the retrenchment of the welfare state, voluntary organizations typically received core funding through grants that allowed them flexibility and autonomy in the distribution of funds (Woolford & Curran, 2011). In the neoliberal era, however, short-term funding contracts are increasingly contingent upon the delivery of *individual* programs and services (Ilcan & Basok, 2004; Woolford & Curran, 2011). As there are often limited resources for programs not directly funded by the state, "contract funding", or as L. Eakin (2001) defines it, "the purchase of defined services with specified outputs and closely controlled funding" (p. i), provides neoliberal governments considerable influence over the activities and orientation of community organizations. This funding model, Evans et al. (2005) explain, is based on principles of market

competition and access to government contracts is usually mediated by an open-bidding process that places third sector organizations in direct competition with one another. In a political and economic context of austerity, competitive tendering increases pressures on organizations to reduce their spending, and through neoliberal managerialism, penalizes those deemed fiscally or administratively inefficient (Ilcan et al., 2003).

To lower the expenditures of contracted organizations and to increase accountability to the state, private sector managerial models such as New Public Management (NPM) have increasingly become prerequisites to government funding. As Baines (2006) articulates,

> NPM is a model of performance management in which public and non-profit social service organizations are encouraged to think of themselves as "business units" and to meet quantitative measures that take the form of performance goals, benchmarks, and ongoing evaluation. (p. 199)

In relying on statistical data and quantifiable outcome measures to evaluate the relative success of contracted programs, NPM models epistemologically align with the positivist paradigm and evidence-based movements. As Ilcan and Basok (2004) explain, in order to meet the rigorous reporting requirements and demonstrate *tangible* outcomes to program funders, voluntary agencies are increasingly focused on providing measurable services at the expense of non-quantifiable activities like social and political advocacy work. Trends of professionalization and bureaucratization as a result of contract funding have led to concerns over legitimacy and the capacity of third sector organizations, particularly CBOs, to remain responsive to the needs of their communities (Carey et al., 2009; Fyfe &

Milligan, 2003). As community organizations have become increasingly dependent upon government funds for the bulk of their operating budgets (Evans et al., 2005), many are left in the precarious position of having to comply with managerial contracting requirements or risk their funding termination.

Experiences of contract relations

The consequences of contract governance for third sector organizations in liberal welfare states has been well documented in qualitative research from the social, health, and political sciences. Critical literature examining the changing dynamics of non-profit health and social service organizations has illustrated the processes through which organizations have become distanced from their communities, depoliticised, and heavily orientated towards fiscal efficiency. In their study of social service non-profits in Winnipeg, Woolford and Curran (2011) illustrate how the neoliberalization of Manitoba's non-profit sector has produced "relational distance", or obstacles preventing relationship building between non-profits and those relying on their services (p. 589). From their interviews with non-profit service providers, Woolford and Curran (2011) identify four trends that contribute to this distancing: entrepreneurialism, competition, accountability, and community offloading. These themes are reflected throughout the literature.

Contract funding and NPM models, as Woolford and Curran (2011) explain, have not only increased pressures on community organizations to become more business orientated and entrepreneurial, but have also heightened overall competition and funding precarity within the sector. With the shift towards short-term, program-specific funding,

Woolford and Curran (2011) found that Winnipeg non-profits dedicate considerable resources to maintaining existing funding arrangements – often by demonstrating clear program deliverables to funders – while also continually seeking new sources of funding. As Woolford and Curran's (2011) research illuminates, in a competitive environment that prioritizes fiscal efficiency over social value, those professionalized organizations with strong communication capacities and business acumen are often more successful at maintaining funding streams than those focused on social advocacy and individual service provision. Similarly, Carey and Braunack-Mayer's (2009) case study of the Oliver Smith Council – an Australian CBO for people affected by Hepatitis C – illustrates how organizations willing to shift organizational focus and adopt the priorities of the government can succeed in precarious funding contexts.

As well as through competitive, market-orientated funding environments, relational distancing, according to Woolford and Curran (2011), occurs through metrics of accountability, and the hierarchical power dynamics of community offloading. In the Winnipeg non-profit sector, Woolford and Curran (2011) found that NPM and the reliance on evidence-based principles impede organizations' ability to respond to context-specific community needs not captured in universalized best practices. Through her research on Canadian social service workers, Baines (2006) similarly found that NPM, and pressures to meet quantitative performance targets, hinders the capacity of social service organizations to address the unique needs of people who require longer appointment times and non-standardized supports. These constraints restrict what Baines (2015) calls the "non-profit ethos", or service provision that is altruistic, advocacy-based,

representative of service users, and social justice oriented. Accompanying the erosion of the non-profit ethos is the depoliticization of community organizations. With public service provision being offloaded on to the third sector, government funders have heightened influence over both the management and the ideological orientation of non-profits. As Woolford and Curran (2011) describe, given that government-funding cuts leave many third sector organizations without alternate funding sources, and in some cases unable to operate, third sector organizations are increasingly reticent to position themselves in political opposition to the state.

Critical health scholarship has illuminated how neoliberal ideology permeates health both epistemologically, through deference to the positivist paradigm in health policy development and research, and structurally, through the reorientation of the third sector to align with the priorities of the state. Within the literature, the intersections of EBM, the marginalization of qualitative research and non-expert perspectives, contract governance, NPM, agendas of austerity, and depoliticization are illuminated in health contexts across liberal welfare states. The remainder of this paper explores the ways in which these trends manifest within the contracting environment for community health organizations in the DTES.

METHOD: THEORETICAL THEMATIC ANALYSIS

To evaluate the effects of the 2GHSS on the landscape of contracting relations in the DTES third sector, a thematic analysis was conducted on a variety of documents relating to the 2GHSS from VCH, CBOs, and local media between the period of 2015 and 2019. This timeframe was chosen to map changes in the DTES contracting

environment in the four years since the strategy's implementation in February 2015. According to Braun and Clarke (2006), thematic analysis is a flexible method for organising, interpreting and analysing patterns of meaning – or themes – across a range of qualitative data (p.79). Rather than focusing on the frequency of particular words or phrases, as Guest, MacQueen, and Namey (2012) explain, thematic analysis explores explicit and implicit *ideas* across reviewed sources (p. 10), and is particularly suited to "capturing the complexities of meaning within a textual data set" (p. 11).

In thematic analysis, themes can be identified both inductively (data-driven), or deductively (theory driven) depending upon the methodological goals of the researcher (Braun & Clarke, 2006). Given the explicit theoretical orientation of this paper, a deductive approach, or a *theoretical thematic analysis* was chosen in order to interpret data through the lens of the theoretical framework, topic literature, and primary research question (Braun & Clarke, 2006). The foundational question underpinning the research was articulated by the primary research question: to what extent do trends of medical dominance and neoliberal governance shape the contracting environment for community organizations in the DTES following the implementation of the 2GHSS? Themes from the literature in combination with the analytical framework of FPE helped focus the data and identify patterns across reviewed documents. FPE shaped the interpretation of the data, and the accompanying question of 'who benefits and who is left out' was returned to through the analysis.

Identifying documents for review was an iterative process that involved hand searching the VCH general website and 2GHSS-specific website, CBO websites, local

media, and submitting a request for information to VCH. Any sources from between 2015 and 2019 that addressed the impacts of the 2GHSS in relation to contracted services, or that contextualized the contracting environment (for example, financial documents) were considered relevant. A sample of reviewed documents includes: press releases from VCH announcing new contracted service providers as part of the 2GHSS, statements from CBOs who lost or gained funding with VCH, information from CBOs' websites describing programs, services, board of directors, etc., CBOs' annual reports, program evaluation reports, local news articles reporting the impacts of the 2GHSS on community organizations, and VCH's annual expenditures in the DTES. Through the process of theoretical thematic analysis, four themes were identified that together illuminate the ways in which trends of medical dominance and neoliberal governance have intensified in the DTES contract funding environment following the 2GHSS: [1] organizations failing to demonstrate a "clear health mandate" have experienced funding losses; [2] the competitive RFP process has fostered tensions in the DTES third sector and benefits organizations that align with the clinical orientation of the 2GHSS; [3] new contract funding opportunities have emerged for clinically focused women's-only services as a result of the opioid epidemic and 2GHSS; and [4] organizations' dependence on VCH has intensified their experiences of financial precarity, particularly within an environment of funding constraint.

FINDINGS

1. Organizations failing to demonstrate a "clear health mandate" have experienced funding losses.

On September 3rd 2015, VCH published a news release announcing the first phase of changes being made to health service delivery in the DTES as part of the 2GHSS. The new initiatives focused on creating improved linkages between clinical health services and DTES "clients" through a range of new programs, including: a drop-in model for mental health and addictions with stronger connections to health services, low threshold addictions services, a peer navigation program, increased hours for Insite, and a pilot program to improve transitions from acute care (VCH, 2015b). The news release made clear that new programs for the 2015/16-fiscal year were not being funded through an increase to the DTES operating budget; rather, funds would be reallocated from existing services. According to the statement, contracted services failing to demonstrate a clear connection to the formal health system were at risk of funding termination:

> VCH's $55 million funding envelope for DTES programs and services will remain unchanged, meaning new programs and services will be funded by reallocating existing resources. As such, VCH contracts without a clear health mandate or those offering stand-alone services without formal connections to health care services may not be renewed. (VCH, 2015b)

In the year following the implementation of the 2GHSS, three CBOs with long-standing annual contracts lost the entirety of their VCH funding (Lupick, 2016c). In 2018, VCH announced the termination of a funding contract for a community health program that had been in operation for over 20 years (VCH, 2018a). While these community health organizations and programs differed in size and focus, they shared being embedded in the DTES community and offering services beyond the traditional scope of the biomedical

model.

Gallery Gachet. Founded in 1992, the Gallery Gachet is a non-profit artist-run-and-governed collective in the DTES that, according to their website, uses art to "demystify and challenge issues related to mental health and social marginalization" (Gallery Gachet, 2019). On September 2, 2015, Gallery Gachet learned their contract with VCH had been terminated after 21 years of receiving core funding from the health authority. In response to the severe funding cuts, Gallery Gachet (2015) released a media statement, claiming their funding had been severed for failing to align with the new clinical orientation of DTES contracted services. In their statement, Gallery Gachet opposed the characterization of their organization as not having "a health mandate", and instead framed their contribution to health in the DTES through their inclusive community space, non-hierarchical environment, and commitment to social justice among other non-clinical supports:

> The decision to remove funding from the Gallery Gachet, made by VCH management, cited the Society's role as not fitting with the "clinical" services that will become the focus for the Downtown Eastside neighbourhood. The organization's relationship to a health mandate, and/or to the health care system, was not addressed. …Our mandate supports artistic development as a means to achieve social, cultural and economic justice and supports the wellness of, and the elimination of discrimination against, people marginalized by their mental health, trauma and/ or abuse experience. (Gallery Gachet, 2015)

For VCH, in not having direct links to the formal health system, Gallery Gachet represented a siloed service incompatible with the goals of the 2GHSS. In a 2015 interview with the newspaper *The Vancouver Sun*, a senior media relations officer for VCH explained the Gallery's funding would be redirected towards health services with art as an *added* activity, rather than as the program's guiding ethos: "What we will be doing with the money is reinvesting it into mental health and addiction drop-in services, which will have an art-focused activity" (Griffin, 2015). Despite losing their VCH contract, Gallery Gachet has maintained operations in the DTES. According to their website, the Gallery continues to be supported by the Government of BC, the City of Vancouver, and The Canada Council for the Arts (Gallery Gachet, 2019).

The Drug User Resource Centre (DURC). The DURC was a user-run community centre providing grassroots supports for DTES community members, with a particular focus on people with addiction to alcohol and drugs. As described on their now defunct website, DURC offered a "broad spectrum of services" with both clinical supports (on site primary care and a methadone clinic), and a range of non-clinical, social justice oriented programs, including: the Women's Action Group, the TRANS collective, the Political Action Group, Cree class, First Nations Sacred Space and Drum Group, a Home Brew Co-op and alcohol exchange, therapy for crack users, Narcan training, and many other programs (DURC, 2016). Most of the DURC programs were peer-run – the Women's Action Group, for example, provided DTES women a safe space to gather and receive weekly connection, support, and advice from other women living in the community. As described in an article memorializing the DURC from the activist,

community-based newspaper, *The Volcano*, the mission statement of the Women's Action Group embodied principles of peer-based support and grassroots advocacy:

> "We are the women who have survived all that poverty, homelessness and addiction could throw at us. We are present and former drug users, sex workers and now survivors. We are fighting for the right to proper health care [and] decent housing." (Diewert, 2017)

In addition to programming, according to their website, DURC provided a "safe, supportive and welcoming space", access to community, and basic necessities like showers, laundry, haircuts, food, and computer and phone use (DURC, 2016). While the Portland Hotel Society – one of the largest health and housing non-profits in the DTES – operated the centre, the DURC was peer-run and- governed, and as described on their website, had a member-elected advisory board consisting exclusively of peer community members (DURC, 2016). The DURC was a central gathering space for the community, and according to reporting by *The Georgia Straight*, had as many 800 to 1500 people visiting the centre each day (Lupick, 2016a).

On April 7, 2016, VCH announced plans to fund a new Mental Health and Substance Use drop-in centre in the DTES that would replace the DURC (VCH, 2016a). As will be explored in the next section, the contract for this new program was awarded to another DTES non-profit – Lookout Housing and Health Society – via a competitive request for proposal (RFP) process. When asked in a March 2016 interview with the newspaper, *The Georgia Straight,* why the RFP process had been initiated for DURC, a spokesperson for VCH stated that "'This is to consolidate services'" (Lupick, 2016a). In

a May 2016 interview with the same newspaper, Coco Culbertson, a program manager with the Portland Hotel Society (the umbrella organization contracted by VCH to run the DURC), expressed concern over VCH's renewed emphasis on clinical rather than community services:

> "From the PHS [Portland Hotel Society] Community Services Society's perspective, nonclinical, nonmedicalized, and noninstitutional approaches to care are at the heart of what we do and why we've been successful in engaging thousands of people every day in the Downtown Eastside … I would hope that VCH will continue to value those interventions." (Lupick, 2016b)

DURC was unable to secure alternative funding sources and while a few of their programs have continued to operate sporadically at varied locations across the DTES, the facility functionally closed in 2016.

ARA Mental Health. ARA Mental Health was a DTES non-profit organization providing individual advocacy services for people living with disabilities and mental illness. As reported in *The Georgia Straight,* ARA Mental Health assisted people in navigating a range of bureaucratic processes, including applying for welfare payments, filling out housing and tenancy applications, and disputing evictions, among other services (Lupick, 2016c). Unable to sustain their funding after losing their contract with VCH, ARA Mental Health closed their offices August 31, 2016. In an August 2016 interview with *The Georgia Straight* shortly before the organization closed, the executive director of ARA, Stephen Findlay, explained that despite trying to find alternate funding

sources, the value of social health service programs like ARA Mental Health are non-quantifiable, and therefore less attractive to program funders:

> “In mental-health care, you don’t get the job done in six months, 12 months, or 18 months,” Finlay explained. “It is years and years of ongoing struggle to provide a decent mental-health service. And so you don’t get results that you can throw on a corporate webpage. Sometimes, the result is, ‘He is still alive’. And we in the business, we know that is a huge success. But it’s not the kind of thing that gives you PR benefits." (Lupick, 2016c)

Positive Outlook Program (POP). The POP was an Indigenous-run, drop-in space for HIV-positive people in the DTES – predominantly Indigenous people – to access medical care and treatment, social services, and meals. The program started in the late 1990s in response to the HIV/AIDS crisis in the DTES and was operated by the Vancouver Native Health Society (VNHS) – a DTES non-profit established in 1991 to, as described on their website, “address the lack of healthcare for urban Indigenous people in Greater Vancouver” (VNHS, 2018a). In partnership with community and provincial agencies, the VNHS operates upwards of 10 health and social service programs with an emphasis on integrating Indigenous knowledge into community service provision.

The POP offered a combination of western medicine, Indigenous health practices, and social services for HIV-positive adults in the DTES. As described in the VNHS 2012/13 annual report, the POP was premised on a low-barrier treatment model that supported culturally appropriate care and provided access to physicians, nurses, social workers, addictions counsellors, Indigenous elders, and a daily hot meal (VNHS, 2013).

According to the now defunct POP page on the VNHS website, as well as access to health services, the POP provided multiple therapy modalities (group therapy, peer therapy, art therapy, music therapy), emergency housing assistance, health system navigation, Indigenous talking circles, Indigenous drum making, and men's, women's, and youth health support groups (VNHS, 2018b). On August 9, 2018, VCH announced that funding for the POP had been awarded to a newly formed organization in the DTES – The Urban Indigenous Health and Healing Cooperative (UIHHC) – following a competitive RFP process (VCH, 2018a). In conversation with the newspaper *The Star Vancouver* in August 2018, Dr. Patricia Daly, the chief medical officer of VCH, framed the funding transfer as part of an effort to reorient VCH's approach to HIV/AIDS care from that of treatment focused, towards medical-based prevention:

> "The contract was in place a long time and when it was first set up, it was a time when HIV was a universally fatal disease," she said. "Now that HIV is a treatable condition, we have shifted focus to supportive care – *with a more medical focus* based on the principle of treatment as prevention." …"This contract is meant to have an Indigenous focus, and as part of the process the successful proponent would have to have that." [Emphasis added] (Seucharan, 2018)

As described in *The Star Vancouver* article, however, POP managers expressed deep concern that shifts in service provision would disrupt the 50-100 daily users of the program, particularly those with long-term relationships at POP (Seucharan, 2018). In a statement to *The Star Vancouver* in August 2018, VNHS board member, Adam Munnings, emphasized the value of trusted, culturally safe spaces in a context shaped by

the legacies of colonialism:

> "Aboriginal people within our community suffer from the traumas of Indian Residential Schools, intergenerational abuse and discrimination. They do not trust colonial institutions and come to us for services because of our unique makeup ...VNHS is working tirelessly to provide services to our community within the confines of colonialist bureaucracy and limited funding." (Seucharan, 2018)

VCH funding for the POP expired on September 30, 2018. VNHS attempted to maintain limited POP operations while seeking alternative funding sources, but was ultimately unsuccessful and the program closed in March of 2019.

2. The competitive RFP process has fostered tensions in the DTES third sector and benefits organizations that align with the clinical orientation of 2GHSS.

In the September 3, 2015 news release announcing the rollout of the 2GHSS, VCH explained they would be initiating an open request for proposal (RFP) process to find "qualified partner agencies to provide some of the new [2GHSS] services" (VCH, 2015b). As a result, contracts for certain existing programs were put up for bid on "BC Bid" – the centralized online service for public sector bid opportunities in BC – and made available to any organization wishing to compete. The contracts that provided funding to both the DURC and the POP were put up for bid through the RFP process.

Some organizational leaders and volunteers involved with DURC and POP, respectively, interpreted the RFP process as a veiled strategy by VCH to sever their long-standing funding relations in favour of other organizations. As reported by Lupick in *The Georgia Straight* in March 2016, the RFP that replaced the DURC asked for a program

proposal that mirrored the services already provided by DURC (Lupick, 2016a). In an interview with Lupick for the same article, a DURC volunteer and long-time advocate for drug-users, Dean Wilson, expressed his view that the RFP process was a mechanism to replace the DURC:

> "They took exactly what we have done for the last 10 years and then put it out to RFP so anybody can bid for more money," Wilson said. "But there should be two. This stuff that we do down here, I don't think they'll be prepared at their new centre to deal with." (Lupick, 2016a)

Prior to 2018, funding for the POP had similarly operated through annual contracts with VCH that were renewed each year without competitive bidding (Lupick, 2018). In conversation with Lupick for a March 2018 article for *The Georgia Straight*, the executive director of VNHS, Lou Demerais, expressed confusion over the abrupt turn to the RFP process: "'What we don't understand is why they [VCH] are doing it,' he said. 'They've never given us an explanation as to why it's necessary at this point. So we think there is some other motivation behind it'" (Lupick, 2018). Demerias also stated in the interview that the VNHS had been given less than a month's warning that the POP's funding was up for bid before the end of their contract, and he perceived the timing as tactical on the part of VCH: "'We think they're waiting until the last minute to weaken our chances of being able to re-apply'" (Lupick, 2018).

In shifting program funding and delivery from one community organization to another, tensions appear to have sparked among certain organizations in the DTES who disagree with the assumption that community health programs can simply be transferred

between service providers. For VNHS, which lost funding for the POP to the newly formed UIHHC, this resentment is palpable in a statement that appeared on the POP page of the VNHS website:

> Notwithstanding the program's [POP] successes as a primarily 'social' response to a medical condition amongst people who are poverty stricken and are mainly disconnected from their families and society, this year POP has had its funding cut off. The funding has been shifted to a medically-based organization [UIHHC] with scant little experience in social services, in what can only be labelled as a questionable process. (VNHS, 2018b)

While VNHS' critique of the UIHHC must be read in the context of having recently lost a competitive bid to UIHHC rather than as an objective characterization of the new organization, the statement illuminates how RFP processes can embitter relations within the third sector.

RFP Beneficiaries:

Lookout Housing and Health Society (Lookout). Lookout is a non-profit organization, established in 1971, that works in the DTES and across the Lower Mainland of BC providing social and health services, including housing, emergency shelters, medical and dental clinics, harm reduction outreach, and peer supports, among other programs. In 2016 Lookout was awarded the contract to operate a new "Mental Health and Substance Use drop-in centre", which had previously been under contract with the Portland Hotel Society to fund the DURC (VCH, 2016a). As described on the Lookout's website, the new drop-in centre, named "Powell Street Getaway", provides

many similar services to the DURC, including “a safe hang-out space”, access to food, peer-led programs, and vocational training (Lookout, 2018).

Where the Getaway appears to diverge from the DURC is in its integration with the formal health system. In the description of the Getaway on the Lookout’s website, the goal of providing a space that offers supportive programming *and* direct access to VCH clinical services is emphasized:

> The expansion of services [at Powell Street Getaway] is designed to create the space as a ‘hub’ where many services are offered, with particular emphasis on *supporting health referrals and outcomes.* We actively refer people in need to the Connections Clinic, operated by Vancouver Coastal Health, which is across the street. [Emphasis added] (Lookout, 2018)

It is also clear, from the Lookout’s 2015/16 annual report that the new drop-in centre was explicitly designed to align with the orientation and services of the 2GHSS:

> “A major achievement this year was Lookout’s successful bid to operate [VCH’s new drop in centre]…, *a new service which aligns with VCH’s Downtown Eastside Second Generation Strategy*. The Lookout Drop-In will complement VCH’s new low threshold addictions service that will open in the DTES this fall.” [Emphasis added] (Lookout, 2016, p. 3)

Another point of departure between DURC and Getaway is that – as previously described – peers (community members using the centre) were central in both staffing, and through the member-elected advisory board, governing the DURC. Although peers are included in program delivery at Getaway, there is no information on the Lookout website to

suggest the Getaway has independent peer *governance* structures.

Urban Indigenous Health and Healing Cooperative (UIHHC). The UIHHC is a newly formed health organization in the DTES that opened with the mission of integrating western medicine, Indigenous elders, and Indigenous healing practices into DTES primary care. As described on the UIHHC website, the cooperative care model does not tokenistically "make space" for Indigenous approaches to healing, rather Indigenous elders and healers are leaders in the cooperative and provide up to 50 percent of the care offered (UIHHC, 2018b). In 2018, the UIHHC won a three year VCH contract for the "Relational HIV Care Treatment and Support Program" replacing the annual funding for the VNHS' POP. While the VNHS has, as described above, accused the UIHHC of being a medically- rather than socially- oriented organization, given that the UIHHC has only recently begun operations (fall 2018), there is limited data to assess how clinically focused their programs will ultimately be. According to the (still developing) programs sections of the UIHHC website, as well as traditional healing and primary care, UIHHC will also have a strong research and education component and be a teaching site for UBC medical residents, and students in social services programs (UIHHC, 2018a). In a February 2019 UIHHC newsletter providing updates on the cooperative's development, it appears non-clinical interventions are also being incorporated, and programs like one-to-one sessions with Indigenous elders, healing circles, and art therapy are available (UIHHC, 2019).

A question that remains is how the transition to new service providers and a new location for HIV care has impacted the users of the POP. In the August 2018 press

release announcing the new contract for HIV care, VCH asserted: “There will be no service disruption for HIV positive clients” (VCH, 2016a). It is unclear, however, how many POP users have transferred their care to the new cooperative, or how VCH has supported this transition.

3. New contract funding opportunities have emerged for clinically focused women’s-only health services as a result of the opioid crisis and 2GHSS.

In 2017, VCH partnered in funding two new women’s-only health initiatives in the DTES: The Rice Block, a supportive housing program with 38 new substance-use treatment beds for women in post-detox recovery, and SisterSpace, the first women’s only overdose prevention site in Canada. The community organization contracted to run both programs, Atira Women’s Resource Society, is a 36-year-old non-profit that works in the DTES and across the lower mainland of BC to provide housing, outreach, and advocacy services to women-identified people experiencing violence, struggling with substance abuse, or needing supports in mental health (Atira, 2011). In their media releases announcing the programs, VCH framed the initiatives both as part of their commitment to support improved access to women’s health services through the 2GHSS, *and* as a contribution to the province-wide opioid epidemic response (VCH, 2017a, 2017b). In contrast to the contract transfers described above, funding for these programs does not appear to be a result of service reallocation, rather these are new jointly funded initiatives between VCH and other large funding bodies including, the City of Vancouver, BC Women’s Hospital, and BC Housing (VCH, 2017a, 2017b). While these programs represent new funding opportunities for women’s health services in the DTES,

they are primarily a clinical response to the acute opioid crisis.

The Rice Block. The 38 new beds at The Rice Block opened in January 2017 and are part of 500 substance-use treatment beds promised by the Government of BC, of which 131 are within the VCH region (VCH, 2017a). According to reporting by *The Vancouver Sun* from January 2017, The Rice Block uses an abstinence-based treatment program and admitted women are able to access supports for both short-term and longer term stays (six to 18 months) while they search for more permanent, safe housing (Ellis, 2017). The program is operated with a combination of organizational and clinical staff, including two around-the-clock staff members from Atira Women's Resource Society, a manager, a nurse practitioner, and a counselor (Ellis, 2017).

SisterSpace. SisterSpace opened in the DTES in May 2017 and is the first women's-only overdose prevention site in Canada. Research has found that many overdose prevention sites – centres where people can consume pre-obtained drugs under the supervision of staff trained in overdose intervention – are largely male dominated spaces where harassment, intimidation, and the reinforcement of gendered roles can occur (Boyd et al., 2018). SisterSpace was opened to minimize the barriers experienced by women seeking harm reduction services. As overdose prevention sites are designed to prevent overdose deaths via short-term supervised visits, they primarily respond to acute medical needs, and are a central strategy in the BC Ministry of Health's response to the opioid overdose public health emergency (Joint Task Force, 2017). While Atira's (2017) three month evaluation report of the program makes clear SisterSpace is committed to supporting the agency and emotional needs of women using the program – for example,

by staffing the site with peer support workers, offering guidelines for the space rather than punitive rules, and rarely enforcing the suggested 30-minute visit time (Atira, 2017) – they are still operating within a harm reduction framework and a mandate to connect women with a range of health services. As highlighted in VCH's (2017b) media release announcing SisterSpace, the program also provides access to an onsite nurse for primary care services, including chronic disease management, pregnancy testing, and testing and treatment for sexually transmitted infections.

When evaluating the development and impact of SisterSpace, it appears VCH has primarily been interested in recording the program's clinical outcome measures. As described in Atira's one-month evaluation report, the SisterSpace evaluation forms required by VCH focused only on quantitative program metrics like the number of women who register, the number of times women use substances, and the number of overdoses that occur (Thulien & Nathoo, 2017). In the three-month evaluation report, Atira explains that in order to incorporate the input of the peer support workers, the data collection had to expand beyond the narrow evaluation forms provided by VCH:

> the original data collection forms, which are provided by VCH, only collect information related to substance use and overdose response. The peer support workers suggested that an additional data collection form be developed to collect information about other services provided at SisterSpace. (Atira, 2017, p. 5)

4. Organizations' dependence on VCH has intensified their experiences of financial precarity, particularly within an environment of funding constraint.

For many health CBOs in the DTES, funding from VCH accounts for a majority

of program operation costs and a significant percentage of overall budget. As such, organizations and programs deemed incompatible with the priorities of VCH and the 2GHSS are faced with severe financial ramifications, and have been forced to either find alternative funders within tight timelines or close operations. For Gallery Gachet, the funding cuts, which accounted for 50 percent of the organization's total operating budget, put the Gallery into a state of crisis (Gallery Gachet, 2015). The severity of the funding cuts were described in Gallery Gachet's 2015 media statement:

> Gallery Gachet learned last week that after twenty-one years of receiving core funding from the Provincial Ministry of Health our contract with the Vancouver Coastal Health Authority is being severed, with ninety days notice. The financial cut amounts to half of the organization's overall budget, and represents the majority of wage and operational resources. (Gallery Gachet, 2015)

Through an intensive fundraising campaign Gallery Gachet was able to secure enough resources to continue operations despite VCH's funding cuts. Due to reductions in their funding budget, however, Gallery Gachet has moved out of their original location into a shared working space (Gallery Gachet, 2017).

With the recent cuts to the POP, VNHS was similarly left scrambling for funding. According to reporting by Lupick for *The Georgia Straight*, the funding loss for the POP represented the majority of the program's operating budget, and 16 percent of the VNHS total annual revenue (Lupick, 2018). On the former POP webpage, VNHS described a state of insecurity and asked for donations in order to help cover program costs:

> As we seek alternative funding, we are sustaining much of the program's services to

> meet the continued demand brought about by those who still rely on our daily drop-in center. Services will be continued for as long as our meager budget permits – as it stands, the program is being run with a reduced number of personnel and an extremely tightened budget. Monetary donations will be very gratefully accepted in any amounts! (VNHS, 2018b)

The financial uncertainty faced by CBOs following the 2GHSS has contributed to an atmosphere of anxiety within the DTES third sector. In a May 2016 article for *The Georgia Straight* – after the funding cuts to Gallery Gachet, DURC, and ARA Mental Health had been announced – Lupick described how several people employed by VCH-funded CBOs in the DTES would not go on the record about the 2GHSS for fear of funding retribution or breaching non-disclosure agreements:

> Several people who have spoken to the *Straight* on a regular basis in the past refused to go on the record for an interview about Second Generation. They cited fears of placing funding in jeopardy. Some pointed to *nondisclosure agreements that are now routinely built into contracts with VCH and even applications for VCH contracts*. [Emphasis added] (Lupick, 2016b)

As Lupick describes, these fears were illustrative of a community "in a state of extreme anxiety" (Lupick, 2016b) about the shifting funding dynamics of the DTES, and the potential for CBOs to find themselves in positions of unexpected financial hardship.

VCH Expenditures in the DTES. The VCH's annual funding envelope for the DTES is not available on the VCH website, however, after a request for information, VCH (2018b) provided financial data and a graph illustrating their expenditures in the

DTES for contracted and direct services, and opioid emergency response funding between the period of 2013/14 and 2018/19 (see Appendix B, figure b1). Using this data, a second graph was created to more clearly display VCH's annual spending and percentage growth rates for contracted services in the DTES (see Appendix B, figure b2). The data illuminates several trends in the VCH funding landscape, which together point to an environment of fiscal constraint for contracted organizations in the DTES.

First, while VCH's total expenditures in the DTES have increased each fiscal year between 2013/14 and 2018/19, the growth has been marginal since the implementation of the 2GHSS in 2015 (Appendix B, figure b1). The DTES budget increased by only 1.7 percent between 2014/15 and 2015/16, 2.9 percent between 2015/16 and reached its highest growth rate between 2016/17 and 2017/18 with a 5.5 percent increase. Second, the growth rate in the annual DTES budget since 2016 is largely a product of emergency response funding provided to specifically address the opioid crisis (Appendix B, figure b1). Without the additional crisis spending, funding for direct and contracted services averaged an annual increase of only 1.6 percent for the three fiscal years beginning with 2016/17. Third, expenditures for contracted services have remained relatively stagnant between 2013/14 and 2018/19, and as of 2016/17, funding for contracted services has displayed a *downward* trend (Appendix B, figure 2b). Although in the first year of the 2GHSS VCH's spending on contracted services actually increased by 5 percent (2015/16-2016/17), in 2017/18 the budget for contracted services decreased by 5.3 percent and then again by 1.6 percent in 2018/19. As a result, the allotted spending on contracted services in 2018/19 is approximately 400,000 dollars *less* than it was in 2015/16. Fourth, despite

the downward trend in funding for contracted services, over the period of 2013/14 to 2018/19 contracted services still averaged a third (32.7 percent) of VCH's annual budget in the DTES (Appendix B, figure 1b). It is therefore clear the third sector plays a significant role in the provision of publically funded health services in the DTES. Of note, a number of VCH funded services were not included in the financial data provided by VCH, including, for example, aboriginal contracted services and HIV contracted services (see footnotes of Appendix B, figure 1b). It is unclear why these services were left out of the data. A request for clarification from VCH has yet to be returned. As such, while these figures are illustrative of general trends in VCH funding, they may not represent a complete account of VCH's annual spending in the DTES.

DISCUSSION

In analysing shifts in funding relations between the public sector and the third sector following the 2015 implementation of the 2GHSS, it is clear that medical conceptions of health and indirect governing tactics shape the reorganized contracting environment for community organizations in the DTES. The 2GHSS reasserts VCH's role in the DTES health landscape, and in reorienting funding priorities, has imposed new constraints on CBOs working within the DTES third sector. While opportunities have opened for organizations with the capacity and willingness to align with the clinical focus of the 2GHSS, so too have new risks emerged for organizations that fall outside VCH's narrowing vision for health services in the community. There has long been need for government support and leadership in addressing the fragmented health system of the DTES, and in the context of the recent public health emergency, this need has only been

exacerbated. However, as the new policy environment privileges biomedical knowledge and measurable, program-specific services, evaluates organizations through competitive, market-based RFP processes, and is operating within a context of fiscal constraint, the 2GHSS deepens the reach of neoliberal governance in the DTES third sector and further erodes community spaces created by those the policy is intended to serve.

From VCH's first news statement in 2015 announcing the early stages of the 2GHSS implementation (VCH, 2015b), the epistemological hierarchy underpinning the policy was immediately apparent. In equating a "health mandate" with having formal connections to health*care*, VCH follows a long pattern of policy bodies dismissing health interventions that lack an evidence-based, clinical component. As outlined in the literature review, the principles of evidence-based policy and decision-making largely inform the types of evidence and knowledge valued in contemporary health policy development and reform (P. Armstrong et al., 2008). At the practical level, the positivist hegemony results in the minimal uptake of non-quantifiable, context-specific forms of evidence within policy (Jackson & Haworth-Brockman, 2007), and a general disregard for the non-measurable or immediately visible skills within contexts of health and care (P. Armstrong, 2013). Accordingly, DTES organizations with broad mandates, flexible programs, and a focus on the arts, advocacy, and the social rather than the medical determinants of health have been less competitive in contract funding following the 2GHSS than have organizations with clear program deliverables and linkages with clinical health services.

A central goal of the 2GHSS has been the development of an integrated system of

health services in the DTES, and the elimination of siloed or stand-alone organizations. In narrowing the view of health to encompass only clinically based services, organizations with an approach to health outside the biomedical sphere appear easy targets for funding cuts. As an arts-based health intervention, the funding cuts to the Gallery Gachet exemplify this trend. Rather than through the provision of healthcare services, the Gallery Gachet supports mental health by addressing social stigma and marginalization. The safe space provided by the Gallery not only allows members to express their experiences and trauma through art, but also provides a space where otherwise marginalized people have agency in their environment and access to community without discrimination. For VCH, redirecting the Gallery's funding towards a mental health and addiction drop-in service with an art-focused *activity* allows the health authority to implement their clinically-based integrated care agenda, while still maintaining they value arts in mental health treatment. However, the value of the Gallery Gachet – as with many CBOs in the DTES – cannot merely be reduced to their component pieces, or measurable programs devoid of context. The trust and relationships formed in community-created spaces are critical to supporting the social and relational aspects of health, particularly in a context where there is severe distrust towards professionalized health environments (Masuda & Chan, 2016), and ongoing experiences of displacement (Masuda & Crabtree, 2010). These relational dynamics are not quantifiable, however, and are missed in conventional program assessments, which instead focus on program measurability and alignment with the biomedical paradigm.

Following this logic of compartmentalization and lack of attention to the social

experiences of health is an accompanying assumption that programs can be moved between providers with minimal disruption to program users. DURC and the POP had their funding transferred to the Lookout and the UIHHC, respectively, because VCH concluded – via RFPs – the new organizations could provide similar services more effectively. There was seemingly little attention given, however, to how the change in location and providers could dislocate program users or shift the tenor of care and relationships. The DURC was a peer-*governed* organization that had as many as 1500 members of the DTES community using the space per day (Lupick, 2016a). While access to certain medical services was provided at the DURC, most of the programs were peer-run and responded to community-identified issues. The Lookout, while still offering a safe community space, is explicitly integrated with the VCH mental health and addictions system and "actively refer[s]" people to the VCH-run addictions clinic across the street (Lookout, 2018). This is a fundamentally different relationship to the formal health system that may impact the ways community members relate to the new space. Similarly, for people who previously received medical, social and Indigenous support services from the VNHS' POP for HIV care, the sudden shift to a newly formed organization that does not have a 20-year history providing services for urban Indigenous people in the DTES may be deeply disruptive. Importantly, this is not an indictment of the Lookout or UIHHC and their capacity to provide high quality care for people in the DTES. In fact in the context of the UIHHC, while still in the early stages of program operations, the cooperative model of joint doctor-Indigenous elder leadership appears an innovative approach to dismantling colonial structures at the level of the clinic. However, there is

also a need to acknowledge that the long-term connections people develop with trusted community-rooted spaces, like the POP and DURC, are not easily transferable, despite the best intentions of new providers. Furthermore, where the VNHS has a long history in the DTES as an Indigenous-run health and social advocacy organization, the UIHHC is a primarily health*care* oriented organization and like Lookout, ultimately aligns with the VCH's vision for an integrated health system of clinical services.

The VCH's approach to the reorganization of the DTES health system reveals not just a particular epistemological orientation but also an interrelated ideological one. In their critical commentary, Masuda and Chan (2016) argue that through the 2GHSS it becomes apparent that VCH does not recognize CBOs as "bona fide health interventions in and of themselves" rather they are "justifiable only as gateways to health care access" and health care professionals (p. 591). Moreover, as described above, organizations appear to be evaluated at the level of individual services, rather than through their holistic contribution to community health. These trends reflect what Shiva (1988) calls epistemological reductionism, or the assumption "(a) that knowledge of the parts of the system gives knowledge of the whole system;" and "(b) that 'experts' and 'specialists' are the only legitimate knowledge-seekers and knowledge-justifiers" (p. 235). As described by Shiva (1988), the reductionist knowledge system is inextricably linked to the philosophies that underpin the capitalist economy – those of efficiency and profit maximization, for example. For Smith (1989), the modern iteration of capitalism can be characterized by the emergence of "relations of ruling", or the "extraordinary complex of relations and organization mediated by texts that govern, manage, administer, direct,

organize, regulate, and control contemporary capitalist societies" (p. 41). The division between what Smith (1989) calls the "authoritative knowledge of the expert" and the "experiential knowledge of the layperson" (p. 40) is continually reinforced because the capitalist economy – and by extension the relations of ruling – function through the continuous exclusion of certain groups and certain types of knowledge. The epistemological hierarchy underlying the 2GHSS that privileges positivist methods and medical conceptions of health has therefore not emerged in isolation, rather it is a product of the relations of ruling and serves a particular form of reductionist governance – neoliberalism.

With the retrenchment of the welfare state, the outsourcing of service provision to the third sector has become a primary mechanism through which neoliberal governments exert control over the management of health and social services while still maintaining a minimal state. As described in the literature review, funding through competitive, compliance-based contracting has produced new forms of "contract governance" (Ilcan et al., 2003) that function to reorient community organizations towards enacting the priorities of the state – a phenomenon Wolch (1990) has named the "shadow state apparatus" (p.15). Expressions of neoliberal governance in the third sector are evident throughout the DTES contracting environment. The VCH's use of competitive tendering is perhaps the most visible transfer of private-sector principles into DTES contracting relations. The RFP process allows the government to evaluate organizations against one another based on their proposed service outcomes and estimated costs. Critical scholars researching third sector contract dynamics in liberal welfare states have established

competitive bidding typically favours the organizations that are most fiscally efficient and willing to align with the goals of the state (H. Armstrong, 2013; Evans et al., 2005; Wolch, 1990). As reporting by Lupick (2016b) revealed, nondisclosure agreements are increasingly built into VCH contracts and contract proposals, and it is therefore unclear whether the organizations that won contracts through the 2GHSS emphasized a capacity to deliver services at a lower cost. However, given that the DTES budget has only marginally increased since 2015/16, and real funding for contracted services has decreased since 2017/18, it is likely organizations' relative economic efficiency was a consideration for VCH in their funding assessments. In terms of aligning with the state, as previously discussed, most organizations that received new contracts under the 2GHSS reflect the clinical priorities of VCH. This is particularly evident in the case of the Lookout where in their 2015/16 annual report the newly funded drop-in program, Powell Street Getaway, was explicitly framed as being developed to align with the 2GHSS.

The impacts of contract governance have also contributed to reshaping the DTES third sector in more subtle ways. As the findings reveal, tensions, competition, and anxiety have permeated the experiences of DTES organizations following the 2GHSS. CBOs that lost contracts through the RFP process – like the DURC and VNHS – have expressed antagonism towards the organizations that won the funding reallocations. As Laforest and Orsini (2005) describe, this reflects a trend across the Canadian non-profit sector where new divisions are being drawn between those organizations who abide by the requirements of the state and gain access to government resources, and those who become excluded "for reasons of ideological opposition, lack of technical skills/capacity,

or both" (p. 492). The result is a shift from a sector premised on cooperation and collaboration to one governed by logics of competition. Anxieties are evident across the sector from both organizations in acute crisis management responding to significant unexpected financial loss (like the Gallery Gachet and VNHS), and more peripherally, from organization *fearing* potential funding loss. As many CBOs in the DTES depend on VCH for significant portions of their operating budgets, fears over jeopardizing their funding looms large. A consequential manifestation of these anxieties, as Lupick's (2016b) reporting identified, has been the increased reticence of managers of VCH-funded organizations to critique the 2GHSS on the record. This self-censorship, along with VCH's selective elimination of funding for organizations like Gallery Gachet and DURC that had more social-justice and advocacy-based programming, risks an increasingly depoliticized third sector and, as Wolch (1990) cautions, an overall reduction in sectoral diversity.

In analysing the aftermath of the 2GHSS, it is evident those organizations that align with the epistemological and ideological orientation of VCH are more likely to succeed in the new funding environment. At the same time, however, as the FPE perspective reminds us, tensions are inherent to the capitalist system, and the neoliberal politics of the 2GHSS have not emerged without contradictions. Structures of constraint may paradoxically produce opportunities, and the increased funding for *certain* women's-centred services in the DTES reflects this tension. Women's health in the DTES has been dramatically underfunded by VCH, and women's organizations have long advocated for resources to address gender inequity in service provision. The women's 2GHSS

companion paper noted, for example, that in 2016 only eight out of 55 VCH contracts in the DTES provided women's-only services despite women being 38 percent of the DTES population (VCH, 2016b, p. 7). The two new women's-only services that have been funded in the DTES following the publication of the 2GHSS women's companion paper – The Rice Block substance-use treatment program and the women's only overdose prevention site, SisterSpace – are both desperately needed programs that support the safety and health of vulnerable women struggling with addiction in the community. At the same time, both programs comfortably fit within the biomedical paradigm guiding the 2GHSS, and directly align with the first priority of the women's companion paper, to increase access to women's *clinical* health services. In contrast, programs like the Women's Action Group at the DURC, which supported social activism and offered an inclusive, non-medicalized space for connection among women in the DTES, or the Rainier Women's Treatment Centre, which was premised on supporting women's agency and integrating non-clinical care into the rehabilitation space, have not received similar funding opportunities under the 2GHSS.

While the new funding for The Rice Block and SisterSpace helps fill a critical service gap, it does not indicate a paradigmatic shift in VCH's approach to addressing issues of gender inequity across the DTES. In only funding programs that respond to specific, measurable health needs through clinical interventions VCH has applied the same reductionist strategy seen throughout the implementation of the 2GHSS to the context of contracted women's health services. Given the severity of structural inequities impacting women across the DTES, this narrow approach to women's health does little to

address the underlying conditions of women's marginalization either within the DTES community or within VCH policy. Furthermore, the funding for the two programs directly intersects with the opioid crisis response, and it remains to be seen how VCH will allocate funding towards women's services once the acute response has shifted to longer-term management. Without VCH's recognition that women's marginalization stems from structural conditions rather than simply from a lack of access to clinical interventions, the gendered health inequities that exist in the community will likely continue to be reproduced in the DTES throughout and beyond the opioid crisis.

In her analysis of the shadow state, Wolch (1990) argues the transformation of the voluntary sector is fundamentally linked to the retrenchment of the welfare state. Wolch (1990) identifies the mass economic restructuring of the late 1970s and 1980s, and the systematic dismantling of welfare state policies as the catalyst for states offloading the functions of the welfare state onto the voluntary sector. The rise of the shadow state apparatus, and the accompanying forms of indirect governance are therefore not new developments within neoliberal political economies, and more specifically, within the context of the DTES. As Roe (2010) describes in his historical analysis of the DTES third sector, public funds have been steadily diverted away from radical activist organizations towards professionalized health agencies since the election of the BC Liberals in 2001. After over a decade of concerted neoliberal restructuring, the province has institutionalized market-based governing principles across the health sector and both the definition of health and of those deemed worthy of providing health services has narrowed. The 2GHSS is a continuation and intensification of a reductionist health policy

trend that privileges medicalized notions of health, values only the tangible, measurable outcomes of health services, and inserts private-sector models into the allocation and management of public funds. As Roe (2010) notes, social justice activism remains central to the DTES, and as neoliberal restructuring has only deepened social and economic inequities, grassroots organizations continue to be on the frontlines of advocacy for the most marginalized people in the community. With the implementation of the 2GHSS, however, DTES CBOs are navigating a new contracting environment of intensified medical dominance and expanded contract governance that has altered the ways organizations are able to respond to the needs of their communities. Within a constricting and competitive funding environment for contracted service providers, the risks of CBOs needing to align themselves with the epistemological and ideological values of VCH in order to succeed in the new policy landscape are steadily being realized.

Future Directions

As a recent and evolving policy with minimal previous scholarly attention, the 2GHSS would benefit from ongoing critical research in several areas. First, research from across Canada examining the impacts of neoliberal policy on the third sector has found that organizations receiving publically contracted funds have experienced increased pressure, and in some cases contractual requirements, to institutionalize NPM and other technocratic managerial models (Baines, 2006, 2015; Baines et al., 2014; Woolford & Curran, 2011). As this paper relied upon secondary sources to survey the effects of the 2GHSS on DTES contracted CBOs, it was difficult to establish the ways in which organizations that have *received* funding under the 2GHSS have been impacted at the

operational level. Primary research focused on DTES health service providers with active VCH contracts would help illuminate the extent to which contract governance impacts the daily operations of third sector organizations in the DTES, and importantly, the ways in which non-profit workers *resist* the constraints of neoliberal managerialism. Second, the province of BC, and the DTES in particular are in the midst of a public health emergency and new funding has been made available for services responding to the opioid crisis. The marginal annual growth in VCH's budget for the DTES is largely a result of these specifically allocated emergency funds, and investment in health services outside the crisis may experience stagnation. Further research is needed to understand the intersections between the 2GHSS, the opioid response, and available funding for contracted CBOs, particularly for organizations focused on women's health. Third, in 2017 the BC New Democratic Party won a minority election at the provincial level, shifting the ideological tenor of provincial politics after 16 years of neoliberal governing under the BC Liberals. Examining shifts in VCH priorities, management strategies, and contracting opportunities for CBOs in the DTES as the New Democratic Party tries to implement a more progressive agenda will illuminate the extent to which changes in provincial political leadership can dismantle the neoliberal structures that have long shaped the BC health sector.

CONCLUSION

This paper began by taking the critiques of Masuda and Chan (2016) as an entry point for investigating how the DTES third sector contracting environment has been impacted by the 2015 implementation of VCH's 2GHSS. In their critical commentary –

published a year after the release of the 2GHSS – Masuda and Chan (2016) suggest the strategy "signals a shift towards a neoliberal clientelist model of health that treats people as patients and the DTES as a site of clinical encounter" (p. 590). Using FPE to examine who has benefited from the reorganized health landscape, who has been left out, and the ideological and epistemological factors informing these outcomes in the first four years of the policy's implementation, this paper supports the conclusions of Masuda and Chan (2016), and extends the analysis to illustrate how medical dominance and neoliberal governing tactics have shaped post-2GHSS contracting relations between community organizations and VCH.

A well-developed body of critical health literature has established that in operating within the biomedical paradigm, conventional health policy often lacks acknowledgement of the social and relational conditions of health and privileges "objective" medical expertise over experiential knowledge systems. Critical research examining the third sector in liberal welfare states has identified the use of competitive and compliance-based contracting as a means for governments to extend the ideological reach of the state into the management of community organizations. The reliance on depoliticized, biomedical models of health and the extension of market-based management policies characterize the expression of contemporary neoliberal governance in the third sector. Informed by the theoretical framework of FPE and through the use of thematic analysis, this paper identified multiple trends in the DTES contracting environment following the 2GHSS that reflect the themes of neoliberal governing described in the critical literature. Funding cuts to DTES organizations without links to

the formal health system, use of competitive RFPs in the allocation of funding contracts, valuing health services based only on their clinical components, and contributing to an environment of fiscal precarity together indicate an intensification of positivist epistemology and neoliberal ideology guiding VCH's approach to health policy in the DTES.

The DTES is a complex space where legacies of colonialism, repeated systematic displacement policies, intersecting experiences of gender and racial oppression, and the dire consequences of neoliberal social restructuring are reflected in the severe social, economic, and health inequities experienced by many community residents. There is a very real need for government support and resources to address gaps in the disjointed health system of the DTES, and in the context of the opioid overdose crisis these needs are intensified. However, there is also a long history of social, political, and health advocacy and community-based service provision in the DTES that provides critical spaces of belonging, and community health supports that extend far beyond clinical interventions. In the 2GHSS policy context, these are the programs and organizations that are increasingly being left behind. During the 2GHSS consultation process, a longtime DTES activist, Ann Livingston, argued that the most critically underfunded thing in the DTES was social support networks for community members, noting poignantly: "'You do harm by giving people clienthood when you should be giving them citizenship'" (Campbell, 2012, p. 24). Within the context of VCH-funded health services following the implementation of the 2GHSS, it appears clienthood is supplanting citizenship and community encounters are considered secondary to clinical.

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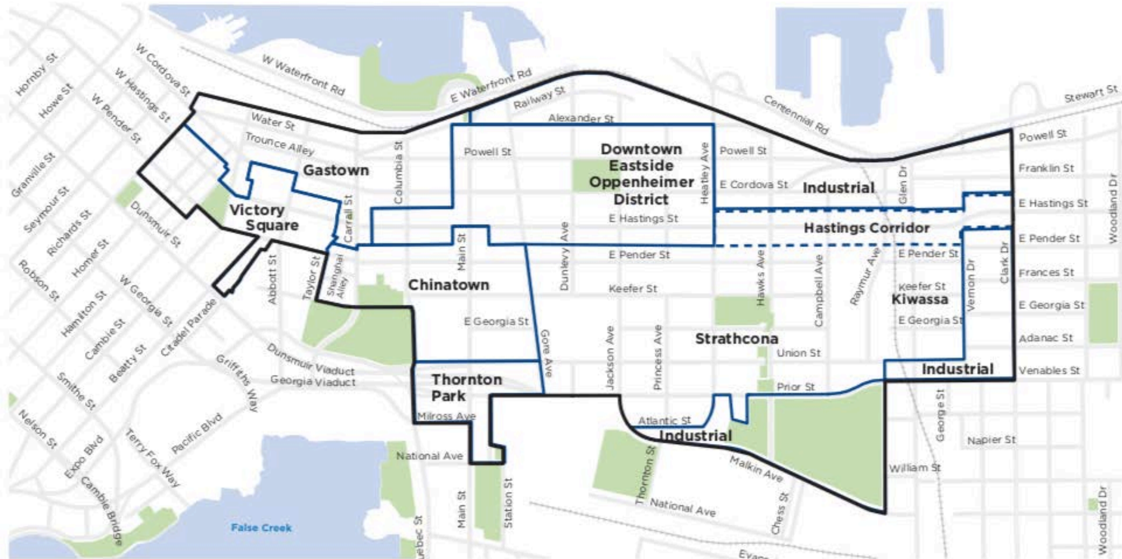
APPENDIX A

Map of Downtown Eastside and Sub-Areas

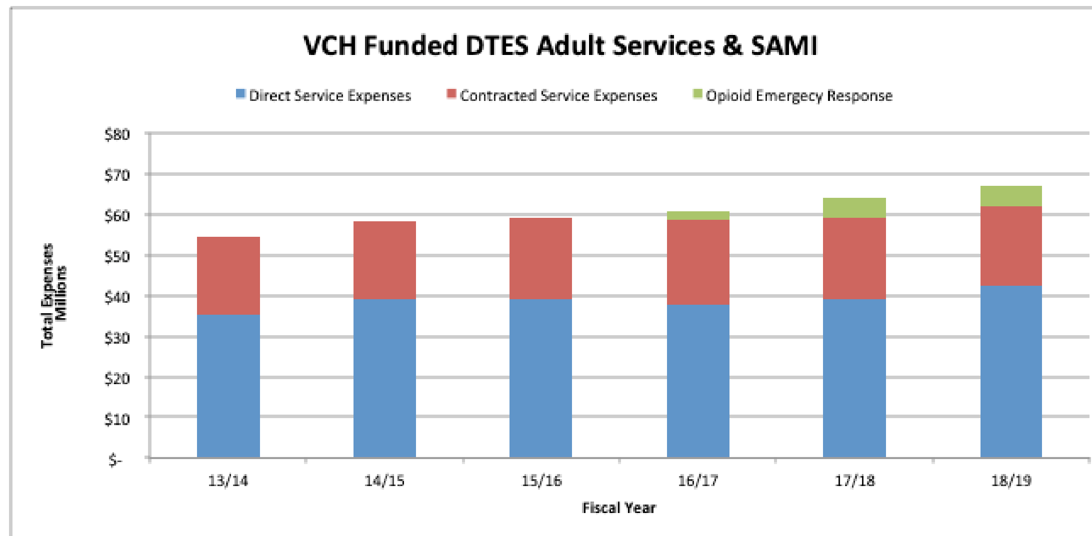


Note. Map reprinted from City of Vancouver (2015, p. 18).

APPENDIX B

Vancouver Coastal Health Expenditures in the Downtown Eastside

Figure b1: VCH Funded Adult & Seriously Addicted and Mentally Ill (SAMI) Services in DTES



Graph Footnotes

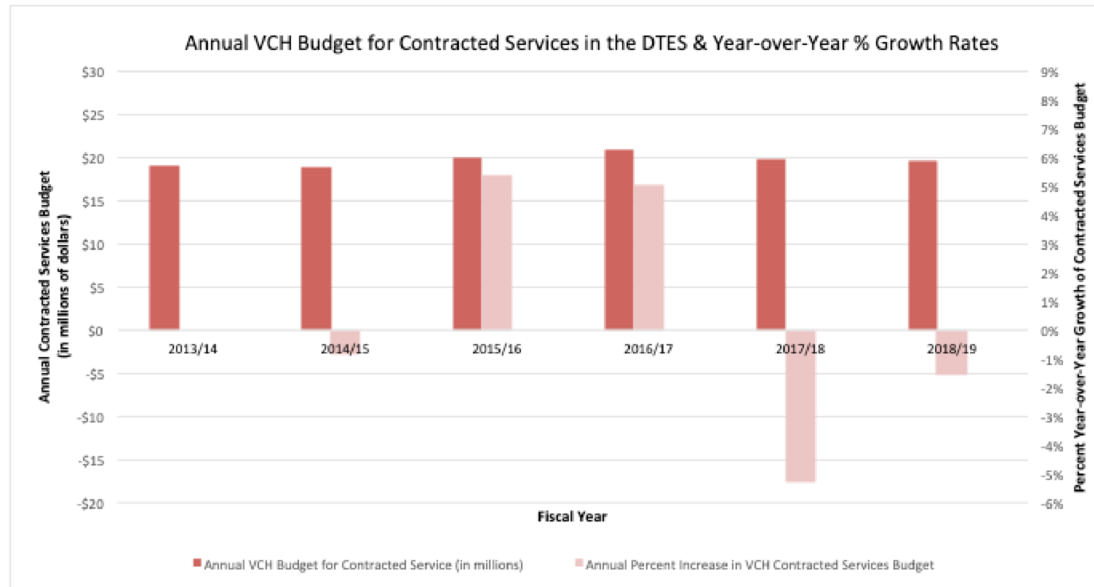
Included: Primary care, Addiction, Strathacona Mental Health, Vancouver Detox (80%), Urban Aboriginal Health Centre, All ACT Teams, Assertive Outreach, Burnaby Centre (25%), Housing and Shelter Services, Prevention and Harm Reduction, Low Barrier Gateway and Navigation, Residential Clinical Treatment (CTCT/PSS), Bosman, Princess Alexander, New POS Funding

Not Included: Providence Health Funded Services, Aboriginal Contracted Services, HIV Contracted Services, Segal, Hope Centre, Tertiary Beds from River View, Youth Beds for Inner City Youth (PHC), Mental Health Older Adult, Primary Care Older Adult

Type	Fiscal Year	Direct Service Expenses	Contracted Service Expenses	Opioid Emergecy Response	Total Expenses	Yr over Yr % Growth	Compound Annual Growth Rate
Historical	13/14	$ 35,316,379	$ 19,065,595		$ 54,381,974		
Budget	14/15	$ 39,072,588	$ 18,901,710		$ 57,974,298	6.6%	5.9%
Budget	15/16	$ 39,072,588	$ 19,913,077		$ 58,985,665	1.7%	5.0%
Budget	16/17	$ 37,628,303	$ 20,913,230	$ 2,178,932	$ 60,720,465	2.9%	4.4%
Budget	17/18	$ 39,150,286	$ 19,809,649	$ 5,111,809	$ 64,071,743	5.5%	3.8%
Budget	18/19	$ 42,290,744	$ 19,501,155	$ 5,043,932	$ 66,835,830	4.3%	3.4%

Note. Financial data, graph, and table provided by VCH (2018b).

Figure b2: Annual VCH Expenditures for Contracted Services in the DTES & Year-over-Year Percentage Growth Rates



Fiscal Year	Annual VCH Budget for Contracted Service	Annual Percent Increase in VCH Contracted Services Budget
2013/14	$19,065,595	
2014/15	$18,901,710	-0.86%
2015/16	$19,913,077	5.35%
2016/17	$20,913,230	5.02%
2017/18	$19,809,649	-5.28%
2018/19	$19,501,155	-1.56%

Note. Graph and table created using financial data provided by VCH (2018b).