Tackling Health Inequalities through Public Policy Action:

Insights from Canadian Policy Academics, Activists, and Advocates

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ABSTRACT: Despite numerous public policy proposals and interventions to address preventable health inequalities, that is, health inequities among and within countries, this societal problem persists. This research addresses how and why health inequities, especially class, race/ethnicity, and gender health inequities, persist in Canada and how to reduce such differences through public policy action. First, I performed a theoretical and critical realist review of existing literature focusing on pluralism, discursive institutionalism, and critical political economy approach to health and policy change. Then I conducted a thematic analysis of the interview data corpus gathered from 23 semi-structured interviews with leading and influential Canadian policy academics, activists, and advocates to address the research questions. Reflexivity also forms part of my methods.

The main findings demonstrated that health inequities or the avoidable health inequalities in Canada are primarily caused by 1) the capitalist economic system; 2) the co-constitutives of capitalism, namely colonialism, racism, and sexism; and 3) maldistributive public policies. Health inequities are further sustained by 1) power, interest, and ideology trumping evidence-based research and policy ideas; 2) unequal wealth and power among competing interests and advocacy groups; 3) the dominance of the business and corporate sector in health politics and public policymaking processes; 4) neoliberal governing authorities; and 5) fragmented and weak labour unions, civil society groups, and social movements.

Canada's health inequities reduction efforts necessitate 1) pushing for redistributive public policies; 2) uniting and strengthening labour unions, civil society groups, and social movements; and 3) engaging in electoral politics. The core strategies to realize these health equity goals are the ensemble of information, education, advocacy, organization, and mobilization. Reducing health inequities in general and class, race/ethnicity, and gender health inequities, in particular, may involve struggling within and against capitalism and struggling for socialism. This study may provoke social actions toward emancipatory social change to achieve health justice.

This dissertation research is dedicated to the memory of

Adelaida Mercado - Mother
Saturnino Borras Sr. - Father
Engr. Alberto Borras - Brother

Max Frivaldo - kasama, kaibigan, kapatid - assassinated in January 2006
Cris Frivaldo - kasama, kaibigan, kapatid - assassinated in December 2006
Jonas Burgos - kasama, kaibigan, kapatid - forcibly disappeared in April 2007
Jayram Iglesia - nephew and childhood friend - assassinated in January 2021

Atty. Ryan Filgueras - kasama, kaibigan, kapatid - died in August 2019
Msgr. Gerry del Prado - spiritual mentor and dearest friend - died in December 2019
Senior Police Officer Wilson Dimen - a dearest friend and brother - died in April 2020

Professor Leo Panitch - key informant - died in December 2020

And to all those who struggle against all forms of exploitation and oppression and become targets of extrajudicial killings and forced disappearances.

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My dear reader: This dissertation research is not mine alone. It is a valuable gift from the research informants. Now, it is also yours.

Sincerely,

Arnel Borras
Mississauga
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TABLE OF CONTENTS

LIST OF TABLES

3

CHAPTER 1
OVERVIEW OF THE RESEARCH

There is no royal road to science, and only those who do not dread the fatiguing climb of its steep paths have a chance of gaining its luminous summits. – Karl Marx, 1867

1.1 Brief background

Health inequalities or differences in health conditions occur among various classes and groups of people. Empirical evidence on health inequalities among and within countries are found in both the classic and recent health studies literature (e.g. see Barber et al., 2017; James et al., 2018; Naghavi et al., 2017). Studies have considered the causes of health inequalities and suggested various ways to address their persistence (e.g. see Acheson, 1998; Bryant & Raphael, 2020; Black et al., 1992; Labonté, 1993; Lalonde, 1974; WHO, 2008; Wilkinson & Marmot, 2003; Raphael, 2016).[1] However, health inequalities persist in Canada, and these may be widening despite many public policy interventions and proposals to reduce them (e.g. see Bryant, 2016; Epp, 1986; Lalonde, 1974; Mantoura & Morrison, 2016; WHO, 2012; Raphael et al., 2004, 2020). For instance, Canada's life expectancy widened between the lowest and the highest quintile income by an additional one year for males and about two years for females between 1996-2016 (Bushnik et al., 2020). Canadians are concerned about their working, living, and health conditions and the excessive mortality, morbidity and actual suffering associated with these conditions. Thus, finding solutions to preventable health inequalities (i.e., health inequities) is imperative. This task becomes even more critical in light of the unequal impacts of COVID-19 upon those already experiencing health disadvantages.

[1] See also: Armstrong et al., 2001; Bambra et al., 2005; Bryant et al., 2011; Coburn 2000; Labonté & Ruckert, 2019; Marmot et al. 2010; Morrow et al., 2007; Navarro & Muntaner, 2017; Raphael, 2011; Raphael et al., 2020; Schrecker & Bambra, 2015.

This chapter presents an overview of the research. First, it provides a brief background, purpose, research questions, assumptions, importance, and potential contribution of the study. Then it briefly introduces the methods and theoretical frameworks used. Finally, it describes key terms, including health inequalities/inequities, theories of health inequalities/inequities, social determinants of health, capitalism, and neoliberalism. Public policy theories, namely pluralism, institutionalism, and political economy, will be discussed in-depth in Chapter 3. A review of these key concepts is crucial because an essential aspect of my study is ascertaining whether my informants are aware of the different health inequalities/inequities theories and the importance of public policy in addressing social and health inequities. Especially, I am interested if they consider the role that competing interest groups, ideas and institutions, and power and influence play in shaping social and health inequities in Canada. The chapter concludes with a self-reflection and positioning myself in this study.

1.2 The purpose of the study

This study aims to examine the causes of health inequalities and the various means of reducing them. It is important because most analyses of the sources and means of responding to health inequalities are divorced from the political economy and politics of public policymaking, and as a result, little has been accomplished in health inequalities reduction (Bambra et al., 2005; Bryant & Raphael, 2020, Navarro, 2011; Williams, 2013). This study contributes to current scholarly and public debates on reducing preventable health inequalities by inquiring into Canadian public policy academics, activists, and advocates' understandings of the sources of health inequities and the means of addressing them. I am taking the position that public policy is a key contributor to health inequities and thus, public policy can also reduce them.

1.3 Research questions and assumptions

The central question I will address is: Why and how do preventable health inequalities, especially class-, gender-, and race/ethnicity-based health inequalities, persist in Canada, and how can such differences be reduced through public policymaking processes? ***My assumption*** is that the sources of avoidable health inequalities or health inequities are to be found in the distribution of power among societal sectors and how this shapes the organization of a society's political and economic systems. These systems shape social relations, with class-, gender-, and race/ethnicity-based dynamics being of special importance in the persistence of health inequities. Any public policy action toward reducing such health inequities will have to address the fundamental question of how class- and social identity-based relations of power manifest in Canada. The inequitable distribution of wealth and power between social classes and groups (e.g. capitalists and workers, men and women, racialized and non-racialized) influence the politics of public policymaking processes shaping the inequitable distribution of social determinants of health, resulting in health inequities, i.e., avoidable health inequalities. The current political scene in liberal welfare state countries such as Canada, which promotes neoliberal approaches to governance, further complicates these issues. My central question can be broken down into these ***specific questions***:

1. How does the organization of society, i.e., its economic, political, cultural, institutional, and ideological systems, shape public policies that create health inequities?
2. How do power and social relations of class, gender, and race/ethnicity interact with these structures to also shape these public policies that lead to health inequities?

3. How do state actors (e.g., politicians and policymakers) understand and shape public policy over time in relation to the politics of class, gender, race/ethnicity, and health inequities?
4. How do public policy academics understand and engage with public policy and politics over time in relation to the politics of class, gender, race/ethnicity, and its impact on health inequities?
5. How do public policy activists and advocates understand and engage with public policy and politics over time in relation to the politics of class, gender, race/ethnicity, and its impact on health inequities?

Methods. To answer these research questions, I first performed a literature review focusing on health and public policy theories. Specifically, partly informed by Labaree's (2022) *theoretical review*, Pawson et al.'s (2005) *realist review* and Edgley et al.'s (2016) *critical realist review* explanations, I reviewed public policy frameworks and paradigms, namely pluralism, discursive institutionalism, and political economy in relation to health. It is important because I expect my interviewees to be applying these theoretical frameworks in their thinking about health inequities and policy change. Locating the state of the art is crucial because it connects the study to the broader continuing discourse, fills research gaps, and expands upon previous studies. It also provides the context for establishing the study's importance and serves as a reference for comparing findings (Creswell, 2009). In this study, the literature review informs my entire research process, for example, formulating the research questions, selecting the key informants, conducting the semi-structured interviews, and analyzing data. I used what I found in the literature as sources of data to reflect upon the interviewees' discussions about social and

policy change in relation to health. The findings from the literature review and semi-structured interviews inform each other.

Second, I conducted 23 semi-structured interviews with Canadian policy academics, activists, and advocates, all of whom are influential and leading experts in their respective fields. After transcribing the audio-recorded interviews, I performed a thematic analysis, that is, "identifying, analyzing, and reporting patterns (themes) within data" (Braun & Clarke, 2006, p.79). Thematic analysis can be *inductive* where themes are robustly related to data (Patton, 1990) or *theoretical,* driven by the investigator's analytical interest in the phenomena (Braun & Clarke, 2006). This dissertation attempts to integrate these approaches – thematic analysis informed by a well-established theory and supported by empirical data and vice versa, strengthens any research.

Theoretical frameworks. I am informed by public policy theories that may be useful in examining health inequalities: pluralism, institutionalism, and political economy (Bryant, 2015a,b, 2016; Bryant & Raphael, 2016), which are briefly described below and expanded upon in Chapter 3. ***Pluralism*** focuses on interest groups competing to influence state policy decisions (Dahl, 1961, 1984). *Classical pluralists* assume that the opportunities to influence public policy -- encompassing health policy -- are numerous. They believe political participation is open to all society members, whereby competing interest groups have equal opportunities to influence public policy (Dahl, 1961) to reduce social and health inequalities (Bryant, 2016). The state only acts as a neutral arbiter of societal and public health affairs that equally considers their interests (Bryant, 2016; Dahl, 1961; 1984; Howlett et al., 2009). In contrast, *neo-pluralists* believe that the state is an autonomous political player that actively promotes and defends its interests and

health policy ideas. The latter further recognizes the corporate and business sector, i.e. the dominant capitalist class possesses significant power and influence in health politics and public policy (Howlett et al., 2009; Lindblom, 1979, 1982; Parsons, 1995).

Institutionalism has different threads: economic, sociological, political, historical, rational choice, and discursive institutionalism (Hall & Lamont, 2009; March & Olsen, 1984; Parsons, 1995; Schmidt, 2008; Steinmo et al., 1992), all concerned with the structures and processes of governing institutions. This study concentrates on discursive institutionalism, which views ideas as constitutive of institutions that are primarily shaped by ideas (Schmidt, 2010a,b). It is a constructivist approach that fuses ideational and institutionalist theorizations to examine health inequalities (Smith, 2007, 2013a,b; 2014).

Critical political economy integrates the economic, political, and cultural dimensions of health inequalities (Armstrong et al., 2001). It scrutinizes the contradictions between ideas and materials, agency and structures, as well as class, gender, and race/ethnicity relations. It focuses on power imbalances shaping the production and distribution of economic and other resources through public policy by which peoples' health is shaped (Armstrong et al., 2001; Bryant, 2013; Coburn, 2010; Raphael, 2015).

What is common between pluralism, discursive institutionalism, and critical political economy is the view that the state plays a crucial role in the organization of resources impacting social life – a major arena for contestations to address health inequities. Nonetheless, the basic unit of analysis of a pluralist approach is competing interest groups, whereas, for the discursive institutionalist, it is the ideas-institutions nexus. Unlike these consensus-based approaches, the conflict-based critical political economy emphasizes social relations of production. These public policy theories are distinct but overlapping. However, as described here and explained further in

Chapters 2 and 3, I believe and take the stance that the critical political economy approach to health is more useful than others as a theoretical framework that captures the reality of health inequities, i.e., their causes and potential solutions.

1.4 The importance of the study

Health inequities or the unjust health inequalities between classes and groups are a major social problem whose extent is shaped by public policies enacted by governing authorities (WHO, 2008, 2012). However, most analyses of the sources and means of responding to health inequalities are divorced from the political economy and politics of jurisdictions in which they occur (Navarro, 2011; Williams, 2013). This neglect of politics, power, and ideology makes effective responses difficult (Bryant & Raphael, 2020). This study examines the sources of and means of responding to this neglect. It is important because health inequalities are preventable, public policy failures contribute to their persistence, and there is a need to transcend the barriers to public policy change efforts to reduce them.

1.5 Potential contribution to knowledge

In Canada, there has been little research on how state actors such as politicians and policymakers understand the sources and means of responding to health inequalities. Little is known about how they view their public policy decisions and the influences upon these decisions (Raphael, 2015; Lucyk & McLaren, 2017). Few studies, therefore, have inquired into the understandings of public policy academics, activists, and advocates hold on the importance of the inequitable distribution of SDH that create health inequalities and means of addressing them (Lucyk, 2016; Lucyk & McLaren, 2017). For this reason, I chose Canadian policy academics,

activists, and advocates as my participants because by inquiring and analyzing their insights, this research can help further identify the causes, barriers, and means to reducing social and health inequities seen in Canada. Moreover, these policy actors may have different and common views about health and policy change and how they engage the politics of public policymaking to influence actions on social and health inequities. It may also provoke social actions toward transformative social change to achieve health equity for all. The main contribution of this research is the insights from Canadian public policy academics, activists, and advocates.

1.6 Key Concepts

Understanding the core concepts at the start is vital to any research, policy, and practice. This section briefly describes health inequalities/inequities, health inequalities/inequities theories, social determinants of health, capitalism, and neoliberalism. The latter is essential because we are in a neoliberal era. I am reviewing these concepts as they are relevant and central to understanding health inequities, and they also inform my analysis of the document and interview data. Meeting of minds between the writer and the reader about the descriptions of the key terms used in this study avoids potential misinterpretations.

1.6.1 Health inequalities/inequities. *Health inequalities* are the measurable health variations between classes and groups resulting from, for example, biological or behavioural differences, or social conditions. In contrast, *health inequities* are systematic, avoidable, and unjust health inequalities, like those resulting from unsafe living and working conditions (Whitehead, 1991). In reality, most health inequalities are health inequities as they are preventable and avoidable and result from the unfair distribution of economic and social resources (Kawachi et al., 2002). Unfortunately, many health scholars interchange health

inequalities with health inequities, muddling both concepts (Borras, 2021). However, since most health scholars commonly use health inequalities instead of health inequities, I attempt to retain how these terms were applied in the cited literature. In this study, I consciously write either preventable, avoidable, or unjust health inequalities when not using the word health inequities to avoid further confusion.

1.6.2. Theories of health inequalities / inequities. Throughout history, health researchers and advocates have studied the sources of differences in health outcomes (e.g. see Chadwick, 1842; Engels, 1845; Virchow, 1848/2006). Especially since the Black Report in 1980, theories for explaining the causes and means to reduce health inequalities have proliferated. For example, the *genetic* model posits that the fundamental cause of health inequalities is genetic variations, while the *cultural-behavioural* accentuates behaviour and lifestyles like smoking, diet, and exercise. The *psycho-social* focuses on the psychological impacts of stressful working, living, or social status, while the *materialist or structuralist* stresses social structures and socio-economic factors like employment and income (Black et al., 1992; Bartley, 2016). The *life course* focuses on how life circumstances shape health from the utero onwards (Krieger, 2001). *Macrosocial policies* focus on public policies but do not necessarily account for social structures, power, and ideologies (Mantoura & Morrison, 2016) whereas, *intersectionality* emphasizes the inextricably intertwined multiple forms of oppression like classism, sexism, racism, ageism, and ableism shaping social inequities (Collins & Bilge, 2016; Crenshaw,1989, 1991) and peoples' health (Hankivsky, 2012; Morrow et al., 2020). Lastly, the *political economy* of health focuses on social structures, power, and ideologies (Raphael, 2015). The first two theories assume health inequalities/inequities arise from the individual-micro level

while the rest, from the societal-macro level. These health inequalities/inequities theories are considered in this research.[2]

[2] At this early, due to the ongoing contentious debates between and within the practitioners of intersectionality and political economy, there is a need to clarify a few things why in this research dissertation, I use the critical political economy framework as the main theory informing my analysis. This is to recognize the perceived weaknesses and strengths of both approaches. Due to time and space limitations, I only provide a panoramic view; further details of the debates between them are beyond this study.

First, this study primarily builds on and expands the works of Bryant (2015a,b; 2016) focusing on pluralism, institutionalism, and political economy approach to health and policy change. So, I set this delimitation of study: pluralism, discursive institutionalism, and critical political economy. Second, emerging from critical race theorizations in the late 1980s to early 1990s, Crenshaw (1989, 1991) coined *intersectionality*. Elsewhere, I wrote: "Some intersectionality scholars understand it as a theory (Bauer, 2014), a concept (Gopaldas, 2013), a method and a disposition, a heuristic, and analytic tool (Carbado et al., 2013), a normative and empirical research paradigm (Hankivsky et al., 2010). Others argue that it moves: as a work in progress, across and within disciplines, across national borders, to engage black women and men, and as a social movement" (Carbado et al., 2013), and that "the current understandings about and definitions of intersectionality are diverse and remain vague" (Collins, 2015). Recently, Crenshaw stated that it *is basically a lens, a prism* (Steinmetz, 2020) (see Borras, 2021, pp.11-12). These unsettled internal debates within intersectionality proponents suggest that intersectionality has yet to attain a universal meaning; it is not a well-established theory. Third, some intersectionality scholars believe that Marx, the originator of critical political economy, and its practitioners emphasize class analysis and ignore sexism, racism, colonialism, and other forms of oppression in examining social phenomena. However, some political economy scholars contend that Marx accounted for class, gender, race, and colonial relations in examining capitalist political economy. Brown (2014), McLaren (2020), Anderson (2021), and Musto and Martinez (2022) provide a glimpse of the tensions between Marx-informed critical political economy and Crenshaw-informed intersectionality.

Brown (2014) states: "Although *Capital* is devoted to the critique of political economy, there is a significant amount of material on gender and the family…. Marx's discussion of gender and the family extended far beyond merely including women as factory workers. Marx noted the persistence of oppression in the bourgeois family and the need to work out a new form of the family" (pp. 5-10). Anderson (2021) further states: "It is important to see both [Marx's] brilliant generalizations about capitalist society and the very concrete ways in which he examined not only class, but also gender, race, and colonialism, and what today would be called the intersectionality of all of these" (p.2). Among the renowned experts in Marx's works and life, Musto observes:

> In the final years of his life, Marx elaborated on many questions that, while often underestimated or even ignored by scholars of his work, are critically important for the political agenda of our time. These include ecology, individual freedom in the economic and political sphere, queer liberation, the critique of nationalism, and forms of collective property not controlled by the state…. In addition, Marx researched non-European societies and spoke out against the ravages of colonialism in no uncertain terms. It is incorrect to suggest otherwise. This is evident in Marx's unfinished manuscripts – recently published in the historical-critical edition of his complete works, the Marx-Engels-Gesamtausgabe (MEGA2) – in spite of the skepticism that is fashionable in certain academic quarters. Thus, 30 years after the end of the Soviet Union, it is possible to read a very different Marx than the dogmatic, economistic, and Eurocentric theorist who has been criticized for so many years by those who have not read his work or have only done so superficially. (Musto & Martinez, 2022, p.2).

From the above explanations, in my view, the contrasting perspectives within the intersectionality field indicate that it is not yet fully developed compared to the well-established critical political economy theory. Moreover, it is not the latter's fault if some scholars emphasized class and ignored gender, race, and colonial relations in examining social phenomena. In this study, I chose the critical political economy theory that integrates class, gender, and race relations into its analysis of health outcomes (Armstrong et al., 2001) as the research's core theoretical framework for understanding health inequities. However, this does not mean I am entirely abandoning intersectionality. On the contrary, I also use intersectionality the way Crenshaw defined it: "It's not identity politics on steroids. It is not a mechanism to turn white men into the new pariahs. *It's basically a lens*, a prism, for seeing the way in which various forms of inequality often operate together and exacerbate each other…" (Steinmetz, 2020, para. 2) (*emphasis mine*). Collins & Bilge defines: "Intersectionality is a way of understanding and analyzing the complexity in the world, in people, and in human experience…[S]ocial inequality…as being shaped not by a single axis of social division, be it race or gender or class…" but by multiple factors mutually influencing each other (p.2). See also Borras' (2021) Venn Diagram.

Nonetheless, to compensate for the perceived shortcomings of intersectionality and political economy, I further draw on McNally's (2015) explanations about the *dialectics of unity and difference in the constitution of wage-labour*. McNally states: "the social relations of race, gender and sexuality, among others, were understood to be *internally constitutive* of class – rather than as radically external to it" (p.131). I agree that class, gender, and race inescapably engage in a dialectical relationship. Thus,

1.6.3 Social determinants of health or SDH. The WHO (2008) officially defined SDH as the life circumstances in which human beings are born, live, grow, play, work, and age. These material and social conditions are shaped by the distribution of power, money, and other resources at the local, national, and global levels. The social, economic, and political forces creating and sustaining the fatal combination of "poor social policies, unfair economics, and bad politics" impacting the SDH are primarily responsible for many health inequities (WHO, 2008, p.35). A Canadian exposition sees the SDH as (un)employment and working conditions, (un)employment security, income and wealth distribution, housing, food (in)security, education, early child development, social safety net, healthcare systems and services, social exclusion, (dis)ability, gender, race/ethnicity/indigeneity, immigration status, geography, and globalization (Raphael et al., 2020). The quantity and quality of SDH distribution arise from state policies, and the health outcomes they generate are human made.

1.6.4 Capitalism. Capitalism or neoliberalism in the contemporary era shapes state policies, including "the quality and distribution of the social determinants of health" (Raphael et al., 2020, p.86), resulting in pervasive health inequalities (Bryant & Raphael, 2020; Muntaner & Navarro, 2004; Schrecker & Bambra, 2015). There are *varieties of capitalism* (Albo & Fast, 2003). I take capitalism in its broader sense as defined by Ellen Meiksins Wood, a distinguished political theorist:

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although class, gender, and race are conceptually and analytically distinct and appear externally related and independent from each other, in reality, they are internally related, co-constitutive, and irreducible to each other. Thus, for me, the better explanation is that class, gender, and race *dialectically co-constitute* each other in which one could hardly be known without the other. So, in this study, I use the term 'co-constitute'. In doing so, I say *racialized capitalism*, *gendered capitalism, or racialized and gendered capitalism* to emphasize the co-constitutiveness of the class (capitalism), gender (sexism), and race (racism). Thus, this dissertation partly combines *intersectionality as a lens* and *critical political economy as a theory* to compensate for perceived limitations, strengthening rather than weakening both approaches when applied in health inequities studies. Notably, this study is informed by multiple health inequities theories.

> Capitalism is a system in which goods and services, down to the most basic necessities of life, are produced for profitable exchange, where even human labour-power is a commodity for sale in the market, and where all economic actors are dependent on the market. This is true not only of workers, who must sell their labour-power for a wage, but also of capitalists, who depend on the market to buy their inputs, including labour-power, and to sell their output for profit...This distinct system of market dependence means that the requirements of competition and profit maximization are the fundamental rules of life... The basic objective of the capitalist system, in other words, is the production and self-expansion of capital. (Wood, 2017, pp.2-3).

In short, capitalism is fundamentally a market-dependent profit-driven form of economic system characterized by its highly competitive nature. Capitalists prefer to treat all that exists as a commodity that can be traded in the marketplace that is dictated solely by supply and demand dynamics. The capitalists aim to maximize profit, accumulate capital, and reinvest capital for further profit.

1.6.5. Neoliberalism. There are *varieties of neoliberalism* (Albo & Fast, 2003). In this study, I take neoliberalism as described by some of the renowned scholars: Distinguished Professor David Harvey, author of 'A Brief History of Neoliberalism' cited over 35000 as of this writing, Distinguished Professor Leo Panitch and political activist Sam Gindin, and in the field of health and public policy, Distinguished Professor Vicente Navarro. To my mind, they are among the most authoritative scholars of the capitalist economic system and its current phase, neoliberalism.

For Harvey (2007, 2016, 2019), *neoliberalism is a political-economic theory* that heavily draws on classical liberalism. In reality, one may see it as a *political project* by the capitalist

class, especially by big transnational corporations that fundamentally promote privatization, liberalization, and deregulation of industries. Panitch and Gindin (2004) argue that although the underlying mechanism of neoliberal capitalism is economic, it is "a *political* response to the democratic gains that had been previously achieved by the subordinate classes" of which, in the minds of the capitalist classes, have become barriers to capital accumulation (p.2). For Navarro (2007a,b), *neoliberalism is the practice and ideology* of the dominant classes that aim to (de)regulate financial, commerce, and labour markets in their favour. Neoliberals work to privatize public services and cut social policy expenditures by campaigning against state interventions that curb their profit interests. Consequently, neoliberal state policies undermined the working classes and other groups and weaken the welfare state system, perpetuating social and health inequalities (Bryant & Raphael, 2020; Coburn, 2004, Labonté & Stuckler, 2015; Muntaner et al., 2011; Navarro, 2007a,b; Schrecker, 2016).

As explained above, neoliberalism has economic, political, institutional, and ideological dimensions. Designed for profit and capital accumulation, its core principles: privatizing public services, (de)regulating the market systems, liberalizing economic activities, and implementing austerity measures favouring the wealthy and capitalist class, shape the inequitable distribution of the SDH, and health inequities. I expect the informants to discuss the role of capitalism and/or neoliberalism in the production and maintenance of social and health inequities in Canada.

1.7 Self-reflection and Positionality

My research dissertation is informed by experiences and knowledge acquired in and out of the academe. I grew up under Marcos's Dictatorship in the Philippines that was ended by the

1986 People Power. In the mid-1980s, educated by some activists about Spain colonialism, US imperialism, bureaucrat capitalism, and feudalism, I became politically involved. While pursuing a BA in Economics in one of Manila's better schools, I became an educator, organizer, and Chairperson of the then Student Youth League Against Rural Injustice and Tyranny, an advocacy group tied with peasant organizations. One victory was ending US military bases in the early 1990s, partly achieved through street protests. From the mid-1990s, the split in the social movements made me focus on teaching in college, heading the production and marketing departments of my parents' business, pursuing MBA, and navigating marriage life.

My young family returned to our rural hometown when my mother -- a retired elementary teacher and guidance counsellor -- died before the new millennium. I then worked with the government, academe, civil society, and earned a BS Nursing degree. Reunited with some local activists, we campaigned against the traditional politicians and supported progressive candidates in every national and local election. Our wins included but were not limited to a party-list representation in the house of representatives, barangay captains, and municipal councillors, including my father -- with more than two decades of experience as a municipal councillor -- and my friend Max, who was assassinated in 2006.[3]

By 2008, my family immigrated to Canada. With unrecognized education and working experiences, my first job was as general labour in a factory before becoming a personal support worker (PSW) and then a registered practical nurse (RPN). While working, I earned an Honours BSc in Nursing for *internationally-educated nurses*. My practicums in the Wilkinson Road Shelter and Regent Park Community Health Centre helped me see homelessness in Canada,

[3] The Local Government Code of the Philippines Book III, Local Government Units (1991) describes: "As the basic political unit, the Barangay serves as the primary planning and implementing unit of government policies, plans, programs, projects, and activities in the community, and as a forum wherein the collective views of the people may be expressed, crystallized and considered, and where disputes may be amicably settled" (Section 384). The chief executive of the Barangay government is called the Punong Barangay or Barangay Captain (Republic of the Philippines Republic Act No. 7160, 1991).

while my internships in hospitals provided background in acute care. From 2009 to 2016, I worked in several Long-Term Care (LTC) facilities. I observed that the healthcare frontline workers are mostly racialized women. When I became a night shift supervisor, I was responsible for the facility's entire operation. My roles included but were not limited to supervising three nurses and eight PSWs taking care of about 190 residents. Chronic understaffing, excessive workload, and burnout are common. These unsafe conditions harm the health of the workers and residents. Since 2016, I have been employed precariously as a Teaching Assistant at York University. Currently, I am working in the LTC, where I worked for about seven years before my Ph.D. studies.

Collective family experiences and knowledge further inform my research dissertation. My spouse has been an RPN in LTC for over a decade. Currently, she is the SEIU Healthcare Nursing Division Vice-President of LTC and a National LTC Services Standard Technical Committee member. Our eldest daughter is a Ph.D. Candidate in Sociology at York University. Her research focuses on transnational migration, citizenship, and healthcare workers. With a double major in BSc. Environmental Health and Global Health, our second daughter, works as a Project Coordinator at Strategy Management Office at Trillium Health Partners. Our youngest daughter and our only son are pursuing post-secondary education while working part-time. We are an immigrant working class in a racialized working environment. We are housing insecure. We are food insecure, that is, rarely able to buy organic, nutritious food. We incurred a significant amount of loans spent toward the children's educational needs and 're-education' on my part. My ideas arise from the material conditions of life and social relations of production in which we participate.

In the beginning, it is important to say that I recognize lived experiences, positionality, and preconceptions influence the entire research process, inevitably (Cohen & Crabtree, 2006; Creswell, 2009; Finlay, 2002; Malterud, 2001). So, I tell a brief personal story to offer the reader a general context of where I am coming from that I believe partly influenced my research process -- unconsciously and consciously -- including developing the research questions, choosing the theoretical framework and methods, preparing the interview questions and probes, analyzing document and interview data, discussing the results, and concluding the study. This is also to signal the reader that 'reflexivity' forms part of my methods (Cohen & Crabtree, 2006; Creswell, 2009; Finlay, 2002; Malterud, 2001), although I did not engage in 'reflexive ethnography'.

CHAPTER 2

METHODOLOGY AND METHODS

My dialectic method is not only different from the Hegelian, but is its direct opposite. To Hegel, the life process of the human brain, i.e., the process of thinking, which, under the name of "the Idea," he even transforms into an independent subject, is the demiurgos of the real world, and the real world is only the external, phenomenal form of "the Idea." With me, on the contrary, the ideal is nothing else than the material world reflected by the human mind, and translated into forms of thought. - Karl Marx, 1873

This chapter restates the purpose of this study, the overarching research question, and the methodology and methods used to answer the research problems. The *methodology section* briefly explains three competing worldviews informing social and health science research: positivism, idealism, and realism. Then it explains three types of health inequalities researchers: policy-focused positivist, emphatic ethnographer, and critical materialist. Finally, it explains why I chose the critical political economy theory to understand the causes of and means to reduce preventable health inequalities. The *methods section* first describes qualitative research and outlines its general characteristics. Then it presents the research procedures used in this qualitative research: conceptualizing the study, study setting, recruiting participants, sampling, sample size, data collection, and data analysis. Finally, it discusses ethical considerations and delimitations of the study, ending with a chapter summary.

The goals of qualitative research vary across and within disciplines. For example, the goals may include the critical examination of social relations of power and 'giving voice' to a specific population (Canadian Institutes of Health Research CIHR, Natural Sciences and Engineering Research Council of Canada NSERC, & Social Sciences and Humanities Research Council of Canada SSHRC, 2018, p.135). The overall goal of this study is to meet its purpose and answer the overarching research question, which I restate below.

This study aims to examine the causes of preventable health inequalities and the various means of reducing them. It is important because most analyses of the sources and means of responding to health inequalities are divorced from the political economy and politics of public policymaking, and as a result, little has been accomplished in health inequalities reduction (Bambra et al., 2005; Bryant & Raphael, 2020, Navarro, 2011; Williams, 2013). This study contributes to current scholarly and public debates on reducing health inequities by inquiring into Canadian public policy academics, activists, and advocates' understandings of the sources of social and health inequities and the means of addressing them.

The starting point of this dissertation is the ***overarching question***: Why and how do preventable health inequalities, especially class, gender, and race/ethnicity health inequalities, persist in Canada, and how can such differences be reduced through public policymaking processes? To answer the research questions, I conducted a critical realist review focusing on health and public policy theories, namely pluralism, discursive institutionalism, and critical political economy. Then complementing the findings in the literature review, I performed interviews with Canadian policy academics, activists, and advocates, all influential and leading experts in their respective fields. Reflexivity also forms part of my methods.

2.1 Methodology

The methodology is a theoretical framework that informs the research (Morrow & Hankivsky, 2007). Many worldviews are available to social science (Denzin & Lincoln, 1994; Wilson, 1993) and health inequalities researchers (Garthwaite et al., 2015). Three worldviews -- drawn from sociology -- inform this study. ***Positivism*** posits no fundamental difference between the social world/phenomena and the natural world/phenomena. It also assumes that phenomena exist and act apart from human beings and their interpretation of those things. The positivists

believe phenomena can only be known through direct sensory experience (Wilson, 1983). In contrast, ***idealism*** posits that the social world/phenomena are different from the natural world/phenomena and that the social world/phenomena could not exist independently from human beings' understanding of those things. The idealists believe that society is merely a construction of human thoughts; hence, their analysis focuses on ideas and feelings (Wilson, 1983).

Like positivism, ***realism*** assumes that phenomena exist and act apart from human beings and their interpretation of those things. However, realism rejects positivist-empiricist's view that phenomena can only be known through direct sensory experience (Wilson, 1983). Like idealism, realism posits that the social world/phenomena are different from the natural world/phenomena. However, realism rejects the idealist's view that society is merely a construction of human thoughts (Wilson, 1983). Contrary to positivists and idealists, realists focus on social relations, structures, and processes shaping the distribution of economic and other resources and how people understand the world. Realists' analysis is neither restricted to the actual, observable, and measurable phenomena nor peoples' interpretation of those things (Wilson, 1983). Instead, realists think that the deep-rooted level of reality is the 'relations and relations between relations.' An example of realism, historical materialism views commodity, class, state, society, and health as relations rather than things (Wilson, 1983). The sources and means to reducing health inequities is fundamentally about social relations.

Three ideal types of health inequalities researchers map nicely onto Wilson's three worldviews (Garthwaite et al., 2015). Informed by positivism (Wilson, 1983), the ***policy-focused positivists*** believe that experimental and quantitative research offers the most valuable understanding of the causes of and means to reduce health inequalities (Garthwaite et al., 2015).

They believe the empirical study is the best way to move health policy actions. Whereas informed by idealism (Wilson, 1983), ***empathetic ethnographers*** focus on qualitative research to understand health inequalities based on the lived experiences of the individuals and communities (Garthwaite et al., 2015). They believe narrating lived experiences can provoke health policy actions. Finally, informed by realism (1983), the ***critical materialists*** who examine social structures and power relations shaping public policy that create and maintain health inequalities can choose either quantitative or qualitative or mixed approaches (Garthwaite et al., 2015). Critical materialists account for the actual, observable, and measurable phenomena and peoples' interpretation of those things. Thus, the latter believe rebalancing social relations of power offers a better way to reduce health inequities in and out of the public policy realm.

According to Garthwaite and colleagues (2015), these three types of health inequalities researchers held on to their ontological, epistemological, and ideological locations. Wilson (1983) states: "Ontology has to do with what exists, what is real. Epistemology has to do with knowing, how we can know what is real" (p.2). In reality, however, contributions made by health inequalities researchers frequently exhibit combinations of each ideal type (Garthwaite et al., 2015), as is the case in this research.

Nonetheless, it is essential to say that between positivism, idealism, and realism, I leaned towards the latter. I believe realism is more useful in this study because it sees the world and social phenomena as fundamentally shaped by *relations and relations between relations*, which is central in examining social relations of power between classes and groups vying to influence health politics and public policy. Moreover, it accounts for relational objective and subjective realities necessary for understanding and responding to health inequities, especially class, gender, and racial health inequities: no social relations, no human societies. Accordingly, I am a

more critical materialist than a policy-focused positivist and empathetic ethnographer.

Furthermore, aligned with realism, I chose the ***critical political economy*** theory to understand the causes of and means to reduce social and health inequities primarily because it is realist, historical, materialist, and relational (Marx, 1867). The practitioners of this theory integrate health inequities' historical, economic, political, and cultural dimensions into their analysis. They examine the contradictions between materials and ideas, agency and structures, as well as class, gender, and race relations shaping health inequalities (Armstrong et al., 2001). Moreover, critical political economists scrutinize power relations shaping the production and distribution of economic and other resources through public policy that impacts health (Coburn, 2010; Raphael, 2015). They also expose the dominant ideologies, interests, and power that influence health politics but act little to reduce health inequalities (Bambra et al., 2011).

Furthermore, health inequalities researchers who work from a critical political economy perspective examine the roles of the market; labour, civil society, and social movements; and state authorities in shaping public policy actions and inactions on the social determinant of health and health inequalities (Bryant, 2013, 2015a,b; 2016; Bryant & Raphael, 2020). It also accounts for the ways in which and the degrees to which sexism and racism are structured within and through economic and political relations to shape further social and health inequalities (Armstrong, 2020; Borras, 2021; Gupta, 1996; Morrow et al., 2007; Messing & de Grosbois, 2001; Krieger et al., 1993; Syed, 2016; Syed et al., 2016; Navarro, 1991).[4]

Importantly, they examine the role of capitalism or neoliberalism in the contemporary era that creates and maintains health inequalities (Coburn, 2004; Labonté & Stuckler, 2015; Muntaner et al., 2011; Navarro, 2007a,b; Labonté & Ruckert, 2019; Schrecker & Bambra, 2015).

[4] For the non-health-focused account of what I refer to as the 'co-constitutiveness' of capitalism (class), sexism (gender), racism (race), and colonialism (nationality), see Brown (2014), McNally (2015), McLaren (2020), Anderson (2021), and Musto and Martinez (2022) for example.

The crux of this theory that I applied in this research is social relations underlying the production of social life without which no human societies would exist. Thus, I firmly believe and take the stance that the critical political economy approach to health is more valuable than others providing the theoretical and analytical lens that captures the reality of health inequities, their causes, and their potential solutions.

2.2 Methods

A health inequalities researcher informed by realism and critical political economy theory can select from quantitative, qualitative, or mixed research methods to examine social relations and power structures shaping the politics of institutional public policymaking that create and maintain health inequalities (Garthwaite et al., 2015). In this study, I chose the ***qualitative research method*** for the following reasons.

Denzin and Lincoln (1994) describe: "Qualitative research is multimethod in focus, involving an interpretive, naturalistic approach to its subject matter" (p.2). The term *qualitative* suggests highlighting the qualities of the phenomena that are, for example, examined not through experimental or quantitative methods using frequencies or quantities. Instead, a qualitative researcher recognizes the socially constructed nature of reality, the relation between the phenomena and the researcher, and the circumstances shaping the study. Thus, the value-laden nature of the inquiry. Notably, a qualitative study searches for answers to the questions that emphasize how and why phenomena are produced and ascribed meaning (Denzin & Lincoln, 1994), in this case, health inequities, especially class, gender, and race/ethnicity-based health inequities. Further informed by Creswell (2009), I observed the following ***general characteristics of qualitative research*:**

Natural setting: A qualitative researcher may gather the data where the participants experience the social problem. This study is bounded in the Canadian context. Each key informant chose the location of the interview: 21/23 were conducted in the Greater Toronto Area and 2/23 in Victoria, British Columbia.

Researcher as a key instrument: A qualitative researcher may gather the data by examining existing literature, behavioural observation, or interviewing. Therefore, I collected, organized, and analyzed existing documents, and interview data relevant to this study's research questions and purpose. Specifically, I developed two sets of questionnaires instead of using instruments and questionnaires created by others.

Multiple sources of data: As shown in this study, I did not depend on one single data source. Instead, I reviewed all the document and interview data and interpreted and organized these into themes cutting across various data sources.

Inductive data analysis. A qualitative researcher examines the collected data and identifies patterns or themes from the 'bottom up' by arranging the data into 'more abstract units of information.' My inductive analytical process is recursive; it involves going back and forth between the data corpus and potential themes until the final themes are established.

Participants' meanings. During the entire research process, I focused on reviewing, analyzing, and interpreting the meaning of the insights provided by the Canadian public policy academics, activists, and advocates concerning social and health inequities. Essentially, I deliberately centred their voices instead of mine.

Emergent design. The qualitative research process develops over time, which means original plans cannot be stringently set. The research process may be altered as the qualitative researcher goes into the field and collects data. For example, as the need arises, without

diverging substantially, I slightly changed the original interview questions by adding COVID-19 questions. Notably, the main idea of a qualitative study is to understand and address the research problems by learning from the insights of the key informants.

Theoretical lens. A qualitative researcher employs an analytical lens to inform their data analysis. I am primarily informed by the critical political economy approach to health, as discussed earlier. However, I also draw on the pluralism and discursive institutionalism approach to health inequalities and several theories of health inequities.

Interpretive. Qualitative research is an interpretive inquiry in which the researchers decipher 'what they see, hear, and understand.' Accumulated experiences and knowledge further inform my document and interview data interpretations. Indispensably, after the final report, the readers would also be able to interpret it, offering other interpretations. When the readers, researchers, and participants provide their interpretations, multiple perspectives about health inequities can be further established.

Holistic account. A qualitative researcher attempts to develop a complex portrayal of the social problem under examination. This study reports the multiple competing but, at times, complementary views of the causes and means to reduce health inequities, illustrating a broader holistic picture of the phenomena. Critically, it accounts for multiple realities and complex interrelationships and system dynamics shaping social and health inequities and the various ways of reducing such inequities in life circumstances.

Qualitative inquiry strategies include but are not limited to narrative, ethnography, case study, and unspecified approaches (Denzin & Lincoln, 2005). In short, "There is no single approach in qualitative research" (CIHR et al., 2018, p.134). This study is based on a literature review of existing document data (see Chapter 3) and a thematic analysis of 23 semi-structured

interviews with Canadian public policy academics, activists, and advocates with in-depth knowledge of health inequities or social inequities and the factors and mechanisms underlying them (see Chapter 4). As mentioned earlier, I acknowledge that personal lived experiences, positionality, and preconceptions influence the entire research process, inescapably (Cohen & Crabtree, 2006; Creswell, 2009; Finlay, 2002; Malterud, 2001). So, I engage in reflexive research practice to a certain degree.

Reflexivity can be understood in various ways. Some say reflexivity is a practice and concept accepted in social and health sciences qualitative research (Subramani, 2019). Others contend, and I agree that in part: "A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions" (Malterud, 2001, pp. 483-484). Reflexivity can also be described as 'thoughtful, conscious awareness' applied in a research process: conception and data collection and analysis. It may also mean personal reactions, accounts of methodology, acknowledging tendencies, and locating the investigator in the research process. However, reflexivity becomes problematic with the preoccupation with subjective personal experiences and feelings (Finlay, 2002). In this study, in the beginning, I provided the reader with a brief account of my lived experiences and positionality potentially influencing the research to a certain degree. Importantly, however, I carefully practiced 'reflexivity' without decentering the informants' voices.[5]

[5] Conscious that I am not engaging in personal or reflexive ethnography and often overworked, I tried but could not maintain a thorough and detailed 'reflexive journal' as others suggest (e.g. see Guba & Lincoln, 1994). I find it too personal and time-consuming. Instead, I continue my strategy of jotting down keywords, phrases, and short sentences before, during, and after gathering document and interview data sufficient to trigger memories, brainstorm accumulated knowledge, and develop ideas based on actual experiences in and outside the academe relevant to dissertation research. I write using scratch paper, notebook, bond paper, and electronic devices throughout my life course to develop and store my ideas. These entries, I consider not 'reflexive journals' or diaries. Until this point, I am less interested in personal diaries or journals nor wish to write an autobiography or autoethnography.

There is no universal method but rather numerous methods in research (Bernard, 2013). Research methods involve the collection, analysis, and interpretation of data. The data sources in a qualitative study may include the existing literature and policy documents or document data, and interviews or interview data (Creswell, 2009). Data analysis may be informed by 'generic' or 'basic qualitative analysis' or analytical steps by a qualitative research method such as a narrative approach. Despite analytical differences, the key to qualitative data analysis is to "follow steps from the specific to the general and as involving multiple levels of analysis" (Creswell, 2009, p.184). Data analysis can employ thematic analysis (Braun & Clarke, 2006).

Thematic analysis is 'a foundational method for qualitative analysis' and can be considered a 'method in its own right' (Braun & Clarke, 2006, p.78). Thematic analysis is a theoretically flexible approach to qualitative data analysis and could be a realist or constructive method (Braun & Clarke, 2009). A qualitative approach using thematic analysis based on interviews has been applied in examining health inequalities and has proven useful (e.g. see Brophy et al., 2020; Pilkington et al., 2010; Smith, 2007). This study employed thematic analysis of the interview data corpus resulting from 23 semi-structured interviews that I conducted. Before conducting interviews, I secured York University's Ethics Review Board approval certificate STU 2019 -135.[6]

Conceptualizing the study. My research problem was conceived out of numerous readings and discussions while pursuing MA and Ph.D. in Health, specializing in Health Policy and Equity at York University. I am curious about why and how health inequities persist, particularly in the Canadian context. Consciously combining the acquired knowledge from the academic world with my lived experiences in the Philippines and Canada, reflecting on my positionality as a de-skilled working-class Filipino male immigrant in Canada who eventually

[6] Copy available upon request.

became a healthcare worker in a racialized and gendered long-term care facility, and thinking about the material and social conditions of our family of six, I developed a research proposal. After the initial write-up and consultation with my dissertation supervisor, Professor Dennis Raphael, I submitted a research proposal to the three-member committee to know whether the proposed study was important. Then heeding the collective advice of the committee, including but not limited to refinements of the research questions, methodology, methods, interview guide and questions, and potential participants, the revised version of the research proposal was approved.

Study setting. Although social and health inequities are global, this study focuses on the Canadian context. Nonetheless, during the interview, I did not limit the insights of the informants to any particular geography. Furthermore, since healthy public policy and public health policymaking occur at various government levels, I did not restrict the conversations to any specific Canadian government level. My original plan was to conduct in-person face-to-face interviews. Since I live in Mississauga, I limited the interviews to be performed in the Greater Toronto Area. The in-person interviews I conducted outside GTA only included Professors William Carroll and Trevor Hancock in British Columbia primarily because of their important work in political economy and health promotion.

Recruiting participants. My literature review informs the recruitment of participants. Specifically, I identified the potential participants through the reading materials, university websites, committee, friends, and colleagues. The main criteria for Canadian public policy academics are based on academic background, expert knowledge, and research experience, whereas for the activists and advocates, based on organizational role, expert knowledge, research experience, and engagements concerning politics and public policymaking addressing social and

health inequities. Then after approval from the committee, an invitation letter with an attached informed consent form was emailed to each potential participant. My thesis supervisor sent the recruitment email first, and I followed up within two weeks. In some cases, I directly emailed the potential participants. I firmly believe no undue influence occurred during the recruitment process. Before the interview, the informed consent was secured electronically, verbally, or written. See Appendix A: Participant Recruitment Letter and Appendix B: Participant Informed Consent Form.

Sampling. I used purposive sampling to recruit informants with expert knowledge about social inequities, social determinants of health, and health inequities. Purposive sampling selects information-rich sources from which a researcher can acquire valuable insights addressing the research questions and purpose of the study (Bernard, 2013; Patton, 1990). The purposive sampling may involve organizations, groups, and individuals with in-depth knowledge about the phenomena under examination (Creswell & Plano, 2011). Since I interviewed distinct populations: Canadian public policy academics, activists, advocates, or their combinations -- health, non-health, or union and healthcare-focused -- my purposive sampling is partly stratified. Stratified purposeful sampling offer variations and not only a common core of understanding (Palinkas et al., 2013; Patton, 1990). Moreover, since a few informants recommended other information-rich potential interviewees, and I interviewed three of them, this research partly utilized snowball or chain sampling (Patton, 1990). Importantly, I maintained an open mind that each informant -- whether or not known to each other -- might offer converging and diverging views about the causes of and means to reduce social and health inequities, especially since I had not sent them the semi-structured interview questionnaire with probes in advance.

Table 1 presents the 23 interviewees in order of appearance. I first classified them into academics, activists, advocates, or combinations. Then I categorized them into health, non-health, and healthcare union. The last column identified some of their previous and current roles.

Table 1. List of Key Informants

Interview Date '20	Name	Aca	Act	Adv	Organization	Health	Non-health	Healthcare Union	Primary Role (s)
Jan 24	Clarke		+		Ontario Coalition Against Poverty		+		OCAP Retired Organizer Current Packer Visitor in Social Justice York Univ
Jan 31	Carroll	+			University of Victoria		+		Critical Sociologist
Feb 01	Hancock	+		+	Conversations for a One Planet Region	+			Retired Professor Public Health Physician Health Promotion Consultant
Feb 04	Crowe		+		Shelter and Justice Network		+		Street Nurse, Current Distinguished Visiting Practitioner Ryerson
Feb 07	Anon N5	+		+		+			Health Economist
Feb 27	Hulchanski	+			University of Toronto		+		Professor Housing and Community Development
Mar 02	Anon N7	+					+		Sociologist
Mar 03	Panitch	+					+		Retired Distinguished Research Professor of Political Science
Mar 05	Armstrong	+	+	+	York University	+			Distinguished Research Professor of Sociology
Mar 10	Sam Gindin		+		Socialist Project		+		Political Activist, Former Visiting Packer Chair Social Justice York Univ
Mar 12	Anon N11		+	+				+	Labour Union Leader
Apr 04	Goldring	+			York University		+		Public Sociologist
Apr 16	McKenzie	+	+	+	Wellesley Institute	+			Director of Health Equity CAMH
Apr 17	Anon 14	+		+		+			Epidemiologist
May 01	Block			+	CCPA		+		Senior Economist
May 04 Jun 05	Khenti	+	+	+	University of Toronto	+			Professor Senior Scientist CAMH
May 06	Stewart		+	+	SEIU Healthcare			+	President SEIU Healthcare Local 1
May 07	Albo	+	+	+	Centre for Social Justice		+		Professor, Political Economist
May 14	Anon 19	+	+			+			Physician
Jun 02	Mehra			+	OHC	+			Executive Director OHC
Jun 12	Hurley		+		OCHU - CUPE			+	President OCHU First VP CUPE Ontario
Jun 18 Jun 23	Jonah Gindin		+	+	OCHU- CUPE			+	Researcher, Collective Bargaining Agreement Specialist
Aug 12	Bryant	+			Ontario Tech University	+			Public Scholar
						9	10	4	

Legend:
Aca = Academic. Act = Activist. Adv = Advocate
CCPA = Canadian Centre for Policy Alternatives
OCHU = Ontario Council of Hospital Unions
CAMH = Centre for Addiction and Mental Health
OHC = Ontario Health Coalition
CUPE = Canadian Union of Public Employees

The first classification was based on the query: "I stratified my participants into academics, activists, advocates, and any of their combinations. How do you wish to be described?" Some I missed asking. Based on their backgrounds and interview data, the labelling is mine for Clarke, Carroll, Hancock, Anon N5, Hulchanski, Anon N11, and McKenzie. In this study, health-focused informants refer to those who see societal issues (e.g. employment, income, housing) as health issues or social determinants of health issues, while non-health-focused informants refer to those who do not primarily see societal issues as health issues or social determinants of health issues.[7] Healthcare union participants are those who belong in a labour union and involve in healthcare.

Sample size. Patton (1990) states, "*There are no rules for sample size in qualitative inquiry.* Sample size depends on what you want to know, the purpose of the inquiry, what's at stake, what will be useful, what will have credibility, and what can be done with available time and resources" (p.184, original emphasis). Some explained that the guidelines for samples sizes in qualitative interviews range from five to 350 participants. For ethnography and ethnoscience, Bernard suggested 30 to 60 compared to Morse's 30 to 50 participants; for grounded theory, Morse proposed 30 to 50 compared to Creswell's five to 25 participants; for phenomenology, Creswell advised five to 25 compared to Morse's six or more; for smaller projects, Chamaz

[7] My decision to include Cathy Crowe among the non-health-focused informants is based on her reply to the query: As I've mentioned earlier, some people see these issues, poverty and homelessness, as health issues through their use of the term social determinants of health where I came from. How do you see the framing of these issues as health issues?

Cathy Crowe: It's actually, I mean, it makes sense, right? But it's actually problematic. Right now, because of the federal government, through Adam Vaughn, who's my member of parliament and he's a friend and colleague. He's a former journalist; he's essentially the policy designer of the National Housing Strategy. But he has framed it all through health. Initially, it sounds brilliant, but what it's done, the way I see it, it has meant that the implementation of the National Housing Strategy is through a whole bunch of different Ministers because he sees it as through health. It's not that he's not correct, but I think it's given him the latitude to support that structure. So, there'll be some housing money that will come through the Minister responsible for Indigenous issues, some through the Minister responsible for family and children, et cetera. But it means, this is just my view, there's not one Minister of like, there is not, there are maybe four Ministers now that have housing in their mandate letters. Whereas way back in the old days, there would be one Minister of Housing and that person, that would be their thing, that would be their specialty, they would roll out a program. So, I think it's kind of backfired, honestly - a little bit.

advocated for 25 participants; and for all qualitative research , Bertaux recommended at least 15 participants (Mason, 2010). My sample size is 23 participants.

Sample limitations. The recruitment process came in three waves: January, February, and March 2020, targeting 17, 16, and nine potential interviewees. The acceptance rate reached 23/42, exceeding the proposed 15 to 20 interviewees. *Equity, diversity, and inclusion.* While the targeted potential informants initially have an almost equal number of males and females representing racialized (e.g. Indigenous, People of Colour) and non-racialized (e.g. Caucasians) from various academic and advocacy organizations, the outcome consisted of 15 males and eight females, 18 presented as visibly white and five presented as people of color, including Asians and Blacks. The BIPOC and women are unequally represented.[8] This result is unintentional. As a working-class racialized immigrant, married to a feminist union leader, and living together with young adult children (three females and one male), I consciously tried to avoid inappropriate exclusions and unequal representation. However, the final set of informants depended on who accepted, declined, or did not reply to invitation letters.

Homogeneity and heterogeneity. The 23 key informants can be further stratified as Canadian public policy academic (6), academic-activist (1), academic-advocate (3), academic-activist-advocate (4), activist (4), activist-advocate (3), and advocate (2). The academics are more represented, followed by activists, and least by advocates. Nine interviewees are health-focused, 10 are non-health-focused, and four are union leaders in the healthcare industry. The informants from the healthcare labour unions are least represented. The interviewees can also be categorized as labour leaders (4), community organizers and leaders (3), sociologists (4), political economists (4), economists (2), physicians (3), epidemiologist (1), housing and community development specialist (1), and public scholar (1) – all experts in their field.

[8] I did not ask them about their preferred gender or ethnicity.

Geography. Of the 23 key informants, 21 reside in the Greater Toronto Area and two in Victoria, British Columbia. Notably, the findings in this study are not generalizable and should be treated as such.

Data collection. The interview data were gathered through one-on-one semi-structured interviews or in-depth interviewing. A qualitative interview is appropriate because I was interested in getting the insights of key informants whom I believe can provide in-depth knowledge complementing the literature review to address the research questions (Bernard, 2013). Specifically, a semi-structured interview allows the participants to freely express their views (Cohen & Crabtree, 2006), enabling in-depth examination of the phenomena, especially when their insights are less known in the topic of interest (Guba & Lincoln, 2005). As discussed earlier, the insights of public policy academics, activists, and advocates about health inequities are underexplored. By engaging the informants through semi-structured interviews, I was able to carry out different lines of inquiry, drawing out their profound insights about the causes and means of reducing preventable health inequalities in Canada.

An interview guide is necessary for a semi-structured interview (Bernard, 2013). An interview guide ensures similar questions are asked to all the informants while offering some flexibility for the conversation to develop (Cohen & Crabtree, 2006). I developed a loose interview guide with broad, open-ended questions intended to open up a dialogue that should last from 30 to 45 minutes (Bernard, 2013; Denzin & Lincoln, 2005). Two sets of interview guides were prepared: one for the health-focused and the other for non-health-focused informants, with minor differences in the language used. The interview questions do not substantially diverge. See Appendix C: Semi-structured Interview Guides.

The interviews were planned to be face-to-face; however, the participants could choose online or by telephone (Bernard, 2013). I did one telephone and eight in-person interviews before the pandemic. Amid the pandemic, five were via telephone and nine online. The informants were informed that only audio recording would be done for online interviews. Heeding the advice of Professor Pat Armstrong - the ninth interviewee - I used two tape recorders. Two recorders help avoid jotting notes and minimize distractions (Bernard, 2013; Cohen & Crabtree, 2006). In addition, having a backup tape increases the chance that the interview conversations will be recorded. Importantly, before the actual interview, I read the brief background, the purpose of the study, and the informed consent. Specifically, I sought consent whether or not the participant wished to waive anonymity: 5/23 of key informants wanted to be anonymous. All informants gave their free and informed consent.

I performed the 23 semi-structured interviews between 24 January to 13 August 2020. Each informant identified the interview location and date. Only one participant was interviewed on any given day. Specifically, I did 9/23 interviews before the WHO declared the COVID-19 pandemic, while 14/23 interviews were done remotely amid the COVID-19 epidemic in Canada. Unable to anticipate, for the former group, I have no questions about COVID-19. For the latter group, I asked questions relative to the COVID-19 epidemic in Canada. The actual interviews lasted approximately 30 to 120 minutes, most of which were between 45 to 60 minutes.

Data analysis. I alone performed the thematic analysis of the entire interview data corpus. Thematic analysis is "identifying, analyzing, and reporting patterns (themes) within data" (Braun & Clarke, 2006, p.79). It can be a 'more detailed and nuanced account' of the theme(s) related to a particular area of interest within the data or a 'rich description of the data set' (Braun & Clarke, 2006, p.83). Thematic analysis can be *inductive* where themes are

robustly related to data (Patton, 1990) or *theoretical,* driven by the investigator's analytical interest in the phenomena (Braun & Clarke, 2006). The former is data-driven, whereas the latter is analyst-driven (Patton, 1990; Braun & Clarke, 2006). Identifying the patterns or themes may occur at the explicit or *semantic level* where the analyst focuses on the surface meanings of what the informants express. It may also occur at the interpretative or *latent level*, where the analyst investigates "the *underlying* ideas…and ideologies…theorized as informing the semantic content of the data". Combinations of these features of thematic analysis are possible (Braun & Clarke, 2006, p.84). This study attempts to integrate these diverging but often converging features of thematic analysis.

There is no universal standard for thematic analysis (Braun & Clarke, 2006). Specifically, I am informed by Braun & Clarke's Six Phases of Thematic Analysis outlined below.

Table 2. Braun and Clarke's Six Phases of Thematic Analysis

Familiarizing yourself with your data	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
Reviewing themes	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Reproduced verbatim from Braun and Clarke (2006, p.87).

Transcribing and familiarizing with data. Informed by the above thematic analysis guide, I began my data analysis by familiarizing myself with the interview data. Transcribing and reading the interview documents multiple times throughout the research process enabled me to grasp the insights of the key informants (Braun & Clarke, 2006) about social and health inequities persistence. Immersed and actively engaging with the interview documents, I became aware of the breadth and depth of the interview data, improving the rigor of my analysis. Transcribing and familiarizing oneself with the interview data can be considered an interpretative act (Braun & Clarke, 2006). During this process, keywords, initial codes, and potential themes were formed in my mind. Finally, I wrote down key ideas to remind me of my first impressions.

Specifically, I used Temi advanced speech recognition software for initial data transcribing and finalized the transcripts manually while listening to the audio recording.[9] This two-step process ensures the accuracy of transcripts. Except for the deletions of some words like the 'ums' and 'ohs' that I deemed unnecessary in this study as they only distract the reader, the transcripts are all verbatim.[10] Data transcriptions were often cleaned within three to five days after the interview. Then I sent each transcript with the audio recording to each participant for confirmation. Some replied with few corrections, in which changes were unsubstantial. Others did not reply, and so I consider it approved. One informant said there was no need for me to send the transcript.[11]

[9] As proposed, I intend to transcribe the audio recordings manually or using NVivo computer software. However, advised by my daughter Jana Borras, a Ph.D. Candidate in Sociology at York University, I decided to use the Temi. My thesis supervisor approved the use of Temi.

[10] I do not intend to interpret the informants' pauses or body language. I do not have the necessary education, skills, and experience to do such interpretations. Instead, I am primarily interested and attentive to the interviewees' insights relative to the questions.

[11] I also sent the transcripts and audio recordings to my thesis supervisor for reporting purposes.

Coding interview data. Informed by the literature review and familiarized with the interview data, I then coded each interview document. Systematically, I coded interesting aspects of the interview data. Coding organizes the interview data into meaningful groups; thus, it is part of data analysis. Researchers can code the transcripts manually or use computer software (Braun & Clarke, 2006). In this study, data management was facilitated by MAXQDA qualitative data analysis software that automatically generated smaller paragraphs for coding. Aside from coding the paragraph, I generated initial codes for the sentences. Specifically, I coded potential themes as many as possible for insights expressed by the informants, whether explicitly (semantic level) or implicitly (latent level) (Braun & Clarke, 2006). My coding process ensures that the context and meaning of the individual data extracts are preserved. The relevant data extracts, which I coded once, twice, or multiple times are subsumed in different potential themes where they belong (Braun & Clarke, 2006). The total of generated initial codes was 244 codes. The MAXQDA showed 7695 coded segments across the data corpus. I coded the interview data between 27 May to 8 August 2021, which I keep on going back for relevant data extracts and re-coding when necessary.[12] See Table 3 and Appendix D for the complete list.

Table 3. Samples of Generated Initial Codes Using MAXQDA

Code System		No. of Coded Segments	No. of Informants
Academics		24	10
Activists		30	8
Advocates		72	18
Balance of forces		26	13
Barriers to policy change		146	23
	Power	66	17
	Ideological	30	13
Capitalism and political economy		134	23
Class		53	15
Colonialism		25	15
Gender		49	21
Race/Ethnicity		94	19

[12] As proposed, NVivo is an option for transcribing and coding. However, advised by Jana Borras, I used the MAXQDA computer software. I sent samples of my MAXQDA-aided initial coding process to my thesis supervisor for reporting purposes.

Searching for themes. Identifying potential themes relevant to my research questions became less complicated with the initial codes applied across the interview data corpus. Still following Braun & Clarke (2006), I gathered the closely related initial codes with subsumed data extracts and classified them into different potential main themes and sub-themes. I used outlines and tables instead of thematic maps during this process. My strategy involved renaming initial codes for precision and reorganizing identified potential main themes and sub-themes. Braun and Clarke (2006) state, "Part of the flexibility of thematic analysis is that it allows you to determine themes (and prevalence) in a number of ways" and "there is no right or wrong method for determining prevalence" (p.83). The MAXQDA automatically counted the prevalence of coded segments under each code across the entire data corpus. For example, the initial code 'capitalism and political economy' generated 134 coded segments from 23 interviewees, as shown in Table 3. Finally, I manually counterchecked the 'potential themes (and prevalence)' across each interview document to ensure accuracy.

Reviewing themes. Having a better grasp of the initially identified main themes and sub-themes, I started fusing, breaking, and excluding potential themes. First, I reread the data extracts under each potential candidate theme and decided whether they formed a coherent whole. For data extracts that seemed off, I relocated to other candidate themes. I then reviewed the entire data set to determine whether they fit the identified potential candidate theme (Braun & Clarke, 2006). Informed by health inequities theories and public policy theories in relation to health inequities, I concentrated my thematic analysis on the most relevant themes and data extracts that address the research questions and purpose of the study.

Defining and naming themes. Having reviewed the potential candidate themes and developed a good outline and table of themes and sub-themes, I proceeded to 'define and refine'

the themes, which involved the investigation of the 'essence' of what each theme is all about. This process also involved determining and analyzing the quality of the data extracts classified under each theme (Braun & Clarke, 2006). Then I organized and reorganized the themes and data extracts until coherence was achieved. My final themes below are distinct but interrelated, all of which addressed the research questions and were consistent with the purpose of the study.

Table 4. Final Main Themes and Sub-themes

Causes of Health Inequities	
Themes	Sub-themes
The capitalist economic system	Capitalism and labour
	Capitalism and poverty
	Capitalism and healthcare
The co-constitutives of capitalism: colonialism, racism, and sexism	
Maldistributive public policies	
Factors Sustaining Health Inequities	
Themes	Sub-themes
Power, interest, and ideology trump evidence	Power trumps evidence
	Interest trumps evidence
	Ideology trumps evidence
	Power-interest-ideology trump evidence
Unequal resources of competing interests and advocacy groups	
Dominance of the business and corporate sector	
Neoliberal governing authorities	
Fragmented and weak labour, civil society, and social movements	
Moving Forward to Reduce Health Inequities	
Themes	Sub-themes
Pushing for redistributive public policies	Social determinants of health
	Electoral reform
	Unionization
Uniting and strengthening labour, civil society, and social movements	
Engaging in electoral politics	
Core strategies	Informing and educating
	Advocating
	Organizing and mobilizing

Producing the report. Beyond paraphrasing and describing, I analyzed and discussed the themes and data extracts in relation to the existing literature and research questions (Braun & Clarke, 2006). My analytical method is informed by different worldviews, theories of health inequities, and public policy theories applicable in examining health inequities. My research questions and assumptions also drive it. Due to time and space constraints, I concentrated on common themes demonstrating a common view of the causes, factors sustaining, and means to reduce preventable health inequalities in Canada. However, it does not mean that I did not compare and contrast the insights of the key informants. As shown in the results section, I ensured that the illustrative quotes were labelled from each Canadian public policy academic, advocate, and activist or their combinations. In doing so, the study further addressed the specific questions of how academics, advocates, and activists view and respond to health inequities, including but not limited to the politics of class, gender, and race/ethnicity health inequities.[13] Importantly, to achieve objective and rigorous data analysis, to the best of my knowledge, I adhered to Braun & Clarke's (2006) criteria for good thematic analysis outlined below. See Table 5. I consciously engage in reflexive research practice (Cohen & Crabtree, 2006; Finlay, 2002; Malterud, 2001).

Data security, handling, and storage. All the electronic data were stored in a laptop encrypted with strong passwords. The hard copies were secured in a locked filing cabinet in the researcher's locked room. No personally identifiable information was audio-recorded and transcribed for the five anonymous interviewees. I used alphanumeric codes to protect their identities. The informed consent forms were protected and locked in a separate filing cabinet.[14]

[13] This research can potentially aggregate the results into academics, activists, and advocates or their combinations, health-focused or non-health focused, for example. I plan to do this task in the future.

[14] As proposed, only the researcher and the committee can access the audio recording and transcripts. This qualitative study secured York University's Ethics Board Review ensuring data privacy and protection, including email communications.

Data dissemination. The potential outputs of this study include but are not limited to the researcher's dissertation, future conference presentations, or publications in refereed journals.

Table 5. Braun and Clarke's 15-Point Checklist of Criteria for Good Thematic Analysis

Process	No	Criteria
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples (an anecdotal approach) but, instead, the coding process has been thorough, inclusive and comprehensive.
	4	All relevant extracts for all each theme have been collated.
	5	Themes have been checked against each other and back to the original data set.
	6	Themes are internally coherent, consistent, and distinctive.
Analysis	7	Data have been analyzed rather than just paraphrased or described.
	8	Analysis and data match each other, the extracts illustrate the analytic claims.
	9	Analysis tells a convincing and well-organized story about the data and topic.
	10	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
Written report	12	The assumptions about, and specific approach to thematic analysis are clearly explicated.
	13	There is a good fit between what you claim you do, and what you show you have done i.e., described method and reported analysis are consistent.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher is positioned as *active* in the research process; themes do not just 'emerge'.

Reproduced verbatim from Braun and Clarke (2006, p.96).

2.3 Ethics

After the thesis committee approved the research proposal, I submitted it and the required ethics forms to York University's Ethics Review Board for approval, which I secured on 11

December 2019. Part of securing ethics approval is to read, understand, and obtain the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans Course on Research Ethics (TCPS: CORE) certificate. I obtained the certificate on 4 October 2019. In this study, I am further informed by the Tri-Council Ethical Conduct for Research Involving Humans, including the General Approach and Methodological Requirements and Practices for Qualitative Research (CIHR et al., 2018). For example:

Chapter 1. Article 1.1. To the best of my knowledge, I followed and applied the interrelated and complementary core principles of 'respect for persons,' 'concern for welfare,' and 'justice.' Importantly, I secured the participants' free and informed consent.

Chapter 2. Article 2.1. Before starting interviews involving Canadian public policy academics, activists, and advocates, I sought approval from the Research Ethics Board (REB). *Article 2.8.* I was aware that should unexpected issues arise with ethical implications or any changes to the approved research, I will report them immediately to the REB. Due to COVID-19 protocols in Canada, as a requirement, I secured a non-substantial amendment to the approved research protocol from the REB. I considered foreseeable risks and took steps to mitigate or remove them. Importantly, I respected the participants' beliefs, values, and culture.

Chapter 3. Article 3.1. Having secured the ethics approval, I informed each potential participant that consent was voluntary and could be withdrawn at any time. I believed no coercion or undue influence occurred during the process. I offered no monetary compensation. *Article 3.2.* I provided full disclosure of all information to the participants so that they could attain an informed decision. *Article 3.5.* I started the interviews only after the participants gave consent. *Article 3.6.* As I engaged in critical inquiry, I paid attention to the risks of breach of privacy and stigmatization of the participants. Notably, I considered their views personal and did

not necessarily reflect or represent the views of their organizations. *Article 3.12*. Finally, I secured signed, oral, or any appropriate informed consent forms as per *Article 10.2*.

Chapter 4. Articles 4.1 to 4.7. My qualitative research using semi-structured interviews was inclusive, except for age. I did not interview persons under 18 years old. Moreover, I intended to have an equal number of males and females and participants from various racial and ethnic backgrounds. However, as discussed earlier, the final set of key informants showed that women and BIPOC are not equally represented, which is not intentional on my part.

Chapter 5. To the best of my knowledge, I complied with "all applicable legal and regulatory requirements with respect to protection of privacy, and consent for the collection, use, or disclosure of information about participants" (p.57). Furthermore, I employed precautionary measures to safeguard the confidentiality of the data from "unauthorized access, use, disclosure, modification, loss, or theft" (p.58). Security measures, including physical, administrative, and technical safeguards and protection of participants through the collection and use of anonymized data, were ensured.

Concluding statements. During the entire research process, I observed a 'constant reflective approach' because reflexivity, responsiveness, and flexibility strengthen the rigor of research (CIHR et al., 2018). Moreover, I recognized that in critical inquiry, involving the analysis of social structures and public policies (CIHR et al., 2018) or qualitative research using the critical political economy approach, which is aligned with the critical theory tradition, control often belongs to the transformative intellectual (Guba & Lincoln, 2005). However, I also believe that "the power literacies and the concern with social change…of critical theoretical research have never been more important to the world" (Kincheloe & McLaren, p.332). In part, this research is about health inequities reduction through transformative social change.

Furthermore, I am aware that thematic analysis is seldom acknowledged (Braun & Clarke, 2006, p.77), although it is now used explicitly by some social and health inequalities researchers (e.g. see Smith, 2007; Brophy et al., 2020; Pilkington et al., 2010). Arguably, good and rigorous qualitative research is shaped by the researcher's epistemological standpoint (Cohen & Crabtree, 2006). The quality of this research, including trustworthiness, is for the reader's assessment.

2.4 Delimitations of the Study

The literature review focuses on Western literature in the English language. The semi-structured interviews involve Canadian public policy academics, activists, and advocates. The study concentrates on class, gender, and racial health inequities and public policy theories, namely pluralism, discursive institutionalism, and critical political economy in relation to health. This research is bounded within the Canadian setting.

2.5 Chapter Summary

This chapter restated the aim, research questions, methodology, and methods used in this study. Specifically, I explained three different social and health science research methodologies: positivism, idealism, and realism. Then I compared the policy-focused positivist, emphatic ethnographer, and critical materialist health inequalities researchers. Finally, I reasoned why I chose the critical political economy approach to health. Furthermore, I described the qualitative method, its general characteristics, and the research procedures used, including conceptualizing the study, study setting, recruiting participants, sampling, sample size, data collection, and analysis. Finally, I provided ethical considerations and delimitations of the study.

CHAPTER 3

REVIEW OF THE LITERATURE

The question whether objective truth can be attributed to human thinking is not a question of theory but is a practical question. Man must prove the truth — i.e. the reality and power, the this-sidedness of his thinking in practice. The dispute over the reality or non-reality of thinking that is isolated from practice is a purely scholastic question. – Karl Marx, 1845

3.1 Introduction

Closely aligned with the realism worldview and critical materialist health inequalities researchers' perspectives, my critical realist review included quantitative, qualitative, and mixed-methods studies investigating the extent of health inequities and discourses on the sources and means of reducing health inequities that help answer the research questions. Moreover, it explores and explains various health inequities and public policy theories relevant to addressing the research problems. Specifically, I focused on public policy frameworks and paradigms, namely pluralism, discursive institutionalism, and critical political economy in relation to health and policy change. Embedded in the literature review's explorations, analyses, and discussions are the politicians, policymakers, academics, activists, and advocates' understandings of social and health inequities and how they engage such social problems in various times and spaces.

Reviewing relevant literature and locating state of the art is essential because it links the research to the broader ongoing discourse, fills research gaps, and expands upon previous studies. Moreover, it offers the context for establishing the importance of the study and serves as a reference for comparing results (Creswell, 2009). To complement the findings in the literature review, I performed interviews with Canadian policy academics, activists, and advocates, all influential and leading experts in their respective fields. In this study, I also used what I found in

the literature as data sources to reflect upon the informants' discussions about social and policy changes impacting health outcomes.

In part, my literature review can be considered a theoretical literature review. For example, Labaree (2022, p.3) defines a ***theoretical review***:

> The purpose of this form is to examine the corpus of theory that has accumulated in regard to an issue, concept, theory, phenomena. The theoretical literature review helps to establish what theories already exist, the relationships between them, to what degree the existing theories have been investigated, and to develop new hypotheses to be tested. Often this form is used to help establish a lack of appropriate theories or reveal that current theories are inadequate for explaining new or emerging research problems. The unit of analysis can focus on a theoretical concept or a whole theory or framework.

My review focuses on health inequities and public policy theories relevant to addressing the research problems: pluralism, discursive institutionalism, and critical political economy in relation to health and policy change. Moreover, aligned with realism, Pawson et al. (2005) and Edgley et al. (2016) informed my literature review. A developing type of literature review, a ***realist review,*** has been proven helpful in synthesizing complex social interventions and policies concerning health issues. It offers an "explanatory analysis aimed at discerning what works for whom, in what circumstances, in what respects and how" (Pawson et al., 2005, p.21). It involves explaining the theories and the impacts of social and policy interventions, examining empirical evidence reinforcing or opposing theories, and fusing evidence and theories. A realist review offers no easy answers to complex questions (Pawson et al., 2005).

Specifically, a ***critical realist review*** engages "with realist ontology as well as normative issues that underpin a critical realist approach" that goes beyond what is empirically observable (Edgley et al., 2016, p.332).[15] It is a literature-based methodological approach to critical analysis, which applies social science theory to investigate social practices, including but not limited to health practices, policies, and interventions accounting for their economic, political, and cultural dimensions and power relations (Edgley et al., 2016). Notably, it is not merely an 'empirical review' of social and policy interventions, as suggested by Pawson et al. (2005), but a 'literature review' – a critical analysis of the literature on social practices. A critical realist review is a distinct method of literature review bringing in theoretical development or *conceptual innovation* to phenomena under examination (Edgley et al., 2016, original emphasis); in this case, pluralism, discursive institutionalism, and critical political economy in relation to health, and other health inequities theories.

There is no single method to perform a literature review. A critical realist review avoids a 'cookbook approach' to literature review (Edgley et al., 2016). Informed by Pawson et al.'s (2005) steps in realist review: clarify scope, search for evidence, appraise primary studies and extract data, synthesize evidence and draw conclusions, and disseminate, implement, and evaluate (p.24) and Edgley et al.'s (2016) recommendations: choosing a research question as a focus for review, literature search, objectivity and values, and structure (pp.322-326), I conducted the critical realist review of the literature in the following manner:

Identifying the coverage and scope. This step presents the research questions, goals, objectives, and theories to be examined in the literature review. My central question is why and how do health inequities, especially class, gender, and race/ethnicity health inequities persist in

[15] For discussions of critical realism, which I successfully applied as a lens in examining the relationships between health, Canada's housing and homelessness policies, and political economy, please see Borras 2016, pp.5-7.

Canada, and how can such differences be reduced through public policymaking processes? It can be broken down into these specific questions:

1. How does the organization of society, i.e., its economic, political, cultural, institutional, and ideological systems, shape public policies that create health inequities?
2. How do power and social relations of class, gender, and race/ethnicity interact with these structures to also shape these public policies that lead to health inequities?
3. How do state actors (e.g., politicians and policymakers) understand and shape public policy over time in relation to the politics of class, gender, race/ethnicity, and health inequities?
4. How do public policy academics understand and engage with public policy and politics over time in relation to the politics of class, gender, race/ethnicity, and its impact on health inequities?
5. How do public policy activists and advocates understand and engage with public policy and politics over time in relation to the politics of class, gender, race/ethnicity, and its impact on health inequities?

The goal of my critical realist review is to address the overarching research questions. The *objectives* are to (a) explore the nature, depth, and extent of the knowledge in existing literature focusing on health inequities and public policy theories in relation to health and policy change; (b) identify arguments, similarities, contradictions, and gaps in the literature; (c) summarize, synthesize, evaluate, and disseminate key findings; (d) offer recommendations to address identified problems; (e) refine and accurately frame the research questions; and (f) find the theoretical approach that will best inform the research questions. My critical realist literature

review focuses on health inequities and public policy theories, namely pluralism, discursive institutionalism, and critical political economy in relation to health and policy change.

Performing the literature search. In this study, I did not set strict eligibility criteria. Stringent inclusion and exclusion criteria are incongruous with the critical realist review, which is open to possibilities and potentialities of research. For example, it may go beyond the health care and medical-focused literature to explore the political economists, philosophers, sociologists, feminists, and geographers' views (Edgley et al., 2016) about social and health inequities or class, gender, and racial/ethnic health inequities. My critical realist review included classic and contemporary studies: primary, secondary, and tertiary sources; statistical data, peer-reviewed journal articles, books, grey literature from government and non-government sources, and explanations from encyclopedias and dictionaries relevant to this research.

A critical realist review employs multiple search strategies. My manual and electronic literature search is interactive, iterative, and evolutionary (Pawson et al., 2005; Edgley et al., 2016). It starts from the study's conceptualization to the research proposal's approval to complete the dissertation covering six years of Ph.D. studies. My first step in this ongoing process is the preliminary identification of relevant literature sourced from references used in my MA and Ph.D. course reading materials, MA research papers, Ph.D. comprehensive essays, published articles, collected books, and subscribed magazines, allowing me to obtain some classic and contemporary studies. Then, through the York University Libraries, I accessed databases such as Proquest, JSTOR, PubMed, and Scholars Portal. I also accessed Google Scholar.[16] Furthermore, I navigated non-, inter-, and government websites, including but not

[16] For example, I entered keywords 'critical/political economy and health inequalities' in York Libraries and Omni Libraries. Then I applied the following filters: resource type (peer-reviewed journal), publication date (2012-2022), subject (public health), database (Proquest, Scholars Portal), and language (English). Other search words: pluralism and health inequalities, discursive

restricted to WHO, OECD, CIHI, and Homeless Hub. Finally, I obtained relevant studies by subscribing to various listservs such as the SDoH, POHG, and Statistics Canada and following news outlets and other sources of information from social media, keeping me updated on the current situation.

After the preliminary identification, I classified the printed and downloaded reading materials into different folders labelling the document data: pluralism and health, institutionalism and health, political economy and health, class and health, gender and health, race and health, and their combinations, for example. Then I primarily selected studies that were relevant to the dissertation questions and purpose. I did not set any inclusion-exclusion criteria on methodology and methods for selecting relevant studies. Hence, studies that employ positivism (policy-focused), realism (critical materialist), idealism (emphatic ethnographer), and quantitative, qualitative, and mixed methods have an equal chance of being represented in this endeavour.

The presentation of the results of literature review is organized as follows. The first section presents a glimpse of the extent of health inequities in Canada. The second offers seven discourses on the sources and means to reduce health inequities. The third concentrates on pluralism, discursive institutionalism, and critical political economy theory in relation to the public policies that create health inequities. Respectively, it provides policy change approaches, including Kingdon's agenda-setting, Hall's policy paradigms, Smith's journey of ideas, and Esping-Andersen's welfare state typology as applied by some health scholars. Public policy failures, barriers, and means to reducing social and health inequities are embedded in the exploration, analysis, and discussion. Reviewing health inequities theories and public policy theories in relation to health and policy change is necessary because I anticipate these areas of

institutionalism and health inequalities; politics and health inequalities; class and health inequalities, race and health inequalities, gender and health inequalities, and any of their combinations, I also used the same search terms in accessing articles from Google Scholar.

inquiry will form part of key informants' insights on the causes and solutions to health inequities. As mentioned earlier, I will classify their insights into these existing public policy theories and policy change models.

3.2 Extent of Health Inequities in Canada

Health inequities can be measured through various mortality and morbidity indicators. In my view, these population health indicators can be better understood through examination of the inequitable distribution of the social determinants of health (SDH), both in quantitative and qualitative terms. So, I present some examples to show the extent of health differences between classes and groups in relation to SDH distribution in this country at specific times and spaces.

The *infant mortality rate or IMR* is one of the better indicators of population health because it is especially sensitive to living and working conditions (Reidpath & Allotey, 2003). Among Organisation for Economic Cooperation and Development (OECD) countries, Canada's IMR ranks 31st of 36 in 2018 (OECD, 2020a). Comparisons of IMR between different classes and groups in Canada are available. The IMR risk conditions include unemployment, inadequate housing, food insecurity, low maternal education, lack of health care access, and poverty. For example, excluding Ontario (no data available), the IMR/1000 live births for the lowest income quintile was 4.7, while for the highest income quintile, it was 3.2 in 2008-2011 (PHAC, 2018).

There are also data available for other health outcomes and risk conditions such as housing and food. In Canada, ~235,000 persons are de-housed or homeless in any given year, of which Indigenous persons are overrepresented (Gaetz et al., 2016). In Toronto, 78% of homeless persons reported that unemployment, low income, and housing costs are the primary reasons for their situations. Unsurprisingly, compared to the general population, they are more likely than other Canadians to experience HIV/AIDS 300x, heart disease 5x, cancer 4x, depression 2x, and

diabetes 2x (Cowan et al., 2007). The life expectancy for homeless women was five years shorter than the lowest income quintile of Canadians and nine years shorter than the highest income quintile of Canadians. For homeless men, life expectancy was six and 13 years shorter than the lowest and highest income quintile of Canadians, respectively (Hwang et al., 2009). Homelessness is the most extreme example of the broader risk condition of housing insecurity.

In Canada, the federal government reported that 1.7 million households were housing insecure, of which 55% were women-led in 2018 (Government of Canada, GOC, 2018).[17] Housing insecurity results in isolation, stress, injury, asthma, infectious diseases, and cardiovascular-related deaths (WHO, 2018). In addition, housing insecurity is also associated with food insecurity: inadequate access to nutritious foods due to insufficient income at the household-individual level (St-Germain & Tarasuk, 2020).

In Canada, 1.8 million households were food insecure in 2017-2018. Food insecurity for children was highest in Nunavut at 79%. Other food insecurity levels were as follows: Blacks 28.9%, Indigenous 28.2%, Arabs and West Asians 20.4%, Multiple Origins 16.7%, South Asians 15.2%, and East and Southeast Asians 11.3%. Food insecurity for White persons was the lowest at 11.1% (Tarasuk & Mitchell, 2020). In Ontario, the marginally, moderately, and severely food-insecure mortality rates were 28%, 49%, and 160%, higher than the food-secure persons (Gundersen et al., 2018).

The poor, low-wage working-class, racialized, and women face higher risks of poverty, housing insecurity, homelessness, food insecurity, and adverse health outcomes (Raphael et al., 2020). Many of the health inequalities they experience are health inequities – preventable

[17] Here, I equate *housing insecurity* to *core housing need*: "…below at least one of the adequacy, affordability or suitability standards...Adequate housing is reported by their residents as not requiring any major repairs. Affordable dwellings cost less than 30% of total before-tax household income. Suitable housing has enough bedrooms for the size and make-up of resident households" (CMHC, 2020, Housing in Canada Online).

differences in health. Therefore, despite being one of the most advanced capitalist economies globally, health inequities remain pervasive in Canada. In part, this suggests that Canada's state policies are failing to effectively address the underlying causes of health inequities, especially class-based, gendered, and racialized health inequities.

3.3 Discourses on the Sources of and Means to Reduce Health Inequities in Canada

The failures to diminish these extensive social and health inequities can be linked to structural, institutional, and ideological barriers. One of the reasons public policy has failed to reduce health inequities in Canada is the lack of a consensus on the causes and means of responding to health inequities. For example, Raphael (2012) argues that seven differing discourses can be used to explain the causes of health inequalities, each of which suggests specific means of responding to them: First, health inequalities seen as due to *biological and genetic dispositions* can be solved by detecting genetic disorders (e.g. human genome project). Second, health inequalities seen as due to *inequitable access to and quality of social and health services* can be reduced by improving such services (e.g. more community clinics).

Third, health inequalities seen as due to *modifiable behavioural and medical risk factors* can be addressed via behavioural and lifestyle change (e.g. diet). Fourth, health inequalities seen as due to dissimilarities in *material living conditions* can be diminished by enhancing such conditions (e.g. quality housing in safe environments). Fifth, health inequalities seen as due to *material living conditions resulting from a public policy* can be reduced by upholding healthy public policy (i.e. policy beyond the healthcare system). Sixth, health inequalities seen as due to material living conditions resulting from *economic and political structures and ideologies* can be decreased by altering social structures that produce and rationalize such inequalities (e.g. liberal

to social democratic welfare state system). Lastly, health inequalities seen as due to *asymmetrical power and influence* can be addressed by empowering those less influential classes and groups (e.g. strengthening the power of labour, political, and social movements).

Raphael argues that the last three discourses are most appropriate for understanding the sources and means of responding to health inequalities, yet many researchers, professionals, politicians, policymakers, and public communities believe the first three are most appropriate. Heavily influenced by *liberalism*, they emphasize *individual* over societal factors shaping health outcomes. This is common in countries like the liberal welfare state of Canada, where *market fundamentalism* remains the dominant way of not only organizing and distributing societal resources but also for understanding their impact on population health (Bryant & Raphael, 2016, 2020; Raphael, 2003, 2009, 2012, 2016). Therefore, these ideas about health inequities -- influenced by broader societal ideologies -- hinder public policy change efforts to reduce health inequities. These seven discourses can also inform my analysis of the existing literature and interview data. The following discussions focus on public policy theories, and policy change approaches to social and health inequities, central to this research.

3.4 Theories of Public Policy and Health Inequities

Public policy theory scrutinizes public policymaking's dimensions to find opportunities to influence its processes and outcomes (Bryant, 2013). The ***public policy change process*** is "an adjustment to an existing policy or set of related public policies," which can be incremental or radical (Bryant, 2016, p. 93). Understanding public policy theories and policy change can help explain how public policy is developed and implemented, recognize barriers to policy actions on

health inequalities, and provide avenues for overcoming those barriers (Bryant & Raphael, 2016, 2020). Understanding public policy necessitates understanding politics and vice versa.

Politics is the examination *of influence and the influential*. The influential are the elite, who with more wealth and power often gets the most of societal resources as in the distribution of positions of power in a formal hierarchy, income and wealth, and health protection, while the mass gets the least. Politics is about "who gets what, when, how" (Lasswell, 1958). Thus, it implies political struggle among competing political actors, i.e., it is partisan (Smith & Katikireddi, 2013). *Politics* is a source of and means to reduce avoidable health inequalities.

Health as involving political science examines public policy theories, policy processes, policy actors, policy contents, and the politics underlying governing authorities' policy decisions, actions, and inactions shaping health outcomes (Bryant, 2016; Bryant & Raphael, 2016, 2020; Clavier & De Leeuw, 2013; Exworthy, 2008; Walt, 1994). Health is political because:

> [L]ike any other resource or commodity under a neoliberal economic system, some social groups have more of it than others. [I]ts social determinants are amenable to political interventions and are thereby dependent on political action. [T]he right to 'a standard of living adequate for health and well-being' is, or should be, an aspect of citizenship and a human right. [P]ower is exercised over it as part of a wider economic, social and political system. Changing this system requires political awareness and political struggle. (Bambra et al., 2005, p.187).

In short, neoliberalism, politics, and power shape peoples' health. The organization of a jurisdiction's political economy and distribution of power among social forces influence the politics of public policy. Public policy, in turn, determines the quality of the production and

distribution of the SDH (Bryant & Raphael, 2020). Reducing health inequities is a political problem requiring political action.

Policy can be defined as a deliberate course of action pursued by policy actors to confront a problem, which requires decisions concerning the distribution of resources (Jones, 1984). A policy can be private or public. ***Public policy*** is "whatever governments choose to do or not do" (Dye, 2017, p.1) to address social problems like health inequalities within the public, not private realm (Bryant, 2016; Pal, 1992; Walt, 1994). As such, "the causes of [health inequities] policy failures are, at root, political" (Jones, 1984, p.1). The state is a major battlefield for health inequities prevention and reduction. State policy can realize, undermine, or obstruct the equitable distribution of the social determinants of health.

Public policy encompasses health policy. ***Public health policy*** is characterized by its preoccupation with the healthcare system, emphasis on biomedical paradigms, and acceptance of the 'givens' in the current social systems to address health inequalities; it is present-oriented (Hancock, 1985). In contrast, ***healthy public policy*** goes beyond the healthcare system and biomedical approaches by questioning and responding to social structures of power that create and maintain health inequalities; it is future-oriented (Hancock, 1985). In Canada, health inequalities-related public policy ideas and actions, for the most part, remain within the realm of the healthcare system (Bryant, 2016). There is a need to transcend the narrow biomedical view of health inequalities to reduce them.

Bryant (2013, 2015a,b; 2016), Bryant & Raphael (2016), and Raphael (2014, 2015) argue that three public policy theories may be helpful in the examination of the SDH and health inequalities: pluralism, [discursive] institutionalism, and [critical] political economy. As

discussed below, these theories offer different reasons for the causes, public policy failures, and potential means to reducing social and health inequities in Canada and elsewhere.

3.4.1 Pluralism. In the mid-1950s, Dahl (1961) examined inequalities in New Haven and argued that in the past 200 years, it "gradually changed from oligarchy to pluralism" (p.11), as evidenced by the changes in the compositions of elected officials: from the complete control of the politically powerful patricians (1784-1839), to wealthy entrepreneurs (1842-1897), to many ex-plebeians (1899-1953). In representative democracies like the USA and parliamentary democracies like Canada, pluralists believe that "democracy is the best form of government" and "every citizen should have an equal chance to influence government policy" to reduce social inequalities (Dahl, 1961, p.1). Thus, in the presence of social and health inequities, the pluralists fundamentally ask who governs in a democracy?

Classical pluralists believe that the healthy public policymaking process mainly occurs within the branches of government. They assume every individual, group, or organization has equal opportunities to influence government actions to achieve their policy goals (Dahl, 1961, 1984), as in reducing health inequalities through the equitable distribution of SDH (Bryant, 2016). Under polyarchy -- rule of the many -- the state is simply an impartial mediator of societal and public health affairs (Bryant, 2016; Dahl, 1984; Howlett et al., 2009).

In a liberal democracy, classical pluralists believe that society has many centres of power and that consensus-based politics mirror competing interests (Mudde & Kaltwasser, 2017). They argue that since non-state actors use their power to shape healthy public policymaking according to their interests, power is dispersed rather than concentrated in the most powerful competitor (Dahl, 1961, 1984; Lindblom 1979, 1982). For Dahl (1957), power means: "*A* has power over *B*

to the extent that he can get *B* to do something that *B* would not otherwise do" (pp.202-203), which means power is a relation, such as the power balance between capitalists and workers.

Classical pluralists further believe that the "incremental pattern of policymaking fits with the multiple pressure pattern" (Lindblom, 1959, p.86) and that health "policy does not move in leaps and bounds" (Lindblom, 1959, p.84). Incrementalism or *muddling through* calls for small political changes to address societal problems (Lindblom, 1979). For the classical pluralists, incremental policy change is the way towards social and health inequities reduction.

The neo-pluralists. Before Dahl (1957, 1961), Mills (1956) already argued that 'romantic pluralism' was over and that the *power elite* dominates power structures in American society. This power elite comprises economic, political, and military personnel who "command the dominant institutions of a dominant nation" (p.17), whose policy decisions impact social life in and out of the US capitalist state. In the neoliberal era, Scambler's (2002) 'Greedy Bastards Hypothesis' exposes the power elite responsible for persistent health inequalities in the UK: the 'capitalist-executive.' The author further argues that the 'governing oligarchy/plutocracy' primarily creates and maintains class, gender, and race health inequalities (Scambler, 2019a,b).

In Canada, Langille (2016) contends the corporate power elite advocated for public policies that satisfied their profit interests but resulted in inequitable SDH distribution, perpetuating health inequalities. The interests of the corporate power elite are represented by *business associations* (e.g. Canadian Chamber of Commerce), *think-tanks* (e.g. C.D. Howe Institute), *citizens' front groups* (e.g. National Citizens Coalition), and *lobbyists* (e.g. Earncliffe Strategy Group). Although power is somewhat diffused, it is unequally distributed among classes, groups, and societies vying to influence healthy public policy and public health policy.

The neo-pluralists believe that big businesses have more power and influence in shaping state policies that impact population health outcomes than other competing interest groups. The latter argues that these big businesses, for example, occupy a privileged position, including organizing employment arrangements, income and wealth distribution, building houses, and delivering food (Lindblom, 1982). The neo-pluralists further believe that the state is not an unbiased referee of societal and public health affairs because it is also an autonomous political actor fighting for its interests and health policy ideas (Howlett et al., 2009; Parsons, 1995). Lindblom (1982) concludes: "market systems imprison policy. Those of us who live in those market-oriented systems that are called liberal democratic exercise significantly less control over policy than we have thought. And we are also less free than we may have thought" (p.336). A pluralist world is not necessarily a democratic, fair, and free world.

Others argue, pluralism results in *corporatism*.[18] For example, liberal corporatism posits that competition among groups ends in oligopoly and in which the internal state structure mirrors the unequal representation of competing interests (Cawson, 1978). Some advance the *multiple-elite theory*, which contends that "fragmentation of power led to unrepresentative government of special interests" (McFarland, 2007, p.51). Multiple-elite theorists recognize that oligarchy -- rule by the few -- exists but is constrained in specific areas like the health insurance industry (McFarland, 2007). Corporate power controls the state and directs its health policy decisions to the advantage of the business sector while curbing the interests of other supposedly politically equal groups like the labour sector.

[18] Cawson (1978) defines: "Corporatism is a politico-economic system in which the state directs the activities of predominantly privately-owned industry in partnership with the representatives of a limited number of singular, compulsory, non-competitive, hierarchically ordered and functionally differentiated interest groups" (p.187). Variations include the societal and state, liberal and authoritarian, or redistributive and conservative corporatism. Further details about corporatism are beyond this dissertation.

Pluralism, public policy change, SDH, and health inequities. Kingdon's (1984/2014) political agenda-setting framework is an example of pluralism. This public policy change approach was based on the examination of transportation and health policies in the USA. Kingdon posits three independent streams in public policymaking processes by which policy agendas and alternatives, including but not limited to health policy, can be set and prioritized: problems, policies, and politics.[19]

The *stream of problems* is typified by the state and non-state policy actors' identification of social problems like health inequities. These policy actors recognize social problems via social indicators (e.g. mortality rates), focusing events (e.g. epidemic), or feedback channels. Moreover, they interpret social situations -- working, living, and health conditions -- by comparing them with their values or circumstances in other countries. Finally, problem framing is crucial; for example, understanding the mobility of persons with disabilities as either a civil right or transportation issue may diverge in policies (Kingdon, 1984/2014).

The *stream of policies* is characterized by policy specialists' communities, including the public administrators, academics, and interest groups who produce and push their policy proposals. These proposals encountered each other in a *policy primeval soup* where they got rejected, revised, or accepted. The accepted policy meets these criteria: congruence with the present national mood, dominant values, legislative or executive political agendas, feasibility, and degree of political opposition or support from other interest groups (Kingdon, 1984/2014).

The *stream of politics* comprises the political events that influence public policymaking, including the changes in national mood, interest groups' campaigns, elections, and governing

[19] According to Kingdon (2014), *Agenda* is "the list of subjects or problems to which governmental officials, and people outside of government closely associated with those officials, are paying some serious attention at any given time" (p.3). *Governmental agendas* get significant government attention, while *decision agendas* are those that are ready for operational decisions. The *alternatives* are those considered by the governing authorities and their close allies. For example, if the rising cost of medical care is the foremost agenda, government officials may consider alternatives such as nationalizing the healthcare system, regulating health care costs, or doing nothing.

authorities. The changes in the elected officials and national mood significantly impact policy agendas, while policy alternatives are considered based on the balance of social forces. Consensus building, compromise, and coalition formation govern the stream of politics. However, politics may shift abruptly regardless of the readiness of the policy specialists or the problems confronting the country have changed (Kingdon, 1984/2014).

The streams of problems, policies, and politics are mutually exclusive until societal conditions cause them to converge and open *policy windows* – short time-bounded opportunities for policy actions such as, in our case, addressing preventable health inequalities. These policy windows open for two reasons: either the problems verge on a crisis or the political stream shifts, creating opportunities for *policy entrepreneurs* and advocates to push their preferred policy proposals. As such, policy entrepreneurs and advocates need to develop their ideas, prepare evidence, and propel their proposals when the policy windows open (Kingdon, 1984/2014).[20]

More concretely, Kingdon (1984/2014) noted that in the early 1970s, the state actors inside the Nixon administration were alarmed that medical care costs skyrocketed [*problems stream*]. In addition, Senator Edward Kennedy's strong presence in the health policy area made those public officials politically insecure, seeing Kennedy as a potential presidential contender [*politics stream*]. These conditions made Nixon's camp amenable to new health policy ideas. However, they encountered hurdles meeting their criteria: congruence with the Republican Party's values of smaller government, lesser regulation, and lower cost. At this point, they got help from Paul Ellwood -- a health policy specialist -- who proposed what he termed Health Maintenance Organization [*policies stream*]. The coupling of these streams of problems, politics, and policies opens opportunities [*policy windows*], culminating with the creation and

[20] Policy entrepreneurs are "people who are willing to invest their resources in pushing their pet proposals or problems, are responsible…for coupling both problems and solutions to politics" (Kingdon, 2014, p.20).

implementation of the Health Maintenance Organization Act of 1973 offering more health protection and benefits.[21]

Kingdon's pluralist policy change approach to understanding the causes and solutions to social and health inequities in the USA has been adopted in the liberal welfares states of the UK, Australia, and Canada in that researchers and advocates act to have their voices heard. However, as discussed below, widespread social and health inequities also persist in these advanced capitalist states. This research attempts to examine why a pluralist approach has failed to reduce social and health inequities.

Before Kingdon's policy change model appeared, the pivotal UK Black Report in 1980 already emphasized greater cooperation and collaboration among government agencies, policymakers, employers, unions, and civil society to realize their 37 policy recommendations focusing on information and research, social and health care services, and a broader strategy beyond the healthcare system to reduce health inequalities (Black et al., 1992). However, Exworthy (2002) argues that because of its political ideology, the then Conservative government closed the policy windows to tackle health inequalities from the 1980s to the 1990s. Nonetheless, a paradigmatic policy shift also occurred as the Labour government published the Acheson Report in 1997 upon its election in the UK.

Specifically, examining the Labour's health policy initiatives and interviewing policy actors in local settings, including civil servants, Exworthy and colleagues (2002, 2003) linked Kingdon's policy change approach with the concept of a *joined-up government*. Concentrating on the *vertical* rather than the *horizonta*l dimension of multilevel governance, they scrutinized the links between actions by the local agencies and the national policy agenda by the central government. The authors found that although reducing health inequalities reached the policy

[21] Details of the Health Maintenance Organization Act of 1973 are beyond this study.

agenda at both local and national levels, its implementation was significantly hindered by unsatisfactory collaboration among policy actors, insufficient coordination among government departments and agencies, shortcomings in how the *centre* evaluates the *local* performance management, and conflict with other policy priorities. They conclude:

> Greater intergovernmental coordination, improved JUG, better local partnerships and improved performance management will be required if national and local policy objectives are to be realised. In terms of Kingdon's notions, national and local streams of health inequalities have been coupled but greater effort will be required to keep them coupled; in effect, the policy windows need to be 'wedged' open at national *and* local levels. (Exworthy et al., 2002, p.93).

By 2008, the influential WHO Commission on SDH's core recommendations to address health inequities focused on enhancing peoples' living conditions, tackling their structural drivers, and assessing SDH policy actions' outcomes. For them, the way forward is: "action on the [SDH] must involve the whole of government, civil society and local communities, business, global fora, and international agencies" (WHO, 2008, p.1). However, despite talks of inequitable distribution of resources, money, and power, Navarro (2009) stated that the CSDH Report was 'apolitical' for neglecting asymmetrical power relations and ignoring neoliberal capitalism.

Two years later, the 2010 Marmot Review provided six policy proposals to reduce health inequities: (*a*) providing children with the best start in life, (*b*) enabling people to maximize their capabilities, (*c*) ensuring fair employment, (*d*) healthy living standards, (*e*) sustainable healthy places and neighbourhoods, and (*f*) preventing ill health (Marmot et al., 2010). The 2020

Marmot Review dropped the last recommendation because it suggested a significant policy focus on human behaviour than social causes (Marmot et al., 2020; Marteau et al., 2020). Marmot et al. (2010) stated: "Delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups" (p.15). These Reviews ignored unequal class (capitalism), gender (patriarchy), and race (racism) relations. The Black Report, CSDH Report, and Marmot Reviews primarily promote classical pluralism and discursive institutionalism to understanding the causes and means to reducing health inequities.

In Australia, Baum and colleagues (2013) interviewed 20 former health ministers who held government positions between 1985 to 2011. They found that public policies addressing the SDH and health inequalities rarely happened because policy windows only opened for a short duration during those 25 years. Other reasons for failures were: First, despite the health ministers' awareness of health inequalities and the importance of addressing SDH, their policy actions were restricted to healthcare and behavioural change promotion with some exceptions such as adopting the *Social Health Strategy* and Indigenous housing reforms in remote areas. Second, they echo Exworthy's (2008) claim that actions on SDH are challenging to realize within the traditional policymaking settings because they are deemed too complex. Third, aligned with Tesh's (1988) arguments that political ideologies influence public health policy, most politicians support individualism as the source of health inequalities.

Fourth, the more powerful group of medical professionals directed health agendas: on *problems stream,* acute care services reinforced by the media and public opinion; on *policies stream*, biomedical solutions to health problems, which most public communities and politicians readily accept; on *politics stream*, the acute care services policy entrepreneurs defeated the less powerful SDH policy communities. Fifth, conversations about SDH and health inequalities have

become muted in the policy arena. Lastly, neoliberalism displaced redistributive public policies. They conclude:

> The political stream was enabling when the general ideological climate was supportive of redistributive policies, the health care sector was not perceived to be in crisis, and there was support for action from the head of government, cabinet colleagues and no opposition from powerful lobby groups. (Baum et al., 2013, p.145).

In Canada, the At Home/Chez Soi project 2008-2013, which adopted the *Housing First* approach to homelessness and mental health, also represents Kingdon's policy change model (Macnaughton et al., 2013, 2017). This Project was conceptualized amid the upcoming Vancouver Olympics in 2010. Specifically, in May 2007, the US 'housing czar' Phillip Mangano expressed at the Vancouver Board Trade the local concerns about homelessness and the potential of the Olympics to realize housing policy change. At the same time, the local housing advocates exposed the problem to local and national media, gathering significant public attention. The then Vancouver Mayor also admonished the provincial government and warned the Conservative Party-led federal government -- a minority government -- to address the problem as the world was watching (Goering et al., 2014; Laird, 2007; Macnaughton et al., 2013, 2017).

By June 2007, the United Nations expressed concern about potential displacements due to Vancouver Olympics. Then, following human rights complaint, a UN Special Rapporteur was sent to Canada in Fall 2007 (Macnaughton et al., 2013). The UN Report (2007) then rebuked Canada for persistent homelessness, housing insecurity, and poverty, of which women and

racialized persons were overrepresented. Interestingly, in the same year, the then Conservative Prime Minister Harper and Minister of Health Clement asked former Liberal Senator Kirby to become the first chair of Canada's newly created Mental Health Commission (Macnaughton et al., 2013) – the Commission that the Kirby Report 2006 recommended. Then in January 2008, the Federation of Canadian Municipalities demanded a national housing and homelessness plan, culminating with the At Home/Chez Soi.[22] Thus, "policymaking does not follow a rational, linear process of knowledge translation/exchange (KTE) and implementation" (p.100), but rather, more informed by Kingdon's streams of problems, politics, and policies (Macnaughton et al., 2013). Kirby, a policy entrepreneur, coupled Kingdon's problems, politics, and policies to concretize housing policy change to reduce homelessness and its adverse health outcomes.

In a particular historical conjuncture, the economic and political conditions influence and shape public policymaking processes impacting the social determinants of health and health inequities. Today, the Housing First approach is at the core of Canada's National Housing Strategy. However, although *housing first* is embedded in the current NHS, on the ground, in the context of housing insecurity, homelessness, substance abuse, and mental health illness in which racialized groups like the Indigenous and women with children are overrepresented, housing

[22] The At Home/Chez Soi Project was funded through and implemented by the Mental Health Commission of Canada in Vancouver, Toronto, Montreal, Winnipeg, and Moncton with $110 million funding for five years. The Project primarily studied whether homelessness harms people's mental health and whether housing can improve the mental health of homeless people (Goering et al., 2014). On the one hand, the Project pales compared to the Kirby Report 2006 recommendations that are broader than housing and mental health. For example, the Kirby Report stated: "Promoting mental health and recovery from mental illness requires interventions that address the social determinants of health — in particular those related to income, adequate housing and employment, and participation in social networks" (Kirby & Keon, 2006, Chapter 3 p.57). For funding: "The Committee also believes that when the Mental Health Housing Initiative is launched, its initial focus should be on rent-subsidized units because of the need to act quickly to address the housing shortage….More specifically, the Committee is recommending that in years 1 through 3 of the MHHI, 80% of the people provided with housing should receive a rent supplement of $6,020 in the first year and $4,250 annually thereafter. The remaining 20% should move into newly constructed units costing $75,000 per unit. In years 4 through 7, the proportion of rent supplements to newly constructed units should be 60/40, and in years 8 through 10 the proportion should be 40/60….[T]he total cost would be $2.24 billion over ten years at an average annual cost of $224 million" (Kirby & Keon, Chapter 15 pp.44-46) . On the other hand, the Conservative-led federal government gained a political advantage without committing to fund social and public housing adequately. In Vancouver, the actual project housing funding was only for three years.

needs are rarely met, especially in diverse cities like Toronto and Vancouver. The At Home/Chez Soi Project examined homelessness and mental health and found through RCT that *housing first* is key to reducing homelessness and its adverse health outcomes; however, the governments continue to fund affordable social and public housing insufficiently.

Moreover, Canada's National Housing Strategy (GOC, 2018), First Poverty Reduction Strategy (ESDC, 2018), and the Food Policy for Canada (Finnigan, 2017; GOC, 2019) are claimed by the governing authorities as products of free and democratic consultative processes. The latter's slogan 'Everyone at the table!' says it all.[23] However, as mentioned earlier, these processes are indeed not 'free and democratic' because, in market-oriented profit-driven liberal democracies like Canada, the masses -- the poor, marginalized, and vulnerable sections of the population -- do not have the democratic control of public policymaking processes. In fact, in Canada, the economic and political elite -- the big businesses and corporations and conservative and liberal politicians and policymakers -- predominantly shape poverty, housing, and food policies.

At a glance, the above-mentioned public policy documents represent the classical pluralist approach to social and health inequities. However, in a closer look, these documents are

[23] The governing authorities claimed that the **First Poverty Reduction Strategy** (ESDC, 2018) was a product of engagement with Canadians. In-person: 600 Canadians consulted through 33 conversations, 5,500 Canadians through the Tackling Poverty Together Project, 13 sessions led by government officials in collaboration with provinces and territories, 29 meetings with multilevel governments, 12 roundtables with stakeholders, 4 public town hall events, 4 roundtables with Indigenous leadership, 17 leaders, academic experts, practitioners, and individuals with lived poverty experiences, and a national poverty conference. Online: 1,127 email submissions, 584 completed surveys, and 199 stories and comments. Unfortunately, this policy document did not provide the names of the social and political movements involved in the policy process for the reader to assess whether or not the consulted individuals and organizations were all close allies of the governing authorities, putting into question the claim of democratic consultation. The **National Housing Strategy** was criticized by the Ontario Federation of Indigenous Friendship Centres (2018). It stated: "The absence of any reference to urban Indigenous communities in the NHS constitutes a barrier to ensuring the needs of urban Indigenous people are rendered visible across government. In Ontario, this omission represents 85 percent of total population of Indigenous people living off-reserve" (p.4). The "Indigenous housing should be designed, constructed, and delivered by Indigenous communities and organizations themselves in order to generate the best possible outcomes for urban Indigenous people" (OFIFC p.14). Finally, the **Food Policy for Canada** (GOC, 2019) listed the individuals and organizations involved in the process. Unfortunately, few were from the food sovereignty coalition, and the document itself did not mention food sovereignty. Currently, Canada has not legislated a comprehensive National Food Policy, which makes one question the governing authorities' sincerity to address food insecurity and its adverse outcomes that impact millions of low-income persons, especially racialized working-class families, including our family.

examples of how in the world of neo-pluralism, the dominant power primarily influences health politics and public policy, shaping population health outcomes. Still, Food Banks Canada (2021), with over 500 affiliates, emphasizes research, advocacy, and cooperation among all stakeholders to address hunger. It works within classical pluralism and discursive institutionalism. However, as introduced, poverty, housing insecurity and homelessness, food insecurity, and health inequities remain widespread. For the most part, these public policies failed because they adhere to an economic and political system that perpetuates neoliberal narratives and practices that inequitably distributes economic and other resources among classes and groups.[24]

Some reflections amidst the pandemic. Amidst the COVID-19 pandemic beginning in 2020, policy windows of opportunities have unfolded in Canada. Many state and non-state actors offer policy ideas, proposals, and solutions to the convergence of health and economic crises. Consequently, some of the advocacies, interests, and power asymmetries between the governing authorities, businesses and corporations, and labour, civil society, and social movements shaping health politics and public policies are further exposed in the following examples.

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[24] **Housing policy:** Elsewhere, informed by critical realism and political economy frameworks, I analyzed Canadian housing and homelessness policies from 1935 to 2016. The *housing first* -- based on a random controlled trial of homeless people randomized between 'housing first' and 'treatment as usual' -- failed to reduce homelessness, primarily because it is not about social and public housing to prevent homelessness. It only means 'housing first' the chronic and episodic homeless people with mental health and substance abuse disorders, which is only 13,000 to 33,000 of the homeless population. Moreover, by adopting neoliberalism, the Progressive Conservative Party implemented massive budget cuts in affordable housing in the 1980s. Then the Liberal Party terminated federal social housing in 1993 and decentralized the housing authority in 1996. These radical policy paradigm shifts resulted in widespread housing insecurity and homelessness, furthering health inequities (see Borras, 2016). **Food policy:** Mendly-Zambo and Raphael (2018) argue that the limits of the pluralist approach and neoliberal policies largely contributed to housing food insecurity in Canada. Moreover, "community programs, like charitable programs, ignore governmental failure to meet the basic human need for food and address HFI in Canada" (p.9). Applying critical political economy and critical discourse analysis, my colleague and I demonstrated that food insecurity is a radical departure from food security discourse. While the food security paradigm integrates access, availability, utilization, and stability as the cornerstones of food security and nutrition at the local, national, and global levels, the housing food insecurity paradigm merely sees inadequate access to food due to lack of income at the household-individual levels. The latter perpetuates the idea of neoliberalism, in which the basic unit of analysis is the individual (see Borras & Mohamed, 2020). In my view, the impacts of Canada's First Poverty Reduction Strategy and National Housing Strategy are too early to assess because of the transitory effects of the COVID-19 Response Measures Act (GOC, 2020).

The part played by the labour, civil society groups, and social movements. Some labour unions have united to fight for pandemic pay, paid sick days, wage increases, and safe working conditions. Some civil society groups have intensified the call for universal basic income, free public transportation, and public housing. Some social movements have amplified economic, racial, and health justice struggles. The environmentalists stressed the climate crisis. Some pushed for food sovereignty. The migrant alliances sought permanent status and citizenship for all. Health coalitions demanded universal Pharmacare and de-privatization of long-term care homes. Students called for cuts in tuition fees. Others pressured for immediate electoral reforms. Most Canadians demanded taxing the wealthy and big corporations more to finance progressive public policies. As I argued elsewhere, the preexisting social and health inequities and the differentiated impacts of the COVID-19 pandemic placed the poor and working-class, women, and racialized groups at more significant economic, gender, racial, and health injustices (Borras, 2021). The masses want social change to improve their working, living, and health conditions. Will the governing powers and authorities and the big businesses and corporations listen?

The part played by the state's governing powers and authorities. The Liberal Party-led federal government and policymakers across political parties speedily approved the multi-billion COVID-19 Economic Response Plan, including but not limited to the Emergency Response Benefit (CERB), Emergency Wage Subsidy (CEWS), and Increasing the Child Benefit. Specifically, the CERB amounting to taxable $500 a week supported workers who lost jobs or experienced reduced working hours, while the CEWS supported employers with a significant drop in revenues. These emergency policies helped the workers and employers; however, the lockdowns bankrupted some small businesses, mainly family-run, while the big

corporations like Walmart profited more. The big corporations swallowed the small businesses – an inevitable outcome of the capitalist way of organizing and distributing economic and other societal resources.

Meanwhile, the Ontario government's emergency powers, invoked during the pandemic, allowed employers to disregard collective bargaining agreements (e.g. vacations, multiple jobs). Calls to scrap Bill 124, which capped salary and total compensation for public sector workers at 1%, were ignored by the majority Progressive Conservative Party-led government. Although they provided a temporary wage increase for personal support workers, they ignored the majority of healthcare workers, including but not limited to the environmental, dietary, activity, and nursing staff causing resentment and divisions among the frontline workers. Until today, the Canadian governments at all levels have not improved the working conditions, especially in the gendered and racialized long-term care settings where frontline workers like my partner and me continue to experience almost daily shortages of staff and thus increased workload and more adverse health outcomes for both workers and residents. The governing authorities inadequately met the demands of the labour, civil society groups, and social movements.

The above conscious and deliberate political choices and actions show that governments are powerful enough to legislate new policies or radically alter existing policies. In most cases, however, state power supersedes some advocacy and competing groups' interests and policy ideas with less wealth and power. The pandemic revealed the state's central role in organizing and reorganizing economic and health affairs. It also exposed state actors' emphasis on the top-down technocratic approach than the bottom-up participatory approach to healthy public policy and public health policy. Unfortunately, rather than the organized labour, civil society groups,

and social movements, the governing powers and authorities listen more to the big business and corporate sector, as further evidence suggests below.

The part played by big businesses, corporations, and billionaires. Some big corporations temporarily increased the workers' wages by a few dollars, and some billionaires donated to pandemic relief. Nonetheless, amidst the pandemic, the business elite accumulated trillions of dollars while millions of workers lost jobs and incomes and became even more susceptible to adverse health outcomes and health inequities. For example, the combined wealth of the USA's billionaires rose by 23% in August 2020 (Americans for Tax Fairness, 2020). By April 2021, it soared 55%, from $2.95 to $4.56 trillion. Specifically, "America's 719 billionaires held over four times more wealth than all the roughly 165 million Americans in society's bottom half" (Collins, 2021, p.1). In Canada, within just six months after the first lockdown in March 2020, the aggregate wealth of the richest 20 billionaires increased by $37 billion (Hemingway & Rozworksi, 2020). These billionaires own and manage big businesses and corporations. The overconcentration of economic wealth and political power in the capitalist class and political elite mainly contributed to social and health inequities before and during the pandemic. Depending on the balance of power among the contending classes and other social forces, the pandemic may lead to public policy changes that can substantially reduce health inequities or exacerbate life circumstances shaping them. State and non-state policy actors are all consciously trying to seize this historic moment to advance their economic, political, and health agendas.

The classical pluralists underemphasize social structures, power balances, and ideologies driving governments' policy responses on SDH, including housing, income, and early child development (Bryant, 2015a,b; Bryant & Raphael, 2016; Raphael et al., 2008). Bryant (2015a) states: "pluralism has been the dominant public policy model in North America" (p.S12), which

has been adopted by many policymakers, academics, and advocates (Bryant et al., 2011); thus, the impasse in healthy public policy change they strive to achieve (Bryant, 2016).

Pluralism may not be the best theory to inform actions on social and health inequities. At best, with closed policy windows, it may only achieve incremental policy changes. The main challenge for the pluralists is how to open the policy windows for the long haul to reduce health inequities.[25] Exworthy et al. (2003) argue it requires evidence-based policy interventions, progress monitoring and evaluation, and the formation of a *joined-up government*. Baum (2007) suggests a 'top down and bottom up pressure' to *crack the nut* of health inequities: "practical action is needed both from governments as well as the civil society" (p.94). Recently, Baum et al. (2020) argued that health equity policy windows could be opened through 'political will' that can be generated by:

> [D]etermining how path dependency that exacerbates health inequities can be broken, working with sympathetic political forces committed to fairness; framing policy options in a way that makes them more likely to be adopted, outlining factors to consider in challenging the interests of elites, and considering the extent to which civil society will work in favour of equitable policies. (p.11).

The preceding discussions reveal the interlinking features of pluralism, discursive institutionalism, and critical political economy theory. Remarkably, coming from a political economy lens, Bryant and Raphael (2016) argue that keeping policy windows open requires

[25] It is important to note that contrary to Lindblom's (1959, 1979) claims, policy changes are not all incremental. For example, Kingdon (2014) found that "there were as many non-incremental as incremental changes" and "many instances of sharp, substantial, sudden changes" in health policy understandings and actions in the USA (pp.81-82). Kingdon stated: "14% of my health respondents in 1977 treated catastrophic insurance as prominent on the agenda; that figure had risen to 33 percent in 1978 and catapulted to 92 percent in 1979" (p.34).

consolidating the power of labour, civil society, and social movements as well as educating, organizing, and mobilizing the public to counter business and corporate power and ideologies and compel the state to address the *social determinants of health inequalities*. These actions are critical because policy windows may open only for a short period. Moving health inequalities research into policy, presenting evidence, and proposing solutions for governing authorities' consideration require precise timing (Whitehead et al., 2004). Moreover, since policy windows rarely open, most politicians and policymakers recommend fitting the research evidence, proposals, and actions on SDH and health inequalities according to the governing authorities' plans (Carey & Crammond, 2015a,b; Petticrew et al., 2004). However, this latter suggestion creates dilemmas because healthy public policy and public health policy proposals and actions from academics, activists, and advocates may significantly differ from the governing authorities' agendas.

Section Summary. The basic unit of analysis of the pluralists in examining social and health inequities is the competing interest groups vying to shape state policies in their favour. For them, reducing health inequities primarily means participating in open public dialogues, producing evidence, presenting proposals, and advocating for policy changes subject to public officials' consideration. The unprejudiced governing authorities then enact and execute health policies reflecting competing groups' common interests.

Classical pluralists naively believe that state and non-state policy actors have unhindered equal opportunities to influence healthy public policy and public health policy. As a result, they understate the class, gender, and race relations underlying the institutional public policymaking processes impacting the distribution of the SDH. Moreover, ignoring ideologies and power

imbalances among labour, civil society, business, and state actors, classical pluralists suggest these multiple stakeholders cooperate and bargain to attain consensus-based health inequities policies. They neglect that some competing interests are inherently diametrically opposed. In reality, for example, the governing authorities' political party dictates their policy agendas that may irreconcilably contradict other interest groups' economic, political, and health agendas.

Contrary to the classical pluralists, the neo-pluralists correctly observe that wealthy and powerful interest groups -- the power elite, oligarchs, and corporate sector -- at the present historical conjuncture have more power and opportunities to shape public policy to their advantage and at the expense of the less influential competing interest groups experiencing social and health inequities. Therefore, health politics in liberal welfare states like Canada is highly centralized, undemocratic, and antagonistic.

The pluralist approach to social and health inequities, for the most part, neglected sexism and racism structured within and through economic and political relations. Moreover, most scholars who used pluralism examined SDH and health inequities in general. In particular, most failed to account for gendered and racialized health inequities, at least as evidenced in the cited literature, indicating research gaps. As mentioned earlier, I anticipate that my interviewees' insights will reflect a pluralist viewpoint; for example, they will speak about competing powers, interests, and advocacy groups concerning social and health inequities reduction.

3.4.2 Discursive Institutionalism. Some scholars describe ***institutions*** as "the formal rules of political arenas, channels of communication, language codes, or the logics of strategic situations" that filter knowledge (Immergut, 1998, p.20), for example, accepting or rejecting a particular health inequality theory. Others say institutions are "systems of established and

embedded social rules that structure social interactions" constituting social life (Hodgson, 2006, p.18). For Hall and Lamont, it means:

> [S]ets of regularized practices with rule-like quality in the sense that actors expect those practices to be observed. They vary, according to how those expectations are established, from formal institutions backed by sanctions, as are many policy regimes, to informal institutions grounded in perceptions that they serve mutual interests or embody patterns of behaviour widely seen as appropriate. (Hall and Lamont, 2009, p.14).

In short, institutions are the collections of practice standards by which the state and non-state actors envisage compliance. The *formal institutions* necessitate authority, and the *informal institutions* – shared interests. However, March and Olsen (2009) argue that institutions are not only about mutual agreements or battlegrounds for opposing social forces because institutions "have a partly autonomous role in political life" (p.2). There is a need to address definitional problems about *what institutions are*. In this study, *institutions* means the established formal and informal state and non-state rules that influence human beings' cognitions and actions. Institutions shape public policy, impacting peoples' working, living, and health conditions.

Institutionalism has different types: economic, sociological, political, historical, and rational choice (Immergut, 1998; March & Olsen, 1984, 2009; Hall & Taylor, 1996; Parsons 1995; Schmidt, 2008; Steinmo et al., 1992). These schools of thought are "characterized by tremendous internal diversity, and it is often also difficult to draw hard and fast lines between them" (Thelen, 1999, p.370). Understanding institutionalism is further complicated by its newest version: discursive institutionalism.

Schmidt (2008) coined *discursive institutionalism*, an analytical framework that considers the discourse in which state and non-state actors participate in producing, debating, and legitimizing ideas involving political activities, contestations, and actions in institutional settings following a logic of communication (Schmidt, 2006, 2010a,b). Discursive institutionalists view "ideas as constitutive of institutions" (Schmidt, 2010b, p.80). Béland & Cox (2011) sum up the ideas-institutions nexus:

> [I]deas are the foundation of institutions. As ideas give rise to people's actions and as those actions form routines, the results are social institutions. The ideas then are enshrined in the institutions. As people interact with institutions, people are confronted again and again with the founding ideas. This confrontation can serve to reinforce and reproduce these ideas. (p.9).

Discursive institutionalism combines 'ideational' and 'institutionalist' theorizations to examine the social determinants of health and health inequalities (Smith, 2013a,b). As further discussed below, for the discursive institutionalists, producing, presenting, and debating research evidence, knowledge, or ideas for consideration by the governing authorities to reduce social and health inequities is of paramount importance.

Discursive institutionalism, public policy change, SDH, and health inequities. Discursive institutionalism (Schmidt, 2008) develops from Hall's (1993) pioneering study on policy paradigms. Smith (2007, 2013a,b; 2014) then applied policy paradigms and discursive institutionalism to conceptualize six journeys of ideas from health inequalities research into public policy. These specific public policy change approaches may be helpful in understanding

the causes of and means to reduce preventable health inequalities.

Hall's (1993) ***policy paradigms*** contribute to the concept of healthy public policymaking as social learning, which posits that (a) the past policies mainly shape current policies, (b) the policy experts primarily advance the learning process, and (c) the autonomous state is hardly susceptible to societal pressures in creating and implementing its policy goals. Hall argued that the policymaking process has three requirements: policy goals, instruments, and instrument settings. The *policy goals* direct public policy in a specific area of interest, like reducing avoidable health inequalities. The *policy instruments* are the techniques employed to achieve the policy goals. The *policy instrument settings* are the exact locations of policy instruments (Hall, 1993). For example, if the policy goal is to reduce housing insecurity as a factor of health inequities, the policy instrument can be socialized housing, and the setting can be at the desired level of gains.

Based on those three policy process requirements, differentiated levels of policy change occur. The *first order change* happened when the instrument settings changed, but policy goals and instruments remained unchanged; for example, increase or decrease in provincial housing budget. Policy instruments and settings are altered at the *second order change*, but the goals remain unaltered; for example, new federal housing mortgage control. Finally, the *third order change* requires concurrent alterations in policy goals, instruments, and settings; for example, "the British experience of 1970-89 was also marked by a radical shift from Keynesian to monetarist modes of macroeconomic regulation" (Hall, 1993, p.279) to neoliberal policies. As discussed earlier, neoliberalism intensifies social and health inequities.

Contrary to the first and second order change characterized by incremental 'normal policymaking,' the third order change is typified by a radical 'paradigm shift' in policy discourse

(Hall, 1993). The latter tends to be propelled more by social forces and factors, including economic and political conditions, rather than purely scientific justifications from policy experts. It is also fueled more by the changes in the position of authority and build-up of puzzling societal developments prompting emergency policy trials and, consequently, policy failures, including the collapse in income and employment policies, resulting in the institutionalization of a new public policy paradigm (Hall, 1993).[26] Hall (1993) concludes:

> Policy paradigms can be seen as one feature of the overall terms of political discourse. They suggest that the policymaking process can be structured by a particular set of ideas, just as it can be structured by a set of institutions. The two often reinforce each other since the routines of policymaking are usually designed to reflect a particular set of ideas about what can and should be done in a sphere of policy. But the ideas embodied in a policy paradigm have a status somewhat independent of institutions that can be used, as in the case of monetarism, to bolster or induce changes in institutional routines. (p.290).

In short, although intertwined, ideas and institutions may function separately to shape healthy public policy and public health policy. Nonetheless, despite overemphasizing the role of ideas in the institutional public policymaking process, Hall (1993) cautions against decoupling the understanding of *politics as a struggle of power* and *politics as social learning*. He states:

[26] The third order change from Keynesian to neoliberal policies in Canada also devastated the working-class and low-income people. As discussed earlier, I analyzed Canadian housing policies from 1935 to 2016. I demonstrated that by adopting neoliberalism, the Progressive Conservative Party implemented massive budget cuts in affordable housing in the 1980s. Then the succeeding Liberal Party terminated federal social housing in 1993 and decentralized the housing authority in 1996. These radical policy paradigm shifts resulted in widespread housing insecurity and homelessness, furthering health inequalities (Borras, 2016). Moreover, applying political economy theory and critical discourse analysis, my colleague and I demonstrated that food insecurity is a radical departure from food security discourse. While the food security paradigm integrates access, availability, utilization, and stability as the cornerstones of food security and nutrition at the local, national, and global levels, the food insecurity paradigm merely sees inadequate access to food due to lack of income at the household-individual levels. The latter perpetuates the idea of neoliberalism, in which the basic unit of analysis is the individual (see Borras & Mohamed, 2020).

"when policy paradigms become the object of open political contestation, the outcome depends on the ability of each side to mobilize a sufficient electoral coalition in the political arena" (pp.287-290). Further examining the links between political institutions, public policy, and health inequalities in Canada, Hall and Lamont (2009, 2013) argue that institutional shifts require changes in practice and discourse, finally realized through politics. Note that political struggle as a power struggle is central to the critical political economy approach to health.

For Hall, a radical policy change may occur within the prevailing political and economic system, not necessarily, a radical shift to a new system, such as neoliberal capitalism to socialism. For the discursive institutionalists, public policy change to reduce social and health inequities primarily happens through contentious intellectual debates, while political actions from various policy actors take a secondary role. Inevitably, however, policy actors with more power and influence institutionalize new policy paradigms, making it harder for less powerful policy actors to influence public policy to redistribute the SDH to prevent and reduce health inequities.

The six journeys of ideas. Partly influenced by Hall and Schmidt, Smith (2007, 2013a,b; 2014) analyzed documents and interviewed state (e.g. ex/ministers and civil servants) and non-state actors (e.g. independent research organizations, academics) working in health inequalities research and policymaking in England and Scotland. Of over 100 participants, the main finding was: while all interviewees claimed that public policies to reduce health inequalities were not based on *evidence*, almost all said that *research-informed ideas* on health inequalities travelled into policy, influencing government decisions (Smith, 2007, 2013a,b; 2014). Amidst the existing health inequalities theories I discussed earlier, those ideas became successful, partial, fractured, recontextualized, weak, and non-journeys.

The *successful journeys* of ideas effectively shaped policy discourses and actions (Smith, 2007). For instance, despite the lack of evidence supporting policies to reduce health inequalities through behavioural and lifestyle changes, most interviewees confirm that behavioural and lifestyle ideas persistently travel into the policy realm more successfully. So, "it is ideas, rather than research evidence, which have travelled from research into policy" (Smith, 2007, p.1438).

The *partial journeys* of ideas demonstrate limited influence on public policy: despite explaining the sources of health inequalities, they achieved little policy change response (Smith, 2007). For example, sufficient evidence backs the structural-material conceptions of health inequalities; however, they travel far less successfully into public policy discourses and actions. Specifically, the socioeconomic determinants of health caught the attention of the governing authorities through the Black Report; however, despite reaching public policy realms in the mid-1990s, these ideas journeyed "no further than policy rhetoric" (Smith, 2007, p.1442).

The *fractured journeys* of ideas happen when only specific parts of research reach the public policy domain (Smith, 2007). For instance, the psychosocial theory of health inequalities "appeared to be an example of research evidence travelling into policy" (p.1443). However, most public policymakers overemphasize its social capital dimension over income inequalities. As a result, the idea that income inequalities are at the root of health inequalities vanished en route to the public policy realm (Smith, 2007).

After several years, Smith (2013a) claimed that early child development is the only successful journey of ideas from research to public policy. She then reclassified behavioural, lifestyle, and health services as *re-contextualized journeys* (e.g. smoking, alcohol, diet, exercise); however, little research suggests these are the fundamental causes of and solutions to health inequalities. Finally, Smith argued that meaningful policy change to reduce health inequalities is

challenging to attain because policy hierarchies and silos filter 'research-informed ideas' by fitting them toward the prevailing 'institutionalized ideas (or policy paradigms)' while altering, if not obstructing, other contending health policy ideas.

Smith then added the weak journeys and non-journeys of ideas. The *weak journeys* of ideas' influence on public policy concerning health inequalities "was only just tangible" (Smith, 2013b, p.95). There are examples. First, ideas that health status influences socioeconomic status and vice versa. Second, culture change is necessary because cultural factors shape behaviour and lifestyles. Third, genetics and IQ can explain health inequalities.

The *non-journeys* of ideas unsuccessfully travel into and thus are absent in public policy, including the political economy of health that examines the macro-level economic policies and ideologies aligned with capitalism. There was no policy interest in these ideas because most politicians, public policymakers, civil servants, academics, advocates, researchers, and funders labelled them as "'impractical,' 'ideological,' 'radical,' and 'unhelpful'" (Smith, 2013b, p.98).

For Smith (2007, 2013a,b; 2014), advancing health inequalities research into public policy requires the following. First, where 'research-informed ideas' imply that minor change to an existing policy is advantageous, collaboration among researchers, knowledge brokers, and public policymakers is most helpful. If radical change is needed, researchers must work closely with the media, civil society groups, and politicians. Second, public policymaking should not be divorced from health inequalities research. Third, 'institutionalized ideas (or policy paradigms)' should be examined to understand the links between health inequalities research and public policy. Lastly, knowledge brokers should be adequately funded for a long time. Smith believes it is helpful to think about health inequalities research and public policy relationships as an

'interplay of ideas.' Smith stresses that ideas rather than evidence be the unit of analysis for explaining public policy change approach to health inequalities.

Some critiques of institutionalism in general. In my view, the significant challenge for the institutionalists is the diverse definitions of 'institutions' and variations of institutionalism. Moreover, institutionalism underemphasizes economic interests in public policy, exaggerates expert knowledge, and assumes diverse policy actors will join forces to reduce health inequalities by producing policy actions that offer consensus-based rather than conflict-based solutions (Bryant & Raphael, 2016). In Canada, because the governing authorities adhere to policy paradigms promoted by business and corporate interests, the institutionalist approach to policy change is insufficient to address health inequalities (Bryant, 2016; Raphael, 2015).

Some critiques of discursive institutionalism. The main challenge for discursive institutionalists is the presence of vague definitions of 'ideas' on the one hand and the absence of definitions on the other hand. For example, Hall (1993) and Smith (2007, 2013a) did not clearly define *ideas* or distinguish them from *paradigms* and *ideologies*. Criticizing Hall (1993), Cairney & Weible (2015) state: "ideas and paradigms are ontologically obscure and, therefore, any attempt to draw explanatory leverage, and generalizable knowledge will be problematic" (p.85). Blyth (1997) laments: "Ideas become desiderata, catch-all concepts" (p.231). The discussions below may help clarify some of the *ideas*' definitional ambiguities.

Béland and Cox (2016) define ***ideas*** as "causal beliefs about economic, social and political phenomena" (p.430). Ideas "may include beliefs, knowledge, worldviews, and shared definitions of policy problems, images, and solutions within groups, organizations, networks, and political systems" (Cairney & Heikkila, 2014, p.365). The commonly shared ideas within the policy communities can be termed a ***paradigm*** (Cairney & Weible, 2015). Paradigm is "a field

of accepted practices that sets the goals, priorities, and content of policy" (Blyth, 1997, p.237). Whereas ***ideology*** "is a more or less coherent set of ideas that provides the basis for organized political action, whether this is intended to preserve, modify or overthrow the existing system of power" (Heywood, 2017, p.10). Ideologies, paradigms, and ideas are not synonymous.

Perhaps, recognizing shortcomings in Smith (2007, 2013a), Smith (2013b, 2014) provides three different conceptions about *ideas* as policy paradigms, policy frames, and policy solutions. Nonetheless, the author defines "'ideas' as 'policy solutions' for addressing health inequalities" (Smith, 2014, p.562). However, it seems that for Smith, ideas and paradigms are the same. The author also tends to equate paradigms with ideologies. In my view, ideas constitute paradigms and ideologies, but not all ideas are paradigms and ideologies. Notably, all these concepts arise from the material and social conditions of life. The originator of critical political economy reminds one: "It is not the consciousness of men that determines their existence, but their social existence that determines their consciousness" (Marx, 1859, p.2).[27]

Section Summary. The basic unit of analysis of the discursive institutionalists examining social and health inequities is the ideas-institutions nexus. For them, reducing health inequities primarily means producing research-informed ideas and policy proposals subject to public intellectual debates to influence governing authorities' policy decisions. Like the classical pluralists, the discursive institutionalists underemphasize class, gender, and race relations underlying public policymaking processes shaping SDH distribution. Unlike the neo-pluralist, but like the classical pluralists, the discursive institutionalists largely ignore power asymmetries

[27] In this study, I understand the 'ideas' as follows. As human beings perceive materials through their senses, they produce immaterial forms of thought that can be described as *ideas*. Thus, the materials are the independent variables, whereas the ideas are the dependent variables. These ideas are expressed through verbal and non-verbal forms of communication. The idea world is the ensemble of perceptions, interpretations, expressions, and reflections of the material world. Therefore, the material conditions of life and not ideas should be the foundation of a more profound analysis of the relationships between materials, ideas, institutions, public policies, social determinants of health, and health inequalities.

among state and non-state policy actors shaping healthy public policy and public health policy. Finally, the pluralists and the institutionalists call for consensus-based policy solutions to health inequities.

The discursive institutionalist approach to health inequities is in its very early stage of development. For the most part, the scarce literature examined social and health inequities in general. In particular, most neglected that sexism and racism are structured within and through economic and political relations. As such, they failed to account for gendered and racialized health inequities, offering potential research areas to fill the gaps. As mentioned earlier, in part, I expect that my informants' insights will reflect a discursive institutionalist viewpoint; for example, they will talk about the role of research, evidence, ideas, paradigms, and ideologies concerning social and health inequities reduction.

3.4.3 Critical Political Economy. The critical political economy theory examines social and health inequities as material-based, real, and knowable; interconnected and changeable; historical, dialectical, and transformational (Marx, 1867). Marx, the pioneer of the critical political economy, views human beings as social beings whose social life is shaped by social relations of production. The ensemble of these social relations constitutes social structures (e.g. economic, political, legal) and corresponding social consciousness. Social consciousness arises from the material and social conditions of life. As social forces enter into a social conflict within the prevailing social relations at a particular stage of societal development, social conflict is settled through social revolution by which social structures are transformed, and a new social formation is established (Marx, 1867).

The critical political economy approach to health integrates the historical, economic, political, and cultural dimensions of social life into its analysis. Critical political economists

examine the tensions between materials and ideas; class, gender, and race relations; and social structures and agency shaping health outcomes (Armstrong et al., 2001; Coburn, 2010). Specifically, they examine power imbalances among classes, groups, and societies that influence the production and distribution of economic and other resources through the politics of public policymaking by which peoples' health is shaped (Coburn, 2010; Raphael, 2015). Furthermore, critical political economists scrutinize the roles of the market, labour, civil society, and state in policymaking processes shaping the social determinant of health and health inequalities (Bryant, 2013, 2016; Bryant & Raphael, 2016, 2020). They also account for sexism and racism structured within and through economic and political relations to shape further social and health inequalities (Armstrong, 2020; Borras, 2021; Gupta, 1996; Morrow et al., 2007; Messing & de Grosbois, 2001; Krieger et al., 1993, Syed, 2016; Syed et al., 2016; Navarro, 1991). They also expose the class interests, ideologies, and power dynamics underlying the state structures that dominate health politics but act little to reduce health inequalities (Bambra et al., 2011; Mantoura & Morrison, 2016). Finally, they dissect the role of neoliberalism in the creation and maintenance of health inequalities (Coburn, 2004; Labonté & Stuckler, 2015; Muntaner et al., 2011; Navarro, 2004, 2007a,b; Schrecker, 2016).

As explained above, the critical political economy theory focuses on social relations of production and the balance of power among social forces underlying the politics of public policy shaping health outcomes. The foundation of all human societies is social relations: no social relations, no human societies. As introduced, I assume that the critical political economy approach to health is more helpful than others providing the analytical lens that captures the reality of health inequities, their causes, and potential solutions.

Critical political economy, public policy change, SDH, and health inequities. Critical political economists explain the causes of and ways to reduce social and health inequities based on social relations of production. For example, in the 19th century, Engels (1845) argued that the capitalist system itself caused the miserable material and social conditions of life for many. He showed that compared to the wealthy and the capitalist class, the unsafe workplaces, low wages, poverty, inadequate housing, homelessness, and hunger -- called social determinants of health today -- result in high mortality and morbidity for the poor and the working class, in which women, children, older adults, immigrants, and enslaved people are further disadvantaged. Engels (1845) called it *social murder*:

> [S]ociety…daily and hourly commits what the working-men's organs, with perfect correctness, characterise as social murder, that it has placed the workers under conditions in which they can neither retain health nor live long; that it undermines the vital force of these workers gradually, little by little, and so hurries them to the grave before their time. [S]ociety knows how injurious such conditions are to the health and the life of the workers, and yet does nothing to improve these conditions. That it knows the consequences of its deeds; that its act is, therefore, not mere manslaughter, but murder, I shall have proved, when I cite official documents, reports of Parliament and of the Government, in substantiation of my charge. (p.84).[28]

[28] Contrary to some Marxists, feminists, race, and intersectionality scholars' understanding that Engels neglected gender and race, Engels wrote sufficiently about the conditions of the poor and working-class, women and children, immigrants, and enslaved people. In short, he accounted for what I referred to in this study as the *co-constitutiveness of capitalism (class), sexism (gender), racism (race), and colonialism (nationality)*. The following provides evidence that Engels accounted for the *co-constitutiveness* of class, gender, race, nationality, and age (popularly known today as *intersectionality*) from a critical political economy perspective. Since the debate around these issues remained contentious, I quote a few lines from **Engels (1845):** "But let all men remember this – that within the most courtly precincts of the richest city of God's earth, there may be found, night after night, winter after winter, women – young in years – old in sin and suffering – outcasts from society – ROTTING FROM FAMINE, FILTH, AND DISEASE. Let them remember this, and learn not to theorize but to act" (p.49). "The Irish have introduced, too, the custom, previously unknown in England, of going barefoot. In every manufacturing town there is now to be

The application of Engel's concept of social murder has been increasing, although some diverge from its original meaning (Medvedyuk et al., 2021). Some did not understand that social murder -- social and health injustices -- are logical consequences of capitalism (Borras, 2021). This is because the bourgeoisie, owning the means of production, maximizes profits and accumulates the nation's wealth in the hands of the monopoly capitalists (Engels, 1845; Marx, 1867). As a result, capital "accumulation of wealth at one pole is, therefore, at the same time accumulation of misery, agony of toil slavery, ignorance, brutality, mental degradation, at the opposite pole" (p.451), in which children, women, and enslaved people are further disadvantaged (Marx 1867).[29] Marx and Engels (1848/1964) thus proposed that capitalism be replaced with

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seen a multitude of people, especially women and children, going about barefoot, and their example is gradually being adopted by the poorer English" (p.68). "The newly immigrated Irishman, encamped in the first stable that offers, or turned out in the street after a week because he spends everything upon drink and cannot pay rent, would be a poor mill-hand. The mill-hand must, therefore, have wages enough to enable him to bring up his children to regular work; but no more, lest he should be able to get on without the wages of his children, and so make something else of them than mere working-men. Here, too, the limit, the minimum wage, is relative. When every member of the family works, the individual worker can get on with proportionately less, and the bourgeoisie has made the most of the opportunity of employing and making profitable the labour of women and children afforded by machine-work" (p.74). "A pretty list of diseases engendered purely by the hateful money-greed of the manufacturers! Women made unfit for child-bearing, children deformed, men enfeebled, limbs crushed, whole generations wrecked, afflicted with disease and infirmity, purely to fill the purses of the bourgeoisie" (p.123). "The same thing is true of the elder girls and women. They are overworked in the most brutal manner" (p.167). These statements remind me of the conditions of the racialized working-class women in the healthcare industry, especially in the long-term care and home care settings where many Filipino women or Filipina work. As mentioned earlier, I believe that class, gender, and race *dialectically co-constitute* each other. Thus, in this research, I use the terms *racialized capitalism*, *gendered capitalism, or racialized and gendered capitalism* to emphasize the co-constitutiveness of the class (capitalism), gender (sexism), and race (racism) from a critical political economy perspective.

[29] Contrary to some claims that Marx, the pioneer of the critical political economy theory, neglected gender and race, Marx accounted for the co-constitutiveness of class, gender, and race. For example, **Marx (1867)** stated: "But as soon as people, whose production still moves within the lower forms of slave-labour, corvée-labour, &c., are drawn into the whirlpool of an international market dominated by the capitalistic mode of production, the sale of their products for export becoming their principal interest, the civilised horrors of over-work are grafted on the barbaric horrors of slavery, serfdom, &c. Hence the negro labour in the Southern States of the American Union preserved something of a patriarchal character, so long as production was chiefly directed to immediate local consumption. But in proportion, as the export of cotton became of vital interest to these states, the over-working of the negro and sometimes the using up of his life in 7 years of labour became a factor in a calculated and calculating system" (p.164). "*Après moi le déluge! [After me, the flood]* is the watchword of every capitalist and of every capitalist nation. Hence Capital is reckless of the health or length of life of the labourer, unless under compulsion from society. To the outcry as to the physical and mental degradation, the premature death, the torture of over-work, it answers: Ought these to trouble us since they increase our profits? But looking at things as a whole, all this does not, indeed, depend on the good or ill will of the individual capitalist. Free competition brings out the inherent laws of capitalist production, in the shape of external coercive laws having power over every individual capitalist" (p.181, original emphasis). He wrote: "In so far as machinery dispenses with muscular power, it becomes a means of employing labourers of slight muscular strength, and those whose bodily development is incomplete, but whose limbs are all the more supple. The labour of women and children was, therefore, the first thing sought for by capitalists who used machinery. That mighty substitute for labour and labourers was forthwith changed into a means for increasing the number of wage-labourers by enrolling, under the direct sway of capital, every member of the workman's family, without distinction of age or sex. Compulsory work for the capitalist usurped the place, not only of the children's play, but also of free labour at home within moderate limits for the support of the family…. But now the capitalist buys

proletarian socialism or communism and that a social revolution is necessary to realize it.[30] Contrary to Chadwick (1842), for Marx and Engels, solving social and health inequities will not happen within the legislature in the capitalist system. The essential requirement is working-class unity and class struggle to overthrow and smash capitalism first.

In the 20th century, after World War II, the so-called 'Golden Age of Capitalism' occurred via Keynesian and state-managed capitalism. However, by the 1970s, Thatcher, Reagan, and Mulroney promoted deregulated and private capitalism: neoliberal capitalism (Wolff & Resnick, 2012). Since then, numerous countries have implemented the US-led neoliberal structural adjustment policies directed by international financial institutions (e.g. International Monetary Fund and World Bank). These radical actions caused the global exponential growth of informal workers and slum residents: about one billion city slum residents and over two billion informal workers (Davis, 2006; Harvey, 2005, 2007; Standing, 2014). It is common knowledge that slum living is unhealthy.

Specifically, neoliberal globalization generated millions of *precariat*: "so-called 'flexible' labour contracts; temporary jobs; labour as casuals, part-timers, or intermittently for labour brokers or employment agencies" (Standing, 2014, p.10). These workers experience

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children and young persons under age. Previously, the workman sold his own labour-power, which he disposed of nominally as a free agent. Now he sells wife and child. He has become a slave-dealer. The demand for children's labour often resembles in form the inquiries for negro slaves, such as were formerly to be read among the advertisements in American journals" (p.272). "The cheapening of labour-power, by sheer abuse of the labour of women and children, by sheer robbery of every normal condition requisite for working and living, and by the sheer brutality of overwork and night-work, meets at last with natural obstacles that cannot be overstepped. So also, when based on these methods, do the cheapening of commodities and capitalist exploitation in general" (p.310). "The discovery of gold and silver in America, the extirpation, enslavement and entombment in mines of the aboriginal population, the beginning of the conquest and looting of the East Indies, the turning of Africa into a warren for the commercial hunting of black-skins, signalized the rosy dawn of the era of capitalist production" (p.533). Thus, it would not be the fault of the critical political economy theory if some practitioners failed to integrate gender and race in their analysis of social and health inequities, as evidenced by some of the cited literature in this section.

[30] Broadly, socialism refers to "societies in which non-capitalist forms of the fundamental class process prevail." It is typified by collective labour participation and surplus labour appropriation (Wolff & Resnick, 2012, p.235). Socialism may be "understood as an economic system in which private ownership was replaced by state ownership of the principle means of production and markets were replaced by some form of comprehensive planning oriented to meet needs rather than maximize profits" (Wright, 2018, p.31). Further details about socialism or communism are beyond this research.

higher behavioural, psychosocial, and physio-pathological risks than other social classes (Benach et al., 2014, 2016; Matilla-Santander et al., 2021; Muntaner et al., 2010; Tompa et al., 2016). Neoliberalism exacerbated the toxic working, living, and health conditions of the precariat and slum-dwellers. It is unjust and inhumane.

In the health field, Doyal and Pennell (1979) showed that health inequalities among and within developed (UK) and underdeveloped ('Third World') countries are created mainly by society's economic and social organization, whose public policies conform with capitalism's logic, not by biological differences. The capitalist system allows wealth accumulation on the one hand and material deprivation on the other hand. It, directly and indirectly, results in healthier and longer lives for the few wealthy capitalist countries and the capitalist class and unhealthier and shorter lives for many poor countries and the working class. Navarro (1976a,b; 1980, 1986) demonstrates that the labour processes under capitalism directly affect workers' health by producing stress, fatigue, accidents, and toxicity. For example, the "mortality rate for heart disease in blue-collar workers (operators) was 2:3 times higher than the rate in managers and professionals" (Navarro, 1991, p.230).[31] In capitalist societies, most workers, regardless of gender and race, experience social and health inequities.

In the health care industry, Navarro (1976a) further illustrates: First, the capitalist state policy interventions maintain the class structure where physicians are mostly upper-middle-class white males, nurses are primarily lower-middle and working-class females, and auxiliary workers are mainly females from working-class backgrounds. Second, the mechanistic-individualistic ideology of medicine complements rather than opposes the ideology of capitalism. Third, the capitalist mode of production results in workers' alienation that adversely impacts

[31] Navarro is also among the soundest scholars who practice the Marxist-informed critical political economy approach to contemporary health studies (Panitch & Leys, 2009; Scambler, 2002).

health (Navarro, 1976a). Class struggles to change these conditions mark the history of the working classes worldwide (Navarro, 1980, 1986, 2007a,b; Navarro & Muntaner 2004, 2017). The typical work arrangement in Western healthcare systems dominated by mostly upper-class non-racialized males points to the co-constitutive character of the class, gender, and race.

The co-constitutive nature of class and gender shapes class and gendered health inequities. For example, Doyal (1995, 2005) found that in developing and developed countries, women experience higher levels of under-nutrition, infectious diseases, cancer, depression, anxiety and less access to medical care because of poverty, which is gendered (Doyal, 1995, 2000). Due to sexist practices and narratives deeply entrenched in a capitalistic political economy and public policymaking processes, although females have longer life expectancies, they have more significant morbidities than males (Doyal, 1995, 2000; Scott-Samuel et al., 2009; Kennedy et al., 2020).

In Canadian workplaces, females also suffer more musculoskeletal problems, mental health issues, heart diseases, hazardous chemical exposures, cancers, and fatigue than males (Messing & de Grosbois, 2001). Gendered health inequities remain pervasive (Morrow et al., 2008) in occupational health (Messing & Stellman, 2006) and health care systems (Armstrong, 2016). Sexism is embedded in capitalism. For Messing and de Grosbois (2001), addressing these social and health inequities requires stronger alliances among the researchers and female workers, occupational health scientists and feminists, and working classes and feminist organizations.

The COVID-19 pandemic further exposed the exploitative economic system that creates social inequities and class and gendered health inequities. For example, the worldwide working-hours losses resulting from employment losses and fewer working hours significantly affected

women than men (International Labour Organization, ILO 2020a). The main reasons were: First, more women worked in industries severely impacted by the pandemic, such as manufacturing and retail. Second, 37 million women out of 55 million domestic workers faced significant working-hour losses. Third, about 80% of women were employed in the health care and social work sector, which is also severely hit. Lastly, school and child centers closures exacerbated unpaid domestic labour, 75% of which is done by women and girls (ILO, 2020b). Worse, employment and income losses due to quarantines and lockdowns intensified violence against women (WHO, 2020). Notably, pre-pandemic violence against women was already rising, resulting from the radical shift from Keynesian to neoliberal policies that weakened the welfare state systems (Morrow et al., 2004). The global capitalist system placed women and girls at a further health disadvantage.

The pre-existing class and gendered inequities and the uneven economic and health impacts of COVID-19 can be linked to global capitalist and patriarchal practices concentrating the wealth and power to the disadvantage of females and other subordinated sexes. Remarkably, the aggregate wealth of 2,153 billionaires, primarily heterosexual men, is greater than the aggregate wealth of 4.6 billion people globally, at the bottom of which are girls and women in poverty. The 22 richest men's aggregate wealth is greater than that of all women in Africa (Coffey et al., 2020). This gendered wealth inequality partly resulted from unpaid and underpaid wage labour provided by females in the production of social life, like caring and domestic labour (Coffey et al. 2020, p.8). The 'sexist economic system' devalues and under-values billions of hours of labour provided by girls and women globally (Coffey et al. 2020, p.2). In short, gendered capitalism shapes class and gender health inequities.

Furthermore, the co-constitutive formations of capitalism, sexism, and racism shape class, gender, and racial inequities resulting in health gaps. For example, in Canada, the unemployment rate for the non-racialized population was 7.3%, whereas for the racialized population, 9.2% in 2016. The unemployment rates for non-racialized women and men were 6.4% and 8.2%, whereas for racialized men and women, 8.8% and 9.6% in 2016. Moreover, the "racialized men [only] earned 78 cents for every dollar that non-racialized men earned" in 2015 – a gap that has remained unchanged since 2005. Worse, the "racialized women [only] earned 59 cents for every dollar that non-racialized men earned, while non-racialized women earned 67 cents for every dollar that non-racialized men earned" – no significant policy changes were made to reduce these gaps from 2005 to 2015. The Canadian labour market is gendered and racialized (Block et al., 2019, pp.4-5). Income from employment in the racialized and gendered labour market shapes health inequities as further demonstrated below.

In Australia, New Zealand, and the Pacific, Indigenous persons generally have lower employment rates, low income, shorter life expectancies, and higher infant mortality rates than the non-Indigenous (Anderson et al., 2006). In the USA, the forerunner of global capitalism, the non-racialized are generally wealthier than racialized groups: The latter have higher unemployment, poverty, and morbidities (Bailey et al., 2017). In Canada, Indigenous persons continue to experience higher poverty levels, inequitable access to healthcare systems and services, and mental health issues than non-Indigenous persons (Nelson & Wilson, 2017). Syed (2016) further states:

> Racialized and migrant workers in Canada experience high levels of precarious work, denizenship, social exclusion, social inequality, and eventually health inequities, which is a

result of discrimination experienced by these groups. It reveals that the government has failed to address these issues because of control and lobby through powerful economic and political structures that benefit from the situation as it stands. (p.449).

The persistence of racialized health inequities is made possible through public policies, legal standards, political and economic systems, and institutional practices that perpetuate land displacements, socioeconomic inequities, higher exposure to toxic environments, racially-driven structural violence, prolonged exposure to psychological stress resulting in adverse physiological outcomes, racism-induced psychosocial trauma, and inadequate and culturally-insensitive health care systems (NCCDH, 2018). The disadvantageous working, living, and health conditions experienced by the racialized groups can be linked to the history of colonialism entangled with capitalism's inherent tendency to cross continents in search of cheap resources, market expansion, and capital accumulation.

In the Canadian healthcare system, long before the COVID-19 pandemic, racialized female workers suffered more significant health inequalities than other groups (Armstrong, 2016, 2020; Armstrong & Armstrong, 2010; Borras, 2021; Gupta, 1996; Morrow et al., 2007; Syed, 2020). Specifically, examining long-term care facilities in Ontario, Syed and colleagues (2016) conclude:

Our study shows how work hierarchies; rigid divisions of labour, and task orientation within LTC are highly complex phenomenon that can intersect with psychosocial factors. Employee job stress, high job demands, and time pressures, which are exhibited in our study, also seem to be linked to the experiences of care work hierarchies and of task oriented work between

and among various worker groups. Care work is gendered and racialized, and these workers' experiences include many types of psychosocial issues and challenges. (p.14).

Not surprisingly, amidst the pandemic, the COVID-19 infection cases in Ontario included 76 doctors, 714 nurses, 2700 personal support workers, cleaners, and others as of May 2020 (Vogel & Eggertson, 2020). Over 9,650 LTC workers were infected, greater than 10% of the country's total cases as of May 2020 (CIHI, 2020). Many were females because they comprise 70% to 80% of the health labour force and 90% of the LTC (Boniol, 2019). Many were low-wage earners, females, and racialized (Armstrong et al., 2020; Brophy et al., 2020). In a capitalist system, the capitalists further exploit the historically subordinated women and racialized workers. Gendered and racialized capitalism produces and perpetuates class, gender, and racial health inequities.

Engaging in reflexivity, the experience of my partner, who was a resource person in Ontario's LTC COVID-19 Commission, will haunt our family for the rest of our lives. The damage of unsafe working conditions to the overall health of the frontline healthcare workers, mostly women and racialized, would be enduring. She stated:

> One day I was called into the management office, and they were threatening to send me home if I keep wearing my N95. I bring my own N95, and I bought it for myself just to protect me and my family. I called my union rep, and they stepped out on my behalf. But I was so scared, and I had to choose between my health and my job, but my employer insist that I have to follow the Public Health recommendation to use surgical Level 1 surgical masks we're wearing, the whole time of our outbreak, with a patient. Even the Labour Council, they came in our home and didn't even know what is Level 1, 2 and 3 mask when I asked.

> Because until now, we don't have in place, we don't have protocol. When we are going to use Level 1, Level 2, Level 3 mask? All the time, all the time of the outbreak, we wearing Level 1 mask, that's why we have so much staff infected, we have so much residents infected and die in our home. The most difficult and hard time, and I can't forget, and I am traumatized: When the resident died, and no one's family beside them. And we, including myself, I wrap; I wrap the dead body in a plastic bag, in the black bag and push them out in our home. That is the most devastating in my life I experience. And I know I am not protected that time. And I couldn't understand why the Government and the employer called us hero? And yet they left us unprotected and work without proper PPE. And most of us at that time understaffing, underpaid. We fighting this for long with the SEIU, but until now, we don't have -- we don't get the action from the Government. We are physically, emotionally, psychologically, financially distressed until now. (Ontario LTC COVID-19 Commission, SEIU, Transcript, October 15, 2020, pp.63-65).

Another way of understanding the critical political economy approach to understanding the causes of and means to reduce social and health inequities is via welfare state systems. For example, although Esping-Andersen (1990) did not focus on health inequities, the author conceptualized the ***three worlds of welfare capitalism*** based on the different political economies of 16 advanced welfare capitalist states relative to some types of economic and social supports. Esping-Andersen clustered these welfare states into the *liberal*, *corporatist* or *conservative*, and *social democratic* regime types based on core qualities: decommodification in social policy, system of social stratification, and roles of state, market, and citizens in public-private pension provision. The decommodification in social policy includes the examination of old-age pension,

sickness benefits, and unemployment insurance.[32] The system of social stratification includes the analysis of liberal means-tested poor relief, private pensions, and public health spending; conservative corporatism and etatism; and social democratic degree of universalism.[33]

Esping-Andersen's (1990) main findings were that decommodification scores were generally high in the social democratic, modest in the conservative, and low in the liberal. He concluded that historical factors and forces, including political power relations between the state, Catholicism, and labour, fundamentally shaped the extent of redistributive public policies and the quality of the distribution of societal resources in various welfare state regimes. Esping-Andersen's pioneering work led to several welfare state typologies, including Saint-Arnaud and Bernard's (2003) model, which illustrates that Canada's public policymaking processes at the provincial and federal levels rarely veer away from the liberal type. The following discussions concentrate on the welfare state system's application in the health field.

The concept of the welfare state brings to light the political and public policy dimensions of health inequities. For example, Navarro and Shi (2002) demonstrate that from 1960 to 1996, the mean IMR/1000 live births was consecutively lowest for the social democratic than Christian democratic, former fascist dictatorships, and liberal Anglo-Saxon welfare states.[34] The authors illustrate that in liberal Anglo-Saxon countries where capitalist influence was stronger than social democratic parties and labour movements, commitments to redistributive public policies were

[32] Esping-Andersen's (1990) welfare states according to liberal, conservative, and socialist regime characteristics as arranged from the highest to lowest cumulative index scores based on their strong degree of liberalism, conservatism, and socialism: *liberal* Canada, USA, Switzerland, Australia, and Japan; *conservative* Austria, Belgium, France, Germany, and Italy; and, *socialist democratic* Denmark, Norway, Sweden, Finland and the Netherlands. The UK had a medium degree of liberalism and socialism.

[33] Decommodification refers to: "the extent to which individuals and families can maintain a normally socially acceptable standard of living regardless of their market performance." In contrast, commodification is: "the extent to which workers and their families are reliant upon market sale of their labour" (Eikemo & Bambra, 2008, p.4).

[34] Navarro and Shi (2002) welfare states: *Socialist Democratic* Austria, Sweden, Denmark, Norway, Finland; *Christian Democratic* Belgium, Germany, Netherlands, France, Italy, Switzerland; *Liberal* UK, Ireland, USA, Canada; *Former Fascist Dictatorship* Spain, Portugal, Greece.

weaker, and health inequalities more profound. In contrast, in welfare states ruled by social democratic parties and where labour movements were strong, health indicators were better due to robust redistributive public policies.

Specifically, the Christian democratic heavily depended on the family for delivering social services to the children, elderly, and disabled. This extra burden of care work resulted in women's labour participation at only 46% compared with the liberal 52.8% and social-democratic 65.2%. The former fascist countries have the lowest women employment at 26%. Not surprisingly:

> In Christian democratic countries, class inequalities have been compounded by large gender inequalities, including gender inequalities in health. Spain's government commission on inequalities in health (the Spanish equivalent of the U.K. Black Commission) found, for example, that in the 30- to 50-year age group, women have twice as many stress-related conditions as men. In fact, women in this group suffer more stress-related conditions than any other group in Spain. (Navarro & Shi, 2002, p.16).

Empirically linking health inequalities, social inequalities, public policy, and politics, Navarro and colleagues (2003) also found that redistributive public policies, including welfare and labour policies, aimed to reduce social inequalities, generally improved the IMR in OECD countries from 1950 to 1998. The economic and political tradition of social democratic parties with egalitarian ideologies tends to carry out those redistributive public policies. Thus, "the political ideologies of governing parties affect some indicators of population health" (Navarro et al., 2006, p.1033). The state authorities and political parties representing the interests of a particular class, through public policy, profoundly shape peoples' health.

Coburn (2000, 2004, 2010) further argues that neoliberalism and economic globalization, fuelled by the power of capital, subjugated labour in the market and undermined the welfare state systems. These conditions decreased social cohesion and increased social, income, and health inequalities. Raphael (2015) categorically states: "the power and dominance of the business and corporate sector in the liberal welfare state translates into public policy that inequitably shapes the distribution of SDOH in a whole range of public policy areas," including but not limited to employment, housing, early child development, and healthcare (p.S19). Specifically, Canada's neoliberal state policies exacerbated social and material deprivation, resulting in psychosocial stress, unhealthy coping behaviours, and health inequalities (Bryant & Raphael, 2020; Raphael, 2014, 2015, 2016). Raphael's emphasis on the significant role of corporate power and influence in health politics and public policy overlaps with the neo-pluralist and corporatist views.

Many other scholars examined welfare state systems shaping population health outcomes (e.g. Beckfield & Bambra, 2016; Eikemo & Bambra, 2008; Muntaner et al., 2002; 2011; Navarro & Muntaner, 2004, 2017; Raphael, 2012; Raphael & Bryant 2015). Despite inconsistent and mixed results, the social democratic distribution of economic and social resources improves population health and reduces health inequalities (Bryant & Raphael, 2020; Quesnel-Vallée, 2015; Raphael, 2015), supporting the claim that consolidated solid working-class power and socialist party representation are core elements in reducing preventable health inequalities.

The preceding discussions demonstrate that capitalism mainly produces social and health inequities. These conditions are sustained by the conservative and liberal political traditions that perpetuate the capitalist system, neoliberal ideologies, and asymmetrical power relations among social forces. The following discussions further examine corporate power in relation to the

inequitable distribution of SDH, resulting in adverse health outcomes and unjust health differences. Carroll and Sapinski (2018) defines ***corporate power*:**

> Put simply, it is the power that accrues to enormous concentration of capital, which, in contemporary societies, are organized as large corporations… From its base in the economy, corporate power reaches into other areas – political and cultural – shaping the institutions, agendas, policies, discourses and values that add up to an entire way of life. That way of life is known as corporate capitalism. (pp. 3-4).

The definition above directs attention to the interrelated but distinct public policy theories: (a) neo-pluralism's emphasis on corporate power, (b) discursive institutionalism's emphasis on ideas-institutions nexus, and (c) critical political economy's emphasis on social relations and balance of power among social forces participating in the production of social life.

In Canada, although Carroll and Sapinski (2018) did not focus on health inequities, they show that social inequities result from how large corporations conduct their businesses. They argue that capitalist forces organized the elite 1% economically, politically, and culturally, solidified corporate power, and weakened labour movements to satisfy their need for profit maximization, capital accumulation, and wealth reinvestment. Gaining hegemonic power, the big corporations influence social institutions, political agendas, state policies, public discourses, and human values (Carroll & Sapinski, 2018). The corporate power elite and their collaborators inside the Canadian capitalist state then enact and implement policies aligned with neoliberalism. Remarkably, they successfully dismantled the Keynesian welfare state system (Banting & Myles,

2013; Finkel, 2018; McBride & Shields, 1997; Peters, 2012) and institutionalized neoliberal policies and ideologies – a radical policy paradigm shift, as discussed earlier.

In Canada's labour market, the power imbalances among classes and other social forces resulted in rapidly increasing profit shares for the capitalists and incremental wage increases for the workers. Specifically, while the elite 0.01% household income shot up by 145%, most Canadians' household incomes stagnated from 1990 to 2010 (Peters, 2012). During this era, concessionary labour wages and benefits and de-unionization escalated. As a result, temporary, part-time, and contractual labour became standard employment practices. Ultimately, the corporate downsizing strategy, which cuts production costs to maximize profits plus the closures of many small and medium-sized enterprises, resulted in massive joblessness, income losses, housing insecurity, and a plethora of social inequalities (Banting & Myles, 2013; Carroll & Sapinski, 2018; Finkel, 2018; McBride & Shields, 1997; Peters, 2012) and health inequalities (Bryant & Raphael, 2020). As discussed earlier, the poor and working-class experience higher morbidities and mortalities than the wealthy and capitalist class.

In Canada's housing industry, neoliberalism produced and maintained housing insecurity and homelessness through public policies that adhere to the corporate-led market-dependent profit-driven housing provision (Bryant, 2016; Gaetz, 2010; Hackworth & Moriah, 2006; Kalman-Lamb, 2017; Young & Moses, 2013). These neoliberal housing policies resulted in the following: First, an ongoing rise in housing prices that far exceed household incomes. Second, the demolition and conversion of low rental housing units into luxury condominiums depleted affordable housing stock. Third, millions of Canadians struggle with high rental costs. Finally, the termination of public and social housing long-term subsidies exacerbated housing insecurity, homelessness, and health inequalities (Bryant, 2016; Hulchanski, 2009; Pomeroy, 2015). As

introduced, housing insecurity, homelessness, and their adverse health outcomes severely impacted the poor and working-class, females, and racialized persons.

In Canada's food industry, the neoliberal governing authorities increasingly relied on temporary migrant farm workers. Before and during the COVID-19 pandemic, these mostly racialized workers faced significant financial and occupational health risks because they did not have the same social and healthcare support as provided to permanent residents and Canadian citizens. Worse, they experience various forms of labour exploitation and oppression. For example, migrant farmworkers commonly experience wage theft (Migrant Workers Alliance for Change, MWAC, 2020). Amid quarantine, most of them could not get adequate food, income, and information support. Some were compelled to work overtime; however, most Canadian labour laws do not safeguard overtime pay and minimum wage. Moreover, racism, surveillance, and threats intensified. Temporary status workers often encountered difficulties asserting their rights to fair employment practices, decent housing, and equitable health services (MWAC, 2020). The big corporations and neoliberal governments perpetuate racialized cheap labour and hazardous working and living conditions in the food system, furthering social and health inequities.

Indeed, Canada's state policies have been adapted to satisfy the profit interest of big transnational corporations (Langille, 2016). The managers and owners of these corporations succeeded in pressuring governing authorities to enact and implement a neoliberal approach to macroeconomic policies favouring the elite 1%, intensifying social and health inequities in Canada (Langille, 2016). As a result, currently, the total wealth of 12 million lowest earners only equals the total wealth of 87 most affluent families in the country (Macdonald, 2018). Wealth and income distribution determine life expectancies. Statistics show that the top ventile

earners' life expectancies for females and males were 3.6 and 8.1 years longer than the lowest ventile earners (Milligan & Schirle, 2018). Capitalism's core hallmark is abject poverty and early deaths on one extreme and affluence and longer lives on the other extreme. In the capitalist economic system, women and racialized workers are significantly more exploited than men and non-racialized workers, furthering class-based, gendered, and racialized health inequities. Sexism and racism are engrained in capitalism – the three co-constitute each other to a greater degree. Gendered and racialized capitalism primarily shapes class, gender, and health inequities.

What is the alternative, and what is to be done? As discussed earlier, in the 19th century, while Chadwick (1842) recommended public policy reforms within the existing capitalist system, Marx and Engels (1848) proposed revolutionary class struggle to overthrow and smash capitalism and replace it with proletarian socialism or communism. Since then, Marxist thoughts have evolved. In the contemporary era, some emphasize class, gender, and race/ethnic relations underlying the economic, political, and cultural structures shaping SDH and health inequities and suggest addressing these issues in an integrated manner (e.g. see Borras, 2021; Krieger et al., 1993; Morrow et al., 2007; Muntaner & Navarro, 2004; Syed, 2020). Navarro (2020) clearly states: "the objective of any emancipatory project should be the elimination of any form of exploitation, whether of class, gender, race, nation, or the environment" (p.1). Notably, Raphael (2009, 2014, 2015, 2016) has been calling to build and strengthen political, social, and labour movements to counter corporate power and *force* the state to enact and implement healthy public policy to improve working and living conditions. Bryant and Raphael (2016, 2020) further argue that reducing health inequalities requires educating, organizing, and mobilizing the public to counter corporate interests and ideologies. There are ways to struggle within and against capitalism and for socialism.

Wright (2018) explains that historically, ***anticapitalism struggles*** against social and health inequities have been fuelled by interacting but distinct 'strategic logics': smashing, dismantling, taming, resisting, and escaping capitalism. Central to *smashing capitalism* is that capitalism cannot be reformed. This strategy is plausible because recurrent economic crises in capitalism open opportunities for revolutionaries to spearhead massive mobilization to capture state power through the revolutionary overthrow of the ruling class or through electoral politics. Seizing state power, the revolutionaries can abolish capitalism's power structures and build the institutions required to establish socialism to address social and health inequities radically. However, 'revolutionary ruptures' in the 20th century did not create an alternative world envisaged in 'revolutionary ideology' (Wright, 2018).

Dismantling capitalism does not see a radical break with capitalism but rather a gradual transition to democratic socialism, plausible through state-led reforms that infuse incremental socialist alternatives within the capitalist system; thus, a mixed economy (Wright, 2018). This strategy requires a secure electoral democracy and a socialist party that can win elections and remain in power for a long period to institutionalize alternative economic structures to reduce social and health inequities. Notably, "Democratic socialism abandoned the idea of smashing capitalism, but still sought a strategy of ultimately transcending its structures by gradually dismantling capitalism" (p.25). However, this reformist route toward socialism suffered heavily with the onslaught of neoliberalism (Wright, 2018).

Wright (2018) categorically states: "Both smashing and dismantling capitalism envision the ultimate possibility of replacing capitalism with a fundamentally different kind of economic structure, socialism. In this sense, they both have revolutionary aspirations, even if they differ in their understanding of the necessary means for accomplishing their goals" (p.20).

In contrast, *taming capitalism* does not struggle to replace capitalism with socialism (Wright, 2018). This strategy informs non-revolutionary socialist and social democratic parties which goal is to 'neutralize some of the harms of capitalism' through state regulatory and redistributive policies, plausible through 'political will' and 'popular mobilization.' An example is the 'Golden Age of Capitalism,' where egalitarian social democratic policies modified the 'rules of the game,' for instance, through high taxation, socialized insurance, and workplace safety regulations to counter social and health inequities. However, the succeeding neoliberal state policies of deregulation, privatization, and austerity rolled back those democratic gains (Wright, 2018).

Resisting capitalism works outside the state (Wright, 2018). This strategy, which informs numerous unions, civil society, grassroots organizations, and activists, is the universal response to social and health inequities. An example is a labour strike demanding wage increases and safe working conditions. Although it does not try to seize state power, resisting capitalism challenges the actions of the elite politicians and capitalists through dissent and other types of resistance beyond the state. Social identities, including but not limited to class, gender, and race relations, frequently energize the resistance. The most rudimentary forms are workers' actions against exploitation and oppression in capitalist workplaces, whereas labour and social movements perform the most advanced forms of resistance beyond workplaces (Wright, 2018).

Escaping capitalism is among the ancient responses to capitalism's harmful effects (Wright, 2018). This strategy, which is more individualistic than collective, sees capitalism as too powerful and too big to be destroyed as it time and again co-opts resistance. Thus, the best way to flourish is to 'insulate ourselves' from the onslaught of capitalism. Some examples: self-sufficient farming, Amish communities, hippie communes, and workers' cooperatives.

However, although cooperatives escape capitalist exploitation in workplaces, these can serve as an alternative economic system that challenges capitalism (Wright, 2018).

A new strategic logic, *eroding capitalism*, may be emerging from social movements (Wright, 2018). This strategy fuses top-down state-centric strategies of dismantling and taming capitalism and bottom-up civil society-centric strategies of escaping and resisting capitalism to respond to social and health inequities. Some examples that may be heading towards this direction: Syriza, Podemos, Sander, and Corbyn phenomenon. The strategic vision of eroding capitalism is to displace capitalism from its dominance in the economy and as a way of life (Wright, 2018).

The preceding discussions demonstrate that the capitalist class and the capitalist state predominantly create and maintain social and health inequities to the disadvantage of the poor and working class, females, racialized, and other marginalized groups. Capitalism is the primary source of the inequitable distribution of the social determinants of health and health inequities. Socialism as an alternative world beyond capitalism is plausible.

Section Summary. Critical political economists' basic unit of analysis in examining social and health inequities is social relations and the balance of power among class and other social forces of production. Like the neo-pluralists, they recognize power differentials among societal sectors, as exemplified by the dominance of corporate power in the production of social life. Unlike the classical pluralists, who assume that the governing authorities are neutral arbiters of societal and public health affairs, Marxist political economists think the capitalist state primarily serves the capitalist class' interests and ideologies. However, some political economists, including Marxists who are supposed to be more critical, ignore gender and race relations in capitalism.

Unlike the pluralists who wait for policy windows to open to push and advocate for their pet health policy proposals and unlike the discursive institutionalists who prioritize formulation of health policy ideas and proposals over concrete political actions, critical political economists combine political education, organization, and mobilization to transform society. The latter think these strategies can help transition from a capitalist to a socialist system that can equitably redistribute the social determinants of health to reduce health inequities.

By de-emphasizing the dominance of capitalism in organizing economic and societal resources, classical pluralists and discursive institutionalists may unwittingly absolve the capitalist class and the neoliberal capitalist state that create and sustain social and health inequities. The greatest threat of the pluralists and discursive institutionalists is their deliberate effort to ignore irreconcilable contradictions and antagonisms among contending classes and other social forces while insisting on compromise and cooperation to address health inequities. Instead of emancipatory social transformation, the pluralists and discursive institutionalists usually settle for incremental healthy public policy and public health policy changes.

In contrast, critical political economists, especially Marxists, think that the exploitative and oppressive capitalist system should be replaced with socialism to realize social change and reduce health inequities. Unlike the pluralists and institutionalists, critical political economists think that health politics is conflict-based rather than consensus-based. Nonetheless, there is a need for other political economists to integrate gender and race in their social and health inequities examination. Contrary to the claims, Marx and Engels -- the pioneers of critical political economy theory -- incorporated gender, race, nationality, immigrant status, and age in analyzing the capitalist economic system shaping social and health inequities. As mentioned earlier, I expect my interviewees' insights to reflect a critical political economist's viewpoint; for

example, they will speak about capitalism and social relations of power, including class, gender, and race, in relation to social and health inequities reduction.

3.5 Chapter Summary

In this chapter, I first discussed the processes involved in my critical realist review of the literature. Then I presented an overview of the extent of health inequities in Canada and the seven discourses on the sources and means of reducing health inequities, ranging from genetics to the idea of power and influence. Then I briefly described politics, public policy, and policy change. Moreover, I discussed pluralism, discursive institutionalism, and the critical political economy approach to health inequities. Specifically, I explained the pluralist Kingdon's agenda-setting, discursive institutionalist Hall's policy paradigm and Smith's journeys of ideas, and political economist Esping-Andersen's welfare state systems as applied by health scholars to address social and health inequities. The literature review demonstrates that although interrelated, each public policy and policy change approach provides different understandings of the causes and means to reduce health inequities. Nonetheless, between public policy theories: pluralism (e.g. Kingdon's model), discursive institutionalism (e.g. Smith's journey of ideas), and critical political economy frameworks (e.g. Esping-Andersen welfare state), I think that the latter is the most useful in addressing health inequities in general and, despite its perceived shortcomings, in examining the co-constitutive character of the class, gender, and race relations shaping health inequities.

Assumptions and synthesizing concepts. As introduced, I assume that the causes of health inequities are to be found in the distribution of power among societal sectors and how it shapes the organization of a society's political and economic systems. These systems shape

social relations, with class, gender, and race/ethnicity dynamics critical in the persistence of health inequities. Thus, any public policy action toward reducing such health inequities will have to address the fundamental question of how class- and identity-based political power manifests in Canada. The current political scene in liberal welfare state countries such as Canada, which promotes neoliberal approaches to governance, further complicates these issues.

Based on the discussions in the previous chapters, several theories for explaining health inequities exist in the literature: genetic, cultural-behavioural, psycho-social, materialist-structuralist, life course, macrosocial policies, intersectionality, and the political economy of health. Raphael (2012) provides seven discourses as to the sources and means to reducing health inequalities in Canada: biological, social and health services access, modifiable behaviour and lifestyle, material living conditions, public policy shaping the material living conditions, political and economic structures and ideologies, and power and influence. Public policy approaches that I assume may help explain health inequities: pluralism, discursive institutionalism, and critical political economy, offer diverging but at times converging explanations as to the causes of and means of reducing health inequities.

Some of the findings from the critical realist review of literature, as explained earlier, are as follows: Health inequities are extensive, and they severely impact the poor and working-class, females, and racialized persons through the capitalistic economic system in general and racialized and gendered capitalism in particular. Class, gender, and race are internally-dialectically related, and their co-constitutive character primarily shapes class-based, gendered, and racialized health inequities. However, unlike the critical political economists, the pluralists and pioneer discursive institutionalists largely ignored unequal class, gender, and race/ethnicity

relations of power underlying the politics of public policymaking, shaping the inequitable distribution of social determinants of health and health inequities.

The pluralists primarily argue that the causes of public policy failures to reduce health inequities are lack of cooperation among societal sectors, inadequate coordination among levels of government and its agencies, and a closed policy window of opportunities. Therefore, the main solution is cooperation and coordination among state and non-state policy actors and opening policy windows for an extended period. The discursive institutionalists primarily argue that the causes of public policy failures to reduce health inequities are the prevailing policy paradigms or institutionalized ideas altering and blocking evidence-based health policy ideas. Therefore, the primary solution is formulating research-informed ideas that can successfully reach the policy realm via public intellectual debates influencing the governing authorities.

Finally, the critical political economists argue that the causes of public policy failures to reduce health inequities are capitalist-dominated social structures, institutions, ideologies, and power imbalances among social forces of production. Thus, reducing health inequities means altering power imbalances among societal sectors, including class, gender, and race relations. For some, it means replacing the capitalist system with socialism. Several ways to struggle within and against capitalism and for socialism are available to inform actions on SDH and health inequities: smashing, dismantling, taming, resisting, escaping, and eroding capitalism (Wright, 2018), all of which necessitates educating, organizing, and mobilizing social forces against the exploitative and oppressive capitalist system. Unlike the pluralists and discursive institutionalists, the critical political economists' understandings of the causes and solutions to health inequities are fundamentally conflict-based than consensus-based social relations of power.

The main results from the critical realist literature review confirm my assumption that social relations of power and influence -- central to critical political economy theory -- fundamentally cause health inequities that primarily impact the poor and working class, females, and racialized persons. The dominance of the corporate capitalist class and neoliberal governing authorities in public policymaking processes over peoples' organizations like labour, civil society, and social movements is the main source of persistent health inequities in Canada. Findings solutions to these preventable health inequalities necessitate looking at them from a conflict-based critical political economy approach to health. In my view, the governing authorities who advance capital interests, unless compelled by organized labour, civil society, and social movements *from below,* will not alter the existing order that creates and maintains health inequities. My critical realist literature review, in part, addresses the research questions:

1. How do state actors (e.g., politicians and policymakers) understand and shape public policy over time in relation to the politics of class, gender, race/ethnicity, and health inequities?
2. How do public policy academics understand and engage with public policy and politics over time in relation to the politics of class, gender, race/ethnicity, and its impact on health inequities?
3. How do public policy activists and advocates understand and engage with public policy and politics over time in relation to the politics of class, gender, race/ethnicity, and its impact on health inequities?

As introduced, complementing the literature review, I interviewed Canadian public policy academics, activists, and advocates who are in a good position to know the causes of and means

to reduce social and health inequities. The interviewees included political scientists, economists, sociologists, epidemiologists, physicians, union leaders and organizers, anti-poverty, housing, and political activists, and health researchers and advocates – all experts in their field.

Based on the preceding discussions, I anticipated my informants would speak about those different conceptions of the sources and means to reduce health inequities. An essential aspect of my study is ascertaining whether they are conscious of the different health inequities theories and the importance of public policy in addressing social and health inequities. My main interest is whether my interviewees consider the role of competing interest and advocacy groups (pluralism), ideas and institutions (discursive institutionalism), and social relations of power and influence (critical political economy) play in shaping social and health inequities in Canada. I analyzed and classified their insights into existing public policy theories: pluralism, discursive institutionalism, and critical political economy. Among other questions, the questions I asked are provided in Table 6 below.

Table 6. Samples of Semi-structured Interview Questions

1	What do you think are the major causes of the inequitable distribution of the SDH?
2	What do you see as the key barriers to public policy change that aim to improve Canadians' working and living conditions?
3	Do you think various competing interest groups have equal chances or opportunities to influence and shape public policy to reduce health inequities?
4	Do you think evidence-based research and ideas influence public policy? If not, why? If yes, do they influence public policy more than the power and politics behind policymaking?
5	What are your recommendations as to the way forward to improving the working and living conditions of Canadians and others?
6	Do you think the previous and present government is doing its best to reduce substantially class, race, gender-based social and health inequities? If not, why? If yes, in what ways?

CHAPTER 4

MAIN FINDINGS, ANALYSES, AND DISCUSSIONS

Après moi le déluge! [After me, the flood] is the watchword of every capitalist and of every capitalist nation. Hence Capital is reckless of the health or length of life of the labourer, unless under compulsion from society.
- Karl Marx, 1867

This chapter provides the results, analyses, and initial discussions of the 23 semi-structured interviews I conducted, complementing my research findings using existing document data. The presentation of the following main findings follows the logical flow of the interview. Applying thematic analysis of the interview data, Section 4.1 focuses on the causes of health inequities, especially class, race/ethnicity, and gender health inequities with three main themes: 1) the capitalist economic system; 2) the co-constitutives of capitalism: colonialism, racism, and sexism; and 3) maldistributive public policies. Section 4.2 focuses on factors sustaining health inequities with five main themes: 1) power, interest, and ideology trump evidence; 2) unequal resources of competing interests and advocacy groups; 3) dominance of the business and corporate sector; 4) neoliberal governing authorities; and 5) fragmented and weak labour unions, civil society groups, and social movements.

Section 4.3 focuses on moving forward to reduce health inequities in Canada with four main themes: 1) pushing for redistributive public policies; 2) uniting and strengthening labour unions, civil society groups, and social movements; 3) engaging in electoral politics; and 4) core strategies toward redistributive public policies, united and strong labour unions, civil society groups, and social movements, and alternative politics. The main themes and sub-themes are analytically distinct but interrelated.

For Chapter 4, I provide a brief introduction to each main theme, followed by illustrative quotations from the interview data. I then analyze and initially discuss the findings in relation to

the existing literature concluding with a summary of findings. Chapter 5 offers further analyses, discussions, and reflections.

4.1 Causes of Health Inequities

My thematic analysis of the interview data identified three main findings as to the causes of health inequities in Canada. The first is that the capitalist economic system is the fundamental cause of social inequities and inequitable distribution of the social determinants of health, resulting in health inequities. The second is that capitalism, which co-constitutes colonialism, racism, and sexism, mainly produces class-based, gendered, and racialized health inequities. The third is that maldistributive public policies primarily create health inequities. The informants' -- academics, activists, advocates -- collective insights about the fundamental causes of social and health inequities reflected more of the critical political economy approach to health and policy change than pluralism and discursive institutionalism.

Specifically, 10/23 of the informants spontaneously identified capitalism, 1/23 identified racism, 1/23 identified colonialism and racism, 6/23 identified the co-constitutive nature of capitalism, colonialism, racism, and sexism, and 5/23 identified maldistributive public policies as the main causes of social and health inequities in Canada. As the interview progressed, all interviewees linked such inequities to the capitalist economic system, and they all recognized that capitalism is, for the most part, entangled with the histories of colonialism, racism, and sexism. All interviewees acknowledged the limits of public policies to reduce health inequities within a capitalist society. These findings demonstrate that the causes of health inequities are primarily structural, institutional, and ideological, occurring at the macro-societal than micro-

individual level, meaning health inequities are not the result of differences in genes, lifestyles, and behaviours.

4.1.1 The capitalist economic system. Although interviewees came from various backgrounds, 10/23 of the informants spontaneously identified capitalism as the fundamental cause of social and health inequities. However, as the interview progressed, 9/10 of the non-health-focused, 6/10 of the health-focused, and 3/4 of the union and healthcare-focused informants came to explicitly mention capital, capitalism, capitalist, neoliberal, neoliberalism, or neoliberalization as the sources of health inequities. Only 5/23 informants did not explicitly use those terms: three are health-focused, one is non-health-focused, and one is a union leader. However, they also speak about the dominant role of the private market system and big business industry in public policymaking processes. In short, all interviewees linked the capitalist system -- either explicitly or implicitly -- to the production and distribution of social and health inequities in Canada.

For this main theme, the presentation of the results is classified into three sub-themes: 1) capitalism and labour; 2) capitalism and poverty; and 3) capitalism and healthcare. After each sub-theme, I present a brief analysis and discussion relative to existing literature. I wrap up with the insights from the late Leo Panitch (non-health-focused) and a brief section summary. The following illustrative quotations from the key informants that complement my findings in the literature review further show why and how social and health inequities exist and how state and non-state policy actors engage in health politics.

Capitalism and labour. Some of the interviewees focused on the relationships between capitalism, employment, and health. For example, Sam Gindin, a political scientist and former Research Director of the Canadian Auto Workers for 27 years and Packer Visitor in Social

Justice at the York University for 10 years, explained that capitalism primarily shapes low wages, unsafe working conditions, and their adverse health outcomes. He explained:

> Capitalism. That's the story… This is what it means to live in a class society. It's unequal for workers, which means not just lower wages, but the pace of work is constantly tightened, which puts pressure on people. It means they live in permanent insecurity, which has all kinds of health and mental health issues… So, it's the basic workings of our capitalist society of one-half of the equation. The second half of the equation is that we haven't been able to build the kind of social forces that have effectively offset that. I think an obvious answer, it's about class and the relative balance of class forces. And the fact that workers aren't a class, they're fragmented individuals, and as fragmented individuals, they don't have the power to take on the capitalist system, inequalities. And the working class over the last 30, 40 years now has been defeated. So, it's no surprise that we find these results.

Gindin emphasized that the 'class and the relative balance of class forces' in which the 'power of capital and the power of the state' defeated the working class drives class health inequalities. He stressed the commodification of labour as a major factor. Finally, he explained that public policy plays a minimum role in reducing inequalities within capitalist society:

> Workers are probably going to have questions when I say this. But when workers fight back, they're fighting the power of capital and the power of the state. And the power of capital and the power of the state has weakened workers further. In terms of inequalities across countries, some of those have narrowed. But at the same time, inequalities within other countries have grown. So, you see that in the Global South. I don't think it's much of a surprise. The nature

> of inequality and the capitalist… The nature of labour becoming a commodity leads to this kind of result. And what the policy does is it tries to make bandages for it, in some way. It doesn't change it. And you know that people have struggled long for that, and it's important to struggle for it. But it doesn't change the reality (Sam Gindin: Political Activist).

William Carroll, a professor of sociology at the University of Victoria since 1991, who is deeply involved with social movement for social justice in Canada and globally, also unequivocally stated that global neoliberal capitalism, which is based on class relations, is the fundamental cause of social and health inequities. He explained:

> I would say that all of those inequities are primarily caused by class relations and, in particular, the social structure of what we might call advanced capitalism. And it's capitalism that's globalized now and neoliberal, and it's a way of life that basically involves this structural divide between those who own capital and control capital and those who work for wages and salaries. And, it's a system that is driven by the class that owns and controls capital. And its interests are primarily in maximizing profit and accumulating capital.

Carroll specifically linked capitalism to unemployment and precarious employment:

> And as that process plays out, the people who don't own capital and don't control capital are positioned in various ways. Some people like me make a fair amount of money and are secure. But many people are precarious in their employment or unemployed completely because there always has to be a certain amount of unemployment in capitalism in order for capitalists to be able to source fresh labour basically.

Carroll further scrutinized the dominant role of corporate power and capital interest in creating and perpetuating social and health inequities. He emphasized the highly competitive nature of capitalism and its driving motive: profit and capital accumulation before everything:

> And then if you look at the occupational questions in terms of health and safety issues, in the workplace, corporate managers and the boards of directors, I study this kind of stuff, my own research, are primarily interested in maximizing their profits because they have to keep up with the competition or get ahead of the competition. And in order to do that, they will cut corners or sometimes expose workers to unsafe conditions. And generally, the workplace is set up in the interests of the people who own and control capital rather than in the interests of decent work, fulfilling work, secure employment... So, I see it in that kind of systemic terms of domination of capital in human affairs and the domination of capital, it's a class relationship, and it translates into a lot of different kinds of inequities (Carroll: Academic).

Luin Goldring, a public sociologist and professor of sociology at York University since 1995, also connected [neoliberal] capitalism to the intensification of precarious work, which impacted even the middle-class families in Canada. She explained:

> Precarious work is certainly on the rise, and that has to do with changes in the organization of labour markets and global trends… I think in Canada, we could trace to the '80s… [P]art of the reason that people are very concerned about precarious work is that it's increasingly reaching into populations that didn't or weren't as likely to have precarious work. So, university graduates, white middle-class people. Part of the reason that the United Way PEPSO project [Poverty and Employment Precarity in Southern Ontario] made such waves

was because the project found that even kind of middle-class families that had not been touched by precarious work were being touched by precarious work because it has become a growing feature of our labour markets and employment arrangements (Goldring: Academic).

The above insights bring to mind the working, living, and health conditions of the people throughout history. As found in the literature review, for example, in the 18th to 19th centuries, the poor and working-class recorded higher mortalities and morbidities than the wealthy and capitalist class (Chadwick, 1842; Engels, 1845; Frank, 1790; Virchow, 1848/2006; Villermé, 1840/1988). In the 20th to 21st centuries, capitalism continued to produce black lung disease with a potential life loss of up to 12 years (Mazurek et al., 2018; Smith, 1983). Global neoliberal capitalism also produced about two billion informal workers and millions of *precariat* (Harvey, 2007; Standing, 2014). These informal and precariously employed persons -- regardless of gender, race, and other identities -- generally suffer higher psychosocial, physio-pathological, and behavioural risks than other classes (Muntaner et al., 2010). As a teaching assistant for about six years, employment precarity negatively impacted my overall health. These conditions of the poor and working-class originated from capitalist practices and narratives informing the governing authorities' policy (in)actions on social and health inequities.

Capitalism and poverty. Some of the interviewees focused on the relationships between capitalism, poverty, and health. For example, John Clarke, a retired organizer of Ontario Coalition Against Poverty, long-time activist and at the time of the interview, Packer Visitor in Social Justice at York University, explained that capitalism produces poverty by exploiting the working class through low wages and accumulating the nation's wealth in the hands of the capitalist class. He also emphasized that the capitalist system ensures little social support for

unemployed workers, including persons with disabilities. Finally, Clarke stressed that neoliberal capitalism intensified poverty and its adverse health outcomes. He stated:

> We live in a capitalist society, and I think the nature of that society, or the functioning of that society is fundamentally exploitative. There's a very small group of people who make a great deal of wealth, and there's a mass of people who essentially produced the wealth for them… The whole strategy that is developed is to ensure as much as possible that those who are in the business of hiring workers rather than workers themselves get this on the most favourable terms possible. And so, efforts are made to ensure that workers have as few rights as possible, that working conditions are as exploitative as possible, that wages are as low as possible. And for those working-class people who are outside of the job market, who have to live on social benefits by reasons of disability, sickness, injury, or periodic episodes of unemployment…the desire is to ensure that the portion of the social wealth that goes to them is as small as it possibly can be… I think those are the primary factors that cause it in this society in general. However, the recent decades had been marked by a neoliberal approach… And so, there is more poverty and resultant assault on peoples' health.

Anonymous N19, a physician, working on the social determinants of health, also linked capitalism to wealth inequality and poverty, shaping health inequities in Canada:

> I would say that based on my experience and also the research that I've done, and also the learning from many other people, that there's a number of key and intersecting issues that perpetuate poverty in Canada and around the world. The first being our economic system,

> which is characterized by an advanced stage of capitalism. And that it results in a growing inequity in the distribution of financial resources between different groups. Capitalism as an economic system, I think is, a major reason why we see things like poverty. Another intersecting aspect is the distribution of power and how that relates to capitalism. So, capitalism results in a system whereby those who have wealth and the means of production, and in our case, access to capital, are able to continually invest that and get returns and those who don't have wealth and capital fall further behind (Anonymous N19: Academic-Activist).

Greg Albo, a professor teaching comparative political economy at York University and Director at the Centre for Social Justice, corroborated Clarke and Anonymous N19 responses. Structural inequalities arise from the class division between the capitalists or owners of the means of production and the workers who sell their labour to live, as Albo explained:

> Structural inequalities are, first and foremost, characteristic of all class-divided societies… In capitalism, these structural inequalities have been characterized by a division between those who have to reproduce their existence through the sale of their labour in a labour market and those who reproduce their existence through the ownership of private property and the ownership of private property extending to the means of production.

Albo further explained one of the inherent contradictions of capitalism: the accumulation of wealth on one end and the intensification of poverty on the other end. Capitalism inevitably creates and maintains absolute and relative poverty:

[The] concentration of wealth is a secular structural dynamic of capitalism. As capitalism develops and the means of production become bigger and bigger, it's also a tendency that wealth or the private property that commands those means of production becomes more concentrated. Therefore, the wealth claims also become more and more concentrated. So as a whole, you have a tendency for wealth to polarize at one end and income or poverty at the other end… We can think of it in terms of absolute or relative poverty.

Albo illustrated how capitalism results in relative and absolute poverty:

[W]hat occurs under the dynamic of capitalism in the core countries is the development of relative poverty. That is, a lot of workers' incomes go up, so their living standards increase. But that living standards increase as tenants always lag after the relative dynamic of wealth concentration. So, you have structural inequalities even as living standards for a good portion of the population are increasing… [A]s capitalism develops, and some workers' incomes are going up steadily, more and more people are put in a position of being marginalized. That is because there's a tendency for accumulation for dead labour to replace living labour, that is, machines to replace workers… So, the workers at the extreme end have more difficulty becoming getting steady employment. Therefore, there's also a tendency for the marginalization of absolute poverty to also occur at the extreme end (Albo: Academic-Activist-Advocate).

Clarke, Anonymous N19, and Albo's collective insights direct attention to the inherent nature of a capitalist economic system that inequitably distributes wealth and power among various social classes. This view aligns with the response of a social epidemiologist and

university professor who stated: “It’s capitalism because the amount of power to produce and appropriate the value of what is produced in the society is in a very small number of hands” (Anonymous N14: Academic-Advocate).

The overconcentration of wealth and power in the hands of the elite may result in an oligarchy furthering social and health inequities. As Trevor Hancock, a retired public health physician, professor and senior scholar of public health and social policy at the University of Victoria, a former consultant at the Ministry of Health in British Columbia, and Green Party first leader in both Canada and Ontario explained:

> There’s actually a very interesting study in Scientific American quite recently. I actually wrote a column about it…a bunch of mathematicians and physicists…what they were able to show mathematically was that the inevitable consequence of a free market trading system is an oligarchy in which ultimately all the wealth is owned by one person. And the rest of us have nothing. Now, if you leave it to run on its own, that’s essentially right where it goes... [A] free enterprise system inevitably results in very few people being extremely wealthy. And with wealth comes power and a lot of other people being very poor and powerless.

It is essential to emphasize that Hancock cautioned about the most likely outcome of an unbridled capitalist system ending in an oligarchy: a societal revolution.

> I guess what also tends to happen with those systems is that…things get so bad that the people at the bottom revolt. We see that from time to time. The French revolution, obviously. The Russian revolution 150 years later. It was happening on the streets of Europe in 1848.

> The barricades were up on there; there was a revolution in the air then. So, to some extent, those systems are almost self-correcting: eventually, things get so bad under that kind of system that people revolt (Hancock: Academic-Advocate).

The above insights help one recall existing literature demonstrating that the global Gini coefficient of 0.657 in 1980 soared to 0.922 in 2014 (Bourguignon & Morrison, 2002; Davies et al., 2017). As a result, by 2019, "the world's richest 1% have more than twice as much wealth as 6.9 billion people" (Coffey et al., 2020, p.10). In Canada, the aggregate wealth of 87 wealthiest families equals the aggregate wealth of 12 million lowest earners (Macdonald, 2018). The inequitable income and wealth distribution determine life expectancy. For example, within Canada, the male life expectancy between the top and lowest income quintile widened from 6.7 to 7.7 years, while for females, 3.7 to 5.4 years between 1996-2001 to 2011-2016 (Bushnik et al., 2020). These statistics are hardly surprising as poor people generally suffer from deprivation, stress, stigma, low quality of life, and ill-health than wealthy people (Raphael, 2020). These inequities seem absurd; however, they are the inevitable outcomes of capitalism. While capitalism is highly advantageous to the wealthy and capitalist class, it is highly disadvantageous to the poor and working class.

Capitalism and healthcare. Some of the interviewees focused on the relationships between capitalism, healthcare systems and services, and health. For example, Jonah Gindin, a researcher for the Canadian Union of Public Employees and assigned to the hospital division to work with the Ontario Council of Hospital Unions and other hospital locals, explained that capitalism chiefly causes the precarious working conditions in the healthcare industry:

> [T]he main cause…is a capitalist system that prioritizes the creation of wealth over the wellbeing of people. [T]he logic of capitalism persists even in a public sector, not-for-profit sector… So, we have hospitals adopting lean management styles and procedures and constantly trying to provide healthcare almost like a 'Just In Time' healthcare. So they have the fewest number possible of any given staff at any given time, which means that any imperfection that arises…like somebody's sick...they typically frequently, aren't able to staff up to replace that person. So, there's chronic understaffing (Gindin: Activist-Advocate).

Gindin further linked the above situations to governing authorities' neoliberal policy of austerity that perpetuated chronic understaffing and casualization, as in the case in Ontario:

> This logic comes from the government and has extended into hospital management, where the expectation is that they can continue to deliver the same level of quality of service with fewer and fewer resources. In Ontario, the effect of capitalism and particularly the kind of neoliberal austerity regime that we've been in for however many decades now means that in Ontario, in the last 25 years, the number of staff per patient and the number of hospital beds per population has decreased steadily while at the same time, acuity and population have increased. And so, we have more and more strain put on the hospitals and less and less resources. And of the staff that remain, there's also been a move towards casualization. So, there are more part-time and particularly casual on-call employees rather than full-time employees.

Anonymous N11, labour organizer and executive committee member of a union working in the healthcare industry, explained that capital and the concentration of wealth in the hands of transnational corporations that do not pay a fair share of taxes has something to do with social and health inequities in Canada:

> The continued shift of capital to multinational corporations who dodge taxes in jurisdictions plays a part because they are allowed to accumulate wealth but not pay their fair share of taxes. The tax burden is then shifted to those who are in lower-income classes. What that creates is an inequity that leads to health inequities where a lower-class individual doesn't have the ability to pay for the necessities of life because they are forced to choose between housing, kid's needs or their personal needs, getting a vehicle to work.

Anonymous N11 then proceeded to expose the plight of the working class in the healthcare industry by mentioning the situations of the home care workers and the role played by the private corporations in maintaining low-level labour standards.

> There's a group of home care workers…their working conditions have been some of the worst working conditions in the entire healthcare system. But the private corporations that are allowed to exist within our public system that get our public dollars are allowed to keep those conditions at the lowest standard. What that creates is a situation where you have racialized individuals… compete with the housing demand. The rent in a place like the city where we are is increasing year over year. To purchase food is increasing year over year. But

yet their standards aren't increasing. But the profits of those corporations are increasing because they are allowed to exist within the system.

Anonymous N11 stressed that the governing authorities let those situations happen, thereby perpetuating the healthcare workers' poor working, living, and health conditions:

> The government allows these types of corporations to exist without raising the standard for these workers. So, I think the imbalance there is a cause for health inequities because what happens is its natural effect is folks get sick and can't take a day off because their standards are so low. They don't have sick days. We're experiencing this virus right now, and these workers are forced to go to work. They don't go to work, what are they going to do? The health outcomes of that…we have…workers that are going to be prone to sickness, prone to not being able to get the proper health medical treatment for themselves (Anonymous N11: Activist-Advocate).

The preceding illustrative quotes remind one of existing literature that before and amidst COVID-19, social and health inequalities existed and persisted in the Canadian healthcare industry (see Armstrong, 2016, 2020; Armstrong & Armstrong, 2010; Borras, 2021; Messing & Grosbois, 2001; Syed et al., 2020; Daly et al., 2011). For example, amidst the pandemic, in Canada, 21.5% of COVID-19 cases were healthcare workers, which was three times greater than the global rate in August 2020 (Canadian Federation of Nurses Union, 2020). Specifically, over 9650 workers were infected in long-term care, equivalent to over 10% of Canada's total cases in May 2020 (CIHI, 2020). Moreover, it is now common knowledge that many residents have been

infected, hospitalized, and died in numerous nursing homes, in which the for-profit were impacted more than the not-for-profit.[35]

The above working, living, and health conditions were mainly due to draconian austerity measures, privatization, and contractualization policies, producing and perpetuating chronic understaffing in various healthcare settings that harm both workers and patients. Instead of adequately addressing the shortages of staff, the governing authorities -- Liberal-led at the federal level and Conservative-led at the province of Ontario -- promoted the practices of neoliberalism, and so the deepening health care crisis. Now, in the hospital where my partner is a part-time employee and in my workplace and many other health care settings, understaffing and increased workload worsened, adversely impacting workers' and peoples' health.

Wrapping up. As mentioned earlier, I will wrap the first central theme: *capitalist economic system as the fundamental cause of social and health inequities* with the insights of the late Leo Panitch. First, Panitch, at the time of the interview, a retired distinguished professor, former Chair of the Political Science Department at York University and Editor of the Socialist Register, cautioned against overemphasizing government policy as the cause of social and health inequalities. Instead, he accentuated that the capitalist system is the fundamental cause and that class relation and the balance of social forces steer state policies:

> In one word, the answer to your question is capitalism, which is not a product of government policy but rather is the nature of the social system, a socioeconomic system in which

[35] Elsewhere I wrote: "In Ontario, compared to residents in for-profit homes, residents in municipality-run homes are four times less likely and residents in non-profit nursing homes are two times less likely to get infected and die from COVID-19. According to Sharleen Stewart, president of SEIU Healthcare, representing more than 60,000 unionized frontline health care workers, the infection and death differences between non-profit and for-profit nursing homes could be explained by unsafe working conditions, including lower staffing levels, casualization, and use of more part-timers, as well as lack of better infection control and unpreparedness during an outbreak on the part of for-profit LTC. Those elevated cases of COVID-19 for both residents and workers in LTC homes can be linked to four decades of neoliberal policies that continuously erode public health systems. These neoliberal policies include government austerity measures such as chronic underfunding and cutbacks in health care systems and services, employers' practice of labor contractualization, and privatization of ownership." (Borras, 2021, p.12).

government policy is located. So, the fundamental parameters of inequalities in a country like Canada are given by capitalist social relations and the requirements of reproducing favourable conditions for capital accumulation and reproducing the class relations necessary for a capitalist society. That's my fundamental answer. That said, it's obvious, the case that government policy, which is a reflection of the balance of social forces in a society given periods of time and particular conjuncture, government policy can modify, ameliorate, exacerbate this fundamental inequality, which is systemic.

Panitch then underscored the crucial role of strong unions and social democratic government in shaping state policy that can benefit peoples' health, like Canada's universal healthcare system. He recalled the social conditions that fractured the ruling class's power resulting in progressive public health policy change in Canada.

In the case of healthcare in this country, the election of a social democratic government at a particularly crucial historical moment at the end of World War II in one of Canada's provinces, the CCF in Saskatchewan, created the initial conditions for the introduction of some elements of universal healthcare, which then in a condition where trade unions were strong. When in the 1960s, you had considerable economic growth and full employment. When the most politically backward region of Canada, Quebec, which was dominated by the Catholic church, in an Alliance with the Anglo ruling class, went through what is known as the Quiet Revolution and the power of that ruling class and the power of the reactionary Catholic church was broken.

Panitch highlighted that without the socialist and progressive social forces and labour unions uniting to fight for a universal healthcare system, Canada's healthcare system would more likely become a private industry that fundamentally commodifies health for profit and capital accumulation. He explained:

> You had a set of progressive Liberal governments in Quebec that, together with the strength of the CCF, but then became the NDP, and the strength of trade unions at that moment created the conditions for the introduction of Medicare in Canada. Had that not happened then, the private insurance industry would have, as in the United States, the private healthcare industry been able to accumulate capital so deeply through the commodification of health that we would be in the same situation as the United States. By virtue of that happening before the commodification of healthcare to that extent, it created a situation in which, and I think, one has to recognize the significance of this in which in the arena of health policy, and that is very fortunate relative to the United States, working-class people, immigrants, even the most marginalized in our society, Indigenous people, are able to secure healthcare of a kind that is in any historical and comparative terms, not bad (Panitch: Academic).

The preceding findings from the interview data and literature review confirm that the consolidation of power of the working class and representation of socialist democratic parties in the institutional politics of public policymaking can significantly reduce health inequities. Unfortunately, Canada remains a liberal welfare state, and most of its governing authorities promote neoliberal capitalism. There is a need to go beyond capitalism's logic to better address social and health inequities.

4.1.2 The co-constitutives of capitalism: colonialism, racism, and sexism. As reported in the first main theme, 10/23 of the informants immediately identified capitalism as the fundamental cause of social inequities and inequitable distribution of social determinants of health, resulting in health inequities. In this part, it is essential to report also that spontaneously, 1/23 said racism, 1/23 said colonialism and racism, and 6/23 interviewees said the cause of social and health inequities: co-constitutive class, nation, race/ethnicity, and gender relations. Only 1/23 of informants explicitly mentioned the term *intersectionality*. No informant right away stated that such inequities are caused by sexism or patriarchy alone. However, as the interview progressed, all informants linked social and health inequities to the co-constitutive character of capitalism (class), colonialism (nation), racism (race), and sexism (gender relations).[36]

For the second main theme, I first present the insights from six interviewees who spontaneously explained that social and health inequities are caused by combinations of capitalism, colonialism, racism, and sexism. Then I present illustrative quotes from those that, at first instance, explained that social inequities and inequitable distribution of health, resulting in health inequities, are caused by capitalism but, when further queried, linked capitalism with those other *isms*. Finally, I wrap up with Panitch and Sam Gindin's insights.

[36] As introduced, to compensate for the perceived weaknesses of critical political economy theory, I specifically draw on McNally's (2015) explanations about the *dialectics of unity and difference in the constitution of wage-labour*. McNally (2015) stated: "the social relations of race, gender and sexuality, among others, were understood to be *internally constitutive* of class – rather than as radically external to it" (p.131). In other words, although class, gender, and race are conceptually and analytically distinct and appear externally related and independent from each other, in reality, they are internally related, co-constitutive, and irreducible to each other. So, in this study, I use the term 'co-constitute' or 'co-constitutiveness' in place of 'intersect' or 'intersectionality'. In doing so, I use the terms *racialized capitalism*, *gendered capitalism, or racialized and gendered capitalism* to emphasize the dialectical co-constitutive character of the class (capitalism), gender (sexism), colonialism (nation), and race (racism). Thus, this dissertation partly combines *critical political economy as a theory and intersectionality as a lens,* strengthening rather than weakening both approaches when applied in health inequities studies. This becomes even more crucial because only 1/23 of informants explicitly mentioned intersectionality, and I did not further probe whether the other 5/23 informants who spontaneously discussed that class-gender-race shaped social and health inequities believe in intersectionality as a theory. Further debates between and within intersectionality and critical political economy are beyond this dissertation. In my view, it will take several years to settle the contentious debates between and within these seemingly competing but complementary approaches to examining phenomena, in this case, health inequities in general and class, gender, and race health inequities in particular. As found in the literature review, the pioneers of critical political economy, Marx (1867) and Engels (1845), although they spoke more about class relations, have sufficiently integrated into their analysis of the capitalist economic system gender, race, nation, immigrant status, and age issues – called intersectionality today. It is inaccurate to claim that Marx and Engels ignored gender and race (see also Brown, 2014; McLaren, 2020; Anderson, 2021; Musto and Martinez, 2022).

The following illustrative quotations complement my findings in the literature review. For example, Pat Armstrong, a fellow of the Royal Society of Canada, distinguished research professor of sociology at York University, cross-appointed to the graduate program in health equity, political science, and gender, sexuality and women's studies since 1987, and specializes in healthcare, explained the *gendered, (neo)colonial, and racialized labour* shaping health outcomes. She first stated:

> [T]he biggest, one of the most important things is capitalism – an economy based on the search for profit, which in turn requires selling more and paying less. So that's what's central to capitalism. And that, in turn, leads to the kinds of issues and employment you were talking about and inequalities. It's not, I think, the only factor, but it's certainly the primary one.

Armstrong then proceeded to link global capitalism with issues of racism and sexism:

> And also, divisions that have been built upon that are related to questions of race and class. And, they too are, of course, importantly linked to the economy, which in turn is linked to capitalism and global forces. In terms of the gender issue, I think that it's certainly not exclusive to capitalist societies. But that the search for profit has taken advantage of gender differences in gender assumptions and reinforced them in ways that perpetuate inequality. And the same can be said of race, especially building economies around racial differences that emphasize those inequalities.

Moreover, using slavery as an example, Armstrong differentiated racism in Canada and the United States. She also directed attention to the nexus of racism and capitalism globally, where the capitalists import cheap labour from other countries.

> So, I mean, I think, for example, that there's lots of racism in Canada, but it takes a fundamentally different form than it does in the United States because we never had a system based on slavery, an economic system based on slavery. It doesn't mean that we didn't have some slaves, but they didn't have the same centrality to the economy that they did in the United States. And so that legacy holds on, I think. Now, as a part of the impact, I think of global development, we see racism perpetuated by the use of labour from other countries to import and to bring in, as John Porter said, a long time ago at the bottom and to fill the jobs at lower pay and with less power (Armstrong: Academic-Activist-Advocate).

Anonymous N7, a professor in sociology specializing in gender and racism, explained the co-constitutive class, nation, race, and gender relations shaping social and health inequities through *precarious work, migration, and education:*

> I would say that the capitalist system is producing all these precarious jobs. The fact that it's a system that is based on maximizing profits and profits are maximized in one sense, by cutting labour costs, and labour costs can be cut in different ways. Like you can substitute labour with technology, or you can take your company to Global South country where labour is cheaper. So, you can employ, you can cut costs that way, or you can hire labour here in Canada, which is ideologically labelled as being inferior labour because of racialization and

sexism and other ideologies that define certain types of labour as inferior labour. And therefore, the rationale is created to pay them less or keep them in a more insecure situation.

Sociologist Anonymous N7 illustrated the relationships between race, class and migration:

[M]igrant workers are kind of kept in a captive situation because they are here only to do labour. And after they finish the labour, they will be sent back to their country. And they're usually coming. And also, people who are from poor backgrounds, like people who have experienced poverty, don't have a lot of options. And also, if, for instance, a person has an education that has not been recognized or does not have an education background, does not speak the official language, their options are less like their alternatives are less. So, they have been produced as precarious labour through racialization, through gender ideologies, through their migration status, through exclusionary processes from educational institutions and so on.

Akwatu Khenti, scientist and educator at the Centre for Addiction and Mental Health, assistant professor in public health at the University of Toronto, and former Assistant Deputy Minister for Ontario's Anti-Racism Directorate, explained that the inequitable distribution of social determinants of health, and stigmatization are mainly produced through interacting class, race/ethnicity, and gender relations. He focused on *inequitable access to healthcare services*.

I would say that unaddressed historical circumstances, which have led to various forms of stigma, stigmatization, public stigmatization related to class, race, indigeneity, sexuality, and

the intersections. There is compound limited access to healthcare that works for various groups and healthcare that meets the culturally specific needs and demands. And this is evident with diseases like diabetes, heart disease, and especially evident with mental health problems, particularly groups such as Black people and Indigenous people. The key is you have the foundations of a lot of stigmas that remain unaddressed and are not priorities of the healthcare system (Khenti: Academic-Activist-Advocate).

Moreover, Sharleen Stewart, President of SEIU Healthcare with about 60,000 union members, although she did not explicitly mention capitalism, colonialism, racism, and sexism, explained that social and health inequities are caused by interrelated race, gender, and class dynamics in *migration, housing, education, and precarious work in the healthcare sector*:

[I]t all points to and lands on communities of colour without a doubt. And that's where you see obviously many immigrants landing in communities of colour. And the majority of those communities are in areas that struggle with exactly what you say housing issues…child and adult education is, you see, at a lower standard in those communities. The primary example is what's happening right now during this pandemic. I'm calling for a study to be done on exactly that. Let's start doing some demographics on the number of people who got infected and who have died. Do they come from an identified community like ethnicity or race, or gender? I think you're finding that even with our personal support workers who died, they were all women, women of colour…The workers that we represent, especially in long-term care, the majority of them are women of colour, and they are the lowest paid in the public system. They have a large amount of precarious work where they cannot secure a full-time job. Some of them have worked for a couple of decades in their positions, and they still don't

have full-time employment: so, very low-paid, very little benefits, very little retirement security (Stewart: Activist-Advocate).

Natalie Mehra, since the year 2000, Executive Director of the Ontario Health Coalition, a coalition of more than 400 organizations and about 70 local chapters representing over 500,000 Ontarians, explained that the inequitable distribution of social determinants of health, shaping health inequities as primarily shaped by the co-constitutive character of the class, race/ethnicity, and gender relations. She focused on *income and wealth inequality* partly resulting from *precarious employment and wage stagnation*, if not decrease in real terms:

So, precarity, increasing part-time over full-time work, increasing disparity in wages and incomes. In Ontario now, probably one-third of the labour force works for minimum wage or within $2 of the minimum wage. And at the other end of the scale, high income has skyrocketed over the last generation. From the middle-class on down, we see wages are stagnant or declining in real terms. We see the number of hours put into the workforce has increased for families, for every income group below the top two income quintiles. By every measure, we see growing income inequality and growing wealth disparity. And for all of that, it is differentially experienced by people who are racialized, by Indigenous peoples, by women.

Mehra further exposed the worsening conditions in the *healthcare industry*:

> We see a very severe erosion of healthcare services, particularly targeted to the elderly… [W]ithin the healthcare workforce, we have seen a downloading of patients from fully public modes of care that provide full-care like hospitals to privatized modes of care, like long-term care and home care. Similarly, a downloading and deregulation of the workforce from RNs to RPNs now to PSWs. So, much heavier work with much lower pay and working conditions. And a very significantly racialized workforce that has taken these heavier care patients with less funding, less resources, less support, less training (Mehra: Researcher-Advocate).

Michael Hurley, activist, President of the Ontario Council of Hospital Unions, the hospital division of the Canadian Union of Public Employees, connected the inequitable distribution of the social determinants of health, resulting in health inequities, with *capitalism, colonialism, racism nexus*:

> We have to look to the nature of the capitalist system to understand how labour is exploited. And in its exploitation, you know, there are significant class divisions, divisions of wealth and access to the social determinants of health. And I think we have to look at how capital uses colonialism and racism in conquering, devaluing labour so that it can be exploited, paid less. And one of the consequences of that is inequitable access to the resources that you described. So, I think we have to look there for an understanding of how this inequality comes to be.

It is equally essential to report that although the 10/23 informants promptly responded that capitalism is the fundamental cause of social and health inequities in Canada, they also

linked these inequities to histories of colonialism, racism, and sexism when further queried. For example, sociologist Carroll spoke about *land grab and capitalist settler colonialism*:

> If you look at the history of capitalism, it's really closely aligned with the history of colonialism. And so, the colonization of the world is something that happens with European capitalism as its epicentre. And, if we look at Canada, it's a settler-colonial, capitalist formation. And that means that from the start, there was a racialization in class relations in Canada and a kind of land grabbing from Indigenous people, colonization of Indigenous people (Carroll: Academic).

Carroll also explained that *capitalism produces racialized cheap labour* through migration:

> At the same time, of course, capitalism has relied on immigrant labour and migrant labour, often to create these cheap labour pools. And so, that is an important piece of the story in terms of how Canada has developed as a capitalist society. Certainly, racialized inequities are an important part of what's happening in Canada today. I would say the most significant ones are around Indigenous relations and the continuing effects of colonization. But there's a lot of racialized inequities that have to do with immigrant groups, visible minorities.

Anonymous N14, the social epidemiologist, who earlier talked about capitalism and capital power as the fundamental mechanisms shaping health inequities, explained neo-colonialism is entangled with capitalism creating and perpetuating *racialized cheap labour*:

> Absolutely. Neocolonial is, in the relations between countries, that would be even the most important, but it's also one that's a manifestation of our mode of production, which is capitalism. For example, in invading, conquering or financing and creating debt with lower-income countries or countries that were colonialized. And also through ensuring that they provide the markets to diverse political means for the products of the welfare countries and cheap labour force that's more exploitable… And, with race, it's a combination of oppression, in terms of marginalizing, providing lack of access to goods, services and property and education for the persons that are most of the time not white; and also discriminating them in the labour market and the sphere of consumption. But the most important I would say is in the labour market.

Jonah Gindin explained that *neocolonialism plays out in the healthcare sector* in the form of unjust labour practices impacting racialized live-in caregivers and homecare and long-term care workers:

> There's certainly a neocolonial framework in that the whole segments of the healthcare sector depend on primarily, you know, there's care work that's provided by the live-in caregiver. There's sort of a path into the healthcare sector through the live-in caregiver program by recruiting at great personal expense individuals from other countries, in particular, in the Global South, to come to Canada and provide incredibly undervalued care work. And one of the most common escapes from the live-in caregiver program, that's for people to end up becoming PSWs and then working in the home care or the long-term care system. So, there's a sort of pathway that's been born that depends on racialized immigrant labour that is

subsidizing the system. It's not being valued. It's not being paid properly. They don't have the same rights as they ought to have (Gindin: Researcher-Activist-Advocate).

When further queried, Block also pointed to sexism shaping the conditions of the female workers in *occupational health and sales service industries*. She also mentioned *unpaid labour*:

You see the patterns of sexism in terms of occupational segregation and incomes and even within some occupations like even some higher status occupations, like physicians. Women are often congregated in the lower-paying specialties: so, more women are GPs… But I mean, the vast majority of women are…in those areas of sales service and caring work. We see a gender distribution… I think we don't only want to look at average hourly wages… We need to back it up and say what are the choices that women have are geared towards in terms of education. We have to look at the unequal responsibilities for unpaid caring work and what impact that has (Block: Researcher-Advocate).

Wrapping up. As mentioned earlier, I will wrap up the second main theme: the *co-constitutiveness of capitalism, (neo)colonialism, racism, and sexism shaping social and health inequities* with the insights from Panitch and Sam Gindin. When further queried, Panitch, who explained capitalism is the fundamental cause of social and health inequities in Canada, traced the histories of colonialism and racism relative to capitalism and class formation. However, he cautioned against overemphasizing government policy and racism as the fundamental causes of such inequities. First, he discussed the complex dynamics between colonialism and capitalism impacting the working, living, and health conditions of the Indigenous people:

Obviously, the history of European colonization in the western hemisphere extending to the Philippines is a very important background factor. And those Indigenous people in this country who weren't eliminated genocidally have been subject to a political regime of rule and a relationship between the Indian reserves and capitalism in Canada that has been extremely fraught. Again, it's a very fundamental explanation. It's not just a matter of government policy. It's a matter of a portion of the population engaged in hunting and gathering, very minimal agricultural means of reproducing their subsistence, whose relationship to resource-extracting capitalism and manufacturing and industrializing capitalism was very fraught. And you see the consequences of that, not so much in terms of exploitation of the individuals, exploitation of the land, certainly that those individuals used to hunt and gather on it. But the marginalization of those individuals, I mean, where native Canadians, well-adapted, well-educated in themselves, interested in becoming part of the industrial working class of Canada, they would not appear to be so marginalized as they are. But of course, there's no reason why they should. I mean, this is a product, the formation of working classes in a capitalist society was a product of a very long and difficult social process. Partly it does have to do with the attempt to retain a relationship to the land that doesn't fit with the capitalist society but fits with the hunting and gathering society. And by virtue of the dominance of capitalist society, this then inherently marginalizes Indigenous communities. Yes, it's unjust. I mean, this is the moral critique. But in terms of a social scientific or historical materialist critique, it isn't just that the white Canadians are bad people or that government policy has caused this. There's a much deeper and more fundamental explanation to this.

Panitch then explained racial relations, focusing on the Black population and the difference between slavery in Canada and the United States. He stressed that social and health inequalities could not be explained through racial oppression, fundamentally:

> Canada was not a slave society for the most part. It did not have a large Black population. It was, to some extent, a haven for Black people who were escaping slavery. There are elements of racism against Blacks in Canada. No question. But not of a kind, I think that is comparatively more significant; indeed, I would say less significant than in other societies. With the wave of immigration of Blacks from the Caribbean and elements of a large Black community in Nova Scotia that goes back to the 19th century, if not before, there had been instances of racism. But I don't think you can say that inequalities in Canada are founded on racial oppression as you can in the United States with its history of slavery and all of the subsequent effects of that, and the very significant portion of the population that is Black.

Furthermore, Panitch explained other forms of discrimination like nativism.

> I'm not sure they're racist. Every wave of immigration has faced an element of what in the United States is called nativism. That is, European immigrants tend then to be discriminatory to later waves of immigrants. So, this first happened with the Irish in Canada, partly because they were Catholic, partly because of their extreme impoverishment at the time of their immigration, which was related to the potato famine in Ireland.

Panitch then explained the plight of the Jews, focusing on their professionalization through social mobility and consequent class transformation. He presumed those who became

physicians may probably support more privatization of the healthcare system, a class-based political action.

> It is true, for instance, I'm a Jew. When Jews came to Canada in great numbers escaping the pogroms in Eastern Europe in the early 20th century, they were subjected to discrimination. Jews weren't allowed to go into medical schools or that kind of thing. But you see a process of social mobility so that you can now speak of the conversion of the Jews, which I don't mean religious conversion. In fact, they're probably more religious now than when they came in the early 20th century when they tended to be socialists or communists. It's a class conversion. Whereas the majority of the working class Jews used to be working class, trade unionists, et cetera, now, by virtue of social mobility in this country, the majority of Jews are professionals. And that is reflected in their political behaviour. A large number of Jews in Canada are doctors. How many, many of them are very progressive doctors. Many of them, I imagine, would be in favour of expanding the role of private clinics in Canada. But that's a reflection of their class position.

Panitch concluded that the analysis of inequalities in the contemporary era tends to emphasize racial relations while ignoring class relations between economic actors:

> I think too much socioeconomic analysis today fails to take account of class position and identifies discrimination in terms of ethnic or racial identity. Whereas I think the deeper vectors of inequality are related to socioeconomic position rather than to ethnic identity, even within the ethnic groups (Panitch: Academic).

Sam Gindin, who at first concentrated on capitalism and class relations, connected the commodification of labour and the fragmentation of the working classes to social and health inequities continuously experienced by the colonized and racialized people, especially those with low income. He first explained:

> As long as you have a system in which labour is a commodity and fragmented, and you put people in a position of having to compete with each other, obviously, the weakest elements are going to be hit the hardest. So, colonialism is critical for the kind of poverty we see amongst Indigenous people. It's horrific. It's not just the land question. It's the nature of life on a reserve. They don't have clean water. They don't have housing. They don't have education. So, Indigenous people are amongst the worst off in terms of health, which is understandable.

Gindin then advised scrutinizing racial inequities by looking at the history of the racialized groups entrenched within class structures and strata. This is because among the racialized people, a class hierarchy exists as some of them are low-income earners while others are high-income earners, and some are big capitalists. He explained:

> Racism: it's a homogeneous category. There are Black people, Asian people, people of a different colour. Even among Black people, you've got people from Somali, people over African Americans, people from Jamaica. Each of them has a different history and different conditions. So, even that, you want to make distinctions what's in it. When you look at the average income, for example, of people from Asia, whether it's in the United States or

> Canada, the average income is higher than Whites. But we know that within those communities, there are great inequalities. We've got personal care workers, and you've got developers in the Asian community or the Chinese community. So, you have to look at class even within each of those racialized groups.

Gindin further explained the interacting dynamics of class, race/ethnicity, gender relations shaping social and health inequities. However, he cautioned against decoupling issues of racism and sexism from class relations:

> I mean, there are women who are married to people in the elite, and there are women on Indigenous reservations. This is a big difference. So, there are ways in which there's been discrimination against women. But always, you have to see how that intersects with class and history. The life expectancy of women is higher than men. I think all these questions of inequality, race, and gender are relevant, but you can't simplify it, and you always have to bring in class as a factor (Gindin: Political Activist).

The illustrative quotations confirm the findings in the literature review that the critical political economy theory is sufficient to explain class, gender, and race/ethnicity health inequities. The interview data demonstrated the co-constitutive characteristics of capitalism (class), sexism (gender), colonialism (nation), and racism (race) seen from a critical political economy lens. *Intersectionality* scholars call this phenomenon inextricably interlinked multiple forms of oppression. The collective insights bring to mind three things:

First, *the capitalist-racist-sexist system shapes social and health inequities*. For example, in the 20th century, working from a critical political economy perspective, Navarro (1976b)

found that in Western healthcare systems: "physicians being primarily upper-middle-class white males: nurses, lower-middle or working-class females; and auxiliary health workers, females of working-class backgrounds" (p.446). Krieger et al. (1993) also discovered that scholars examined classism, racism, and sexism shaping social and health inequalities more in silos, few on two combinations, and least together. In the 21st century, some health scholars used the term 'intersectionality' to explain class, gender, and racial health inequalities (e.g. see: Schulz & Mullings, 2006; Hankivsky, 2012; Mcgibbon & McPherson, 2011; Morrow & Weisser, 2012).

Second, the capital-colonial-racial system shapes social and health inequities. For example, in Canada, the life expectancy difference between Nunavut and the national average is ~10 years (Statistics Canada, 2018). In terms of morbidity, Indigenous persons continuously suffer from the adverse effects of the residential school system (Kim, 2019). Specifically, they were 10x more likely to use shelters than non-Indigenous persons (Duchesne et al., 2019). Moreover, the Indigenous were disproportionately impacted by fetal alcohol spectrum disorder (Yousefi & Chaufan, 2021) and pandemics throughout history (Hillier et al., 2020). Meanwhile, while the food insecurity level for the non-racialized was the lowest at 11.1%, the racialized groups' food insecurity levels ranged from 11.3% to 28.9% in 2017-2018 (Tarasuk & Mitchell, 2020). This is partly because Canada's labour market is racialized (Block & Galabuzi, 2011). Specifically, "people of colour and immigrants face poverty levels more than double that of white, and earn, on average, 30% less income" (Curry-Stevens, 2016, p.84).

Finally, *the capitalist-sexist system shapes social and health inequities*. For example, globally, the aggregate wealth of 2,153 billionaires, primarily males, is greater than that of 4.6 billion people, at the bottom of which are females living in poverty. In part, this wealth inequality persists due to unpaid and underpaid labour provided by females, amounting to $10.8

trillion annually (Coffey et al., 2020). This 'sexist economic system' (Coffey et al., 2020) produces poverty, the most significant determinant of health inequities. For instance, the link between poverty and diabetes has been established (e.g. see: Chaufan & Weitz, 2009; Chaufan et al., 2011; Dinca-Panaitescu et al., 2011, 2012; Pilkington et al., 2010).

Canada's capitalist nation is built on European colonial practices and narratives. The co-constitutive spheres of (neoliberal) capitalism, (neo) colonialism, racism, and sexism underlie class, race/ethnicity, and gender health inequities. These internally dialectically related interacting social systems adversely impact peoples' working, living, and health conditions, especially for the colonized, racialized, and females. Gendered and racialized capitalism fundamentally shapes class, gender, and racial health inequities. Thus, there is a need to address class, race/ethnicity, and gender health inequities in an integrated manner. Despite their perceived weaknesses, *critical political economy as a theory* and *intersectionality as a lens* are helpful in examining health inequities in general and class, gender, and race health inequities in particular.

4.1.3 Maldistributive public policies. Another cause of health inequities in Canada is the unfair or inequitable distribution of economic and other social resources resulting from maldistributive public policies enacted and implemented by the governing authorities. As reported earlier, 5/23 of the informants spontaneously responded that maldistributive public policies are the major causes of social and health inequities in Canada. However, as the interview progressed, 23/23 interviewees recognized the failures and limitations of public policies within a capitalist economic system. For example, Sheila Block, senior economist at the Canadian Center for Policy Alternatives – Ontario, researcher, analyst, and advocate who works primarily on the labour market and public finance, explained that social and health inequalities

result from ‘inadequacy of government policies’ around ‘pre-distribution’ (e.g. minimum wage), ‘redistribution’ (e.g. taxation), and ‘provision of public services’ or ‘social wage.’:

> [T]he major causes of those factors that you listed are government policies and, in particular, the inadequacy of government policies on a kind of broad fronts. One of those fronts is what’s called pre-distribution. So, it’s how is the private sector economy regulated? Part of that regulation has to do with minimum standards, like minimum wage legislation… And how do those policies contribute to inequality in the area of pre-distribution? The second area is around what’s often called redistribution. And what that is, is the impact of tax policies. How much tax policies reduce inequality? And while our tax system does reduce inequality, it doesn’t do it sufficiently. And then the other piece of that is around the provision of public services, which is often called the social wage. Social wage is more important to low-income individuals than to high-income individuals. So, I think those kinds of three buckets of public policy make an important contribution to the lack of progress on reducing income inequality.

Toba Bryant, a public scholar and professor, specializing in social determinant of health and health policy, explained that the inequitable distribution of SDH like housing, income, food, employment, and social support result from the lack of redistributive public policies:

> There are many dimensions to this. I would say it’s the public policies that we have in place. Governments have really drifted away, as Banting and Myles argued in their excellent volume about the lack of redistribution… So, they’re not collecting as much in the way of

taxation. So they don't have the resources available to support people when they're buying a new home or any measures in place to ensure that people have access to the services that they need.

Bryant provided an example focusing on the *housing rent and ownership policies* where the informant differentiated the material and living conditions of temporary and permanent renters and homeowners:

> There are no rent controls in place in Ontario. The rent control we have is limited. It only covers buildings that were constructed prior to 1990. So, a good proportion of the newer housing stock is not covered by rent control. And most people, as a result, are spending more than 30% of their incomes on their housing alone. My doctoral supervisor informed me when I was doing my doctoral research that there were about three types of people. Some people are going to be temporary renters like university students. They're more likely to rent for a brief period of time until they're able to afford a home, hopefully. And there are those who will never rent. They own their own homes, so they're homeowners. They have the income to do that. But then there's a group that will be always renting. They'll never have enough money for a down payment on a house. So, those people are very vulnerable to any changes in housing policy.

Bryant elaborated on regressive housing policy shifts implemented by the Conservative Party-led Harris government resulting in evictions:

It was after something like 25 years that the Harris government, in 1995, without even mentioning this in its election platform, decided to replace rent control with vacancy decontrol. So, it meant that when a rental unit became available, landlords were free to jack up the rents as much as they wanted. So, it exposed very vulnerable, economically insecure populations to really high rents. So, it means that there were more evictions. People defaulted on their rents because they just didn't have the income. So, most people, they're spending a significant proportion of their income just on their housing alone.

Bryant then connected housing insecurity with *food insecurity, precarious employment, education, and welfare state retrenchments* demonstrating the interconnected nature of various social determinants of health shaping health inequities:

And that means they don't have much leftover to buy food and meet other necessities. So, that's why they ended up going to food banks. They may also be working precariously. They don't have job security. And unfortunately, having a post-secondary education does not guarantee someone will not end up in precarious employment. We don't have any measures in place to prevent employers from exploiting workers in this way. You know, requiring them after a certain point of time that, all right, you've had this employee on the payroll for so many months, now you must offer them permanent employment. We don't have those measures in place. And at the same time, the welfare state has been ratcheted back in many areas because governments are more obsessed with government deficits (Bryant: Academic).

Cathy Crowe, a street nurse, member of the Order of Canada, founding member of the Shelter and Housing Justice Network, a distinguished visiting practitioner at the Ryerson University, and long-time social justice activist working on housing and homelessness, pointed to the *termination of public and social housing programs and welfare cuts* implemented by the promoters of neoliberal capitalism, the Conservative Party and Liberal Party governments:

> [T]he policies of neoliberalism… For example, two federal governments, over '93, '94, Conservative and Liberal, cancelled our national housing program. And when that happened, we lost the production of 20,000 new units of social housing a year across the country. If you do the Math, from 1993 to now, you can calculate the deficit in terms of the production of new housing. And of course, when that happened, it happened silently. There was no protest. There was no awareness. There was no analysis to speak of that was evident. There're probably were pockets of it in academia or research facilities, or national housing entities, but it didn't seek through the general public.

Crowe recalled her experience:

> I was a street nurse at Sherbourne and Dundas at Street Health at the time. And I wasn't even aware that the federal government was cancelling this program. And of course, they were doing so because they could and because their decisions would allow the benefiting through corporate tax cuts or through shifting federal expenditures to the military, for example. So, for me, that was the first big sign I saw. And then it happened at the provincial level. In '95

> or '96, the Conservative Premier Mike Harris, his government cancelled the provincial housing program and, along with that, welfare cuts (Crowe: Activist).

David Hulchanski, a professor at the University of Toronto, specializing in urban planning and working on social policy, low-income communities, housing, and homelessness explained the causes of social inequalities producing health gaps in four parts: *regressive policy changes in the labour market, housing, social support and taxation, and discrimination*.[37]

> The first major cause, changes in the labour market… we're doing slightly better until the late 1980s … late '80s and early '90s, income inequality took off… there were more people with less money... there was lots of deregulation… And then, the minimum wage was not adjusted for inflation… The rent and the cost of housing have not been going down in real terms... [T]here's been no real income increase over the last couple of decades for the racialized population. But rents keep going up. Housing costs keep going up… way faster than income.

As quoted above, Hulchanski linked *deregulation* to stagnant wages and rising income inequality and emphasized the racialized nature of income inequality. He explained further:

> In 1995, a Conservative government was elected in Ontario. Mike Harris was the Premier... So, in October 1995, there was a 21% cut in the amount of money people on social assistance received… Homelessness goes right up. People are unable to pay rent… The federal

[37] Hulchanski discussed his co-authored the *Opportunity Equation in the Greater Toronto Area* by Dinca-Panaitescu et al. (2017).

> government in the mid-1990s changed unemployment insurance to what they call employment insurance. A name change, but fewer people qualify for it, and they get less money… [T]hey cut taxes. And tax cuts mainly benefit who? People who pay a lot of tax. The people who pay a lot of tax are high-income people. Low-income people pay very little tax or no tax. The tax cut doesn't help them too much. And a tax cut helps a middle-income person just a little bit. It's a redistribution of income happening when you have a tax cut. And this is under the belief. The ideology of letting people in the marketplace have more money, and we're going to have more prosperity if we let rich people have more money, and they're going to invest more and create more jobs. Well, it's just ideology that justifies cutting taxes.

The preceding quote illustrates the *draconian austerity measures* the neoliberal-oriented Conservative Party government implemented, including tax breaks for the wealthy and capitalist class. Hulchanski then spoke about discriminatory public policies in the labour market, housing, and education:

> Discrimination in the labour market, discrimination in the housing market, discrimination in education from grade school all the way through. There are barriers to people who are not Canadian-born and not white Canadian-born. The difficulty of degrees being recognized, credentials being recognized. When we study some census tracts, I remember once seeing some data about a poor census tract, poor neighbourhoods. And we looked at the income and education and all of the people there like the education was quite high, but the income was really low, and they were racialized, and they were newcomers (Hulchanski: Academic).

The illustrative quotes, in part, bring to mind the impacts of neoliberal housing policies, as discussed earlier. First, the housing costs surpassed household incomes. Second, the conversion and demolition of low rental housing into luxury condominiums diminished the affordable housing supply. Finally, long-term social and public housing support termination resulted in widespread housing insecurity and homelessness (Pomeroy, 2015). These findings validate that neoliberalism produced the housing crisis through public policies that promote market-oriented profit-driven housing provision (e.g. see Bryant, 2016; Gaetz, 2010; Hackworth & Moriah, 2006). Before the neoliberal era, there were few de-housed persons in Canada. Now, about 235,000 Canadians are homeless in any given year (Gaetz et al., 2016). Housing insecure households like our family buried in loans and living paycheque to paycheque primarily due to education-related endeavours, constantly worry about the dangers of sudden homelessness.

The preceding findings in the interview data and literature review validate that maldistributive public policies shape the inequitable distribution of social determinants of health, resulting in health inequities. Specifically, the radical shift from Keynesian to neoliberal policies has exacerbated social and health inequities. Indeed, in a capitalist system, existing redistributive healthy public policies are susceptible to regressive policy reversals. Finally, redistributive public policies that can reduce health inequities encounter political, institutional, and ideological barriers in a capitalist nation with a liberal-type of welfare state system like Canada.

Section Summary. Unanimously, interviewees who do not necessarily focus on health inequities but do work on at least one of the factors that shape health outcomes unambiguously state that the fundamental cause of social inequities, including but not limited to precarious employment and unemployment, income and wealth inequality, poverty, housing insecurity, and

homelessness, is capitalism or neoliberalism in the contemporary era. The result is the same for those who directly work on health and healthcare: (neoliberal) capitalism is the fundamental cause of the inequitable distribution of social determinants of health, creating health inequities.

The findings in this section also demonstrate that the capitalist economic system, to a greater degree, co-constitutes (neo) colonialism, racism, and sexism, producing a myriad of social and health inequities. Racialized and gendered capitalism creates class, gender, and race/ethnicity-based health inequities. Finally, the capitalist-oriented governing authorities implemented maldistributive public policies contributing to widespread class, gender, and race/ethnicity health inequities. The following section presents the factors maintaining health inequalities.

4.2 Factors Sustaining Health Inequities

My thematic analysis of the interview data identified five main findings regarding the factors or circumstances sustaining health inequities in Canada. First, 16/21 informants explained that power, interest, and ideology trump evidence-based research and ideas. Second, 23/23 informants recognized that unequal resources among competing interest groups result in an unequal policy advocacy field. Third, 23/23 informants acknowledged the dominance of the business and corporate sector in public policy institutions. Fourth, 23/23 informants recognized that the governing authorities and political parties in power contribute to public policy failures to reduce health inequities. Finally, 23/23 interviewees acknowledged that fragmented and weak labour, civil society, and social movements contribute to Canada's persistent class, gender, and race/ethnicity health inequities. The interviewees' -- academics, activists, advocates -- collective insights about the factors sustaining social and health inequities reflected more the neo-pluralist

and critical political economy theory than discursive institutionalism. Remarkably, the interviewees' spontaneous collective replies have almost a universal agreement about the factors sustaining health inequities than what causes health inequities.

4.2.1 Power, interest, and ideology trump evidence. Power, interest, and ideology superseding evidence sustain health inequities in Canada. Informed by discursive institutionalism, I specifically inquired from my informants whether evidence-based research and ideas influence healthy public policymaking processes. Some replied *yes*, a few *no*, and most did not answer *yes* or *no*. Nonetheless, their collective insights demonstrate that although evidence-based research and policy ideas may influence governing authorities' policy decisions to reduce health inequities, their impacts are minimal.

Sixteen of the 21 informants (two informants I missed asking) expressed that the degree of the influence of evidence-based research and policy ideas to reduce health inequities is dependent on power, interest, ideology, and their combinations. Specifically, 12/21, 10/21, and 8/21 informants communicated the dominance of power, interest, and ideology over evidence, respectively. Most interviewees discussed these terms in any of their combinations. Five informants did not explicitly speak about the influence of power, interest, and ideology on healthy public policymaking processes.

For this fourth main theme, the presentation of the results is classified into four sub-themes: 1) power trumps evidence; 2) interest trumps evidence; 3) ideology trumps evidence; and 4) power-interest-ideology nexus trumps evidence. In each sub-theme, I present illustrative quotes then a brief analysis and discussion relative to existing literature. Finally, I wrap up with the insights from Panitch, Hancock, and Albo and a section summary. The results complement the findings in the previous chapters and show why and how health inequities persist.

Power trumps evidence. As reported earlier, 12/21 informants communicated that power trumps evidence-based research and policy ideas concerning health inequities reduction. Some interviewees linked power with either interest or ideology or both. Specifically, 4/21 informants focused on the interplay between evidence and power. For example, before I even asked about the interactions of evidence-based research and ideas in healthy public policymaking, Armstrong already talked about them when discussing competing interest groups. She explained:

> An old union leader used to say it's not the power of your argument; it's also the power behind your argument. And some people have more power behind their argument than others, and it takes that power. It takes different forms. I mean, academics have to have union stewards, and so that our research might help make arguments for change, but it's not. It's seldom enough. I mean, you have to be then able to use those arguments in ways that really pressure for fundamental change.

Armstrong explained that the failure and success of evidence-based research and policy ideas to reduce health inequities depends on power dynamics. She elaborated using the debate on harm reduction that became a 'moral question' rather than an evidence-based health issue:

> You need the evidence, and of course, some evidence is more acceptable than other evidence. As I always say to my students, whose evidence counts and what counts as evidence are really important questions that are about power and not just about the quality or the nature of the research. And even then, quantitative research is more valued than qualitative research. My students were just debating…whether you should have safe injection sites or not. And

they were talking about Tony Clement, who was the Minister of Health, saying that the evidence was that they weren't safe when there's tons and tons of evidence of all sorts indicating that they were a very good way of addressing the problem. So, it's clear that evidence didn't matter to him. It became a moral question, not an evidence question. Sometimes evidence matters. I mean, I think it's harder to fight for something without the evidence. I think it's unlikely that evidence alone will bring you success (Armstrong: Academic-Activist-Advocate).

Stewart categorically said that power based on wealth have more influence than evidence:

The policy and research should absolutely influence the decisions. But again, the power lies where the money is and the intellect. So even if you do present a strong case through policy research with all the backup of why and pointing out what improvements it would bring to society or the issue, still, money seems to have the influence (Stewart: Activist-Advocate).

Sam Gindin corroborated Stewart's view that evidence-based research and policy ideas to reduce health inequities do not influence public policy more than power and politics. He stated: "Well, generally, no. They don't have that kind of power." However, Gindin explained that organizing, mobilizing, and pressuring the governing authorities to accept evidence could improve peoples' working, living, and health conditions, as exemplified by the collective power struggle against asbestos and collective power struggle for universal healthcare system:

In workplaces, there's a lot of chemical-related diseases. There's a lot of cancer, and it's because, for a corporation, it might be cheaper to use a particular chemical even if it kills workers. So, the only way you can change it is if the workers organize to fight against it. But sometimes they won't because they're worried that if they organize to fight against it, the place may close, and that's happened. So, even the workers themselves might be reluctant to do it. So, suppose you get a good study that shows that this workplace and these chemicals destroyed peoples' health. You can do things with it. We've been able to get rid of asbestos, for example, in car brakes, in using it in homes, and using it anywhere children are near the school walls. That came about because people organized it, and there was enough pressure on the government because everybody cared about their kids. Other people got worried too. Office workers got worried. So, they were able to have some impact, but it still is a small impact. People have to fight over every little thing. So yeah, they're always at a disadvantage. That doesn't change. That's what capitalism is. It's an unequal society… But if you organize and mobilize, you can win some things. There's no question; we've won things, including the medical system, which the United States doesn't have.

Sam Gindin reiterated that power imbalances in a capitalist system hinder transformative health policy changes. He said: "So yes, you can win things, but that doesn't make the system equal. It's still unequal. You still have richer people who will still live longer. People still travel to the United States to see a specialist if they want". Gindin shared a personal experience:

My father was dying. We were able to give him good care because we had the income to do it. And the people are giving him good care, with people like yourself. That's where he got good care. In Manitoba, where this was, there was some good care for older people, and

that's because people fought for it. And you can do it. I don't want to say you can't do it, but there's still is always a limit. The barrier is the system itself. If you have unequal power, you're going to have unequal care in terms of treatment, but also in terms of the costs of all of these. You know, the rich aren't going to work in asbestos (Gindin: Political Activist).

Goldring also pointed to power as a determining factor in the influence of evidence-based research and policy on reducing social and health inequities. She stated: "I think there are people in power who support evidence-based research as a basis for determining public policy. I think part of that depends a little bit on the party in power."[38] Goldring provided an example:

Under Harper, the idea of evidence-based research was somewhat contested. The elimination of the long-form census is an example of people getting rid of an instrument that would have been very useful for evidence-based policy. At the same time, even if you have the data to develop evidence-based policy and even if there is lip service being paid to evidence-based policy, it doesn't mean that it's necessarily carried out. So, I think it's kind of a liberal model to think that evidence-based policymaking happens. You know, that sort of suggests that the research will always point the way, and that would seem to ignore political realities most of the time. So, I think it's a bit off (Goldring: Academic).

Nonetheless, Goldring recognized that the state does not have all the power as there are other contending forces within the state attempting to influence healthy public policy:

[38] Addendum: "Others do not support evidence-based policy." - Goldring

> But I also don't think that the state operates in a completely monolithic way. [T]here are different ministries…organizations in and outside of government. And while I would not say that they all have an equal chance of influencing public policy, I think they do try. And so, there is contention, and what one hand of government does, or one branch does, does not mean that there's consistency or coherence across sectors. [O]ne example… in the past, the immigration, humanitarian policy in Canada for refugees has gone towards opening doors for certain categories of people… gender-based violence and sexual orientation became an important basis for claiming refugee status. So, that opened things up on the one hand. On the other hand, the bureaucratic functioning of the Immigration and Refugee Board was always very directed at making sure that only genuine refugees got accepted... So, sometimes, you have these contradictory processes going on.

Goldring also spoke about powerful forces outside the state mobilizing for evidence-based research and policy to reduce health inequities and win:

> Going back and forth on access to health care for refugees is also an example of that. At one point, they cut the IFH; then they brought it back because doctors got out in the street. The doctors were out there making arguments for expanding healthcare on humanitarian terms and healthcare terms based on the idea of evidence-based policy. And so, they were pushing that kind of argument against a government that was trying to eliminate access to healthcare.

The illustrative quotes demonstrate that the influence of evidence-based research and policy ideas to reduce preventable health inequalities plays a relatively insignificant role in

institutional public policymaking. Power precedes evidence. The relative power of state and non-state policy actors determines the success or failure of evidence-based research and policy ideas to reduce health inequities. Contrary to the claim elsewhere, in Canada, it is not 'institutionalized ideas' or 'policy paradigms' (see Smith, 2007, 2013a,b; 2014; Hall, 1993) that filter public policy to reduce health inequities but power. Power trumping evidence maintains health inequities.

Interest trumps evidence. As reported earlier, 10/21 informants communicated that interest trumps evidence-based research and policy ideas concerning health inequities reduction. Although these interviewees linked the interplay of evidence and interest with either power or ideology or both, I present illustrative quotes focusing on evidence-interest nexus. For example, Clarke affirmed that evidence-based research and ideas influence healthy public policymaking processes to 'some degree.' However, he stressed that interest drives governing authorities' policy decisions, including homelessness, more than evidence. Clarke reiterated the state's role as the executive committee for the wealthy and capitalist class.

> [I]t comes back to the point that I don't think governments function in the interests of most people. So yes, it's an expensive proposition in many ways to abandon people on the streets. And in California, it's reaching the point now where they have a public health crisis as a result of the level of destitution that they've created. But the developers don't want social housing. They want to build luxury housing. The speculators and the bankers similarly are not interested in providing truly affordable housing for most people and dealing with the crisis and homelessness. And so, even at incredible social and economic costs, those inequities continue. They should be challenged. They are challenged. And evidence-based

> research is a vital tool to use in the fight. But the limitations of it have to be understood because we're not up against the system that is fundamentally rational, in my view (Clarke: Activist).

Khenti provided examples of public policy changes involving the tobacco and alcohol industry. He explained that 'political interests' influence those policy changes:

> Policies that worked, such as with respect to alcohol pricing and access to alcohol in shops and supermarkets and keeping alcohol within LCBO jurisdiction, actually worked to prevent and reduce levels of alcoholism and the harms of alcoholism. But despite decades of evidence that show this is what works, those policies were dumped because it's in the interest, current political interests to open up the alcohol market for whatever reasons. The reasons are beyond me. But I do know that the research evidence is clear: reduce access to alcohol; you will reduce the harms associated with alcohol. Reduce access to tobacco; you'll reduce the harms associated with tobacco. Manage the pricing of these products; you'll reduce the harms associated with the products. Despite the evidence, those tools, evidence-based suppositions aren't being heeded (Khenti: Academic-Activist-Advocate).

Anonymous N5, an economist working on labour-health axis responded: "I don't think it's so cut and dry." The interviewee asserted that public policy decisions impacting health outcomes do not hinge on evidence alone but many factors. First, the informant cautioned that some academics are being 'incentivized' and thus more interested in publishing in top journals than having their work reach the public policy institutions:

> What academics do sometimes seem very far removed from anything relevant for a large swath of society. This is one side. When I look to my colleagues at universities, they're more concerned about publication in peer-reviewed journals than getting new work out to the policy arena. They're not incentivized to package their work for policy consumption. They're incentivized to publish in the top 50 ranked journals in their discipline… And then on the other side, decisions are made on many things…it's not exclusively just evidence-based… There's also are hidden histories, precedents, a number of other political issues. Is it feasible? Because it's a minefield to move forward on, even if there's compelling evidence to suggest it would be worth doing based on some kind of policy analysis kind of thing. And then the evidence…it's not absolute. Everything in our human world is a social construction.

Anonymous N5 theorization that evidence is 'not absolute' and that 'everything in our human world' is a 'social construction' is more informed by *idealism*, which is relativist and subjectivist. The informant then explained the crucial role of 'value system' and 'value judgment' in deciding 'whose interests and wants' must be prioritized:

> Research is funded based on somebody's value system. When SSHRC or CIHR, or whoever the funder is, decided to do a special call, somebody's there behind it, deciding…we value this more than other research… Everything is constructed in our society. As an economist... I have to put my values at the door when I do my analysis because I'm not trying to impose my value systems, right? So, invariably, we are human, and we think about what are the accepted value judgements that we can work within our scientific analyses… Nothing is value-free. Science builds on some human understanding of what we want and desire as a society. So, there's no absolutes to that. So then, it has to take whose interests and wants in segments of

society should take precedence. It's a value judgment. There's no absolutes (Anonymous N5: Academic-Advocate).

The illustrative quotes demonstrate that the influence of evidence-based research on healthy public policymaking processes plays a minimal role. Interest supersedes evidence. Contrary to the claim elsewhere, 'interest' more than 'institutionalized ideas' or 'policy paradigms' (see Smith, 2007, 2013a,b; 2014; Hall, 1993) filter, alter, and obstruct evidence-based research and policy ideas to reduce health inequities. Interest trumping evidence maintains health inequities in Canada.

Ideology trumps evidence. As reported earlier, 8/21 informants communicated that ideology trumps evidence-based research and policy ideas concerning health inequities reduction. Although nearly all these interviewees linked the interplay of evidence and ideology with either power or interest or both, I present illustrative quotes focusing on the evidence-ideology axis. For example, Bryant explained that the governing authorities' ideology influences public policy, and evidence plays only a minor part in health inequities reduction. The informant posited that the ruling governments seek evidence to support their policy decisions, but that evidence should fit their ideology:

My Ph.D. thesis was all about whether evidence played any role in public policy decisions. And I concluded… and I still think this is the case: It's the political ideology, rather the ideological commitment of government, that really shaped policy. I think they make the decisions; then, they look for the evidence to support their decisions to justify their action or inaction. So, it may play a small role certainly when various civil society, labour groups, et cetera, present briefs to governments. Governments expect, or the committees that hear these

briefs, expect them to present solid evidence. But I don't know how much of that is taken into account when they're making decisions. I think it's really a question of who has louder voices.

Bryant critiqued the lack of willingness of the governing Liberal Party to decisively act on poverty and precarious employment and for promoting 'job churn':

> [Y]ou can point to poverty, lack of employment security, et cetera… these are all issues that governments just don't seem to recognize or are unwilling to take action. Well, just after the Trudeau Liberals won the election in 2015, Bill Morneau, the Finance Minister, had the audacity, the arrogance to say to, in response to students, our young peoples' concern about the lack of employment opportunities that, well, they just have to settle for, you know, precarious employment. He called it the job churn… These attitudes must change. That's what people have to challenge (Bryant: Academic).

Khenti also emphasized evidence-based research is necessary, but "evidence alone does not lead to change" because "ideology gets in the way." He explained:

> So, if you want to address issues of racialized persons and systemic racism, you absolutely need evidence. But having evidence alone doesn't lead to change because we've seen that you get the evidence, and then… decision-makers don't want to hear from you… You could have all the evidence, but… there are no opportunities for you to present that evidence because ideology gets in the way. What we have seen is that ideology, political ideology

matters. And that you could have the political ideology that trumps evidence (Khenti: Academic-Activist-Advocate).

When further queried, Clarke stressed that ideology plays a part in governing authorities' policy decisions, but that ideology is fundamentally based on material needs and interests:

Yes, there is absolutely a prevailing political ideology that drives this. It's an ideology that reflects material interest. It's not just the people who've made cranky choices for some reason… there is an ideology that argues for self-reliance in place of dependency and that they always have ways of rationalizing it. Margaret Thatcher infamously said that there's no such thing as society. I mean, they have their ideology, but it's important to understand that the ideology reflects actual material needs and material interests (Clarke: Activist).

The above insights help recall earlier discussions that Canada is a capitalist society that promotes the ideologies of market fundamentalism, liberalism, and individualism (see Raphael, 2012). The findings demonstrate that health inequities evidence play a minor role in public policy partly because of ideology. Dominant ideology determines the success or failure of evidence to reach the public policy realm. Contrary to the claim elsewhere (see Smith, 2007, 2013a,b; 2014; Hall, 1993), it is not 'institutionalized ideas' or 'policy paradigms' that filter evidence-based research and policy ideas to reduce health inequities but ideology. Ideology trumping evidence maintains health inequities in Canada.

Power-interest-ideology nexus trumps evidence. As reported earlier, 16/21 informants explained that the impact of evidence-based research and policy ideas to reduce health inequities is contingent on power, interest, and ideology. Specifically, 11/21 informants discussed that their combinations trump evidence. For example, sociologist Carroll explained that evidence-based research and ideas do influence public policy to reduce social inequalities, especially under the left-leaning governing authorities that account for the public interests:

> I think they do. I'm quite involved. Actually, in this SSHRC partnership, I mentioned to you, the main partners are the University of Victoria and the Canadian Center for Policy Alternatives. In particular, the BC office, the CCPA, and so they're a really good group, and I'm quite involved with the CCPA, and we've published a whole number of reports through the CCPA. So that's a kind of evidence. What they do is an evidence-based policy analysis and research and a kind of advocacy on behalf of, I would say, in a sense, the public sphere. Like it's really trying to democratize public policy by providing perspectives that take into account the needs and interests of most people as opposed to the kind of top-down corporate perspective that otherwise tends to claim most of this space in policy discussion. So, I think they do, particularly if there's a government in power that is left-leaning. Then an evidence-based approach that is socially progressive can get some traction with some issues.

Although Carroll recognized that evidence influences public policy, he stated that it is 'very difficult' to achieve substantial policy changes to reduce social and health inequalities. He explained that although some state actors and the state itself may be interested in reducing such inequalities, the dominance of the 'power of capital' comes in the way:

> But, it's still very difficult for the reason that was my starting point in terms of the way that capital dominates human affairs. And so, even if a politician or political party or government is really wanting to make major changes, it's not easy to do them. It's very difficult without ruffling the feathers of the business community and possibly precipitating a so-called capital strike. And so, state managers are always aware of the fact that capital holds the trump card, really, in terms of what might happen if a certain policy comes into play, like, say, nationalizing private insurance companies or something like that. Once you make any kind of move in the direction of infringing on the power of capital, there's a big push back. And so, the basic structure that reproduces these inequalities is really hard to reshape, to change.

For epidemiologist Anonymous N14, the influence of evidence-based research and ideas in public policymaking is shaped by various factors, including 'scientific culture,' 'interest of the majority,' will of the political actors, power of capital, and 'balance of political forces' shaping social and health inequities. The informant explained:

> First is the scientific culture of a society. If it doesn't exist, it's not possible to translate the interest of the majority in reducing health inequities. So, evidence on the social determinants of health, in general, because of the same mechanisms that we were talking about before, it's not sufficient. It's the preferred means because it uses the science of affecting inequities. But it depends on how much the political actors are willing to commit action to this sort of inequities. So, that's the principal factor. And since this is lacking most of the time, the evidence doesn't translate into policies to reduce social inequalities.

Anonymous N14 further stated: "policy world is very secondary to the realities of class power, which are more determinant of whether a policy to reduce health inequalities may be implemented or not." The informant explained that global health inequalities in relation to the pandemic, economic embargo, migration, and war are ignored by those in power:

> You need this balance of political forces. That is what matters the most, either for gender, race, or class and definitely international. Internationally, it's definitely a total disaster. There is very little equity internationally. Many countries have been actually squeezed during the COVID epidemic. And inequalities increased rather than reduced. And yet, the consequences of blockade and embargo are well known, and there is evidence of the suffering that they inflict in a country. And other countries staying by without complaining of the crisis of migration in Europe. People are dying in the Mediterranean or the wars in the Middle East. I mean, there is enough evidence that different policies would have improved the health of these populations, reduced the inequalities between these and European countries, and nobody cares. Even worse, they are letting it happen without actually any confrontation between countries. There seems to be a consensus to look the other way (Anonymous No.14: Academic-Advocate).

Mehra of the Ontario Health Coalition stated that the influence of evidence on public policy is not clear-cut. However, she explained that although 'power and politics are dominant,' health policy changes protecting public over private interests may materialize when fought for:

> So, conditions of work are conditions of care. And there's a meeting of the interests between residents and staff, not always. I mean, sometimes you want to protect the staff against the

tyranny of over-demanding and sometimes even abusive families or residents. And sometimes you want to protect the residents like it's the same from the staff. But, in general, there's a common interest in improving the hours of care, the amount of funding that goes to care rather than being siphoned off for profits and so on. Over the years, we have periodically won and lost regulations that would protect staffing levels or care levels in the homes or enforce the existing standards and regulations (Mehra: Researcher-Advocate).

Jonah Gindin, CUPE researcher, assigned in the hospital division, explained the dominance of power and interest over evidence as demonstrated by the governing authorities' lack of preparedness to prevent devastating impacts of public health issues, such as SARS and COVID-19 as they also toe the line of for-profit interest societal sectors.

We already had a disastrous epidemic in Toronto with the SARS crisis. And the healthcare system was woefully unprepared to deal with that. As a result, the special Commission, there were all sorts of recommendations, and the government has kind of paid lip service to it for a little while and then didn't end up actually implementing them. And that's why they initially purchased a whole bunch of N95 masks… and then they let them expire so that by the time COVID-19 rolled around, they didn't have it. So, evidence-based research is really important, but it won't be implemented unless there's power behind it. The power that is currently shaping policy is primarily the power of the for-profit companies that are involved in healthcare in all sorts of different aspects that permit profit, in particular, in the long-term care sector. And those interested are looking to expand the opportunities for profit within healthcare. Evidence-based research to be more relevant for the actual development of

policies, unions and communities have to be able to exercise a similar level of power to balance that out of the power of the elite interest in order to advance that research (Gindin: Researcher-Activist-Advocate).

Wrapping up. As mentioned earlier, I will wrap up the fourth main theme: *dominance of power, interest, ideology, and their combinations over evidence-based research and policy ideas sustain social and health inequities* with the insights from Panitch, Hancock, and Albo. They are among the informants who explained the interplay of evidence-power-interest-ideology together. When queried whether evidenced-based research and ideas influence public policy to reduce social and health inequities, Panitch spontaneously replied: *Yes*. He explained:

I think governments need to know what is happening in the societies they govern. And I think that Canadian governments for the most, obviously how they received that evidence is ideologically coloured. They all have a self-interest in social scientific and scientific evidence being presented to them. Of course, you can say that. And this is one of the great dangers of this conjuncture: That the Trumps and the Dutertes will suppress any evidence they don't find convenient. But I think, for the most part, again, out of their own interests, governments in capitalist societies have an interest in evidence. And the reason the Social Science and Humanities Research Council spends so much money on supporting above all research in health is, you know, not to create some kind of pretense that they're progressive when they're really not. No, I think they're genuinely interested in the evidence that will be produced out of this research. Sometimes they will be embarrassed by it. And it's very important that those who do the research not sign away their ability to publicize the research because when governments are embarrassed by it, it's very important that the truth comes out.

Panitch then focused on the impact of 'postmodernism' in evidence-based research and policy, which brings to mind Anonymous N5 emphasis that everything in human societies is a social construction and there are no absolutes in the human world. Panitch explained:

> I think one of the damaging aspects of social science and the humanities at the moment has been the postmodernist claim that truth is relative. I think that's done more damage probably to evidence-based public policy than has capitalist power because it has fed a political ideology that really all that matters is your position, your subjectivity and not the truth. And the Left tended to think that if you proclaim the Black subjectivity or an Indigenous subjectivity, that would morally and ethically win in some way.

'Subjectivity' nurtures the narratives and practices of right-wing authoritarian populists and weakens the validity of evidence-based research, as Panitch further explained:

> In fact, it feeds the Trumps and the Dutertes of this world who can use the rejection of truth, the rejection of evidence much more powerfully than those people who say my subjectivity as a Filipino is all that matters. I know what it is to be oppressed because I'm a Filipino maid. And that's the real truth, but it's not the real truth. I mean, in so far as this is true, it reflects that Filipino maid's experience in the real world, not simply because she's Filipino and a maid. It reflects what she has learned objectively about how the world works. Whereas a lot of people start with I'm a Filipino, so I'm oppressed. There are capitalist Filipinos too… I'm picking on Filipino. They're the least likely to do it. It's usually the daughters of capitalist Filipinos who come to the university saying: All I need to know is that I'm an oppressed

> Filipino. I'm sure you experience this. You hear this much more in Canada, not from Filipino. You hear it from Indigenous students at universities. You hear it from Black students at universities. You can even hear it from Jewish students at universities who generally don't come from poor families. But all it matters is my subjectivity and my sense of oppression and marginalization or my gendered sense of oppression or my sexual sense of oppression. This detracts from the validity of evidence-based research. Imagine if Marx hadn't spent all that time in the British Museum studying the evidence-based nature of capitalism and all he did was say capitalism is bad (Panitch: Academic).

Hancock also explained that evidence has less influence than the politics behind healthy public policymaking. He stated: "Oh no, not at all. What I've said for years is the evidence that evidence changes policy is pretty slim". He used climate and tobacco issues as examples:

> The best example right now is climate change. We have all kinds of evidence, but is it changing policy? Hardly at all. In the US, not at all. In Brazil, not at all. In the Philippines, probably not at all. In Canada, not at all. Why does the NDP government support the LNG pipelines and LNG industry? Why does the federal government support the Alberta tar sands industry and the pipeline? The evidence that those are bad things to be doing is really quite clear. The evidence that most of the fossil fuel that we have in Canada actually has to stay in the ground if we want to avoid two degrees centigrade warming doesn't really seem to affect policy very much. Another good example, if you go back to the 1960s, the evidence on tobacco took 30, 40 years for that to be turned into really effective public policy. We didn't start to get ready for effective public policy until the 1980s, and it's still not fully effective.

> And now we have the tobacco industry going into the vaping industry. So, no (Hancock: Academic-Advocate).

Hancock elaborated on *information, ideology*, and *interest* shaping governing authorities' policy decisions on social and health inequities. He explained that ideology and interest, especially when taken together, usually prevail over information or evidence. For instance, climate change has become an ideological rather than evidence-based health issue:

> I often go back to Carol Weiss. Years ago, she said three things that go into the decision-making… information, ideology, and interest. And then she went on to say, don't for one moment think that information can trump either ideology or interest. So if you look at the whole climate debate right now, it's actually an ideological debate. The right-wing, the Republicans, some Conservatives here, their rejection of the evidence has nothing to do with the evidence. It's really an ideology… our group thinks this way, and we are aligned with the fossil fuel industry because they're rich and powerful. Our whole system is based on cheap energy. And so we have to keep going kind of thing. And bugger the evidence. And that second one, which is actually very closely related to that, is interest. By interest, she meant power and wealth and stakeholders. So, who gets the policy they want? The people who have the money and power to influence it. So, the fossil fuel industry is very powerful. The tobacco industry, for years, was very powerful. The alcohol industry is quite powerful still. And so, no matter what the evidence is, they have a financial interest in not having any controls upon them or having the minimum of controls. And so, that will triumph usually. So, you put together ideology and interest, and it will almost always overcome evidence or information.

The degree of influence of evidence-based research and ideas to reduce social and health inequities is partly dependent on political actors making political choices. Albo then advised to link evidence-based research and policy with participatory politics and collective mobilizations to achieve healthy public policy goals:

> I think the role of an honest researcher, an honest scholar, a socially committed scholar, and one who's in at the end of the day for following wherever the evidence-based policy leads one is to conclude that if there's obstacles in the way, how do we remove those obstacles to follow up with the policies tell us to do? And then that ranges us into a participatory research agenda and participatory forms of politics because it's only with combining that evidence with participatory forms of politics, collective forms of mobilization, that we can take the policies' outcomes in the direction that the evidence is pointing us to. And, therefore, it's understanding evidence-based policy not in the narrow sense or science-based policy in the narrow sense, but by pulling it up that the science is telling us this as a structural policy and structural policy limit. And therefore, the evidence points us to find ways to remove that obstacle. And that's when politics and participation start becoming important. And that's where the hardcore of the state and the hardcore of inequality start limiting those choices (Albo: Academic-Activist-Advocate).

The illustrative quotes help recall existing literature demonstrating that interest groups compete to influence public policy in their favour and that power imbalance among societal sectors and the governing authorities' ideologies aligned with the capitalist system creates and maintains health inequalities (e.g. see Bryant, 2015a,b; 2016; Raphael, 2014, 2015). The preceding findings demonstrate that evidence hardly influences public policy to reduce health

inequalities, as also found elsewhere (e.g. see Carey & Crammond, 2015a,b; Petticrew et al., 2004; Smith, 2007, 2013a,b; 2014; Whitehead et al., 2004). However, in Canada, it is not 'institutionalized ideas' or 'policy paradigms' that filter evidence-based research and policy to reduce avoidable health inequalities but power, interest, and ideology. The themes below examine pluralism in relation to social and health inequities.

4.2.2 Unequal resources of competing interests and advocacy groups. Another factor sustaining health inequities is unequal resources among competing interests and advocacy groups attempting to reduce social and health inequities. Informed by pluralism, I specifically asked the informants whether competing interest groups have equal opportunities or chances to reduce health inequities through public policy actions. Only 1/23 interviewees spontaneously said *yes*, reflecting a classical pluralism viewpoint, 13/23 said *no*, reflecting a neo-pluralism viewpoint, and 9/23 did not explicitly answer yes or no. However, as the interview progressed, 23/23 informants recognized that unequal wealth and power among interest groups means unequal advocacy influence in healthy public policy and public health policy.

Albo provided a backgrounder on the political dynamics in parliamentary and liberal democracies like Canada that reflected the close relationship between pluralism and critical political economy theory. He first explained the 'equal structure of representation' like equal voting rights for each citizen to gain representation in political institutions:

> No. When I'm teaching my first-year or second-year politics class, I haven't taught those for a while, but that was the first week's lesson that there isn't an equal chance – the inequalities of access. When we are teaching political science in liberal democracies… we usually begin

with the theme of the structure representation in liberal democracies. And usually begin with the formal aspects of liberal democracy and the equal structure of representation from one citizen, one vote and the whole equal access to mobilize equal access to gain representation, equal access under the rule of law, et cetera. And so you lay out those institutions, and then you move from the equal structure of formal representation to the unequal actual structure representation (Albo: Academic-Activist-Advocate).

Albo then explained the material-based 'unequal structure of representation' shaping social inequalities, including class, gender, race/ethnicity health inequalities:

So, you then break down that unequal structure representation in terms of material interests; that is, who has the wealth, who dominates access, who controls the parties, et cetera. And then, the unequal structure of representation in dealing with the various forms of social inequalities; that is, the social inequalities of class and the social inequalities that come along with gender or racial differentiations in societies in Canada. This is also of national differentiations for First Nations and Indigenous peoples. Historically, a strong unequal representation for the Quebecois in the Canadian state… that's equalized a fair bit over time. But, there are still historical remnants of the unequal representation of the French in the Canadian state structure.

Albo's view that inequitable access to economic and other resources means unequal representation in public policy institutions was corroborated by Anonymous N5. The latter

voiced that the *less powerful groups* are rarely heard in healthy public policymaking processes, reflecting neo-pluralist theory:

> Certainly, there's power and influence differences in different stakeholder groups. So, no, they don't have an equal chance to influence policy… Certain groups have more clout in the system than others for a variety of reasons. People who are marginalized often have the littlest say: poor people, recent immigrants, people with low educational attainment, little human capital, there's not much wealth. They get very marginalized, and they don't have as much of a say in how their society gets shaped (Anonymous N5: Academic-Advocate).

Mehra emphasized that the *Indigenous communities* are underrepresented if not misrepresented in public policymaking processes. As a result, they experience sustained social and health inequities, including but not limited to water and housing issues. Mehra explained:

> In Northern Ontario, First Nation, for example, that has no clean water, that does not even have basic safe housing that is healthy for people to live in, for them to get access to government… they would need money to travel. They would need support to create submissions. They would need not just have a call out for hearings… They would need to be invited. People would need to go to them and seek out their opinions, to research the conditions... There has to be extra support: a kind of affirmative action to ensure that marginalized voices that represent those communities that have faced severe discrimination and severe inequality and inequities couldn't possibly even participate (Mehra: Researcher-Advocate).

Anonymous N19 specifically spoke about the kind of Mills' *power elite* group making health policy decisions for the rest of the people:

> [T]he decisions that are being made in the halls of power are made by folks of a certain group of society. It's a very homogeneous group... people who have gone to university, who often have professional roles, and who are making these decisions, and relate to others who are the same economic and social background. I see this a lot in health policy where it strikes me how often, and I count myself among these very privileged people… when I go to meetings with government, how often we all know each other… there's a social connection between… these elites who are involved with the discussion. I don't know if it applies in other sectors, but I suspect it does. But certainly, in health policy, there's a very small circle of people who are all personal connections of one another, colleagues, collaborators, even family, friends, sometimes even people who have married one other because they find themselves in the same circles, but who are also part of that.

Anonymous N19 critiqued the lack of democratic participation in public policymaking involving the healthcare system in Ontario. It rarely involves the *frontline healthcare workers*:

> It's interesting that you worked as a PSW. This is actually an area of work that we're doing now. PSWs, there's something like a hundred thousand in Ontario. It's a huge group. But how often have we ever heard a PSW on the radio talking about their perspective on the healthcare system? How often do we hear nurses or others involved in healthcare? It's almost really kind of this certain small group of academics of health policy, so-called experts, and

physicians often who are very much shaping that discussion (Anonymous N19: Academic-Activist).

The unequal resources -- i.e., wealth, power, social capital -- among competing interest groups shaped the unequal advocacy field. More concretely, Crowe, a housing justice activist, spoke about the more powerful academic and *housing advocacy groups* getting more financial resources from the governing authorities than other groups working to alter the prevailing social structures and institutions that create and maintain poverty, housing insecurity, homelessness, and their adverse health outcomes. Crowe explained:

> Nearly all people in academic institutions and national housing organizations receive funding from the federal government through what do you call SSHRC grants… How can they critique? We've had Housing First going on since the early 2000s. And it's only now that a few of them… with careful wording, begin to say, we have to have a national housing program. They received so much money, and they are in such positions of privilege with six-figure salaries… The Toronto Alliance to End Homelessness has the ear of government... They receive funding from wherever… They have a corporate-style executive director position. And then you have the Shelter and Housing Justice Network. We do not have one dollar. And then you have the Ontario Coalition Against Poverty... They have a few dollars, very few. But we are the voice. We, two groups, are the voices of people with massive experience from the faith sector, social work, nursing, drop-in sector, shelter. Some of the people have been doing it like me for over 30 years. And do we have the ear of the

government? Right now, we do not feel the support of one single city councillor for our work. I mean, it comes in waves.

Crowe's insights mirror neo-pluralism than classical pluralism. Moreover, Stewart, labour leader, discussed that although advocacy groups have the opportunity to present studies and lobby for health policy changes, their chances to shape public policy in their favour are unequal: "They have the opportunity to present their page and their arguments and their concerns and lobby for changes, but the outcomes speak to equity. And if we don't see outcomes, then obviously, they do not have equal opportunity to get things done."

When further queried whether *labour movements* influence healthy public policy and public health policymaking processes, Stewart confirmed they could, depending on the governing authorities in power. So far, there were incremental policy changes that they won:

> Yes, we can. Obviously, it depends greatly on what party is in power as well. I'm really hoping to be able to change some policies for long-term care after coming out of this pandemic. But it's been a challenge and a struggle. We've been able to move small steps. We have a whole lot more to do and a lot more successful outcomes. We were able to move some of it, but again, it's not equitable compared to other stronger, more powerful lobbying groups that have a lot of money to influence the government to make the decisions (Stewart: Activist-Advocate).

Stewart emphasized that competing interests and advocacy groups with more wealth and power often influence the governing authorities' health policy decisions, reflecting the neo-pluralist's viewpoint. Moreover, Hurley, a labour leader and activist, spoke about the relatively

weaker power of the *seniors' groups, healthcare unions, and health coalitions* compared to Big Pharma and powerful capitalists that support politicians and public policymakers:

> We don't have the same level of influence if you look at the unions in Ontario in the healthcare sector and the health coalition, for example. As advocates, some seniors' organizations for improvements to healthcare, they're set off against powerful interests, like the pharmacological companies and the long-term care industry private sector interests. Those companies offer jobs and directorships to politicians and senior bureaucrats. They bankroll campaigns. They are political donors. They employ many people. They're very powerful interests, and they are more influential with the government like this one and probably with a government like the last one.

Furthermore, Mehra emphasized the corporate capture of other *non-profit organizations* or *civil society groups* and the decline in financial support for *progressive advocacy groups* working toward social change to reduce social and health inequities:

> In Canada, there has been a very significant change over the last generation in terms of advocacy from non-profit organizations and funding those organizations to support social change. And that has made a huge difference. The non-profit sector has become more corporatized, with corporations on their boards of directors… There's been a sort of neoliberalization of civil society organizations. There have also been very dramatic cuts to government funding. Today, there's almost no funding at all available for advocacy

organizations or groups that advocate. The right-wing groups have got around this, but the progressive groups have not been able to (Mehra: Researcher-Advocate).

Mehra elaborated on the situation of advocacy groups like the *Ontario Health Coalition*:

Groups like ours can't be charities; can't use your tax receipts. There is no government funding available. It's what you can raise yourself. It's very difficult in this country to even fund advocacy. Even non-profit status requires restrictions on advocacy work. I think advocacy has to be seen as a welcome part of the democratic process, and that'd be actually supported. It's hard to make policy change without being able to have paid staff time to coordinate and bring groups together to build consensus around policy ideas and reform, and so on.

The lack of financial support weakened some advocacy groups like the *seniors' groups*. As a result, they shifted their advocacy work to charity work, as Mehra explained:

There's just so little funding for that in this country that there really are very few organizations that continue to exist. We've seen a real erosion of the seniors' groups. A sort of a generation of activists from the 1960s died and not really been replaced, with no staff to sort of keep them going to help to organize them. The seniors' groups that do exist have become more like charitable models and less advocacy models.

Mehra then critiqued interest groups from the USA that fund right-wing, neoliberal, and conservative groups influencing Canadian public policymaking processes:

> The other thing is that we don't have serious strong enough limits on funding for advocacy from the right-wing, from the neoliberal and very conservative groups in Canada that come from the United States, you know, groups like the Fraser Institute that are funded by the Koch brothers.

Mehra concluded that the advocacy field is unequal:

> I haven't really thought this out. This is again beyond the Health Coalitions' purview… I don't want to call it a playing field because that is too good for, you know, it means a very inequitable field for advocacy. Governments have actually moved to restrict corporate and union donations and so on to the political party, and to some extent individual donation, but I mean, money does play a big role in influencing politics. And, you know, all of those democratic protections need to be in place (Mehra: Researcher-Advocate).

The illustrative quotations bring to mind the findings in the literature review that numerous interests groups compete to influence healthy public policymaking processes in their favour (e.g. see Bryant, 2015a,b; 2016; Dahl, 1961; Kindon, 1984). However, contrary to the claim of the classical pluralists, the preceding findings affirm the power elite (Mills, 1956), corporatism (Cawson, 1978), neo-pluralism (Lindblom, 1982), and multiple-elite (Macfarland, 2007) theories of healthy public policy. Competing interests groups do not have equal opportunities to influence public policy to reduce health inequities because the distribution of wealth, power, and social capital among them are highly differentiated. Unequal resources reflect unequal policy advocacy in the health field.

4.2.3 Dominance of the business and corporate sector. Another factor sustaining health inequities is that the capitalist class that prioritizes profit and wealth accumulation over people's lives, communities, and ecological systems, heavily influences and controls Canadian political institutions and policymaking processes. For this sixth main theme, I first present the results, then illustrative quotes wrapping up with the insights from Anonymous N7, and a summary.

As reported earlier, 23/23 informants recognized that the business and corporate sector has greater wealth and power than other competing interests and advocacy groups attempting to reduce social and health inequities. The collective insights of the interviewees reflected critical political economy and neo-pluralist viewpoints. For example, reflecting the corporatism perspective, a strand of neo-pluralism, Carroll stated: "In terms of interest groups and their access and the way they shape public policy, it's really primarily the corporate sector that has the voice." Carroll discussed the more significant power and influence of the corporate sector *in the fossil fuel industry*:

> My initial answer to that has to do with some of the research we've been doing in the SSHRC partnership I mentioned that we're looking at the power of corporations, and particularly the fossil fuel sector. And it's an important sector, but the same kind of argument could be made in other economic sectors. But when we look at the fossil fuel sector, its relationship to the federal and provincial government in BC, we've mapped out the lobbying relations and the access that big capital has to the major players, the major kind of deputy ministers and state managers and politicians, the access that big corporations have is just incredible. It's a continuing conversation that's going on. So, that's the main conversation in terms of policy

formation. I think the really powerful economic forces are well-resourced, they are taken very seriously, and it's difficult for NGOs and social movements and community groups to match that in terms of their voice. I'm not that involved at this point in terms of any particular NGO or community group, but the research that we've done makes it clear that there's this real, very un-level playing field. And it makes it just really difficult for alternative policy ideas to be taken in the same way as the corporate sector. The corporate agenda tends to be accepted by the political leadership (Carroll: Academic).

Similarly, epidemiologist Anonymous N14 explained that Big Oil influenced governing authorities policy decisions that jeopardized the well-being of the Indigenous communities:

[T]he capitalist classes, the one that has the largest power. Other groups do not manifest the same degree of power in shaping legislation and its enforcement, implementation. And that works in international neocolonial relationships as well as within the country. In Canada, we can observe how the pressures of the resource-driven capitalist industry of oil are stopping the government from following the constitutional rights of Indigenous peoples or failing to protect the communities that may be put at risk, so, pipelines (Anonymous N14: Academic-Advocate).

In the labour market, Block explained that advocacy efforts to reduce social and health inequities encounter strong resistance from the 'power of capital.' She shared her experience in pushing progressive labour policy changes in Ontario:

> A very clear example was an enormous effort and pushed back from the Chamber of Commerce and others against those amendments into Bill 148. I mean, in a certain way, it wasn't successful because the Bill was passed. And so, it had a limited impact. But there's unequal access to resources in terms of business interests. And interests in favour of the status quo have a lot more resources than progressive groups do. And as a result of that… they can buy a lot of communications advice. There's a whole range of things that they can draw on. And so, it's really a very kind of unequal advocacy effort between grassroots groups or small groups… like our organization that are trying to support grassroots groups, employer groups, and the Chamber of Commerce (Block: Researcher-Advocate).

Anonymous N11, a labour union organizer-leader in the healthcare industry, expressed that the business and corporate sector wins most public policy. However, there are opportunities to influence governing authorities' policy decisions, like when labour and advocacy groups organize and mobilize for a minimum wage increase. The informant explained:

> I wouldn't call it equal. If I had to provide a range from like 0 to 100, I would say, business wins 65% of the time or corporations win 60 to 65% of the time. I think there's an opportunity depending on the issue of the day or the catalyst behind folks trying to organize and mobilize. There is a chance for the pro-labour community and allies to work together to move the government on certain things. The fight for a $15 minimum wage is one example. The government didn't just do that on their own. It was a push from organizations in the community, labour, policymakers, and researchers who said: if we want a good Ontario, we need to do this. So, I think there's a way to balance that out (Anonymous N11: Activist-Advocate).

In the healthcare industry, Hurley, a labour activist, stated that capital power and interest struggle for more commodification of health, against public interest: "I'm most familiar with healthcare. There are tremendously powerful corporate interests that are pushing to commodify services." Jonah Gindin, researcher-activist-advocate, who is also involved in labour relations in the healthcare systems, posited:

> I think that the healthcare system in Canada and Ontario exists despite the interests and intentions of the capitalist class and the ruling parties that typically are acting directly or indirectly in the interest of the capitalist class. Having a socialized healthcare system has benefits to employers because they don't have to provide extensive employee benefits. But, it's a tremendous sector of the economy that is not acceptable to them for rent-seeking rent-based [inaudible] initiatives like providing for-profit healthcare. There's lots of little slots that they've cut into the system for providing for-profit healthcare. But there's still a large portion that remains not-for-profit and fully public. And that is problematic from the perspective of segments of the capitalist class that see that as a real wasted opportunity.

There is danger in overemphasizing the dominance of the business and corporate power and influence in healthy public policy and public health policymaking when one ignores class structures and the balance of class forces shaping wealth and power distribution among competing interests and advocacy groups. As discussed earlier, labour unions, civil society groups, and social movements could increase their power by organizing and mobilizing. For example, working from a critical political economy perspective, although Panitch recognized that the corporate sector predominantly obstructs redistributive public policy to reduce social and

health inequities, he cautioned against thinking that the capitalist class possesses all the power. He explained:

> No. Of course, not. But there is a vulgar way of looking at this, which is that business has all the power. If that were the case, you wouldn't be able to explain why we have Medicare in Canada. Class relations reflect reciprocal power. There is asymmetric. Capital has more power than labour, but because labour is necessary, that means labour has some power. And depending on how well it organizes, with what degree of political understanding it organizes, whether labour is just selling itself as a commodity in order to buy more commodities or whether it's organizing. So, I just give that as an example, but that applies to any assessment of which interest groups have more power than others (Panitch: Academic).

Panitch then differentiated the power asymmetries between Big Capital and Filipino homeworkers' organizations. Power differentials fundamentally hinge on how class forces organize, historical conjuncture, political culture in specific locations, and class consciousness:

> Obviously, interest groups representing Bay Street, which is the center of capitalist power in Canada, have more influence than an organization of Filipino homeworkers. I mean, it's banal to say this. But does that mean that an organization of Filipino homeworkers has no power? No. It depends on the balance of class forces, how they organize, in what call activity they organize, whether they're demanding in a coherent way the provision of public goods that meet collective needs or whether they're demanding something that meets their individual needs as consumers. So, there's no general answer. At one level, it's obvious. At

another level, it depends. It depends on the conjuncture. It depends on the particular political culture of the city you're in or the province you're in. It depends on the class consciousness of the groups in question.

Panitch recalled some historical events involving the militant nurses' unions that, in my view, align with the concept of *resisting capitalism* than *smashing capitalism* discussed in the literature review. In the late 1960s to early 1970s, amidst the second wave of the feminist movement in Canada, the nurses' unions were making revolutionary demands around wage increases, but not an anti-capitalist revolution, as Panitch explained:

Some nurses' unions in Canada have been quite militant. In the 1970s, nurses in Canada were making demands for 30% wage increases, sometimes 40% wage increases, as they were getting organized into unions. Getting certified because they were in nurses' associations, but they were becoming unions by being certified for collective bargaining. Most of them were women. That was part of a reflection of the most successful social movements in Canada, which was the second wave of the feminist movement from the late 1960s, early 1970s on. That was the biggest social revolution in Canada. And women who were nurses were saying, why should we be paid less than plumbers? But a 30% wage increase is a revolutionary demand. And they weren't making an anti-capitalist revolution. So, sometimes they got very big wage increases, but you know, it was limited and constrained. And it didn't involve a change in class relations inside the hospitals. So that authority relations inside the hospitals remain the same. And it drove many women out of nursing.

Panitch then historized the triumphant nurses' strike amid the onslaught of neoliberal capitalism in Alberta in the mid-1990s. Although illegal in Alberta, the strike was massively supported by the public, forcing the governing authorities to meet their demands:

> In the mid-1990s, there was a very, very successful illegal, not legal, nurses' strike in Alberta and Canada. You should look it up. It was illegal for nurses to strike in Alberta. It's legal in some places, but it was illegal in Alberta. And the nurses struck. They stayed out on strike. They had tremendous public support. They had so much public support that when the government caved in and gave them all of their demands, they then said: but we will fine you because you broke the law. We will fine the nurses' union so many hundreds of thousands of dollars for having been on strike. And they said: no, we're not going to pay this. Well, they could have put them in jail, the nurses' leaders, but they didn't, and they didn't fine them. It was an incredible victory.

Indeed, organizing and mobilizing could compel the state authorities to prioritize the working class's interests over capital and the ruling class's interests. Nonetheless, Panitch cautioned that the Canadian governments could also weaken labour unions by using their powers to pass laws like back-to-work orders that limit, if not remove, union's rights. He explained:

> I got invited to the next convention after the strike of the Alberta Nurses Union because I have written a lot about trade unions in Canada and the way in which governments discriminate against public sector unions immediately use legislation even though they strike following the exact details of the law. You know you can only go on strike under certain

conditions after a certain period of collective bargaining. Even though public sector unions meticulously followed the rules, as soon as they would go on strike, governments at the provincial and federal levels would pass a special law that will say: we're taking away your union rights, and we're requiring you to go back to work. Even if they followed the general law, governments against public sector workers would pass a specific law legislating them back. It didn't work with the Alberta nurses. It really didn't work.

Despite the nurses' victory, Panitch expressed concern regarding the nurses' lack of class consciousness, contributing to working class' fragmentations. He recalled an experience:

I gave a keynote address. They asked me to give an address in which I advised them that in their next round of bargain, they should make their first priority, not increased pay, but instead one hour a week paid time in every ward where all of the workers in the ward, the nurses, the cleaners, the doctors, the people providing the food, et cetera, would meet together to discuss the labour process in the ward. And the next round of bargaining, three years later, they should make the top priority, another paid hour a week where everybody in the ward would meet to discuss the labour process with the patients. I got a standing ovation… [A]fter the coffee break, the first item of business was that the orderlies… Most of them are men or used to be men because it involved a lot of heavy labour. And they had supported the nurses' strike. Their union made an application to join to merge with the nurses' union, and the executive of the nurses' union, who were very militant and progressive, supported this. So, they proposed to the convention that they, the orderlies, be accepted into their union. And there were two microphones on the convention floor. One a

‘yes’ microphone where you would support the executive saying orderlies should be part of our union and the ‘no’ microphone. And nobody went to the ‘yes’ microphone.

Panitch then explained craft unionism as a source of working class’ fragmentation:

The nurses all went into the ‘no’ microphone. Why? Because they’re crafts. It’s a craft union. Nurses are a craft. Orderlies are manual labour. We don’t want them in our union. They’re not educated. They don’t have the skills that we have. So, you see, if you’re going to assess the balance of forces around health policy, you need to assess the nature of labour in healthcare. Is it collective? Is it professional? Is it a reflection of the old type of craft unionism, which is against the collective organization of the subordinate classes and their needs and demands? And when people get excited about teachers’ strikes or nurses’ strikes, they need to look very carefully. What is the nature of the demand? I think it’s very important, what’s happening now, very positive. But I think the usual questions and easy answers you’ll get to the questions you’re posing is that yes, rich people are more powerful than poor people, businessmen are more powerful than labourers, doctors are more powerful than nurses. Of course, I mean, this is banal. You can use this for propaganda purposes, but for social scientific purposes, you know, it’s not very useful (Panitch: Academic).

Wrapping up. Only Anonymous N7 explicitly said that competing interest groups have equal chances of influencing healthy public policymaking processes, reflecting the classical pluralist’s viewpoint. Nonetheless, the informant explained the necessity of research, advocacy, and organizing -- reflecting the interrelatedness of discursive institutionalism, pluralism, and

critical political economy -- in pressuring the governing authorities to legislate and implement redistributive public policy to reduce social and health inequities:

> I think so. I think that activist organizations do have an impact on policymaking. It's difficult work, but I think that it's because of these activist organizations that we've seen changes. In whatever security we have, it has had to be fought for by activist groups, by unions, by community organizations. I guess academics have played some role by doing research in the areas by pointing out precarious labour: what it is, how it has changed, what it does to people. So, all of these groups, I believe that we do have an impact. Otherwise, there would be no change because change is not going to come from just good-hearted people. It comes because of pressure because of actions people take. And we've seen that historically. Those people who are not organized, who are not able to do advocacy, their working conditions are not very good. They're the worst. And those people who have more organization, more bargaining strength, those people, they can actually bargain for something: maybe higher wages, maybe more security. Like the teachers are on strike now, they are fighting for security. Because they're organized, I think that does have an impact. I'm not saying that it solves all the problems, but it is something needed. It is needed. Otherwise, we wouldn't have any change in our society (Anonymous N7: Academic).

When further queried, Anonymous N7 explained that businesses and corporations are also organizing and pressuring the governing authorities to enact and implement public policy satisfying their profit interests. Specifically, the informant explained migration policy changes impacting the food industry favouring the corporate interests:

I think that just like activist groups, they are also another group within society that organize themselves, and they push for their interests in policymaking. Like the other day, I was reading about migrant workers in British Columbia and how in the service industry, like in fast-food and so on. The business interests, they got together, their association. And they started lobbying the government to bring in migrant workers, even though there are Canadians who are available to do the work. But they advocated, and they pushed the government. This was a case study that was done in I think 2011, 2014. So, a few years back. As a result, the government opened up. They made it easier for the fast-food industry to bring in migrant workers who would be paid less and who would not have a lot of bargaining power because they are here only to do a job. And also, many of them want to become permanent residents. So, they wouldn't want to complain. They're compliant labour, but their compliancy has been constructed legally because if they complain or if they protest, then they can be deported. It's just an example to show that businesses also associate with each other, and they also push. It's really in the final analysis; how hard does each side push, and who does the government listen to?

The illustrative quotes confirm existing literature showing that big businesses and corporations dominate public policy institutions, maintaining social and health inequalities (e.g. see Baum et al., 2013, 2020; Bryant, 2015a,b; Langille, 2016; Raphael, 2015, 2016; Scambler, 2002, 2019a,b). The findings support the neo-pluralists contention that big businesses and corporations have more power to influence public policymaking than other competing interest groups (e.g. see Cawson, 1978; Lindblom, 1982; Macfarland, 2007; Mills, 1956). However, most informants' insights also reflected a critical political economy viewpoint: the imbalances in

social relations of power can be altered when the less influential classes and groups organize and mobilize against capitalist powers, interests, and ideologies and neoliberal governing authorities that sustain social and health inequities. The state's role in creating and maintaining health inequities in Canada is further revealed in the seventh main theme below.

4.2.4 Neoliberal governing authorities. Another factor sustaining unjust health inequalities is the governing authorities that uphold the capitalist system, i.e., neoliberal capitalism in the contemporary era. For this main theme, I first present the results, then illustrative quotes wrapping up with the insights from Panitch and McKenzie, and a summary. All 23 interviewees -- explicitly or implicitly -- explained that the (neoliberal) governing authorities and political parties in power contribute to policy failures in addressing social and health inequities in Canada. The collective insights of the interviewees reflected the interrelatedness of critical political economy and pluralist approach to social and health inequities.

For example, McKenzie, CEO of the Wellesley Institute, Director of Health Equity at the Centre of Addiction and Mental Health, and member of the National Advisory Council on Poverty, discussed the difference "between the position of the government and the intention of government" informing its policy decisions, actions, and inactions on social determinants of health and resultant health inequities. He explained:

> The position of the government often, especially if it's a Liberal government, is that it doesn't like the social inequities of health. But their intention often is not to do anything about it. Part of their reason for not doing anything about it is, they have, over many years,

had an actual, in real terms, decreasing proportion of the GDP… Proportionately, they're smaller than they used to be because the rich are getting richer, the poor were staying the same or getting poorer. Consequently, the actual amount of money that the government has to spend in real terms as a proportion of GDP has not been rising in the way it could do. So, the government has, in many ways, been considering how to save money and how to better use money rather than how to invest or grow the society. Part of the reason they don't want to spend is they don't want to be seen as tax spending governments. They believe it's not electorally acceptable.

McKenzie also pointed to jurisdictional issues, political shifts, and changes in the governing authorities' compositions as contributing factors to the persistent health inequities:

There's also the problem of the federal government not wanting to make sure that it upsets Alberta and Quebec. Quebec, in many ways… doesn't necessarily believe that it has to do as much for racialized groups. And Alberta certainly doesn't think it needs to do stuff for racialized groups. And so, I think the slightly right-wing tilt that's happened makes it difficult at a federal level to be going towards the social determinants of health. At a provincial level, we were more successful. We were involved in advising on the basic income. We're involved in trying to get a $15 minimum wage. We were involved in getting sick days. We were involved in getting socio-demographic data collection in health and mental health. We're involved in trying to sort of billions of dollars that we're going to get into mental health and all of these things. And we were involved in getting the provincial government to set a target of no chronic homelessness by 2025. And we're involved in building the work of the anti-racism directorate. So, at a provincial level, we had got a

reasonable amount of traction under a Liberal government in moving forward some of the social determinants of health, housing, income, sort of fairer jobs, mental health and racism, and anti-racism directorate. But then they left the office.

McKenzie further explained that advocacy groups attempting to reduce social and health inequities are being played against each other by the governing authorities. He also discussed the divided worlds of governments and communities. Finally, the informant spoke about the crucial role of social connections in creating a 'win-win' scenario for the governments:

I think part of the problem is that there are competing groups and the fact that groups competing with each other makes it difficult for groups for change to happen because they get played off against each other. But I think organized groups with a constituency that will vote on their issue have a pretty loud say. And I also think, certainly at the provincial and definitely at the federal level… both governments are not particularly well attached to communities. So, people who know how to get in front of the right people in government and who know how to produce a pitch that produces a win-win situation for the government are the people who are going to be most effective. So the first thing is access. Can you actually get in front of the right person? Can you get in front of the government? The second thing is, do you know who the right person is to get in front of? The third is, do you know what they want? And can you set up a win-win situation? And then, if you can do all of that, the question is, can you produce a pitch, which does actually produce what they need and what you need? (McKenzie: Academic-Activist-Advocate).

To reduce health inequities effectively, McKenzie advised examining how the government and the elected officials function. First, health policy advocates must understand that policymakers need to deliver positive changes for their 'constituency.' Second, advocates should generate a 'bureaucratic win' within one to two years. Third, advocates should create a 'narrative win' that can deliver more votes for the politicians. He explained:

> The important thing is that there are needs that you have to meet and create at, at least three levels. You have to produce for the people whom you serve. So, you have to have something that will actually make a difference to your constituency to keep your constituency on board. You have to create a bureaucratic win, which is usually something that can actually be done in a year or two that will actually, the process will work… But you also have to produce a narrative win so that the politicians can actually have a narrative that will get them extra votes. And if you can't, if you don't produce something that does all three of those things, then the most likely scenario is you will not be effective. And so, a lot of groups know how to make noise, but there's a difference between knowing how to make noise, knowing how to make change. They're not the same thing. Some of it is access. Some of it is understanding how the government works. But a whole bunch of it is a lot of really great people with a really great heart who are very, very passionate but really don't know how to get stuff done. And the more marginalized folks in more marginalized communities with less, less experience of government are the people who are seen more often having huge amounts of passion but not have been strategic, and sort of governments just play them off against each other.

McKenzie's insights are closely aligned with pluralism: the 'win-win situation' can be viewed as a theory of negotiation based on unhindered participation, cooperation, and compromise to create healthy public policy and public health policy satisfying the needs and wants of many competing interest groups. However, reaching a common ground among labour, civil society, social movements, businesses and corporations, governing authorities and political parties, and other contending forces inside and outside the state might not be realistic. For instance, labour leader Anonymous N11 explained that some governing authorities stifled the democratic consultation processes:

> It's interesting because the government is there, elected by the people, but yet certain governments take the position that they don't really need to listen to the people. So, it's an interest in dynamics that gets created when certain governments take office. For instance, we used to have two years ago before this government took over, like real consultations when any policy was being contemplated or any change to a regulation or legislation was being contemplated. I remember there was a tour. There was an opportunity for the general public to go into these meetings and meet with their elected officials and hear the proposals. Well, what we've seen in the last couple of years is we haven't seen that at all. We've heard backdoor dealings with corporations and multinational organizations who've been a part of the decision making, who been at the table, getting their voice through in the legislation. But the frontline worker, the average member of society's voice, isn't reflected there… I think the system and the way it's set up where there are no mandatory consultations needed for certain parts of implementing legislation, the regulation, I think that needs to be checked. Or else like what are we doing? I mean, it's like, this is a democracy, you don't get a democracy.

Anonymous N11 elaborated that despite claims that Canada is a democratic country, the concerns of the majority of the people are rarely heard. Thus, there is a need for them to unite:

> You don't get a democracy. People should have a voice, and people should be able to voice their concerns. And so, that's what I think is important because I think that's where it starts from. I think the government sets the tone, and if it's a tone of inclusion where we want to hear your voice, we want to hear what your concerns are, and we'll take it into consideration, I think that's where it starts from. So, I think how things get shaped and created starts from there and then everything sort of filters down. But if the government is taking the position of like we're not interested in hearing from the people, then I think it creates an atmosphere of division. But I think there's also an opportunity for people to come together at that moment.

Anti-poverty activist Clarke firmly stated that the so-called democratic consultation processes in Canadian public policy institutions are bogus. Instead, the governing authorities merely serve the interests of the wealthy and capitalist class, as Clarke explained:

> That's a very interesting, very intriguing question because of the myth that governments put forward. And Liberals are generally better at doing this than Tories, although the Tories played the same game, just not quite as well. But they try to suggest that governments are sort of wise King Solomons who listen to everybody's point of view and then take this, why, is the decision in the best interest of most people. I've never found that to be the case. The notion that all stakeholders come to the table equally, equally respected and listened to by the government is, I think, a myth. The sham of consultation is a shame. Fundamentally, I can't

say that I've seen any Ontario government or any government I've ever experienced anywhere in both countries that I've lived in. I've never seen any government operate, anything other than essentially an executive committee for rich people. And so, yes, I think, you know, the Chamber of Commerce and the representatives of big business come to the table, and formally, they're just given a hearing just like anybody else. But in reality, in a thousand ways, they're the ones who are accommodated.

Anonymous N11 and Clarke's insights reflected the theory of neo-pluralism. Furthermore, Carroll explained that the corporate sector bankrolls both the Liberal Party and Conservative Party and that these governing authorities merely manage social and health inequities than substantially reduce them:

We have two dominant parties, and they're both very corporate. They're both supported by large corporations, and they both have that perspective that primarily policy needs to be shaped and implemented in the interests of corporate power so that the jobs will stay in Canada. It's a very simple kind of narrative, and you hear it over and over again. It's all about jobs, jobs, but it's really about continuing the power of corporations who control the purse strings on those jobs. So, I think, basically at the federal level, what we have is this kind of revolving door between the Liberals and the Tories, and one comes into power. The Harper government was especially bad, but the Trudeau government isn't much different. I mean, the differences are small… There's no, in terms of really addressing issues of class, gender and race inequality and how they really manifest themselves in people's lives. I don't think either of those parties has very strong commitments to change. No. They're mainly

interested in managing the situation, managing dissent and trying to secure enough consent that there isn't any political crisis. And so, you can have business as usual; that's their primary goal politically. I think the NDP is a little bit different. Of course, if we get to the provincial level, we have in Québec, Québec Solidaire, which is more of a left-wing party with a real social justice agenda. NDP has a bit of that too… [T]hey're still distinctive compared to Liberals and the Tories, but I think that what they're representing now is a relatively weak form of social democracy (Carroll: Academic).

Carroll's emphasis on the dominance of corporate power in healthy public policymaking processes falls more within neo-pluralism and corporatism. His earlier insights that social and health inequities are caused fundamentally by unequal class relations and advanced capitalism fall within the political economy approach to health inequities. Block corroborated Carroll's insights. She explained that some progressive policies are 'policies of last choice' for governing authorities' political survival. These public policies are also subject to reversals:

The most recent experience that our organization has been involved in is the Labour Law Reforms around Bill 148. I think some of the reasons for these failures have to do with the power of capital. And…governments tend to implement these policies very late in a term when they think they're going to lose power… These are policies of last choice and desperation for governments who want to be re-elected. An example of that was Bill 148, the Amendments to the Employment Standards Act and the Labour Relations Act… And because this policy came just before an election year, there were many reversals…a very sizable increase in the minimum wage from, I believe, $12 and change to $14. However, we

didn't have the next step to $15, which was supposed to occur. And many of their changes including paid sick days, which were for emergency leave days, which of course, the lack of that is having terrible impacts. Reversal was there as well. So, I think the power of vested interests has a big impact (Block: Researcher-Advocate).

Jonah Gindin, healthcare industry labour relations and collective bargaining specialist, explained that the governing authorities favour private over public interests, as evidenced by the inclusion of former Premier Mike Harris in the COVID-19 special task force:

My first response to that question is to laugh. But it's a bitter laugh because absolutely not. There are special interest groups that are lobbying groups, very, very, very well connected. So, just to give you an example, in dealing with the COVID-19 epidemic right now, the government has a special task force that they've struck. One of the people on the task force, advising the government, is Mike Harris: the former Premier of Ontario, who personally is probably primarily responsible for all of the devastation that has arisen specifically in the SARS crisis. Specifically, in COVID-19, because it was the Harris government that first really took the Act to Healthcare and created the situation that Ontario finds itself in now, where we're chronically understaffed, chronically not enough beds, even before a pandemic hits (Gindin: Researcher-Activist-Advocate).

Anonymous N11, a labour leader, shared their experience advocating for progressive public policy changes in the healthcare system in three areas: wage, training, and a central

registry for home care workers. The informant recalled the successes and failures of their labour actions to move public policy to their advantage:

> We had proposed to the government to do three things that we thought were going to be the things that would move the state of home care from a very, very low standard to a moderate standard and provide a decent career for folks to work in. This was maybe 2008… We have to increase the wages of this industry. Back then, the minimum wage for a home care worker was $12.50. You can imagine living in a large city at $12.50 is not going to get you far… The second thing we had asked for was the training. It's pretty easy to see that traditional institutional care is shifted more into the community. More people wanting to get care at home. This shift that is gradually increasing year over year, you have to have enough support. As they're discharged from the hospitals, and they go home, and they need care... And then the third thing that we had proposed was a central registry for these workers to exist. That way, if you were seeking a support worker at home, you can go on this registry and choose and select. So, you have an opportunity to participate in the selection of the caregiver that comes to your house. That way, you provide yourself with a continuity of care. So those were the three things that we proposed. The only thing that we were able to move the government on was wages. We moved them from $12.50 an hour to $16.50 over three years. The other two items in our policy didn't get implemented. What you have now is you have the wages that have increased, but the training hasn't changed… We're still continuing to push for those things, but I think it's an example of the government looked at what is the easiest to do that could give us a political win at the time. And they did that. They introduced

the change in wages in 2014. And that was it. There hasn't been any recent talk of those other two policies (Anonymous N11: Activist-Advocate).

Hancock explained that redistributive public policies tend to be carried out more by the socialist party or left-wing party, although limited in a capitalist system:

It's sometimes a matter of what governments don't do. But if we're talking about what they do, it does to some extent depend upon the sort of political complexion of the government. So, you're more likely to get progressive policies, obviously with a socialist or NDP or social democratic or labour or other sorts of a left-wing party. But… unless they're truly revolutionary, they're somewhat constrained by still operating within a capitalist economic system. For example, we have seen an increase in the minimum wage here in BC because we have an NDP government. So you're going to get things like that. But I'm not sure that we are, for example, taxing the wealthy and even very much more than we ever did.

Hancock explained the governing authorities' taxation policies that decreased the share of taxes for the wealthy and corporate class, coinciding with the rise of neoliberalism. He also spoke about tax loopholes where corporations hoard their accumulated wealth in offshore tax havens:

I'm not an expert on taxation policy... But if you look at what has happened to taxation generally over the last 30, 40, 50 years, that since the 70s, taxes on the wealthy had been reduced, taxes on corporations have been reduced. And so, they're not paying their fair share. Well, a classic example would be there are all kinds of tax evasion going on in high-income

earners in this country. And they moved their wealth offshore, and they avoid taxes in all sorts of ways, and they have clever accountants who can help them do that. But I've never seen any serious attempt by now. Of course, we've never had an NDP government nationally, but I've never seen any attempt by the Liberals or Conservatives to seriously close those tax loopholes and make sure the rich pay their fair share (Hancock: Academic-Advocate).

Albo corroborated Hancock's insight about the limitation of public policy to reduce health inequities within the domain of capitalism. Specifically, Albo pointed to governing authorities promoting neoliberalism that permits accumulation of capital on the one hand and undermining of labour unions and slashing of social supports on the other hand:

The policy regime of neoliberalism is designed to force flexibilization and allow the concentration of capital… And flexibilization was a code word for lowering the bottom end of the labour market, the welfare support, the housing supports, and so on and weakening union power so you'd have more dispersion in wage outcomes and more flexibility in the labour market. So, its foundation was to generate inequalities at both ends. This was the policy in capitalist governments of both the parties of the right and parties of the center. So, it encompassed the Conservative parties. It encompassed the Liberal parties. And steadily, it coverages the parties of the centre-left, the social democratic parties. The Social Democratic parties moved away from a redistributional Keynesian politics of defending and building the welfare state and adopted a variation of the same agenda around flexibilization and growing any capital concentration, just posed in a slightly different way, but accepting the same agenda.

Albo further explained that the 'capitalist state and capitalist power' primarily maintain social and health inequities. The governing authorities that adhere to capitalism marginalize other competing interests groups advocating for public policies that attempt to veer away from capitalist production and property ownership modes. Democracy is very limited under capitalism:

> I think this is really a question about understanding the capitalist state and capitalist power. The possibilities of influencing the state are limited under capitalism because a capitalist state is structured to limit democracy through a representative form, meaning, elected officials of a most minimal kind deliberate about the tactics over the reproduction of the existing society. And that existing society includes the forms of production, the forms of ownership, the forms of private property, and so forth. Everything that would challenge those structures is kind of put to the side or marginalized.

Albo elaborated that the 'capitalist political systems' are fundamentally structured to back the parties of the capitalist classes than the working classes and middle classes. As a result, the capitalist state itself sustains class-based and other forms of inequalities that adversely impact peoples' lives:

> So, the political system from the beginning establishes a series of blockages to provide non-capitalist solutions to any social problem. There are also then the blockages that go along with inequalities. The capitalist political systems divide into parties of the business classes, the property classes, parties of the middle classes and parties of the working classes. And

they're contesting over at different policies and maybe even over capitalism itself. But the system is structured particularly to support the parties of the capitalist class. That is the systems of representation, the amount of money in politics, the access to media, and so on. So there's a structural inequality established in the system of political representation and the systems of political mobilization. So, the terrain of the state is in itself is structured to be a terrain that reproduces that class relationship and, therefore, the inequalities of that society and so forth.

Wrapping up. When queried why some public policy proposals from academics, advocates, and activists attempting to reduce social and health inequities are enacted and implemented by the ruling governments while others are not, Panitch counterposed a question: Why is "the expansion of the commodification of healthcare" is not being implemented as probably perhaps being pushed by business schools:

I don't know that I can speak to that in relation very much to the health field. It differs in different areas. I know this will sound reactionary, but I'm not so sure that progressive public policy advocacy in the health field in Canada is not implemented…. I'm questioning the premise. I'd be more interested in actually asking the question, why is it that people in the business schools who probably are making a case for the expansion of the commodification of healthcare, why that isn't implemented, given my premise that this is, after all, a capitalist state and it's a capitalist state?

Panitch stated: "What does it mean to be a capitalist state?" He explained that the capitalist state and its legitimacy fundamentally rely on the accumulation of capital for taxes and

revenues necessary for healthy public policy and public health policy. Because the state believes in a capitalist system, it filters health policy proposals whether they decelerate or accelerate capital accumulation:

> It doesn't mean that the ruling class that lives in Rosedale or Thornhill phones up Prime Minister Trudeau and tells him what to do every day. The ruling class doesn't know how to govern. The bourgeoisie is a divided, competing class. Individual industries and corporations and capitalists and their representatives in the business schools make proposals. But the reason the state is a capitalist state, even if a socialist government is elected, for the most part, is that it's dependent on capital accumulation for its own revenues, for its own tax base. So, it, therefore, needs to facilitate the making of commodities and profits and exports in Canada and its legitimacy. The legitimacy of any elected government is dependent on there being economic growth and jobs, et cetera. Those are the fundamental reasons why governments reproduce capitalist social relations. Now, it's true, a Liberal government, which is dependent on Bay Street money, as part of their financing, and that has an ideology, which even if it's a progressive ideology, believes that capitalism is the best of all possible will be oriented to looking at public policy in terms of whether the proposals that are being made will undermine or facilitate capital accumulation.

Panitch provided an example of a reformist public policy change on *employment:*

> During the Great Depression, when Unemployment Insurance was introduced in Canada, and that was one of the great reforms in Canada in 1940, that people who had been working would be able to, if they lost their job, have a certain stipend for a certain period of time. But

that program was structured in such a way as not to destroy the capitalist labour market. That is, you have worked for a certain time in order to be eligible for unemployment benefits. You have to be showing that you were looking for a job while you're on unemployment benefits. The benefits only lasted so long in relation to how long you have been working. Proposals that were made by the Communist Party in the 1930s that you should have the equivalent of a guaranteed annual income were rejected, including by the insurance industry, because this would undermine a capitalist labour market. Why would people go to work?

Panitch further explained how social forces and competing interest groups shape public policy changes in the *healthcare system*:

You could see with the introduction of Medicare in Canada that you could have social forces in play. It was introduced at the time of the minority Liberal government, which was trying to get support from the NDP but also trying to counter trade union militancy by giving a social wage… Most trade unions don't like to admit this, but of course, it's true. If you make too many demands upon your boss, he's not going to be able to stay in business. So, by taking up the costs of healthcare onto the public domain, it removes some of the pressure for workers to be demanding higher wages… At the time that universal healthcare was introduced by the CCF government in Saskatchewan… left-wing civil servants, some of them Marxists… proposed that it should include dental care and Pharmacare. And they were told by the person who is known as the father of Canadian healthcare, Tommy Douglas, that that was too expensive. And was it not, this is a calculation of a government needs to make? But what he was looking at was what would be the tax base at that point of Saskatchewan. Being

introduced in Canada generally, what would be the tax base for being able to pay for dental care and Pharmacare? And this is something the capitalist government always needs to take account of. So that's a very roundabout way of answering your question (Panitch: Academic).

Panitch's views reflected the inherent interconnections between pluralism, discursive institutionalism and critical political economy. McKenzie further explained three kinds of public policy changes. Maintaining or reducing health inequities might occur via the existing policies, new policies, and forced policies:

There is the government that has a policy that's working, and you produce nudges or changes to try and improve that policy or decrease the negative impacts of that policy... Another group is a government wanting to create a new policy. And it's a different sort of set of skills to get them to create a new policy that promotes equity, where they're interested. And then a third lot of policy is a policy that is foisted upon them. Not that they necessarily want to do it. But you get an extraordinary situation like COVID-19, or you can get a change in the sensibilities of a society, or you get incredibly effective movement like Black Lives Matter or like the Idle No More. Or you get the groups like that, that means the government has to act, even though they don't really want to. The challenges for public policy are different for each of those. Obviously, it's easier to move forward government policy that's already there and improve it.... When they really have no idea what they want to do, and it's been foisted on them from outside, and if you're quick, you can really make change quickly. One of the problems we had with COVID-19 is almost nobody thought equity. Everybody was just

thinking about medicine. Nobody thought of social change. And because of that, we've got a pandemic response, which is going to make inequities greater.

McKenzie's above insights reflected the critical political economy approach, which examines the role of social movements to influence public policy. Specifically, McKenzie explained that the initial COVID-19 response around budget allocation showed that the Ontario government prioritized the business sector rather than the health sector and the communities:

We miss the opportunity of moving forward equity through this crisis. And now, we're on the back foot trying to make things better than they were. So I think, back to the previous answer again, which is that some of the barriers that are sitting in place are that, and you could tell that just from this COVID-19 response. In our province of Ontario, there's a $17 billion package, initially. And $10 billion of that package went to industry. About half of the remaining went to health, and only $200,000 went to communities.

McKenzie then scrutinized the size of the government's various departments:

When you look at how the government is set up, the big ministries are industry, health, education. Social services are there, but the money isn't anywhere near as high as you think. And the actual way that the government is organized and what is considered the good jobs as opposed to the poor jobs, children's services, for instance, that's one of the smallest ministries. When you look at those different ministries, you very quickly see the Ministry of the Attorney General, big ministry. Health, big ministry. Education, big ministry.

> Communities, there's not even a Minister of Equity. So people forget that ministries are made up of people and the politicians and their staff who are trying to move up their internal sort of hierarchy. And then there are bureaucrats who are trying to move up their particular hierarchy. If you cannot see the importance of a particular issue is hardwired in the actual shape of a government, if you want to know what the major problem is, sort of equities, social conditions, and the social determinants of health, it's no one's job. And if it's no one person's job, then it's not important in government.

McKenzie advised:

> So, people can talk about all sorts of things. But the basic is, from a policy perspective and a politics perspective, you have to have someone you go to who makes things happen. And on the provincial level, there is no one. At the federal level, Economic and Social Development is a fairly big ministry, is one of the biggest ministries. And so, if you really want something, a place to go that's going to try and equalize things; actually, it would do better at the federal level than you do at the provincial level because it's a big ministry. It's not as big a ministry as finance. But it's a big ministry (McKenzie: Academic-Activist-Advocate).

McKenzie's insights bring to mind the pluralist Kingdon's concept of problems, policies, and politics converging to open windows of opportunities for policy entrepreneurs to push their most preferred health policy proposals for the governing authorities to consider (Kingdon, 1984/2014). It also helps recall the political economist organizing and mobilizing strategies to pressure the governing authorities to reduce health inequalities (Raphael, 2014, 2015). As

discussed earlier, discursive institutionalism, pluralism, and political economy are distinct but interrelated public policy theories.

The results demonstrate that contrary to the claim of classical pluralists that the state is a neutral arbiter of societal and public health affairs (Bryant, 2016; Dahl, 1961, 1984; Howlett et al., 2009), it is not. Although the Canadian governing authorities act autonomously, their public policy decisions often support the interests of powerful groups, especially big businesses and corporations. In contrast, they relegated to the margins the interests of the working class and other advocacy groups trying to improve their working, living, and health conditions through public policy. One reason is that the latter groups are fragmented and weak and thus less powerful than the business and corporate sector, as further demonstrated below.

4.2.5 Fragmented and weak labour, civil society, and social movements. In Canada, the divisions among labour unions, civil society groups, and social movements weaken them. As a result, they failed to overcome the dominance of the big capitalists and neoliberal governing authorities, furthering social and health inequities. For this eighth main theme, I first present the results, then illustrative quotations wrapping up with the insights from Albo and Stewart, and a summary.

Based on the interview data corpus, 23/23 informants -- explicitly or implicitly -- recognized that the fragmented and weak labour, civil society, and social movements contribute to the persistence of social and health inequities in Canada. The collective insights reflected more on the critical political economy and neo-pluralist and less on the discursive institutionalist approach to health inequities and policy change.

For example, Bryant, a public scholar specializing in the health field, observed the weakening of the *labour movements*, which the informant explained partly due to capitalist co-optation, if not total corporate capture of some labour unions:

> I think the power of the labour movement has diminished over time…partly because some of them seem to have been co-opted by their employers. Some unions have engaged in concessionary bargaining, thinking that aligning itself more closely with a corporate employer will save jobs and protect their workers, but it doesn't. We saw that happen in Oshawa with the GM plant. First, we had the CAW, which was much more radical under Bob White's leadership. Over time, it became more conciliatory towards the employer in the collective bargaining process and didn't make the changes, like, Buzz Hargrove negotiated away the right to strike at Magna in 2007. The right to strike is one of the few strategies working people have to influence their working conditions, and that was taken away from them. Then the CAW merged with the Communications, Energy and Paperworkers Union to form Unifor. Unifor seems less willing to challenge employers as the CAW had, especially under Bob White's leadership. As a result, they didn't seem to see that the long-term aim of GM was probably to shut down the GM plant in Oshawa.

Like Bryant, Crowe, a housing justice activist, did not just connect the failures of public policy and persistence of social and health inequities to the dominance of neoliberal capitalist forces inside and outside the Canadian state but also the absence of strong *labour unions* leading peoples' movements to struggle against neoliberal policies. She explained:

> In '95 or '96, the Conservative Premier Mike Harris, his government cancelled the provincial housing program and, along with that, welfare cuts… And that had just absolutely devastating impacts. And they did it because they could because there was not a groundswell of organized resistance. And now, there is even less than then because there were protests during the Mike Harris years. There were some. There was something called Days of Action that was labour organized. There was a large protest unlike today, where the stresses of the economy, the recession in 2008, the impact of trade agreements have meant closures of plants. If you look at the GM situation in Oshawa, there's a famous plant that I'm blanking on right now, but earlier, another plant closed and moved to Mexico.[39] That leads to a weakened labour movement. It leads to more unemployment. It leads to more homelessness. Recently, I looked at all the websites of all the national labour unions to see who was even talking about housing, like housing for workers because it used to be that they cared. And it was a political agenda issue for them. And I couldn't find anything (Crowe: Activist).

Jonah Gindin, labour researcher-activist-advocate, stated that *trade unions* remain the strongest defenders of working class interests. However, most trade unions are not decisive in tackling issues beyond workplace issues, despite their adverse impacts on the living and health conditions of the working class. He explained:

> [W]e certainly have numbers on our side, but we need more unity. We need, you know, trade unions are probably the best example of an institution that exists for the purpose of defending working-class interests. But, many trade unions are very uncomfortable advocating for issues

[39] Addendum: 'The plant that moved to Mexico was Inglis.' – Crowe

that may be extremely relevant to their members but that aren't workplace issues. Housing, for example. It's a critical issue for the many in Canadian society, and yet few unions are actively campaigning seriously on housing. Many, many, many other examples of social issues that affect union members and non-union members that are ultimately in the interest of the working class. And trade unions are hesitant to engage on those issues and typically focus on their engagement on bread and butter kind of workplace issues, which are also extremely important obviously but tend to, first of all, only impact those direct members of the union. And secondly, there's only so much that could be controlled in the workplace. And there's other factors that obviously affect peoples' living and working conditions.

Gindin observed that the labour unions maintain a defensive instead of a strategic offensive stance. The lack of coordination among various labour unions is also evident. Moreover, labour unions failed to see the interconnectedness of various social issues as issues of wealth and power redistribution and increasing provisions of public goods and services. As a result, labour unions failed to consolidate the power necessary to address social and health inequities:

And unfortunately, I think, generally, for those of us who are trying to expand public service and expand equality in our society, we are on the defensive and putting kind of in a crisis mode rather than a strategic, long-term offensive mode. And as a result, there's a lack of coordination and a lack of consolidation. So, you can have different unions, for example, who have completely separate campaigns that are on ultimately, in some cases, they're identical issues. I mean, there're probably every union that has healthcare workers had some

kind of campaign around combating the for-profit, you know, profit-taking in long-term care, for example. And yet, there's little to no coordination between them on those campaigns. That's the problem. But even more than that, campaigns that are around police brutality and systemic racism in the police force, campaigns that are around access to housing, campaigns that are around labour rights, campaigns that are around public healthcare are treated as completely separate sort of issues that have no particular connection. And yet, at the same time, they're about redistribution of wealth, redistribution of power, and expansion of public services and rights to people.

Hurley, also a labour activist, attested to the weakened power of the working class:

[T]he working-class, generally speaking, worldwide, has been in a period of retreat for the last, maybe, I don't know, 40 or 50 years. It's a real challenge for us. We're not very strong. De-industrialization has weakened, for example, the working-class in Ontario and the United States. People are more vulnerable. They can't get unionized jobs. There are falling labour standards. So, I'm a big believer in organizing people to campaign, to fight for themselves.

McKenzie also observed the *fragmented labour, civil society, and social movements*, each bringing each particular siloed issue. These siloed pressure groups with less power are ineffective in achieving the social change required to reduce health inequities. He explained:

One of the problems in society, in general, is that people are siloed. And if you can silo different interest groups, you can essentially make them ineffective because none of them

have a big enough constituency to bring down governments. When the unions were strong, and when I was in the UK, they could bring down the government. But at the moment, we have loads of siloed, smaller pressure groups who are not really articulating. You've got people who are interested in housing. People are interested in health. People are interested in race and racism. People are interested in gender. People are interested in trans issues. People are interested in city issues. So, it goes on. The more people focus on smaller siloed issues, the less effective they are overall.

McKenzie pointed to the absence of 'a real rainbow coalition' among those siloed competing interests and advocacy groups as the missing piece toward transformative healthy public policy change:

And the lack of a real rainbow coalition that tries to say something really simple, like you realize that 95% to this are trying to move out surviving towards thriving. And there are 5% who are doing incredibly well, but that 95% did not work effectively. If they did work effectively and if peoples' rights were, you know, if there were a rainbow coalition of these groups that realize that you can actually rise all boats on the tide, you would do better. But as we've got these little pressure groups and they all get happy with getting crumbs from the table. And then they all forget it's actually their table. This is perhaps one problem. So, we need a rainbow coalition (McKenzie: Academic-Activist-Advocate).

Hancock observed the *fragmented social movements and absence of health movement*:

> I think part of the problem is that public health has become a health profession, and it's not got roots any longer in, I'm not sure it ever did, but it doesn't have roots in, or it's not allied explicitly with social reform movements or democratic reform movements and all of that. So I think it's telling, for example, that there is a labour movement. There is a women's movement. There is a peace movement. There is, I think you could say, a social justice movement. There is no health movement. I don't know of a health movement. You know, to the extent there is a health movement… It has been about what loosely we could call holistic medicine, holistic health, you know, lifestyle and personal behaviour and alternative therapies and diets and all of that stuff. But it hasn't been about social conditions. So we, we have failed. Health promotion never did become a health movement, a popular health movement.

Hancock explained that it is rather the *environmental advocacy groups* leading the work for public health. He also called for a broader alliance among diverse social movements.

> I think we need to think about that as how do we tie our roots? For example, I work with environmental groups, have done for years, and I've always said that the environmental movement has done public health's job for the last 30 or 40 years when it comes to environment and health, that they have been the leaders. Public health has not been the leader. Public health is only just catching up in terms of climate change and things like that. So, we have not linked up to the allies we should have and the environmental movement, the peace movement, the labour movement (Hancock: Academic-Advocate).

Sam Gindin, a political activist, advised that to understand and tackle the barriers to improving Canadians' working, living, and health conditions, one needs to "look at these things historically as one thing." He first explained that *class fragmentation* is a factor in public policy failures and maintenance of social and health inequities:

> In the 50s and 60s, at a time of growth, unionized workers were able to win good programs for themselves: pensions, health care insurance, Pharmacare, dental care. But they won it for themselves. It wasn't a universal program. The problem with that is that as circumstances changed, the workers who won things were attacked. And they became isolated; they had it, other people didn't. So, one of the barriers is even amongst workers themselves; when they fought for this, they often fought for themselves in collective bargaining. And that meant they weren't building the class and winning it for everybody. And when you don't win it for everybody, it's always dangerous… It's always divided. So, there's a problem amongst workers themselves for not having a class perspective. That's one problem.

Gindin reiterated that corporate power and capitalism itself and the failure of the workers to defend themselves as a class are the main barriers to reducing social and health inequities:

> The bigger problem is that these are political questions. If you've got an unequal society, you're going to have inequalities in politics. Corporations can threaten to leave if they don't get tax cuts. Then you don't have money for social programs. So, power is always the question. It's always the fundamental question: what's happening with power? And then part of the barrier is our own inability to try to defend ourselves as working people rather than

> thinking about it as a class. But it's still a question of even if you're strong, if you're operating under capitalism, there will always be limits about it because capitalism, it's not there to improve your health. It's there to make profits. So, you're always fighting the logic of the system, which means that you're always defensive even when you're making some gains.

Gindin explained that *peoples' low morale* also contributes to persistent social and health inequities. It is necessary to change oneself and the society at the same time:

> Other barriers are peoples' expectations. In some cases, people, they get defeated, they lower their expectations. Why aren't people angry? Why aren't they in the street? Why aren't they saying, how can a rich person's son have good health and good circumstances and I don't? It's because people get socialized into accepting their place and are demoralized about the possibility of change. So, you end up with, the problem is us, in a way, too. We have to change ourselves if we're going to change society… So, it's the whole structure of society. It's the first big problem. And then within it, they're a lot of smaller problems that you can try to deal with.

Wrapping up. Albo, an academic-activist-advocate, emphasized that in the present historical conjuncture where the governing authorities relentlessly promote neoliberalism, the best scenario is progressive healthy public policy and public health policy changes in the peripheries. A core requirement to significantly address social and health inequities: *structural change in power distribution* among class forces. In part, Albo's insights assert my assumption concerning power distribution among classes and groups shaping society's economic and

political systems and vice versa. Thus, any public policy action to reduce social and health inequities in general and class-based, gendered, and racialized health inequities, in particular, necessitates addressing class and identity-based power relations. He explained:

> I don't think that's possible in the existing policy regime, the neoliberal policy regime. All we can do is change things at the margins. We can kind of change things right now at the level of provisioning that exists under neoliberalism. So, we'll come out of this and want to provide more money into the healthcare system. But it's not going to really change the overall structure of the healthcare system. And it might come at the expense of social housing. It might come at the expense of climate change policies. It might come at the expense of unequal taxation burdens and dealing with the debt that comes forward. So, I don't think there's any kind of incremental way out of this problem. It really depends upon a fundamental change in the balance of class forces and the balance of power in our society.

Albo's insights run against the pluralist's incremental policy change approach to address social and health inequities. Instead, reflecting more on the critical political economy approach to health and policy change, he elaborated that the *capacity for a collective mobilization* that can alter 'the neoliberal policy regime' is largely absent. One reason is the lack of deep division within the capitalists and ruling classes.

> And at the moment, that capacity is not present. We don't have the level of collective mobilization that's able to overturn this regime. There are no major divisions within the capitalist classes over public policy. There are some tactical differences over how to handle

something like the COVID-19 crisis and how quickly to get out, and what should be the different ways that the debt that's being incurred now should be paid off. But these are tactical differences, not kind of differences over the main strategy. And how are we going to move on? This is dependent on being able to break out of that balance of class forces. And we don't have the strength at the moment to shift that balance of class forces.

Albo explained the *fragmented and weak power of the working class* contributing to public policy failures and persistent social and health inequities in Canada:

And our difficulty is, for me, we don't have any of the, well, maybe go back to the three levels I spoke before. At the level of the workplaces, unions aren't, and workers aren't collectively organizing enough to overturn the trend towards de-unionization over this period of neoliberalism. So, at the workplaces, workers are still relatively weaker. You see some fightbacks. Whether that can cumulate enough to shift the overall level of organization in workplaces is still a big open question.

Albo then explained the *differentiated organizing efforts at the community levels* by the working class and low-, middle-, and upper-class income groups, each stratification yielding differentiated results as measured by the degree of distribution of societal resources.

I think at the level of community, there's a lot of variation, and there's a lot of organizing going on. So middle-income neighbourhoods and middle-income people like myself, the

higher-income, you know, in those neighbourhoods there's a lot of capacity to defend your interest. You understand what developments can go on in your area to defend what the street corner will look like and all that kind of stuff. To defend that, you will have a community health clinic that's running in good and that you'll have a record. People like me are doing okay in that sense. And the rich are even doing better.

Albo stressed that the necessary 'working-class solidarity' to expand the provisioning of public goods and services at the community level is largely missing:

But what we're having in the working-class and low-income neighbourhoods is difficulty protecting what's there and then especially not having a great deal of the success of expanding it. So, you have a lot of organizing that's just people taking care of themselves struggling to fight back a bit but not able to kind of develop in a way that's able to push back and transform the amount of resources that are coming into those neighbourhoods. And part of the difficulty is that's a class project that has to extend beyond those in the marginalized groups into the core workers taking on that as their own agenda too: the redistribution of resources from the strongest workers to the weakest workers. And we only have that kind of political project at the level of community. We have at the level of community to fight back in their particular isolated ways by that income stratification itself. But not to develop a, you know, within the working class solidarity enough within the working class itself over community provisioning.

Albo further explained the *weak power of left-wing political parties* as a contributing factor: the lack of political parties advancing the standards of social democracy, socialism, or communism toward an 'alternative society' where redistributive public policies to reduce social and health inequities are more plausible than within the neoliberal capitalist system:

> And at the local level, at the level of parties, we're dealing with this really difficult historical period and the history of capitalism and the history of the left where we don't have ascended political parties carrying the banners of an alternative society. And an alternative society going into the names of socialism or communism and not even one that carries the banner of historical, social democracy. And that is, we're going to tax the rich enough so that we have free public provisioning of healthcare, free public provisioning of transport, free public education and so forth. And we're going to make those better every year, and we're going to do it in a way that's reducing income inequality. We don't even have that anymore.

Albo observed efforts to resist and fight 'neoliberal policy regimes' at the workplace, community, and state levels but the degree of collective mobilization necessary to achieve fundamental social change is hardly powerful enough to overcome neoliberal capitalism's dominance.

> Without that level of political aspiration and collective mobilization, I think we don't have the ability to do effectively that solidarity within the working class, so community becomes not just the community in the narrower sense of protecting your own neighbourhood, but making sure that all neighbourhoods in a community are protected and improving. And then

in workplaces, it's crucial, for not fighting at our workplaces, meaning there, visioning, it's hard to kind of collectively organize in other places. I think there's inklings of this fight back, but we're not making those measures of the political organization able to push back against that.

Finally, Albo spoke about right-wing authoritarian populist and self-styled feminist politicians and policymakers hindering serious efforts to reduce social and health inequities:

And in particular, I think this deals with the fact that we're dealing with more and more defensive and reactionary forms of responses to these inequalities. You know, the kind of politics forming, by the Duterte in the Philippines or by Orban or Trump or Trudeau in Canada being the liberal face of that same stuff. You scratch it. Maybe Trudeau has an inclusionary neoliberalism way. It will speak like a feminist, but the politics are essentially the same kind of inegalitarian politics. He thinks he's enough of an equalizer through feminism because he has X number of ministers at the table. But if you're not doing enough around precarious work and so on, you're not really dealing with the issues related to the most marginalized women and the equalities that gender has for those particular women.

Stewart, labour leader, stated that some policy proposals to reduce social and health inequities are not enacted and implemented by the governing authorities because *political representation does not mirror the marginalized communities*. She explained:

> Part of the problem, I think, is because there's not enough policy and decision-makers that reflect the community. So you take a look at MPPs: very few that aren't white… from higher-class... many of them have got high education criteria. So, that's the first step; that is what I think why we're not seeing more successes that people who live that and have the experience are not reflective of the policy and decision-making tables. What can we do about it? We continue to point that out. But then again, within SEIU, first of all, it starts at home. So, we are absolutely working on reflecting that. Basically, what we say, you know, walking our talk. So, we are doing our own internal restructuring to reflect more diversity, allowing more people of colour or marginalized communities to get the opportunity to receive education through our organization so that they can climb up into management, leadership positions, and decision-making positions. So, we're doing that in our own organization, as well as trying to groom and educate our members to be able to run for political positions, whether it be on city councils or provincial legislature or even federally (Stewart: Activist-Advocate).

The illustrative quotes demonstrate the failure of labour unions, civil society groups, and social movements to unite, organize, and mobilize a massive peoples' movement countering the dominance of the wealthy and capitalist classes, especially the corporate sector, in public policymaking processes, contributes to persistent health inequities. In my mind, this is one of the significant findings of this study that may help individuals, groups, and organizations rethink health inequalities research, policy, and practice, at least in the Canadian context.

Section Summary. The results demonstrate that the most significant barrier and reason for public policy failures to reduce social and health inequities is capitalism itself or neoliberal capitalism. Moreover, the key factors sustaining health inequities are: First, power, ideology, and interest trump evidence-based research and policy ideas. Second, the unequal wealth and power distribution among competing interest groups result in an unequal health policy advocacy field. Third, the big business and corporate sector's dominance in healthy public policy and public health policymaking processes hinder redistributive public policies that may curb their interests to maximize profit and capital accumulation. Fourth, the governing authorities that adhere to neoliberal capitalism shaping maldistributive public policies perpetuate health inequities. Lastly, the fragmented and weak labour unions, civil society groups, and social movements contribute to public policy failures, maintaining health inequities.

The above findings significantly differ from the claims elsewhere. For example, Mackenbach (2010, 2011) argued that the English Strategy failed to reduce health inequalities due to neglect of employment and income inequalities, limited scope, and non-implementation of evidence-based policies. The results also diverged from the claims of Smith (2007, 2013a,b; 2014) that health inequalities reduction failed because of 'institutionalized ideas or policy paradigms' that filter research-informed policy ideas. Instead, the findings are aligned with the claims that political ideologies hinder redistributive public policies to reduce health inequalities (Baum et al., 2013, 2020; Exworthy, 2002; Navarro et al., 2006). A discursive institutionalist approach to health and policy change may not be the best approach to reduce health inequities, especially class-based, gendered, and racialized health inequities, in particular.

The results also support the claims in Australia that the lack of 'political will' on the part of the governing authorities, the dominance of more powerful interest groups, and neoliberalism

contribute to sustained health inequities (see Baum et al., 2013, 2020). Neoliberal governing authorities and corporate power dominance also brought about the 'fading of redistributive politics' resulting in persistent social inequalities (Banting and Myles, 2013; Carroll & Sapinski, 2018) and health inequalities in Canada (Langille, 2016; Bryant & Raphael, 2020; Raphael, 2015). A pluralist approach to health and policy change may not be the best approach to reduce health inequities, especially class-based, gendered, and racialized health inequities. The critical political economy approach to health and policy change is the most applicable theory to explain the causes of and factors sustaining health inequities, neo-pluralism to a moderate degree, and classical pluralism and discursive institutionalism to a lesser degree, in the Canadian context.

4.3 Moving Forward to Reduce Health Inequities

The preceding findings from the literature review and interview data have addressed the research questions of why and how health inequalities exist and persist in Canada and other liberal welfare states. I have explored, analyzed, and discussed the causes of and the factors sustaining avoidable health inequalities. This section now presents the thematic analysis of the interview data addressing the research question, how to reduce health inequities classified into four main themes: 1) pushing for redistributive public policies; 2) uniting and strengthening labour, civil society, and social movements; 3) engaging in electoral politics; and 4) core strategies toward redistributive public policies, united and strong labour, civil society, and social movements, and alternative politics. Then I wrap up with the insights of Stewart and Albo and a section summary. Finally, I ended with McKenzie and the late Leo Panitch's insights as a postscript and a chapter summary. The collective insights reflected the interconnectedness of

pluralism, discursive institutionalism, and a critical political economy approach to reducing health inequities, especially class, gender, and race/ethnicity-based health inequities.

4.3.1 Pushing for redistributive public policies. As health inequities are partly caused by maldistributive public policies enacted and implemented by the governing authorities, they can be reduced by doing the opposite: pushing for redistributive public policies. The collective insights of the informants are pushing for at least 39 public policy recommendations to reduce social and health inequalities in Canada. On top of the proposals, 12/23 to 14/23 informants recommended redistributive public policies around taxation, employment and working conditions, social support, income support, and healthcare. In the middle, 6/23 to 11/23 informants, suggested addressing housing and homelessness, pharmacare, education, childcare, poverty, unionization, and climate. At the bottom, fewer than 5/23 informants proposed an electoral reform, disability benefits, public transit, food security, anti-discrimination, senior and retirement benefit, migration and refugee support, permanent status, participatory democracy, dental care, rent control, recreation, government coordination, de-commodification, nationalizing finance, Green New Deal, Just Transition, degrowth, healthy urban living, small business support, anti-scab, undocumented workers support, race-based data collection, de-stigmatization, clean water, internet access, and rehabilitation.

Since most of the above public policy recommendations have long ago been forwarded elsewhere and in Canada and due to space limitations, for this ninth main theme, I only present illustrative quotes focusing on the following sub-themes: 1) employment, 2) income, 3) housing, 4) healthcare, 5) taxation, 6) unionization, and 7) electoral reform, representing top, middle, and bottom policy proposals. Then I wrap up with the insights from Stewart and Sam Gindin. To emphasize: other policy proposals are embedded in the presentation and discussion of the

results. However, I believe all the informants' public policy suggestions can reduce health inequities, perhaps to varying degrees, especially in the Canadian context.

Since most informants discussed their general recommendations and specific public policy proposals to reduce social and health inequities in an integrated manner, I present an opening illustrative quote reflecting their interrelatedness. For example, Carroll suggested *eroding corporate power* and pushing for *economic democratization*. He explained:

> [T]he key thing is to, on the one hand, try to erode the power of corporate capital in Canadian society. On the other hand, while eroding the power, sort of regulating, checking the power. The state has some capacities to do that. In terms of stronger environmental regulations, for example, or health and safety regulations or stronger enforcement of labour regulations… [I]t's also a matter of trying to actually create alternatives like alternative economic structures, more cooperatives and credit unions, support for sort of social economy. Those are important ideas to sort of move away from the kind of corporate form of social organization and to democratize the economy.

Carroll then outlined his specific healthy public policy recommendations, including but not limited to guaranteed annual income, public transit, clean and sustainable environment, healthy city living, national Pharmacare, and progressive taxation:

> Perhaps, a guaranteed income is a good idea. In that, it's always the devil in the details. Like how big will the guaranteed income be? Like if it's substantial, that can really make a difference. If it's just a token thing, then it's not… But, those kinds of initiatives lead toward

a kind of de-commodification. And that's important because our world is so commodified… [W]e need to be shifting away from that toward a more of a commons, for example, public transit. Like a lot of what I'm studying is around the climate crisis and corporate power…and…cities are now talking to make public transit free. And to de-commodify public transit would be a really important move in improving peoples' quality of life and access to transportation for poor people. But also, in decarbonizing and reducing the carbon emissions… Similarly, the whole policy framework of more livable cities, cities that are designed so that people can live in them and not need automobiles to get around… I mean, there's so many aspects of the changes that need to happen to address the big issue that you're raising. For example, to develop a national Pharmacare program is a really good idea. But, there is that kind of challenge of the entrenched pharmaceutical industry and how you actually develop that program. But, it's become somewhat commonsensical. So, it's difficult to challenge, and people say, well, you can't raise taxes. But of course, if we can't raise taxes or at least make the tax system fairer, more progressive again, we don't have the resources to really create the changes that need to occur (Carroll: Academic).

The quote above brings to mind Wright's (2018) conceptions of the different anti-capitalist struggles in the 21st century, including eroding capitalism, discussed in the literature review. Working from a critical political economy and neo-pluralism approach to social and health inequities, Carroll stressed that redistributive public policies are hard to realize within a capitalist system. It requires pressuring the capitalist class and governing authorities to rebalance power distribution among social forces.

Improving employment and working conditions. The interview data revealed that 12/23 of interviewees recommended public policy changes in employment and working conditions, including but not limited to full-time employment, job security, increasing the minimum wage, providing a living wage, paid sick days, employment equity, and pay transparency to reduce social and health inequities. For example, Block, an economist working on the labour market and public finance, suggested:

> [A]lthough there is federal jurisdiction for labour standards, the vast majority of employment is in provincial jurisdiction; I think it's around raising the floor on labour standards. And that includes increasing wages, improving working conditions that include advance scheduling, eliminating the kind of differences between temporary workers and permanent workers in terms of both the employer liability and in terms of wages and benefits. So, a lot of things to reduce the incentive for employers to hire people in ways that push costs and risks onto the worker as opposed to having the employer have those costs and risks… [W]e need not only to build childcare centers but to pay child care workers a decent wage… [W]e need to see concrete improvements in labour market regulation… [W]e need to see less opportunities for corporations to evade taxes... I think something that I didn't really talk to you about are issues that directly address racism and sexism in the labour market. And I think those measures really look to two areas. One of which is if you have populations that are disproportionately represented in low-wage, precarious work, general policies, regulatory policies that raise the floor are helpful to them in particular because they are disproportionately in those occupations and industries… [T]he other piece that we really need to look at and talk about is employment equity policies (Block: Researcher-Advocate).

Block points to the co-constitutive character of capitalism, sexism, and racism seen from a critical political economy theory or intersections of class, gender, and race in the labour market seen from an intersectionality lens. Furthermore, Stewart, SEIU Healthcare President, proposed: a "full-time job that provides a decent living. Even the minimum wage at $14 is still a poverty wage." Moreover, Albo suggested: "particularly dealing with unemployment." Specifically, Anonymous N7 recommended policy changes improving the working and living conditions of the migrant workers and the precariat:

> I think for migrant workers, we need to have permanent residency. If they're working here for years, then we need to give them legal status. Otherwise, we need to tighten up the minimum labour standards like minimum wage, overtime hours, maximum hours… They should be expanded to cover contract workers, part-time workers, temporary workers because right now, like, for instance, the food couriers, they recently got recognized as a union or something like that. Previously, people who worked in that way were not covered by the Employment Standards Act because they were not seen as workers. They were seen as self-employed independent contractors. So, I think that sort of thing we have to do away with, because if you are a worker, then you should be covered by employment standards. And why should we have to spend years and years and years fighting just to establish the fact that they are workers, which is what the food couriers have to do. The food deliverers, just to prove that they are workers, had to go through the whole court system and so on. I don't think it should be that difficult for people to establish that they are working people, that they're not self-employed. Some things can be done legally, I think, in the legal realm (Anonymous N7: Academic).

The shared insights of 12/23 informants around employment policy changes help recall existing document data that amidst COVID-19 epidemic in Canada, 296,000 persons lost their jobs, and 247,000 persons lost half of their working hours from February 2020 to March 2021 (Statistics Canada, 2021). These workers face higher economic and health risks. For example, although Wilkinson (1989, 1992, 1997) ignored class relations (Muntaner & Lynch, 1999) and was silent about the role of neoliberalism in shaping health inequities (Borras, 2021), Wilkinson's studies have long ago demonstrated that unemployment and employment income are causative factors of relative poverty and mortality differences among social classes. It has also been established that the working class, especially the precariat and unemployed, face higher morbidity risks than other social classes (e.g. see Muntaner et al., 2009, 2010; Navarro, 1976a,b; 1986; Tompa et al., 2016). Improving employment and working conditions can reduce avoidable health inequalities.

Increasing income support. In general, 12/23 informants call for more income support. While some interviewees said public policy changes to increase 'income support,' others proposed 'income redistribution,' 'secure income,' 'guaranteed annual income,' and 'basic income.' For example, Anonymous N11 suggested 'basic income' to address the needs of the older adults facing poverty. A 'basic living income' may help senior Canadians access nutritious food, making them healthier and thus reducing hospitalizations. The informant explained:

> This is not an organization's perspective. This is my own personal perspective. But I think the basic income, the one piloted in Hamilton, makes sense for a number of reasons. There's too many Canadians, too many elderly Canadians that are suffering. I think we are treating the most vulnerable horribly. The fact that someone could work for a number of years,

throughout their working years and then move to retirement, whether it's because of inability to work, or just they're at that age and not have like a basic income. I mean, the CPP only extends so far. The GIS only extends so far. The OAS only extends so far. When you put all of those together, I mean, seniors are living in poverty, and there's something wrong about that morally. But also, principly. So, I think if the basic income were in place and they tried it, but obviously, this government has done away with it. I think we start to alleviate, one, the poverty amongst a group of vulnerable citizens; but two, a dependency on the health system is one example. Because one, if folks are able to take care of themselves better because they have a basic living income, they are now equipped to maybe buy healthier foods, maybe exercise a little bit more… When they're not equipped, or they're not able to do that financially, their health deteriorates. That leads them to the hospital (Anonymous N11: Activist-Advocate).

It is equally essential to report that not all informants recommended 'basic income.' For example, Albo stated: "I'm inclined, yes, to less to a universal basic income to universal basic servicing, service provisioning and expanding the range of de-commodified services that are provided to everybody."

The illustrative quotes bring to mind existing document data that, coinciding with the intensification of neoliberal capitalism, Toronto's income inequality soared by 31% from 1980 to 2005 (Butler, 2016). Worse, one year amid the pandemic, the Canadian billionaires' total wealth increased by $78 billion. As a result, the accumulated wealth of 47 Canadian billionaires now amounted to $270 billion (Hemingway, 2021), while millions of Canadians remain in

poverty. Income and wealth inequality determines IMR. As introduced, in Ontario, the IMR for the highest income quintile was 3.2, while the lowest income quintile was 4.7 from 2008 to 2011 (PHAC, 2018). One remembers the Manitoba Basic Income Experiment that reduced healthcare access and improved mental health (Forget, 2011). Increasing income support can reduce health inequities.

Providing public and social housing. In the middle of the public policy proposals, 11/23 informants -- explicitly or implicitly -- recommended public and social housing at the federal, provincial, territorial, and municipal levels. These housing programs should ensure adequacy, affordability, and suitability. Clarke and Crowe also suggested sufficient shelters to address the immediate needs of the homeless persons because they are dying on the streets. Crowe said:

> [T]he ultimate goal has to be a return to funding social programs, including the national housing and provincial housing programs and enhanced municipal. There has to be a direction to reduce the reliance on the charitable sector, such as the out-of-the-cold program… It's been a seasonal approach where the city is refusing to recognize that these are people that need shelter all year long because they're moving in the Housing First direction, which is about diverting funding from shelters. But we're decades away from having enough housing for people. We're going to need shelters for a very long time. So, securing adequate shelter and funding for shelters is critical. Berlin…created a rent freeze... We need…vacancy tax and more inclusionary zoning. But those are just still band-aids compared to having targets to build X number of thousand social housing units per year… Increasing social assistance rates and minimum wage rates as well so that people can actually afford their various social determinants of health, including food (Crowe: Activist).

Crowe emphasized that Housing First, which is embedded in the National Housing Strategy, cannot solve the housing insecurity and homelessness problems because:

> Housing First, by definition, is not about Housing First for women and children. It is not Housing First for seniors. It is not Housing First for Indigenous people. So, like it's a reverse bias, it's Housing First based on the pathology of mental illness or addiction. And there's nothing wrong in terms of equity with prioritizing individual illness for housing. But then why not cancer? Why not other conditions?... Like it's based on stigma, but it's also based on wanting to remove those people, remove them from the streets, remove them. Sure, put them in housing. That's good. But then how can we justify in a country that used to have a national program that was about housing and now we replace that with Housing First. So, it's very biased and very discriminatory. In my new book, one of the chapters is all on Housing First.

Hulchanski suggested addressing the causes of the inequitable distribution of social determinants of health that he discussed earlier. He explained:

> So, it goes back to where I began. I have it here; these four things I mentioned: the labour market, the housing market, income support, discrimination. Changes in those four things. And they're not going to change in a big way quickly. The reality is that small changes and all of them, made every year, some new small change and every one of them every year will add up. And you've got three levels of the government, you've got corporations, you've got social agencies, you've got institutions like universities (Hulchanski: Academic).

The illustrative quotes remind one of the pluralist Kingdon's policy change model and the incremental Housing First approach to homelessness and mental health (Macnaughton et al., 2013). Not surprisingly, despite numerous advocacy groups promoting Housing First, housing insecurity and homelessness remain widespread in Canada. As discussed in the literature review, compared to housing-secure, the housing-insecure persons suffer higher injury, stress, and cardiovascular-related deaths (WHO, 2018), and the de-housed have shorter lives (Hwang et al., 2019). In contrast, Canadian history shows that social and public housing can significantly reduce housing insecurity, homelessness, and adverse health outcomes (Borras, 2016). Specifically, affordable, adequate, and suitable public and social housing can reduce health inequities.

Expanding healthcare systems and services. Thirteen informants proposed protecting and strengthening Canada's universal healthcare system. For example, Jonah Gindin suggested moving away from for-profit nursing homes: "Expanding the universal healthcare to include Pharmacare, to include the long-term care, which is kind of outside of the actual provision of public healthcare to remove profit from the equation."

Anonymous N7 concentrated on more redistributive public policies around the Ontario Health Insurance Program to address the issues of the de-housed, undocumented workers, new immigrants, migrant workers, university students, and the young. The informant explained:

> Universal healthcare is good because everybody has coverage. But then some people don't have coverage. For instance, homeless people… it's more difficult for them to be covered because I think if I'm not mistaken, there are some specifications that you have to have a

residence. There are some disenfranchised populations because of poverty because of legal status, like undocumented workers, for instance; I don't think they are covered by OHIP… Also, new immigrants for the first three months, they're not covered by OHIP or by any kind of health insurance. [M]igrant workers, they're not covered by the first three months and… if they get seriously ill or develop cancer…then they're sent back to their country. That shouldn't be the case; they're working here. According to human rights legislation, everybody who is working in Canada should be covered. It doesn't matter what their status is. It's a social justice issue… So, I think universal healthcare…should be expanded more… The youth should be covered. University students should be covered below a certain age. I think those are good things, and of course, reducing poverty (Anonymous N7: Academic).

The illustrative quotes bring to mind existing literature that health and healthcare are human rights and social justice issues. For example, human rights defender Marcia Rioux stated: "Health, then, is not a condition that is set apart from issues of social justice, social values, or citizenship" (p.85). People's well-being is protected under international human rights instruments that guarantee legal protection, equal rights, and access to health and healthcare services (Rioux, 2019). Unfortunately, the Canadian governments failed to fulfill their obligations to safeguard the right to health, as evidenced by vast social and health inequities.

Closely related but analytically distinct from general healthcare is *Pharmacare and dental care*. Specifically, 9/23 informants recommended universal Pharmacare, while 3/23 suggested dental care. Panitch explained:

> I think in Canada, it's extremely important that Pharmacare and dental care, which are basic human needs, be de-commodified. And I think that public policy, the public health policy, health community should be devoting most of its efforts to ensuring that that's the case, especially because both the NDP and the Liberals have a big policy commitment to achieving universal Pharmacare in Canada now. So, I think pressure on them, both of a political kind but a public policy proposal kind is very, very important in this context. That's a very reformist demand, but one that could be won. It could be achieved (Panitch: Academic).

The shared insights of the informants help one remember that the goal of Canada's healthcare policy is "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" (GOC, 2021, Canada Health Act, Section 3). Unfortunately, however, the Indigenous, racialized, seniors, LGBTTQ+, persons with disabilities, and rural people continue to suffer from inequitable healthcare access, perpetuating health injustice (McGibbon, 2016). In addition, Canada's poor are at higher risk of financial hardships resulting from expensive over-the-counter and prescription drugs, eye and dental care services, and diagnostics and medical bills not covered by the Health Act. These conditions are exacerbated by the neoliberalization of the supposedly universal Canadian healthcare system. Expanding rather than limiting healthcare services can reduce health inequities.

Enhancing progressive taxation. Obviously, the proposed public policy changes require adequate funding. The top policy proposal, 14/23 informants, recommended more progressive taxation to finance public policies to improve Canadians' working, living, and health conditions and reduce health inequalities. Specifically, most interviewees -- explicitly or implicitly --

suggested increasing taxes for the wealthy and big corporations. For example, labour activist Hurley said: "I would start by dealing with the restoration of tax revenue to restoring our corporate and taxes on the wealthy to a level that allows us to sustain vibrant public services."

Armstrong, Principal Investigator of Re-imagining Long-Term Residential Care, stated:

> Are we going to get a Pharmacare plan? We'll probably get some tiny version of a Pharmacare plan. When I listened to the debates that came out when the Ford Government first announced all of its cuts to public health and to autism and to all of this other stuff, so many progressive people came on saying: 'Oh, I understand there have to be cuts.' Why, why do there have to be cuts? Like, why do you accept that as the premise to start with? No, there doesn't have to be cuts. We could raise taxes. That's the only way to go. So, how have we come to the point where so many, even progressive people say: 'well, of course, taxes are bad, and we can't raise taxes.' We do have to get in peoples' heads too in order to make those kinds of policy changes.

Armstrong emphasized what is required is a 'fundamental change' instead of 'incremental change' as exemplified by the implementation of the universal healthcare system:

> [Y]ou know, to go back to the old notion of revolutionary reforms, we need reforms that make fundamental change rather than simply incremental change. And those have to be ones that change peoples' ways of thinking, which is what universal healthcare did in Canada. It

> changed peoples' notions of the right to care…. We have to start at a very minimum taxing the major corporations and making them transparent, and demanding accountability from public policymakers, from governments. Ford, doing a secret contract for license plates is just a tiny example of saying we shouldn't be taxing developers' extra money for community organizations because otherwise, they won't build our houses (Armstrong: Academic-Activist-Advocate).[40]

Armstrong's insights support the findings in the literature review that the pluralist-informed incremental public policy changes are insufficient to address social and health inequities. In contrast, history shows that Canada's radical universal healthcare system is a political economy conflict-based approach to tackling health inequities.

Researcher-advocate Block further recommended closing tax loopholes and addressing corporate tax evasions. She also proposed tax increases in general. She explained:

> [W]e need to see less opportunities for corporations to evade taxes through tax havens. And other kinds of policies like that. We also need a general increase in taxes that everybody pays because we have to have the public understand that is a good use of their money and that it may, in the end, increasing taxes will save them money, not cost them more.

[40] Addendum: Reading back over this interview I am struck by two major changes in the wake of COVID-19: 1) Ford's significant rise in popularity, primarily as a result of appearing sympathetic on public media every day rather than actually doing something; and 2) how suddenly we have money for government to do all kinds of things and more support for government intervention. As we come out of this pandemic, I think we could either have a focus on austerity and on government power used against popular interest or we could go the route we did after WWII and expand the welfare state. – Armstrong. See also Re-imagining Long-Term Residential Care website: https://reltc.apps01.yorku.ca

Khenti observed an opening for progressive taxation policies targeting corporations:

> The biggest opportunity now is a tax opportunity because the corporate sector especially has not been paying its fair share of taxes anywhere in the world, but especially in North America jurisdictions. And not only they haven't been paying the taxes, but they've also been using tax havens to a significant extent. Now that they require rescue, as so many do because of COVID-19, and many have come asking for help, it's ethical to ask for things in return. If the Canadian taxpayer bails you out, why shouldn't you be paying a higher rate of taxes to support the Canadian society that you don't have no compunctions calling upon during an emergency? But you have compunctions being called upon to pay equitable taxes that sustain a health infrastructure that's bigger than the one that we have now or public health or basic income or whatever the case may be. So, I think there's an opportunity to have a more equitable tax structure. And also to bring home or compel some of those institutions that don't pay any taxes at all because they situate the head offices elsewhere as tax havens (Khenti: Academic-Activist-Advocate).

The illustrative quotes remind one of existing document data that in Canada, neoliberal public policies resulted in corporate income tax rates declining from 36% in 1980 to 15% in 2019. In addition, the income tax decreased from 43% in 1980 to 33% for the highest income earners in 2021. The Canadian government is losing over $40 billion in tax revenues annually (Broadbent Institute, 2021). One also recalls the Panama, Paradise, and Pandora Papers that exposed individuals, elected public officials, and corporations hoarding their accumulated wealth

in offshore tax havens, in which Canada lost $8 billion in tax revenues in 2019 (Broadbent Institute, 2021). The Canadian governments at all levels should listen to the public instead of corporations: 62% of Canadians believe that Canada's taxation system is not fair, and 72% and 70% believe that the big corporations and the wealthy are not paying their fair share of tax, respectively (Broadbent Institute & PIPSC, 2021). A more progressive taxation system to support public policies is necessary to reduce social and health inequities.

Intensifying unionization levels. In another policy proposal, 6/23 interviewees explicitly recommended unionization to improve the employment and working conditions of non-unionized workers. For example, Albo emphasized the decrease in union membership rates and the importance of enhancing union density to address precarious employment produced by capitalism. In doing so, it will improve the living conditions of the workers. He explained:

> Unionization levels have fallen off. And that unionization levels have to be connected with addressing precarious forms of work, non-standard work. Non-standard work has always been part of capitalism, and you must kind of have unionization to offset that non-standard work. So, that level of organization is just necessary to kind of raise living standards to deal with non-standard work. And I think at this point in time, as we can see something like the GM shutdown in Oshawa, what's happening in the aerospace industry with some of the problems happening with Bombardier in the transport sector is that you need that higher level of unionization so that unions are becoming more active in developing counter plans to the company about how production should take place. So, it has to be a fixation of this unionization, not just on raising income wages and benefits structure. But it also has to be developing kind of counter plans to what the companies are proposing and what should be

provided and what should be produced and where it should be produced and so on (Albo: Academic-Activist-Advocate).

Healthcare industry labour researcher-activist-advocate Jonah Gindin stressed the need to veer away from neoliberalism to achieve redistributive healthy public policies and to guarantee the right of the workers to unionize:

I think there's a lot of different specific public policy changes that CUPE would like to see. All of them would require a shift in the priorities of government from a perspective sort of a neoliberal race to the bottom in terms of lowering regulation and lowering taxes, encouraging investment by kind of reducing any possible friction, including the right to unfettered right to unionization. And to exercise power in the workplace through collective bargaining.

Specializing in the health field, Khenti observed the benefits of unionization:

[T]he Nordic countries show that the more organize your labour forces, the better off they are. So, I think that in many sectors where workers currently aren't allowed to unionize, they should be allowed to unionize. There's no reason why people working for Amazon and Walmart and some of these places aren't allowed to form unions in Canada.

Khenti called on advocates and governing authorities to support unionization:

People who are working in restaurants and who are poorly paid and who cannot unionize or aren't unionize or aren't in the position to unionize, how do you improve their working conditions when they are not in a position to improve it themselves? That's where advocates are needed and that's where the state has to get involved. Otherwise, it's never going to happen.

Like Jonah Gindin, Khenti asserted the rights of the workers to form unions:

Until you have labour rights, studies show that in places that have greater rates of unionization, people enjoy better working conditions and living conditions. But I think one way to improve the situation is to support the unionization of the labour force to a greater extent. And I would definitely recommend that and work for that as a key lever to improve working and living conditions. Unions need to be empowered, and people need to be empowered to form unions where there aren't unions. We have huge pools of labour working in Walmart or what have you. They should be unionized to improve their working conditions. Not only allowed to be unionized but they should be supported to be unionized. I think the union, labour rights, and the levels of unionization are key factors…to the improvement of the working conditions.

Khenti cautioned that unionization alone could not solve social and health inequities. He noted that some unions discriminate against other groups of people:

I mean, there's no one-solution-fits-all. That's the challenge. A human rights approach isn't going to improve everything. A unionization approach isn't going to improve everything.

> The unions are a problem when it comes to racialization and racial access to some of the jobs. I mean, like, you know, when unions kept out racialized groups, they have actually oppressed racialized groups. Although I advocate for unionization, I don't see unionization as a one-size-fits-all. This is going to solve everything. It isn't (Khenti: Academic-activist-advocate).

The collective insights of the informants bring to mind that compared to the liberal welfare states, the social democratic states have better health outcomes. Specifically, compared with Canada, Sweden has a higher union density (82% v 31%), total taxes as a percentage of GDP (56% v 36%), social security expenditures as a percentage of GDP (31% v 13%), public employment in health services, education, and welfare as a percentage of the working-age population (20% v 4%), women's labour participation (74% v 57%), and redistributive effect of the state as a percentage reduction of income inequality affected by direct taxes and payments (53% v 25%) between 1945 to 1980. In addition, Sweden's public expenditures on health rose from 3.2% to 7.9% against Canada's 2.3% to 6.9% of GDP from 1960 to 1990 (Navarro & Shi, 2002).

Not surprisingly, with robust redistributive public policies, Sweden's child poverty rate was 3% compared to Canada's 15.3% in 1990-1991, and Sweden's IMR was 4/1000 against Canada's 6/1000 in 1996 (Navarro & Shi, 2002). However, over the past two decades, Sweden's trade union density dropped from 81% to 65.2%, whereas Canada's declined from 28.2% to 26.1% between 2000 to 2019 (OECD, 2021a). Nonetheless, Sweden's IMR ranked 5th at 2.1/1000, whereas Canada's ranked 29th at 4.4/1000 among 38 OECD countries in 2019 (OECD,

2021b). As discussed earlier in the literature review, health outcomes are better in capitalist welfare states where labour is strong. Unionization is crucial in reducing health inequities.

Electoral reform. Only 4/23 of interviewees -- explicitly or implicitly -- recommended electoral reform toward increased participation and representation in the institutional public policymaking processes. For example, Crowe stated: "I'm not an expert on this, but I think our voting system, the first-past-the-post is very problematic in terms of who gets elected and how long they stay elected." McKenzie said: "we probably need proportional representation because the first-past-the-post way that we run our government actually makes it fairly difficult for everyday people to make choices that make sense to them."

Bryant explained a need to encourage people to engage in the politics of public policymaking processes and push for electoral reform to ensure fair political representation:

> I think it's also getting people to take more seriously and become more politically engaged. We don't have an engaged population. I think the political system just makes them feel like they have no power, so they don't even vote. We have that to deal with this political apathy. I think the electoral system does not encourage people to participate. So, maybe if we did have electoral reform, which Justin Trudeau prevented a few years ago, claiming that Canadians weren't ready for it. He was ready to dismantle an electoral system that delivered him a big fat majority. Canadians are ready for electoral reform. So, I think we really need to seriously consider, not just consider, embark on changing to proportional representation, a form of proportional representation. No system is perfect, but it has to be better than the first-past-the-post system, which just seems to help reelect neoliberals (Bryant: Academic)

The illustrative quotes help recall that electoral reform includes but are not limited to voting systems, campaigns, and political parties' regulations (Pilon, 2016). This study partly accounts for the current voting system in Canada: a plurality system commonly called single-member plurality or first-past-the-post. Under this voting system, the candidate with the highest votes wins regardless of voting percentages garnered by other candidates, meaning it is a winner-takes-all system. In contrast, proportional representation means: "Basically, if you get the votes, you get the seats. A party that gains 20% of the vote, for instance, stands to gain about 20% of the seats, more or less" (Pilon, 2016, p.50). There is a need for a better voting system that equitably distributes political representation, especially for Canada's marginalized classes and groups.

Wrapping up. Labour leader Stewart emphasized that the governing authorities should redistribute wealth and power among various classes and groups of people to reduce social and health inequities:

> Again, like many countries, the richer are getting richer, the poor are getting poor, and we're losing the middle-class. So, this is the hard decision elected officials have to make: sharing and distributing the wealth in our country among the citizens. People absolutely deserve to make a living wage. That's all any of us want is just to get an education to work until retirement, buy a house, put our children through school, and then when all of that is done to be able to retire with a decent pension plan. So, that I think is the simplest thing in life. Unfortunately, there are a few that are able to do that, many who are not. If you take a look at those who, as I said, have a lot of power, have a lot of money, and we're forgetting a whole

class of people. That's what they have to do. They have to share the wealth. And that means taking a look at the tax system, taking a look at how much profits people can make as well, on the backs of these workers who aren't getting the results of their hard work. It's going into big corporations and shareholders. It's gotta be put back into families and the frontline workers.

Nonetheless, Sam Gindin cautioned that narrating public policy proposals to reduce social and health inequities is not too difficult to do. Instead, the main challenge is the capitalist system itself that fundamentally obstructs the realization of redistributive healthy public policy and public health policy.

In terms of the policy, it's not hard to say things. The hard thing is getting them done. A fairer, better redistribution of income is obviously good, having minimum wages so that people don't have to work two or three jobs and affect their health… A better redistribution of working hours is important. Secure income is important. Adequate healthcare is obviously critical. Would they get it?

Gindin elaborated on seniors and home care workers and conditions of work:

There's all kinds of questions of the old people. Should we be spending more income, money, resources on old people or just young people? But old people still need social space. It's not a good idea to just put them away in a warehouse. It's good that they have some cultural places to go to, that they have a comfortable place that they live at, that the ratio of

health is high. For example, I think home care workers shouldn't be considered private workers. I think they should be part of the healthcare system, and they should be negotiating with the government to have new standards. If we think that good healthcare is important, we should pay the people who provide it. You're not to be a genius to recognize this. But to do it is another thing because there's a bias against this. You know, people would rather hire Filipinos and pay them cheap income pay than decent pay. It's a virtue of respecting people at work. So, if we think about work, it's about the pace of work, the hours of work, security of work, the income of work, having all the benefits of work insurance, so you don't get sick, so you don't come to work when you're sick and get more sick and make other people sick.

Gindin also suggested:

We should have free dental care. We should have free Pharmacare. The opioid crisis is horrific, like people dying. Why does this happen? Why are companies, they look to push drugs to treat people like this and not be responsible?

Gindin concluded that to address social and health inequities better, pressuring the governing authorities is needed. But, importantly, capitalism itself should be challenged:

What I'm emphasizing is, it's everything. You can't make people healthier unless you're dealing with food, income, security, health, environment, air. We know this. It's been documented… It helps because you can take the evidence into the government and say, here's the evidence. Do something about it. And morally, to do something. Of course, how

> much will they do and how much they do have to do with how much we could organize the pressure. But ultimately, you really do have to think about capitalism is a system that's not going to create healthy people or as healthy as they could be. Historically, capitalism has been helpful because material increases make us healthier, but now that we have all this potential, we have to distribute it differently, change our priority (Gindin: Political Activist).

The collective insights of the informants yielded at least 39 specific public policy recommendations to reduce social and health inequities. As discussed in the literature review, most of these recommendations have been forwarded elsewhere and in Canada (e.g. Acheson, 1998; Black et al., 1992; Labonté, 1993; Lalonde, 1974; Marmot et al., 2010, 2020; Raphael, 2016; Raphael et al., 2020; WHO, 2008). The 39 proposed public policy changes include but are not limited to improving employment and working conditions, increasing income support, providing public and social housing, expanding healthcare services, more progressive taxation, increasing unionization levels, and electoral reform. To my mind, the last three are less commonly proposed public policy changes to improve health and reduce health inequities.

It is essential to emphasize that despite numerous public policy recommendations and interventions to address health inequities in Canada, the problem persists. Thus, there is a need to go beyond institutional public policymaking. Among the causes, reasons for public policy failures, and barriers to reducing health inequities in Canada are capitalism itself, the dominance of corporate power, neoliberal governing authorities, and the fragmented and weak labour, civil society, and social movements. The following themes offer ways to respond to these causes, reasons, and barriers to reduce social and health inequities.

4.3.2 Uniting and strengthening labour, civil society, and social movements. As presented and discussed earlier, 23/23 informants recognized that social and health inequities in Canada persist, in part, because the labour, civil society, and social movements are currently fragmented and weak to overcome corporate power and influence and neoliberal governing authorities that, in tandem overwhelmingly shape public policy satisfying private economic and political interests over public interests. Logically, the informants -- explicitly or implicitly -- unanimously suggested uniting and strengthening labour, civil society, and social movements, which I collectively refer to as *peoples' movements* in this research. In other words, there are three major contending social forces in Canada: the big business and corporate sector, neoliberal governing authorities, and the peoples' movements.

Again, since most interviewees explained their general recommendations and specific policy proposals to reduce social and health inequities simultaneously, I present an opening illustrative quote reflecting their interrelationships. A long-time activist, Clarke provided an example of their victorious struggle to stop public policy changes that may adversely impact vulnerable persons. He emphasized the importance of *peoples' collective action* in shaping governing authorities' policy decisions and winning. However, he cautioned that a policy win within the capitalist system is highly susceptible to a policy reversal. He explained:

> The only thing that makes a difference is when people actually challenge what is going on… [A] social cutback that was going to happen maybe forestalled because people take action… [W]e and many others agitated very strongly when the previous Liberal government in Ontario wanted to merge Ontario Works and ODSP into one. And at that moment, it was forestalled. However, the present Ford government is looking to redefine disability in a

totally regressive and restrictive way. Their first attempt to do that has failed. And it's failed largely because of opposition that's been raised… So, this ongoing drive towards austerity is something that you confront. And if you win victories, they're very fragile because there'll be coming for those victories later.

Clarke posited a need to *alter the existing social system* because the global wealth is concentrated on a few wealthy and capitalist classes. He explained that reorganizing society could not be accomplished in a short time:

I think we would have to fundamentally reorganize society. I think we can't have a situation where a couple of thousand billionaires have more wealth than half the population of the planet. We can't have a society organized along those lines and expect to achieve a just and fair society. There's a fundamental contradiction in terms. I confess that I don't see the prospect of that system of society being changed in the next six months. And so, more is the pity. But, that being the case, the question is, how do we challenge?

Clarke emphasized that changing the social system that favours the interests of the elite instead of the masses, *uniting and mobilizing peoples' movements* is what is required. Beyond that, one may see a spiralling social decay before the governing authorities address pressing issues like public health and homelessness. He explained:

How do we challenge in the here and now? I believe that primarily movements and social mobilization and communities that are active and struggling and challenging are the only way

to put any limits on what they can achieve. Outside of that, you can only hope that things reached such a level of social dislocation, such a level of public health crisis, that they're forced to take some measures there. That debate is taking place at the moment in California, where the level of homelessness has reached such a point that you have the outbreak of diseases that no one ever expected to see. You have a public health crisis. You have a situation where the sheer horror of mass destitution is starting actually to interfere with business dealings.

Clarke elaborated on homelessness and the dangers of capitalist-oriented authoritarian governments addressing homelessness crisis impacting business and corporate interests:

The commercial centers of Los Angeles and San Francisco are starting to have such a visible, destitute, desperate, impoverished, homeless population starting to greater a crisis for them. But as some politicians say, we must build some housing. We must deal with this. We must. The Trump administration is looking at properties on the fringes of the city that can be turned into de facto prisons for homeless people. So, an authoritarian and an unjust solution is also on the cards. So, fundamentally, however dire the situation becomes, if we leave it to them, I think the solutions will always be regressive. And progressive solutions are something that is going to have to be fought for.

Clarke suggested that to tackle social and health injustices, one must organize at the community, workplace, and state levels. Peoples' *informed organized actions* might take the forms of parliamentary and 'extracurricular' struggles, for instance.

> I would say we must organize to confront this injustice. We must organize in our communities. We must organize through our unions. We must take political action, electoral and extracurricular, to try to ensure that this injustice is challenged, and when we do so, we need to do so on a highly informed basis. So, the research activities of medical professionals and scientists and people with expert knowledge are vital in terms of the struggle as well. We need to confront these injustices in an informed, articulate, but highly organized fashion. But I think we need to put aside the illusion that we're dealing with objectivity and impartiality, and fairness. We're dealing with entrenched injustice, and we need to approach it accordingly.[41]

The opening illustrative quote brings to mind the distinct but interlinking public policy theories examining social and health inequities. First, the discursive institutionalist approach focuses on producing research-informed ideas to influence institutional public policymaking processes. Second, the pluralist approach focuses on competing interest groups and advocacy. Third, the critical political economy focuses on organizing and mobilizing to alter exploitative and oppressive social relations of power without ignoring evidence and information.

Physician Anonymous N19 emphasized the need for *'popular movements'* spearheaded by people who experience social and health inequities. Revitalizing the labour unions and fortifying *labour movements* is crucial in uniting peoples' movements and actions. The informant explained:

[41] Addendum: We are going to be dealing with huge numbers of people without income and adequate food and whose housing is at risk. Employers are going to be trying to impose wage cuts and governments to implement social cutbacks. I feel the attacks coming will make the austerity of the last few decades look mild and incremental. The period ahead can perhaps be best compared to the Great Depression. The building of mass social movements will be essential. I believe we are going to see a crisis of legitimacy for capitalist society, and the basis for a struggle for a very different one is being laid. – John Clarke, sent via email amid the COVID-19 lockdowns.

> I've seen the power of really popular movements of really campaigns led by the people affected. And anything that can continue and sustain those, I think, can make a big difference. So I think about things like the fight for $15 and the fairness campaign around workers' rights and the minimum wage. It's a very powerful movement that led to significant changes. I think about movements like organized labour and the kind of very early, I think, renewal of the labour movement where we start to see like people growing out of the idea that all unions are just, you know, a waste and just that, and seeing that unions have this really incredible power to unite people and to lead to real change.

The informant saw opportunities for reinvigorating *labour and popular movements* as the younger working people realized the advantages of belonging to a labour union. There is also the presence and support of some of the *allies of the working class*, including academics pushing for healthy redistributive public policies:

> And I think there's a generation of workers now who are growing up seeing the downsides of not having a union and seeing the positives of being in a unionized position, even though, of course, only a small proportion of people are now in unionized jobs. So I'd say pop movements led by the people who are most affected and that others are allies too is a way to see change. And, we've seen some like the fight for $15 and fairness. I think we've seen this with the movement around people who use substances that's been really quite powerful and gotten more attention. A good example where academics, I think, worked as allies to folks (Anonymous N19: Academic-Activist).

Armstrong stressed the need for united *'progressive unions'* and *'collective movements'* challenging the structural causes and barriers to reducing social and health inequities. Such peoples' movements also collectively work to make people understand the factors and forces shaping peoples' working, living, and health conditions. She explained:

> I think it's still the case that our major strategy is unions, progressive unions, and organizing in and through unions, precisely because they are collective. But we need unions that aren't business unions, but unions that are progressive social movement unions. And we have to have, I think, other forms of social movements that are also very powerful. The environmental movement is proving to be quite important, I think, and effective. And so, I don't think it's just unions, but collective movements, that fundamentally change people's heads as well as their conditions. I don't think changing peoples' heads comes first. I think they have to come together with changing structural factors. But, I think we have to do both. And the barriers to that are pretty big. But I think there is no alternative to making those kinds of changes to turn Margaret Thatcher on her head (Armstrong: Academic-Activist-Advocate).

Public scholar and health specialist Bryant called for *united, militant labour movements and civil society groups*:

> I think we do need the labour movement, but it needs to be more radical. It needs to be more assertive. Civil society organizations also have to be willing to stick their necks out and ask the tough questions that otherwise will not be asked. So, you know, raise issues that are

otherwise going to be ignored. But I think they have to work together to influence the public policy process (Bryant: Academic).

Long-time grassroots activist Crowe highlighted that a '*large national movement'* composed of labour unions, non-profit organizations, and faith communities, among others, is necessary to reduce social and health inequities. She historized their struggles around housing and homelessness issues that resulted in the legislation of a federal-level homelessness program:

[I]n the '90s, we had a large, large national movement on housing and homelessness. It was launched by Toronto Disaster Relief Committee in 1998. All the materials are still on our website: tdrc.net. We issued a state of emergency declaration. We partnered across the country. We had two national networks. We coordinated one of them. And the other one was more faith-based and other national organizations. And as my colleague, Beric German, says, we would be throwing demonstrations right, left, and center. Like we would be organizing rallies and demonstrations all the time. We would be meeting with housing ministers all the time. We had postcard campaigns. It was a very vibrant, popular movement supported by everybody, supported by unions, supported by foundations, supported by faith groups. And ultimately, that had a huge win that a lot of people don't know about. It was the win of a new federal program. Do you know what it was? It led to a new federal program to fund homelessness, and it was called SCPI: Supporting Community Partnership Initiative.

Crowe specifically critiqued the Homelessness Partnering Strategy and National Housing Strategy and reiterated the centrality of a *nationwide peoples' movement* pushing for healthy public policies in the present era. She explained:

> When the Conservatives got elected, they changed the name to HPI, Homelessness Partnering Strategy. Still, it exists to this day, but it wasn't a housing program. So, the problem continued. We got close. We got close. We got close. A number of times, when it came time to the budget, federal budget, we would be close. Then we would get a phone call from the Minister of Housing, Joe Fontana, or whoever, saying he couldn't convince the entire Cabinet around the decision to put money back into housing. Then we come to the 2017 National Housing Strategy, which has been a massive failure. That's partly why in my memoirs, I write about a lot of that because people don't know that history. And that's why it's still helpful. I wrote an op-ed in the Globe and Mail that you might want to look at. The reason we got a housing program for the first time was after World War II. So, I tell that story in the op-ed. It was because veterans came back from the war, and there was a housing shortage. And they protested. And they took over empty buildings. And it was a national movement that led to the first national housing program. And my argument was, that's what we need again now to deal with the problem (Crowe: Activist).

Sociologist Carroll, involved with the social movement, emphasized that surmounting the barriers to reducing social and health inequities requires a *'movement of movements.'* Such movement should *organize and mobilize 'from below.'* He explained:

> There needs to be a kind of movement of movements. And I think it needs to be both a social justice movement of movements and an environmental justice movement of movements because the environmental crisis is a major health crisis and will be more and more as it plays out. The climate crisis has enormous implications for human health. So, the movement has to come from below. Like basically, as I said, this structure is entrenched in terms of class power and connections between the dominant class and the state so that any kind of real change process can only occur through popular mobilization from below. Bringing together these somewhat disparate, they seem to be somewhat disparate interests, whether they're interested in homelessness or occupational health and safety or the trade union movement there. They all have their own specific agenda, but they all need to converge on a common agenda.

The above illustrative quotes help one recall Wright's (2018) anti-capitalism struggles in the 21st century more aligned with the critical political economy approach to health. In varying degrees, the quotes are associated with resisting, taming, and eroding capitalism. *Resisting capitalism* challenges the elite capitalists and politicians but does not attempt to capture state power. *Taming capitalism* calls for redistributive public policies to mitigate the harms of capitalism but does not struggle to replace it with socialism. Finally, *eroding capitalism* combines bottom-up civil society-centric strategies, and top-down state-centric strategies anti-capitalism struggles to address social and health inequities (Wright 2018).

It is important to report that while some of the informants implicitly suggest uniting and strengthening peoples' movements should be forged against capitalism being the fundamental cause and barrier to reducing social and health inequities, others openly expressed that part of the

solution to class, gender, and race/ethnicity-based health inequities is ***going beyond capitalism***, as also demonstrated in the previous themes. For example, Carroll categorically stated:

> I think class, race and gender and ethnicity are all sort of bundled together, but I do tend to see the structure of capitalism as the primary driving force. And it actually historically has incorporated relationships of race, ethnicity, and gender in certain ways. It reproduces those inequalities. Well, you're probably going to ask me about what the solution is. I think, obviously, part of the solution is getting past capitalism. But, I think one also has to at the same time address these other inequities (Carroll: Academic).

Carroll's insights point to the earlier discussion of the co-constitutiveness of class (capitalism), gender (sexism) and race (racism) in the production of social life examined through critical political economy theory or intersectionality lens. Furthermore, Hancock, a retired public health physician and Green Party's first leader, posited that capitalism in general and neoliberalism, in particular, is nearing its end. Thus, there is an opportunity to establish an alternative social system beyond the world of capitalism. Hancock first explained the need for 'Just Transition':

> One of the hope, whether the opportunity, if we're going to reinvent our entire economy, if it is the death of industrial capitalism, it's also the birth of something new. So, what's this something new? Why is it better? In what way is it better for you? And how do we work with you to manage what people are calling the Just Transition? So, there's a lot of talks these days about Just Transition. So, how do you manage a Just Transition? For example, if they

were here in town, I'd write it. I mentioned it in my column: an example from the Seeds of the Good Anthropocene. There's a group in Alberta called Iron and Earth. And Iron and Earth is a group of fossil fuel workers in Alberta who are working to retrain themselves and others to work in green energy. So, how do we help people do that? So, I think we have to recognize that what we're seeing is the end of an age of capitalism and particularly neoliberal capitalism, capitalism in general. Because the inevitable consequence of this form of capitalism is, on the one hand, oligarchy, which I talked about earlier. And, on the other hand, the destruction of the Earth's resources. It's the logical consequence of our form of capitalism, and it's not sustainable. And if we don't stop it, then society will collapse sometime in the next 50 to 100 years.

Hancock emphasized that 'Just Transition' is not only about getting rid of fossil fuels. Instead, it may mean 'to basically overthrow capitalism' toward the establishment of 'alternative positive futures.' He elaborated:

So how do we manage a Just Transition? And I think that transition is not just about fossil fuels. It's transition in a lot of different ways. There's some very interesting scenario work, which I also wrote about in a recent column about two or three weeks ago. Scenario work out of a group associated with the Seeds of Good Anthropocene. And what they've looked at were alternative positive futures. And what they found was that in order to get there, you had to basically overthrow capitalism. You had to have decentralization. You had to have degrowth. You had to have a bunch of stuff. So I see that as, to some extent, inevitable, probably not quite in my lifetime. I'm 70 now, I'm not sure what to happen in the next 30

years, but it'll be quite well down the road in the next 20 or 30 years. So how do we position ourselves not to defend the current system but to promote the new system?

Hancock advised:

I think you might want to look at the potential role of faith communities and spiritual communities in all of this, both from a social justice point of view and for a sort of reverence for nature, a reverence for Earth's point of view. Look at the current Pope, who is a Franciscan, after all. So, what is the role of that?

Hancock categorically stated that it is not enough to critique capitalism, but equally essential is to offer an *alternative system beyond capitalism*. He suggested:

And I think you need to be, but I think where we focus is not so much on criticizing the current system as building the better one. So it's no good. It's no good saying, you know, the current system really sucks and then stopped it. It's like, okay, what's better? And the better can't be a kind of socialist paradise version of the current capitalist system, because the current capitalist system, it doesn't really matter whether it's state capitalism like Russia, or free enterprise capitalism like the US, but what used to be state capitalism, they both treat the earth as something to be used up. They actually both create their inequalities in their own way. We're going to have to transition to something that is radically different fairly quickly (Hancock: Academic-advocate).

The above illustrative quotes are somehow aligned with the critical political economy-informed *smashing capitalism*: the capitalist system cannot be reformed, and it must be replaced through the revolutionary overthrow of the ruling class or via electoral politics. The alternative is a socialist system (Wright, 2018). Uniting and strengthening peoples' movements is key to reducing health inequities. The next main theme focuses on parliamentary struggles.

4.3.3 Engaging in electoral politics. As presented and discussed earlier, 4/23 informants proposed electoral reform toward increased political participation and representation in the institutional public policymaking processes. Logically, they believe in participating in electoral politics as a means to reduce social and health inequities. Moreover, it is important to report that other informants who did not explicitly recommend electoral reform also suggested engaging in electoral politics.

Bryant, specializing in health and policy change, reiterated the need for electoral reform:

> We need electoral change. As I said, electoral reform would help. We need, I think, bolder political parties. Jagmeet Singh ran a reasonable campaign in the last federal election, and they need to do more of that. They need to be a little more upfront and be more explicitly focused on promoting redistribution in our social and health policies and economic policies. But making clear, I think people need to be informed about the issues, and they need to be encouraged to vote and participate (Bryant: Academic).

A Member of the Order of Canada, nurse activist Crowe, who stated that the first-past-the-post voting system is problematic, explained that people should engage in politics:

> People have to become more engaged in provincial politics. People have to know who the critics are. They have to appreciate that NDP is the official opposition right now. So, at the next election, people have to volunteer and take part in campaigns. Now, some people would argue that electoral politics are just one narrow way to work; that it's more important to do more grassroots politics and organizing. But I think you have to do both. And unions, there's been a sluggishness in their ability or their willingness to call for a general strike, province-wide strike, which has happened in the past through Days of Action. But I think tackling hate and tackling right-wing politics whenever we can because it's encroaching all the time.

While some expressed support for NDP, other informants are ambivalent. For example, sociologist Carroll stated: "Political parties are important. I don't know if the NDP will ever be the party that could really enact these kinds of changes. I'm doubtful, but it's the party on the left that we have now. So, one possibility is to try to push the NDP in a stronger direction".

Epidemiologist Anonymous N14 suggested 'broad political coalitions' composed of non-traditional politicians but cautioned that there might be no other way but to struggle 'from the street.' The informant explained:

> Use the technology that we have and other means to create, pressuring governments with broad-based coalitions. And in the Canadian case, maybe new political actors. Situations of crises like this epidemic create an opportunity. But, I don't have a specific strategy. It's the combination of the window of opportunity with broad political coalitions that have a common interest in reducing health inequities. And not through traditional parties. Maybe

pressuring them just from the street. There is no other means. (Anonymous N14: Academic-Advocate).

Political activist Sam Gindin pointed to the challenges faced by the 'left' and the opportunities offered by the Corbyn and Sanders phenomena in the field of electoral politics:

People are frustrated with their lives. That's the first thing. People are frustrated with their lives. Their expectations haven't been met, and they're frustrated. They're frustrated with the conditions of their kids. They're worried about their kids; they're frustrated with their lives. So, the question is, what happens to that frustration? The left hasn't been able to take advantage of that yet. You have signs, Sanders, Corbyn, but generally, the left has failed. Social democracy has failed to speak to those frustrations because they tried to take a middle road. And that failed. It didn't work, didn't excite people. So, when the left fails, it leaves it open to the right, and the right has occupied that territory. It speaks to all that frustration. The difference is that the right isn't interested in really changing the conditions of working people. When the right takes it over, it's very dangerous because they're not going to take on the corporations and the wealthy. So, what do they do? They get more racist, they attack immigrants, and they become more authoritarian to avoid a real debate. The failure of the left is very dangerous. It's opened it for the right. This should be ours. We should be leading this. So, this is very dangerous, and I think it's dangerous everywhere. And the challenge is for the left to be able to take on this challenge. You know, as Corbyn tried to do, and Sanders tried to do. We shouldn't get discouraged. This is just the beginning.

As presented and discussed earlier, Albo observed the absence of political parties waving the flags of socialism or communism or even social democracy that advances alternative politics toward an alternative society where redistributive public policies to reduce social and health inequities are more plausible and realistic. I requote to emphasize:

> And at the local level, at the level of parties, we're dealing with this really difficult historical period and the history of capitalism and the history of the left where we don't have ascended political parties carrying the banners of an alternative society. And an alternative society going into the names of socialism or communism and not even one that carries the banner of historical, social democracy. And that is, we're going to tax the rich enough so that we have free public provisioning of healthcare, free public provisioning of transport, free public education and so forth. And we're going to make those better every year, and we're going to do it in a way that's reducing income inequality. We don't even have that anymore. (Albo: Academic-Activist-Advocate).

The preceding illustrative quotes align with the critical political economy approach to health and policy change. Specifically, to a certain degree, they are associated with *dismantling capitalism* that calls for a gradual transition to democratic socialism that necessitates a stable parliamentary democracy and a socialist party that can be victorious in elections. They are also aligned with the strategic logic of *eroding capitalism* that aims to displace capitalism's dominance in social life. This strategy is fueled by social movements and the Sander, Corbyn, Syriza, and Podemos phenomena (Wright, 2018).

The results also bring into mind existing literature demonstrating that the success or failure of public policy partly depends on political actors' ability to "mobilize a sufficient electoral coalition in the political arena" (Hall, 1993, p.287). In addition, Brown et al. (2020) showed that "Lower voting rates are consistently associated with poor self-rated health" (p.4). Electoral participation may mean supporting the traditional political parties or forming alternative political parties. The results demonstrate that a socialist political party as an alternative to Liberal Party, Conservative Party, Bloc Québécois, New Democratic Party, and Green Party may be required to push for redistributive healthy public policy and public health policy within the capitalist system or beyond capitalism itself to establish socialism. Engaging in electoral politics is key to reducing preventable health inequalities.

4.3.4 Core Strategies. In this research, the last main theme I identified is core strategies or methods toward healthy redistributive public policies; united and strong labour, civil society, and social movements; and alternative politics. As reported and discussed earlier, 16/21 interviewees explicitly expressed that the influence of evidence-based research and policy ideas to reduce health inequalities is dependent on dominant power, interest, and ideology. Moreover, 23/23 informants recognized that the health policy advocacy field is unequal.

From the above insights, logically, the interviewees -- explicitly or implicitly -- unanimously suggested that informing, educating, advocating, organizing, and mobilizing are necessary methods to reduce health inequities in Canada. Since most informants speak about these core strategies toward health equity and justice in an integrated manner, I present an opening illustrative quote demonstrating their interconnectedness. Then, informed by discursive institutionalism, pluralism, and critical political economy approach to social and health

inequities, respectively, I present the following sub-themes: 1) informing and educating; 2) advocating; and 3) organizing and mobilizing.

Hulchanski, specializing in urban planning, social policy, poor communities, housing, and homelessness, first discussed social change and the requirements to realize social change:

> So, you're talking about social change, aren't you? That's a question about social change. And does a research report change society? Well, through history, some have, perhaps. But what changes society is some sort of social movement. So, anybody who engages in social justice campaigns of one type or another. We know what union organizers know. We know what environmental organizers know. What feminist activists know. Well, first off, you have to advocate for a change. You have to know what's going on. You have to advocate first. And then second, you mobilize. You try to bring people together. You have anything from seminars to demonstrations for your issue. But those by themselves aren't good enough. You have to do the third thing, which is organizing. You have to have an organization, either formal, formal and informal or be organized and keep at it.

Hulchanski then emphasized the importance of social movement to produce social change. He emphasized that social change begins with knowing the causes of the phenomena, in this case, the causes of health inequities, especially class, gender, and racial health inequities:

> And then a big issue, you do have something called a social movement. There is the women's movement. There is the civil rights, anti-racism movement. There is the environmental

movement. There was the anti-slave movement, and nobody wanted to be a slave. When I talk about this classic, raise your hands: Who wants to be a slave? The first organizing rebellions were slave rebellions. And then it was labour unions. Laws were made that made it illegal to organize, but they were organized, and they would go on strike, and the police would shoot some of them down and this and that. That's the old days. But anyways, social change comes about by sticking with it. But it starts with knowing what's going on. The things we just talked about as to what the causes are, the more that we understand the causes, then we can name some things that need to be changed in different categories.

Hulchanski then focused on the inequitable distribution of the social determinants of health mentioned earlier: housing, labour, discrimination, and social benefits. He provided examples of progressive and regressive public policy changes resulting from information, advocacy, and mobilization efforts of social movements:

What can be done about housing costs? What can be done about labour laws? What can be done about discrimination? What can be done about social benefits? Then all those categories where we can make positive changes there and campaign for positive changes. Through the years, for sure, some things have gotten better. There's the federal Liberal government of Justin Trudeau, they didn't do much about housing, but they did increase a child benefit that has helped a bunch of low-income families in a measurable way. They did it once, I think. They should do it more and all that. But that's just an example where something has been done. It has been helpful. They need to do more of it, but they're not doing more of it. So, we can find in different areas where some of the research and some of the campaigning and

organizing have paid off. The city in the province now officially has an anti-poverty program. And, we allegedly have a national housing strategy. We have all these things. That's because of all the advocacy, mobilization, and organizing.

Hulchanski outlined some of the gains and failures of social movements in shaping public policies. He stressed the need to address widening wealth and income inequalities in Canada. The evidence is available. What is required is advocating, organizing, and mobilizing to pressure the governing authorities to reduce social and health inequities. He explained:

> But they all have to deliver. There's not a lot of delivery happening, but there's been progress in advocacy and mobilizing and organizing. Not everything is dark and gloomy. The big trends have not been turned around. Wealth inequality is really grossly unequal. Income inequality is really unequal compared to 20, 30 years ago, and it's not turning around yet. It's still slightly becoming more unequal. And we have this socio-spatial segregation then of rich and poor, rich and poor neighbourhoods. That's where my team's research comes in. See that the inequality between census tracts, the high-income census tracts and low-income census tracks is much greater today than in the past, and we have these nice charts that show that (Hulchanski: Academic).

The opening illustrative quotes demonstrate that informing, educating, advocating, organizing, and mobilizing around the issues of the causes of health inequities, factors sustaining health inequities, and potential solutions to reducing health inequities as discussed in this study is a must. The thematic analysis of the interview data corpus yielded the following results

classified into three sub-themes: 1) informing and educating; 2) advocating; 3) organizing and mobilizing to reduce social and health inequities in Canada.

Informing and educating. As reported and discussed earlier, 23/23 informants explained that presenting evidence is essential despite the minimal influence of evidence-based research or research-informed ideas in health politics and public policymaking processes. Logically, the informants unanimously suggested -- explicitly or implicitly -- information and education to realize their general recommendations and specific public policy proposals. For example, street nurse and housing justice activist Crowe explained:

> There are a few reasons for our weakened movement right now. And one of them is education systems. You would know yourself from having gone through nursing school… How little public policy training and education there is there, right? I had a nursing faculty refuse to allow a nursing student to do a placement with me a couple of years ago. What were we doing at the time? What was I doing? We're working with families and children that were homeless to mount a charter challenge. Like, how more relevant could that be like, and that nursing student wanted to do that and would've had the opportunity to work with vulnerable families and children. But, they didn't see that because they're churning out hospital nurses, and why is that?... [N]ursing students, they write me in desperation, and they say: 'you know, I'm a nursing student at such and such a thing. And I know, I know in my heart, I want to do community. But they tell me I can't. They tell me I have to do hospital first or I'll never have the skills to be employed.' And I say: 'No, that's wrong. You fight for it.'

Sociologist Anonymous N7 emphasized the need of informing and educating people about the links between colonialism, racism, Indigenous poverty, and health inequities:

> We need a lot of extensive education and action to really deal with these issues, like Indigenous poverty, for instance, and health issues. But like so many young people committing suicides, it's not an easy problem because it's connected to colonialism. It's connected to racism. It's connected to poverty, connected to their economies, traditional economies being destroyed (Anonymous N7: Academic).

Hancock, the Green Party's first leader, who earlier discussed the information, ideology, and interest influencing governing authorities' policy decisions on social and health inequities, emphasized education and training around the population health and ecology. He explained:

> We have something here called Health Officer's Council in British Columbia. And every six months, the provinces, medical offices of health and other public health doctors get together. It's partly a training thing and an educational thing, and they get credit for it towards their continuing professional development and so on. We have a group on population health: the Health Officer's Council. We've had some years of population health committee that puts on a session on population health for the last three or four years. I pushed them into setting up ecological determinants work… [T]he population health committee is doing a session in our meeting in April that I'm helping plan on the health implications of the Green New Deal. So we're trying to link the work of public health to the Green New Deal. And the Green New Deal is part of that new transformative future we're talking about. It's probably one of the

better examples we have at the moment. It's not a perfect example, but it's not bad. So I think that's part of what we have to do in population and public health, working with the Green New Deal and others who are building the new economy (Hancock: Academic-Advocate).

Public scholar and health specialist Bryant expressed the need for 'alternative media' to inform and educate people to get them involved in social movements pressuring state authorities to address pressing social problems like social and health inequities:

[T]here are a number of groups that are working on all of these issues... The Council of Canadians is doing a lot of work. Environmental groups are working on climate issues… [T]here are various groups trying to bring into the mainstream, some of the news stories about what governments are doing and the kinds of issues that are emerging. But I think it takes a combination of different groups working on it. I think one is having alternate media such as PressProgress, which was started by the Broadbent Institute, and rabble.ca. There are a number of alternative online media outlets. And sometimes, they get a news story before the mainstream media picks it up. So, that's helping to get some issues on peoples' and governments' radars. We need alternative media. We need people to be aware of what's going on. It's educating people. Getting them to work through movements and putting pressure on opposition parties to raise issues in the House of Commons, in Queens Park, and in all the provincial and territorial legislatures to ensure that the issues affecting those people are being raised and addressed (Bryant: Academic).

Political activist Sam Gindin saw an opportunity: the 'delegitimization' of the capitalist economic system and its analogous ideology like individualism. He explained:

> Ideology is important. If you have an ideology that says everybody should take care of themselves, you're not going to be in a good situation to change social things because you're giving it to individual responsibility. I think that there's been a delegitimization of individuality and neoliberalism, and market solutions. There's been a delegitimization… It used to be accepted that capitalism is good, neoliberalism is good, the government is bad, social programs are not good, don't tax us – all that used to be legitimate.

Gindin focused on information and education openings around the healthcare system:

> Now, people are wondering about it. Now, a lot of people are asking questions. They're saying, well, you told me that if we do more of this, my life will be better. It isn't. I want better health care. So, people are now starting to question a lot of things they didn't question before. That's an opening. We can say, look, the healthcare system works. Well, because most people like the healthcare system, why don't we expand it? Why don't we have dental care? Why don't we have pharma care? I think that's an opening. We can say this, look, it works for you; even in the United States, old people have health care. If it works for old people, why should we give it up?

Armstrong emphasized that educating people is necessary to push for *structural change*:

> I think it's really important to educate people. Like I think that the experience of universality, structural change can make people supportive of structural change. But I think, also in the process we have to educate people about that (Armstrong: Academic-Activist-Advocate).

The illustrative quotes demonstrate that as essential methods, informing and educating individuals, groups, and organizations about social and health inequities may occur inside and outside the formal educational institutions. Engaging in reflexivity, as mentioned earlier, I started to become politically involved when I learned about capitalism, imperialism, bureaucrat capitalism, and feudalism from political activists working outside the academe. It is important to emphasize that informing and educating people about the causes of health inequities, factors maintaining health inequities, and potential solutions to persistent health inequities, as presented and discussed earlier, is a must. Informing and educating are within the realms of the discursive institutionalist approach to health and health policy change to address health inequities.

Advocating. As reported and discussed earlier, 23/23 informants acknowledged that unequal resources among competing interests and advocacy groups result in an unequal health advocacy field. Nevertheless, logically, the informants unanimously suggested -- explicitly or implicitly -- sustained advocacy efforts to realize their general recommendations and specific public policy proposals. For example, economist Anonymous N5 specializing in occupational health explained:

> It requires persistence and perseverance, and never giving up. When you think about lots of advocates, I don't try to play the role of advocates much because I want to be an academic, but I can sympathize with a lot of the concerns of the advocates, and they don't give up.

There's always a need to be an advocate. As soon as you feel you've accomplished an issue, you don't just go pack up your stuff and go home and do change your life and do something else because the world ebbs and flows and things fall back. You see the pendulum swinging all the time from one side to the next in terms of the acceptability of different things that are good or bad. You know, like when we think about where the US is going very much to the right backwards in terms of religious fundamentalism and human rights issues across the board.

Academic-advocate Anonymous N5 emphasized:

We have a responsibility to contribute. We can't just say anything about ourselves. We have all as human beings in our society, have a role to play and be contributing in return through being advocates through our ability to make a difference in our voting system, through our role, whatever job we have, we should always bear that we have to contribute back to humanity and never give up. And that's the only way it's going to work.

Public sociologist Goldring stressed the need to advocate for working-class issues as an expression of solidarity. She explained:

We all like the convenience of feasible delivery from Foodora, Just In Time Amazon deliveries. We've kind of become accustomed to being consumers in this gig economy. We also need to change that, and we have to be willing to support and act in solidarity with people, with workers who are organizing for better pay, better work conditions and so forth.

> And I don't know how we do that. But we somehow need to find ways of getting beyond our little privileged areas and really making networks of solidarity and in support of people who are not as privileged as workers, as consumers, as we are. We benefit as consumers from the gig economy, but we have to recognize that that's not a healthy economy (Goldring: Academic).

Homelessness and housing justice activist Crowe emphasized the centrality of advocacy, for example, in the form of supporting the workers who are striking to improve their working, living, and health conditions. She explained:

> So, that means going out with the teachers who were on strike this week and supporting them on the picket line and supporting organizations, including unions that are trying to protect what we have. There has been a little bit of success in terms of slowing down the changes to social assistance and the redefinition of disability. And that came about just through a broad connection of many groups that came together, including RNAO, I believe, to fight the redefinition of disability that would have left a lot of people cut off. So, all that's been postponed. It's not totally a win, but it's partly.

Seeing social and health inequities exacerbated by the COVID-19 pandemic, former Assistant Deputy Minister for Ontario's Anti-Racism Directorate, Khenti, emphasized the need to unite individuals and advocacy groups to pressure the governing authorities to address these pressing societal problems decisively. The time to act is now to counter austerity measures, as Khenti explained:

> Academics, researchers, think tanks, people in the street, people in various advocacy groups, now is the time to drive the demand for change. And say, we're not stopping now. This is the time. Right now, everything is on the table. This is it. This is the moment. We have to grab the moment. Otherwise, the new status quo will be worse than the old status quo because what we're going to have is imposed austerity. If we don't make these demands now, because these bills have to be paid, they don't want to raise taxes; what are you going to do? Cut programs. If you don't want to raise taxes, you have to cut programs. So, you have to circumnavigate around that anticipated demand for austerity. It's coming. It's coming. It's already come.

Khenti emphasized that academics must also advocate for healthy public policy changes to reduce class, gender, race/ethnicity-based health inequities because the poor and racialized and marginalized people are 'fed up':

> We will have to be advocates. Let me put it that way. It's not enough to be just an academic. We are in a moment that demands ethically more from everyone because people at the receiving end are fed up. Blacks are fed up. Indigenous people are fed up. Transgender people are fed up. People who are gays and lesbians are fed up. We all want to be treated as human beings, equal human beings. Equitable treatment now. We don't want to wait (Khenti: Academic-Activist-Advocate).

Academic-advocate epidemiologist Anonymous N14 categorically stated:

> If you are in public health, if you are an academic, you need to be also an advocate. I mean, this is not a spectator sport… So, you need to be an advocate and academic if you're in public health. If you were into, say, entomology, you don't, or you know physics or basic chemistry. But if you're in public health, you need to advocate because your task is political. It's a social technology. So, you need to act on the world. Advocacy is part of work. So, how I see myself, there's three things, like I also work with political parties.

The illustrative quotes demonstrate that as a core method, advocating to reduce social and health inequities takes various forms, including but not limited to engaging in research, disseminating evidence in the media, writing op-eds, or supporting pickets and strikes. It is important to emphasize that advocacy efforts should focus on the causes of health inequities, factors maintaining health inequities, and potential solutions to persistent health inequities presented and discussed earlier. Informing, educating, and advocating are within the realms of the pluralist approach to health inequities.

Organizing and mobilizing. As presented and discussed earlier, 23/23 interviewees recognized that social and health inequities in Canada persist because the labour, civil society, and social movements are fragmented and weak to prevail over big business and corporate power and neoliberal governing authorities shaping public policy prioritizing private over public interests. Logically, the informants unanimously suggested -- explicitly or implicitly -- uniting, organizing, and mobilizing peoples' movements to realize their general recommendations and specific public policy proposals. For example, Block explained:

> Well, even though my life has sort of based on policy development and evidence development, I think it has a very limited impact on public policy. And I think sometimes we, researchers, delude ourselves in terms of what we think is important. And I think I'll often also come across community groups who think, you know if you just come up with this one number for us it will change the course of policy… [W]hat's effective about policy, and I'm going back to Bill 148, is you need really effective grassroots organizing, and it needs to be a kind of long-term process. And you also need relationships with the government, I think. And those two, I think, are much more important than public policy development or evidence-based research, unfortunately (Block: Researcher-Advocate).

Hurley, President of the Ontario Council of Hospital Unions, explained that to reduce social and health inequities, what is needed is an '*organized solidaristic' militant labour movement*:

> I take a class-based view of these problems, Arnel, in the sense that I think that these workers are being exploited. When I think of healthcare workers, they have special legislation that makes it difficult for them to bargain effectively. They have special legislation that restricts their ability to refuse unsafe work. If those workers are going to assert themselves, they need to be organized solidaristic, and they need to be militant. And you do see examples of that. For example, [inaudible] nurses' unions in Ireland recently, and in the United States, you see that kind of rising militancy, which has feminism, and other theories incorporated into it. You know, which is determined to try to eliminate the exploitative nature of the working conditions. That's really what's required (Hurley: Activist).

Long-time political activist, public intellectual, and former Canadian Auto Workers union Research Director Sam Gindin explained that although competing interests and advocacy groups have unequal resources resulting in unequal health advocacy field, the less powerful individuals and groups could increase their resources through *organizing*. He advised:

> Jane McAlevey, she's an organizer in the US, and you should take a look at her books. She is trying to organize in hospitals, like bringing everybody together: the lab technicians, the cleaners, the nurses, the registered nurses, all of them. And she says, if I can't bring them together, we can't win. That's true. And she brings them together because she's a good organizer. She has to get them to learn that they have to be together to effect their shifts, to effect their hours, to effect patient loads. Those are all the important questions. And to get that, you need the public on side, and you need everybody in the hospital on side. So, you always have to come back to organizing questions. How do we build our power collectively, in the hospital, in the school, at university? So that you have as many, well, maybe, not as many, but you have resources that can counter those who have more power. So, that's always the challenge. And people are fragmented. You know, they've worked long hours, they're tired, they go home. People used to, in auto plants, have to work, they go and have a drink together. Then they talk, they get to know each other, they build something. But if they're tired, and they live far away, and they have childcare and have to pick up their kids, they just go home, and they just want to live, they live in a living room, and it's a problem.

Gindin's insights made me reflect on my partner's work as a union steward keeping their members, including environmental, dietary, activity and recreation staff, social workers, personal support workers, and registered practical nurses, united in their efforts to push for their collective interests to improve their working, living, and health conditions. Because I am also a union member, we try to encourage the diverse members of our unions to become politically active to address our toxic working conditions, for example. However, mainly because of hard labour and stressful environment, long-term care workers like us rarely meet after work, and we only occasionally gather as friends outside the workplace. Meanwhile, being housing insecure, my partner and I have also been sleeping in our living room, adversely impacting our health.

Gindin observed some opportunities arising from peoples' discontent. He emphasized that social change occurs when people come together to alter the current state of affairs:

> We have to organize. There's a lot of dissatisfaction with the status quo, and we have to build that dissatisfaction into a social force. That's the opening. And there's a lot of that because people say: 'We used to be told that if you lower taxes, we'll all be better off. We're not. If we attract more multinational corporations, we'll be better off. We're not.' Everything that they've said in the Philippines or here, it's the same story, and people can learn from it. But a lot of times, people don't learn. They just say that's the way the world is. The job of organizing is to say: No. You can change things, not by yourself, but you can change things together. And that's the lesson.

Retired Ontario Coalition Against Poverty organizer and activist Clarke reiterated that throughout Canada's history, peoples' movements continue to *mobilize* to improve their working, living, and health conditions:

> Well, I mean, I sort of impressed what I said. I talked to the need to mobilize, but perhaps there's a sort of unintended implication there that we're starting from nowhere, and we're, in fact, not. I mean, in this country, there is a rich tradition and a rich history and a current reality of people resisting. People in poor communities have resisted the conditions that they face historically. Trade unions have organized to make a real difference.

Clarke explained that at present historical conjuncture, working-class and Indigenous peoples' struggles are intensifying. He recognized that although 'a lot of work to do' has to be done to reduce social and health inequities, a potential 'social mobilization' can defeat the agenda of neoliberal state authorities, as exemplified by the Ford government:

> Right now, at the Co-op refinery in Regina, there's an absolutely pivotal moment in the struggle for workers' rights going on. Indigenous people are challenging the pipelines in BC, and people everywhere are looking to them with respect and admiration. So, I don't think we're starting from nowhere. I think we have the basis for a social mobilization that can win and certainly a social mobilization that can overcome Doug Ford and the kind of agenda that he puts forward. We've got a lot of building to do and a lot of work to do, but I'm not trying to deliver a message of pessimism. I think there's every reason to be optimistic.

Clarke provided another example of *organizing, mobilizing, and pushing* for redistributive healthy public policies and winning. He recalled their successful struggle for a redistributive healthy public policy around social support for people on special diet:

> In OCAP, we took up a fight for an extended period to get people access to a benefit called the special diet for people on social assistance. And the Auditor General was very upset that this had gone from a benefit paying $6 million a year to $200 million a year. And this was all money that went for people to eat and to feed their families. And that was a real gain. I mean, people are healthy; people are healthier because of that fight. We made a difference, or be it in a worsening context; we made a difference. So, those examples are precious, and we need to build on them, and we need to learn from them.

Crowe, a founding member of the Shelter and Housing Justice Network, stated:

> We're trying to mobilize with the petition that we're doing. And we did a big action in January at the Homeless Memorial. It was a very, very large, very impressive action. We had hundreds of people that came. We added the 1000th name to the Memorial. We had a march that went to the Mayor's office. We did a die-in at the Mayor's office. We delivered the petition of 25,000 names. We're still building it now. We're at close to 30,000. We're trying to build that momentum. But everything is getting worse. I'll send you the full wording of the petition because to look at that and to not understand what the Mayor and City Council will not defend what we're calling for to have an emergency declared is just shocking (Crowe: Activist).

Sociologist Carroll, who is involved with social movement and earlier suggested eroding capitalism and going beyond the domain of the capitalist system, emphasized that what is required to reduce class-based, gendered, and racialized health inequities is: *organizing and mobilizing from below*. He explained:

> I think it's possible. I'm not all that optimistic. But the only real solution is from below: it's organizing. It's organizing people who are exploited, oppressed, marginalized – organizing them in a way that recognizes the diversity of different groups that are oppressed but also recognizes a basis of unity.

There is a need to *unite, organize, and mobilize the progressive transnational social movements to counter global capitalism*, as Carroll further explained:

> Part of the solution also has to be international because capital itself is so internationalized now that there needs to be much more transnational solidarity among progressive movements. That's one of the big problems that we face: the capitalist class has become transnational, and its governance mechanisms are, to some extent, transnational now. But the rest of us are not transnational. And so, there's an enormous strategic advantage that capital has in the era that we live in now. And we need to think about how to address that through organizing, organizing from below. Because as I say, in my view, that's the only solution.

Carroll reiterated the need for an *inclusive movement of movements* struggling to realize a transformative social change that deals with ecological, economic, and health crises. He stated:

Of course, people like me, for example, who are not particularly oppressed need to be active and aligned with progressive movements. So, it's more than just relying on the agency of people who are at the margins and exploited. It's very much a matter of trying to mobilize all the progressive social forces into, as I say, a movement of movements that don't collapse diversity, but that finds a kind of convergence around the need for a social transformation that deals with the ecological crisis, and the crisis of livelihoods, and health and people's wellbeing.

Wrapping up. As mentioned earlier, I will wrap this section *moving forward to reduce health inequities* with the insights from Stewart and Albo. First, Stewart, the President of SEIU Healthcare, explained:

Well, simply, Arnel, those barriers have to be knocked down. Nobody can deny that there are barriers to improving conditions for a large class of our society. So, people have to identify those barriers, get rid of them, and let the people who don't have the money and the power to be able to present their case, to lobby, to give the research. And then somebody has got to step up and address it. Basically, that's it. We have to have people who are bold enough in decision-making positions to do the right thing. And this is hard because money is very powerful. And, you know, people want to get elected. They want their jobs as well and the money. And some of those folks are the people who get them elected. But we need to share. Definitely, share the profits. And the rich have to share in this. So, simple answers. We have to eliminate the barriers (Stewart: Activist-Advocate).

Albo, political economist, Director at the Centre for Social Justice, and Editor of the Socialist Register, further explained that the capitalist state is a fundamental barrier to public policy changes that can reduce health inequities. Progressive policy changes depend on the capacity of the working classes to *collectively organize and mobilize to achieve representation*:

> [T]he terrain of the state is in itself, is structured to be a terrain that reproduces that class relationship and, therefore, the inequalities of that society and so forth. So, when we're able to change some of those policies that depend upon collective action and collective mobilization in a way that is quite different from the way the capitalist classes can mobilize through money, access to power, access to the media, access to the state, representation directly in the state, the state particularly being structured to listen to their policy preferences and so on, so that really depends upon the capacity of the working classes to mobilize and develop representation.

Albo elaborated that representation has three fundamental forms: representation at the workplace, community, and state levels. He first explained representation at the workplace level that might be concretized through unionization, wage increases, involvement in decision-making processes, and production output distribution:

> One of them is a representation at the workplace and the capacity to collectively form unions and unions that can then protect the workers and push more strongly for wages. So, in all kinds of controls over the workplace. And you know, that's one way that questions of

inequality can be addressed in equalizing to some extent, representation over management decisions and over the distribution of the output that is produced by a particular company.

Albo then discussed representation at the community level:

The second form of representation is that, loosely, the community level, that is, the wider set of social relations we establish in a community, a neighbourhood or a city in the way that we develop support networks and then reproduce a class. But also in reproducing class politics. Also, tending to reproduce cultural and actually material supports to assist our neighbours that fall out of work or need a hand -- all of these kinds of community associations.

Albo elaborated on the importance of city politics dealing with public health and distribution of social determinants of health like education and healthcare systems:

And obviously, when we're dealing in modern urban cities, those community associations transform themselves into the politics of the city. That is, the public health systems of the city, the community centers, the educational systems, et cetera. And that community politics then transform when you think of all those things that the city provides transformed themselves into social provisions that deal with equality, access to healthcare, access to the education systems, access to recreation, access to the cultural facility and so on. So, it can have an impact; those kinds of community politics in reducing those inequalities. And so, that politics that can form, at a particular place, at a community level, moving from the workplace to community level, become very important.

Albo stressed that community politics can pave the way to the establishment of 'alternative political possibilities' like the formation of 'red zones or red belts.' He stated:

> And they become important in building spaces of alternative political possibilities that we've often discussed as red zones or red belts. We sometimes had a red belt in Toronto, the red zone in Colonia, Italy, or some of the red zones in Paris or some of the red islands in the Philippines. You know, that kind of politics.

Albo then discussed representation at the state level, including building and strengthening political parties supportive of working-class struggles for redistributive healthy public policies and political mobilizations beyond public policymaking.

> The third component of it is the formation of political parties that can be fundamental forms of struggle for working-class people at the level of the state. At the level of the state in the sense of pushing specific program or reform, but also at the level of the state in being a widen up political force that you can defend workers on strike, that you can defend political mobilizations around foreign policy issues, political mobilizations around healthcare, and so on. And so, it's not just about the representation at the level of the state and in how legislation is being passed and the dissenting or putting forward alternative forms of legislation. But it's also the capacity to lead those kinds of political struggles.

Albo posited that social change could only be realized through collective organization and mobilization and 'oppositional politics' simultaneously occurring at the workplace, community, and state levels:

> And it's only I think, realistically, when there is oppositional politics at all those three levels, are we really able to be successful. If we're missing one of those and we tend to, you know, give voice to certain issues, but you do not have the level of collective action that is able to offset the power of the capitalist classes, in particular, the power of the capitalist classes when there is so much concentration of wealth. You have to have a different logic of collective mobilization, collective organization across all these scales, workplaces, communities, national state structures to be able to push against that concentrated power.

Albo provided some examples of their community engagements. First, he spoke about their 'struggle over the GM plant closing in Oshawa.'

> And the struggle to convert it into producing socially useful goods, which we initially posed as either being a way to deal with climate change and in public transit and electric vehicles. But even from the beginning, we also put forward on the medical equipment. And as the COVID crisis kicked in, et cetera, also became logical to put forward, that's a factory with its capacities and the skilled workers and all the engineers around it that they should be able to produce masks, I think. And ventilators in a whole range of other equipment should be converted there.

Albo also spoke about their struggles around austerity measures in healthcare systems:

> Another example would be the long-term fight over austerity in the healthcare sector, and running of hospitals at over 100% capacity meant exactly that they would not be in a situation to handle a pandemic crisis or any kind of emergency crisis. And that would have consequences, not only for the handling of that crisis but also the regular flow of people on medical emergencies to people who just have the normal kind of needing to get some medical procedures done on a knee or something like that.

Albo also pointed to struggles for unionization and struggles against contract churning in the airline industry:

> We'd done a fair bit of work on helping develop a Council of Unions at the airport at Pearson, where there are so many partialized unions, and there is a lot of what's called contract churning. This raises one interesting example of your earlier question about racialization. So, the contract churning, particularly in the airport, when we go through them that there's an incredible racial stratification of employment structures. Sometimes the racial stratifications are for the benefit of racialized people. And sometimes they're not. It's not just one way. But there's a lot of clientelist kind of hiring at the airport. But the contract churning problem was particularly hitting more recent immigrants from South Asia or Latin America and so on where the companies would spin off new companies all the time and therefore the old contract within and so on. And so, it became a focus of ending that contract churning and particularly raising the minimum wage level at the airport.

The above insight shows how racialized capitalism operates in the airport industry – just like in the highly gendered and racialized long-term care settings. Nonetheless, Albo emphasized the successful struggle to raise the workers' minimum wage resulting from the working class's solidarity. The strongest unions supporting the weaker unions:

> So, it was one of the first places of the struggle around the fight for $15 that was particularly concentrated at the airport initially to raise that level up and provide a minimum. And therefore, also if you've raised the minimum of it and provide some measure barrier against the contract churning, and then also develop protection. So then it becomes the strongest unions providing support for the weaker unions to kind of deal with those issues. When you look at it, there's an incredible number of unions at the airport. There's something like 20 or 30 different unions, so you have this incredible partialization. And so, that was also a relative success of finding a way to kind of begin finding cooperation and a way to find common struggles and pushing the strongest unions of the strongest workers to take an interest in what was happening to the lowest wage workers at the airport and extend union protections.

Like Carroll, Albo stressed the need to *internationalize the struggle against capital*:

> This is an issue that affects almost every airport around the world. I'm sure it affects the airport in Manila as well as in Toronto. It certainly is. We developed support from the International Transit Union because they were facing the same problems in Schiphol in Amsterdam, in Frankfurt, at London Heathrow. These big mass airports all have the same

problem. They're all trying to find a way to kind of get unions at the airports to cooperate and then particularly to find a way to support the weakest unions and using the leverage of the strongest unions in the baggage handlers and the machinists and so forth (Albo: Academic-Activist-Advocate).

The illustrative quotes demonstrate that organizing and mobilizing are core strategies to improve working, living, and health conditions. It is important to emphasize that organizing and mobilizing efforts should focus on the causes of health inequities, factors maintaining health inequities, and potential solutions to persistent health inequities presented and discussed earlier. Informing and educating, advocating, and organizing and mobilizing are within the critical political economy approach to health inequities.

Section Summary. The results demonstrate that reducing health inequities requires pushing for redistributive public policies, uniting and strengthening peoples' movements, and engaging in electoral politics. The informants' collective insights yielded 39 healthy public policy proposals. Most of these have been recommended elsewhere and in Canada. Uniting and strengthening peoples' movements may mean struggling within and against capitalism and struggling for socialism. Engaging in electoral politics may mean establishing a socialist political party. The core methods to achieve these goals necessitate integrating information and education, advocacy, and organization and mobilization efforts. Pluralism, discursive institutionalism, and critical political economy theory, when applied in an ensemble, may prove most helpful in examining social and health inequities.

Postscript. When queried about his key recommendations as to the way forward to improving the working and living conditions of Canadians and others, Professor McKenzie, a practicing psychiatrist, member of the National Advisory Council on Poverty, CEO of the Wellesley Institute, Director of Health Equity at the Centre of Addiction and Mental Health, and Board Member of Ontario Health Association and United Way, emphasized the need to address power asymmetries, particularly, the dominance of the 'industry' in public governance. The big businesses and corporations are only after their interests for profit and wealth accumulation:

> There needs to be an articulation of what the social deal should be in Canada. Because at the moment, there is no agreement necessarily on what we're trying to achieve. And because of that, people are getting off in completely different directions, and that allows people who do not want social change to stop social change. I think there needs to be a re-balancing of power. I believe the industry is much too strong, and because they are so strong, the government is not doing their job. The government's job is to protect us from the excesses of industry. The industry just wants to make money. It doesn't care about people, and it doesn't necessarily care about their working conditions. And the point of government is to say, in a market economy, the point of government is to say, there are limits to what you can do in a market economy, and there are limits to what you can do to people. I, myself, think it is extraordinary that we can be in a position wherein that all of these industries have been making huge amounts of money to get to their shareholders. And as soon as we not even hit a downturn, it looks like we're going to hit the downturn; they get rid of everybody, and they pass them on, and they try and pass them back to the government to pay for them.

The dominance of corporate power and influence in public policymaking processes shaping the distribution of the social determinants of health should be addressed. The wealthy and capitalist classes do not pay their fair share of taxes and hoard their accumulated wealth in offshore tax havens. Worse, when facing financial losses, they pass the responsibility to the people and the state, as McKenzie further explained:

> This is the same group of industries that haven't been paying or trying not to pay taxes. The super-rich who've been hiding their money so as not to pay tax. But as soon as they need, as soon as it looks like they may have a problem with making money, they abdicate any responsibility for the individuals who have been making their money for them. And they say they are the responsibility of the state, and they're not their responsibility for the industry. I would really hope that people wake up to the fact that that is unreasonable behaviour. You do have a responsibility for somebody who has been making money for you for many years. If you haven't saved any of that money so you can help them through hard times, that is actually your responsibility. Or if you want it the other way around and you say, when tough times come, then it's the government that has looked after people, and you do have to pay your taxes, and you have to pay a more significant amount of corporation tax.

McKenzie admonished the governing authorities for allowing the big business and corporate sector to dominate Canadian society and life. People need to demand more from their governments to realize the social change necessary to reduce social and health inequities:

I believe that governments have not been as muscular as they should be. I think they haven't been as hard on the industry as they should be. Consequently, industries think that they can do anything it wants to. And I think that if we are going to move social conditions forward, then we need to be asking more about government, and for more protection from our government We should ask whether the business models that are in place, it seemed to allow the industry to behave badly with impunity, really their business models that we want going forward. So, I think until that social reality of policy develops, it's very difficult in a globalized world to get the social change that we necessarily need in a smaller and weaker economy like Canada.

Mckenzie identified opportunities and challenges to realize the emancipatory social change that can improve Canadians' working and living conditions during and after the post-COVID-19 pandemic. He explained:

One of the things that happened in this pandemic is that there has been a huge social change. If somebody had told you a year ago that the government were going to tell everybody to stay at home, yeah, that businesses were going to change to go online and that government we're going to do this and make this big social change because they were worried that 2000 or 3000 people were gonna die or 4000 people were gonna die. I know they said 100000 people might die, but actually, at the moment in Canada, we're at a thousand deaths, right? And it may be that we end up with 5000 deaths, and 5000 deaths is about twice as many deaths we have on the road each year. And if somebody turned around to you and said they'd be 5000 deaths

and because we're worried about it and that we are going to completely change the way we live, you'd probably think that they don't make sense. But that is what happened.

McKenzie emphasized that the state has the power to 'produce huge social change' supported by the public:

And so, what the government has managed to show is that it's possible to produce huge social change. It's also possible if the public believes you to probably hit our, for the first time this year actually, hit our reduction in fossil fuel use and carbon greenhouse gases. We've got cleaner cities. We've got people trying to cooperate as much as possible. We've had these huge social changes, which a lot of people said would say wouldn't be possible. We got the federal government producing an online mental health resource for all Canadians. It's free. We've got the federal government giving people 2000 bucks a month with very little in the way, evidence that people need it. They just say they need it. These things, everybody said it's impossible. They're happening.

McKenzie observed some threats and challenges, including but not limited to the closures of some hotels, retail stores, and restaurants. He then put forward a series of questions to ponder in creating a new world amid and post-COVID-19 pandemic.

So, the real question we have now, and this is a big social policy question, is, where do we want to be at the end of this? Because we actually don't have to go back to where we were. We actually don't have to go back to everybody being in a car driving places. We will have

lost a whole bunch of industry. We'd have lost our hotels. We would have lost retail stores. We would have lost loads of restaurants. And the question is, what do we want to fill that economic space with? Do we want it to be thinking about different ways of living that are going to be better for everybody? Do we want more entrepreneurship from diverse populations? Do we want a more self-sustaining local industry? Do we want more industry that wears on climate change? Do we want a significant injection into the social sector to rebuild the country? Do we want big infrastructure projects? They're going to make a difference. How are we going to think about this? Because everything is on the table. Do we want to re-balance the power between industry and the people who are keeping us alive, which is government? I think there's some big questions that we have to think about, and we have a chance to do that now. So yes, there are terrible things going on, but you know, everybody talks about a revolution, which is [words unclear]. And what are we going to do with it? That's the question (McKenzie: Academic-Activist-Advocate).

Before closing this chapter, I think about the final insights of the late Professor Leo Panitch. When asked how he wished to be described in this research, whether as an academic, activist, advocate, or any of their combinations, he explained:

I think I always thought of myself as a professor in terms of having an enormous opportunity to educate people into socialist values and historical materialist analysis. So, I've always operated as a socialist in the academe. I've been an explicit open Marxist while believing that Marxism is very deficient in many ways, and our role as Marxists is to improve Marxism rather than to think it has all the answers. That means, as a professor, I was also always

involved in trying to create the conditions for the emergence of a socialist political organization. And I've been much more of a failure in that respect than as a Marxist academic, where I've had a lot of influence as a Marxist academic. And the Socialist Register, it's a very highly regarded, probably the most serious and scholarly of any Marxist journal in the world. It's mostly read by academics rather than by workers. The repeated attempts to try to create the types of organizations, including the Socialist Project, but long before them that would give rise to a socialist party in Canada, and that has not happened. So, I guess you'll have to define me as a professor, a successful professor, not a successful activist.

4.4 Chapter Summary

This Chapter provided the thematic analysis results of 23 semi-structured interviews I conducted, complementing the critical realist review of the literature. The 12 main themes are presented, analyzed, and discussed in three sections. First, the *causes of health inequities in Canada*: 1) capitalist economic system; 2) the co-constitutives of capitalism: colonialism, racism, and sexism; and 3) maldistributive public policies. Second, the *factors sustaining health inequities in Canada*: 1) power, interest, and ideology trump evidence; 2) unequal resources of competing interests and advocacy groups; 3) dominance of the business and corporate sector; 4) neoliberal governing authorities; and 5) fragmented and weak labour, civil society, and social movements. Finally, *moving forward to reduce health inequities in Canada*: 1) pushing for redistributive public policies; 2) uniting and strengthening labour, civil society, and social movements; 3) engaging in electoral politics; and 4) core strategies to realize redistributive public policies, united and strong peoples' movement, and alternative politics. Compared with

pluralism and discursive institutionalism, the critical political economy approach to health and policy change is a sufficient and most useful theoretical framework to explain these interrelated findings. However, when applied in an ensemble, pluralism, discursive institutionalism, and critical political economy theory may prove most helpful in examining social and health inequities. The next chapter offers further analyses, discussions, and reflections.

CHAPTER 5:

FURTHER ANALYSES, DISCUSSIONS, AND REFLECTIONS

The philosophers have only interpreted the world in various ways; the point is to change it.

– Karl Marx, 1845

Chapter 4 presented the main results of the thematic analysis of the interview data corpus, with initial discussions and analyses supported by existing documents. This chapter summarizes, analyzes, and discusses further the 12 main findings by linking them with the literature review and document data. Then I reflect on the relevance of the results relative to the study's purpose and overarching question: Why and how do health inequities, especially class, gender, and racial health inequities, persist in Canada, and how can such differences be reduced? To achieve consistency and avoid confusion, I follow the presentation in Chapter 4. The first eight main themes answer why and how health inequities persist, while the last four main themes answer how to reduce such health inequities in Canada. The following thematic findings are distinct but interrelated and should be viewed and treated as such.

5.1 Causes of health inequities

There are three major causes of health inequities or preventable health inequalities in Canada. First, capitalism is the root cause of social inequities, inequitable distribution of the social determinant of health, health inequities, and their persistence. Second, capitalism co-constituting colonialism, racism, sexism, underly class, race/ethnicity, and gender health inequities. Lastly, maldistributive public policies around the SDH produce health inequities.

5.1.1 The capitalist economic system. As discussed in Chapter 4, unanimously, the key informants understand that capitalism, or neoliberal capitalism in the contemporary era, is the fundamental cause of social and health inequities. This finding is not new. However, most striking is the informants' common insight -- expressed more explicitly than implicitly -- that capitalism or neoliberalism are the primary mechanisms driving health inequities in Canada. Not a single informant stated that genes, behaviours, and lifestyles produce health inequities. This result is significant because this research is probably among the first to gather diverse influential Canadian policy academics, activists, and advocates' insights about social and health inequities.

As discussed in the previous chapters, it was established long ago that the working class has higher morbidity and mortality rates than the capitalist class because of capitalism (e.g. see Engels, 1845; Marx, 1867). To reiterate: neoliberal capitalism has created millions of *precariat* in precarious employment. Precarious employment primarily impacts manual labourers, young workers, workers with low education, immigrants, and women (Matilla-Santander et al., 2021), meaning in a capitalist system, some groups are further disadvantaged due to their age, nationality, race/ethnicity, and gender. The precariat experience higher physical and psychosocial health risks than other classes (Benach et al., 2014, 2016; Matilla-Santander et al., 2021; Muntaner et al., 2010). Precarious work deepens health inequities between classes and groups.

Neoliberal capitalism has not reduced wealth and income inequalities. On the contrary, it intensified class inequalities. For example, the world's Gini coefficient of 0.640 in 1950 that slightly decreased to 0.635 in 1960, climbed to 0.650 in 1970, and 0.657 in 1980 and 1992 (Bourguignon & Morrison, 2002). Then it skyrocketed to 0.804, with the richest 10% taking a global wealth share of 71.2% in 2000 (Davies et al., 2007). Then, again, the world's Gini

coefficient rose to 0.922, with the richest 10% taking a global wealth share of 88.3% in 2014 (Davies et al., 2017), meaning the bottom 90% share of the global wealth was only 11.7% in 2014. By 2019, the richest 1% aggregate wealth was more than twice the wealth of 6.9 billion people (Coffey et al., 2020). Capitalism fundamentally caused global wealth inequality (Davies et al., 2017). Capital accumulation and concentration in the few hands create penury for many.

Worse, amid the COVID-19 pandemic, wealth inequality, poverty, and health inequity intensified. For example, while the aggregate wealth of the world's 2,690 billionaires soared from $8 trillion to $13.5 trillion or a gain of $5.5 trillion from March 2020 to July 2021 (Collins, 2021), the global poverty rate increased from 9% in 2019 to 10.4% in 2020. With 131 million added into the ranks of the poor, there are now 803 million global poor with income less than $2/day and about 4 billion low-income people with income between $2.01/day to $10/day (Kochhar, 2021). In Canada, while the billionaires' aggregate wealth soared by $78 billion, about 5.5 million workers lost their jobs or reduced their working hours (Hemingway, 2021). Meanwhile, Toronto households with less than $29,999 annual income recorded 27% of COVID-19 cases despite only 14% of the population, while households with over $150,000 annual income recorded 7% of COVID-19 cases despite being 21% of the population as of August 2020 (City of Toronto, 2020). Under capitalism, with or without a pandemic, the poor and working-class experience greater economic and health risks than the wealthy and capitalist class.

The capitalist economic system is the fundamental cause of health inequities or preventable health inequalities in Canada. The findings confirm that the *materialist, macrosocial policies,* and *political economy* are more important than *genetic* and *cultural-behavioural* theories of health inequalities. It disconfirms the dominant biomedical view that individual genes, behaviours, and lifestyles are the primary sources of health inequalities (see Bartley,

2016). Moreover, it somehow contradicts the claims elsewhere that the political economy approach to health that examines the macro-economic policies and ideologies aligned with capitalism is "'impractical', 'ideological', 'radical' and 'unhelpful'" (see Smith, 2013b, p.98). The result shows that critical political economy theory practically exposes the deeper underlying causes of health inequities and the potential ways to effectively address social and health inequities.

It is now established that capitalism results in health inequities. Indeed, as informant political activist Sam Gindin stated: "Capitalism. That's the story." The capitalist political-economic system is highly beneficial to the wealthy and capitalists and detrimental to the poor and workers regardless of race, gender, and other social identities. The outcome of neoliberal capitalism is super profit and wealth accumulation on one end and income, wealth, and property dispossession on the other end. As a result, it produces affluence and longer lives on the one pole and extreme poverty and shorter lives on the other. Thus, to address health inequities in Canada, one must confront capitalism head-on and replace it with an alternative political-economic system that prioritizes peoples' health over profit and wealth accumulation.

5.1.2. The co-constitutives of capitalism: colonialism, racism, and sexism. As discussed in Chapter 4, all informants recognized that an ensemble of dominant social systems: (neoliberal) capitalism, (neo) colonialism, racism, and sexism primarily causes social and health inequities. However, at first, only six interviewees explained -- explicitly or implicitly -- the co-constitutive character of capitalism (class), colonialism (nationality), racism (race) and sexism (gender), seen from a critical political economy theory or the intersections between class, nationality, race, and gender relations, shaping health inequities seen from the intersectionality lens. It is important to emphasize that only one interviewee explicitly mentioned intersectionality. One said racism, and

one said colonialism-racism fundamentally causes social and health inequities. No interviewee right away stated that sexism or patriarchy alone causes health inequities.

The following existing literature further supports the above findings that racialized capitalism exacerbates health inequities between classes and groups. According to Canada's National Collaborating Centre for Determinants of Health, racial and ethnic health inequities are shaped by white supremacy, settler colonialism, and structural racism. Structural racism, which influences institutional, political, and legal systems, moulds policy and population health outcomes (NCCDH, 2018). Structural racism creates health inequities through state violence, land grabbing, toxic environments, psychosocial trauma, inequitable distribution of SDH, and social inequalities (NCCDH, 2018). Racism, which creates inequalities in socioeconomic status, results in racialized health inequalities (Link & Phelan, 1995; Phelan & Link, 2015). Racism, entwined with colonialism and capitalism, produces health inequities.

More concretely, in the imperialist-colonialist USA, the epicentre of today's global capitalism, generally, the non-racialized Whites are economically well-off than the racialized Indigenous, Blacks, and Latinos. The latter group has higher unemployment, poverty, and diabetes-associated mortality rates than the former. Moreover, Whites are more affluent and have lower levels of psychological distress than Asians (Bailey et al., 2017). In Australia, New Zealand, and the Pacific, the Indigenous have higher unemployment, lower relative income, shorter life expectancies, and higher IMR than non-Indigenous (Anderson et al., 2006). In Canada, the Indigenous experience deeper poverty, lesser access to health care, and more significant mental health problems than non-Indigenous (Nelson & Wilson, 2017). These conditions shorten their lives such that the female/male life expectancy in British Columbia was 85/80 years, while in Nunavut, it was only 74/69 years in 2013-2015 (Statistics Canada, 2018).

Furthermore, amid the COVID-19 pandemic, the capitalist state and corporate class's dominance over the working class are further revealed in the biggest outbreak in North America in the Cargill meat plant in Alberta. Although nearly a thousand workers got infected with some deaths (Dryden & Rieger, 2020), the plant was hastily reopened without workers' representation in the investigation (Smith, 2020). The labour force on this facility mainly consists of temporary foreign workers: Filipinos, Chinese, and Vietnamese, who have few social supports and health benefits (Dryden & Rieger, 2020). The capitalist state and corporate class prioritize profit over the health of these racialized workers, most of whom continuously experience (neo) colonial practices of economic exploitation and oppression. Racialized capitalism entangled with the long history of colonialism creates co-constitutive class and racial/ethnic health inequities.

However, social and health inequities are not only shaped by class and colonial-racial relations but also by unequal gender relations underlying health politics and policy. For example, in OECD countries, females only occupy minority leadership roles despite comprising most of the labour force (OECD, 2020b), meaning they are under-represented in high-level policy decision-making necessary to push for their economic and health agendas (Borras, 2021). Moreover, across 104 countries, although females occupy 70% of the jobs in the health industry, males are paid higher than females. The gender pay gap is 28% (Boniol, 2019). As discussed earlier, during the early stage of the COVID-19 pandemic, working hour losses also impacted more females than males (ILO, 2020a). This is because: First, more females (40%) than males (37%) were employed in the severely affected industries like food services, retail, and manufacturing. Second, out of 55 million domestic workers, 37 million women faced higher employment and income losses. Third, between 70-80% of females were employed in the social

work and health sectors. Lastly, unpaid domestic labour, 75% shouldered by females, increased due to lockdowns (ILO, 2020b).

Worse, employment and income losses due to lockdowns intensified violence against women (WHO, 2020). In Canada, the Minister for Women and Gender Equality reported that gender-based violence increased by 20% to 30% and a high 400% in some places during the early pandemic (Patel, 2020). These upsurges were facilitated by close contact with the violent partner, disrupted social support, constrained legal aid, and reduced access to health services (WHO, 2020). Gendered capitalism produces co-constitutive class and gender health inequities.

As discussed in the previous chapters, before and amid the COVID-19 pandemic, female workers suffered more adverse health outcomes than other classes and groups in the Canadian healthcare system (e.g. see Brophy et al., 2020; Messing & Grosbois, 2001). In the LTC, due to low wages, the racialized female workers have multiple jobs, exposing them to further health risks. Moreover, these mostly frontline workers experience understaffing and heavy workloads, contractualization and casualization, racism and sexism, and various forms of abuse and violence harming their well-being (Armstrong, 2020; Armstrong & Armstrong, 2010; Armstrong et al., 2020; Borras, 2021; Daly et al., 2011; Gupta, 1996; Morrow et al., 2007; Syed, 2020). In retrospect, my partner and I and numerous co-workers, immigrant workers in a racialized and gendered workplace, continue to experience these conditions in varying forms and degrees. Racialized and gendered capitalism mainly caused the ensemble of class, gender, and racial health inequities.

The critical realist review of literature and thematic analysis of the interview data corpus demonstrate that Canada's capitalist state is built upon an enduring history of colonialism. However, the all-encompassing cause of health inequities in today's Canada is not colonialism,

racism, or sexism. Instead, the central problem is capitalism, entangled with all other 'isms' for the most part. Capitalism, colonialism, racism, and sexism -- acting in combinations more than in silos -- adversely impact Canadians' working, living, and health conditions: the colonized, racialized, and subjugated females are further disadvantaged. These findings are significant because they can provide individuals, groups, and organizations a solid foundation for concentrating their research and social actions toward health justice: addressing class, race/ethnicity, and gender health inequities requires confronting racialized and gendered capitalism.

5.1.3 Maldistributive public policies. As discussed in Chapter 4, only five informants spontaneously responded that social and health inequities are the outcomes of Canadian governments' policy actions and inactions. However, as the interview progressed, all informants acknowledged the limitations of public policies to address health inequities. The enacted and implemented public policies, especially under the neoliberal governments, failed to distribute the social determinants of health equitably.

The following literature further supports the above findings. For example, the United Nations reproached Canada for persistent poverty, housing insecurity, and homelessness for the third time. The United Nations (2016) categorically stated:

> [The] Committee is concerned about the significant people living in poverty.... the persistence of a housing crisis... (1) absence of a national housing strategy; (2) insufficient funding for housing; (3) inadequate housing subsidy within the social assistance benefit; (4) shortage of social housing units; and, (5) increased evictions related to rental arrears....

> increasing number of homeless persons... the lack of adequate measures to prevent homelessness... (pp.6-7).

Perhaps, due to international and national pressures and the upcoming federal election in 2019, the governing Liberal Party released Canada's First Poverty Reduction Strategy and the National Housing Strategy in 2018. In 2018, Canada's child poverty rate was 11.8%, compared to Norway's 8.1% and Finland's 3.5% (OECD, 2021c). In addition, Canada's housing insecurity level was 12.7% (GOC, 2018), and its food insecurity level was 12.5%, impacting 1.8 million households and 4.4 million persons, including 1.2 million children in 2017-2018 (Tarasuk & Mitchell, 2020). These statistics support the claims that Canadian state policies are failing and significantly lagging behind the social democratic countries.

In my view, while the federal government steered Canada's First Poverty Reduction Strategy and National Housing Strategy, the impacts of these policies are too early to assess because of the transitory effects of the COVID-19 Response Measures Act (GOC, 2020), and given the socioeconomic and political conditions remaining highly volatile. Still, Canada does not have a 'National Food Strategy,' which speaks for how the federal government treats food insecurity and the capitalist mode of food systems. Meanwhile, housing prices soared, the homeless were displaced from encampments, the food insecure drove in flocks to the foodbanks, and the historically disadvantaged groups were unequally infected, hospitalized, and died of COVID-19. The billionaire pandemic profiteers boastfully rocketed into space amid these human miseries.

Furthermore, it is essential to emphasize that redistributive public policies are subject to reversals, especially under neoliberal governments, as the informants attested. Thus, I reflected on Ontario's Progressive Conservative Party policy actions within the first few months of their

governance. First, they enacted Bill 47, freezing the minimum wage at $14/hour, scrapping the paid sick leave, and repealing equal pay for casual and part-time workers (Legislative Assembly of Ontario, 2018) – these are pro-capitalist and anti-labour policy changes.

Second, the Conservative government terminated the basic annual income pilot project. Obviously, they ignored that the MINCOME experiment has improved the social and health conditions of those living in poverty (see Forget, 2011). Again, this is an anti-poor policy. Third, they dissolved the Roundtable on the Violence Against Women that advised the province on women's violence-related issues (Hayes & Stone, 2018). This policy change negatively impacts women-child and parents' health. Fourth, the Conservative government cut its funding to the Ontario College of Midwives (Syed, 2018) and many other healthcare cuts documented by the Ontario Health Coalition (OHC, 2019), eroding Canada's universal healthcare systems.

Finally, the Conservative government slashed the size of the Toronto City Council from 47 to 25 wards (CBC, 2018). This political action is more informed by the market principle of downsizing and less by a democratic representation of peoples and communities as diverse as Toronto. This policy change is anti-pluralistic and anti-democratic. Instead of pursuing more political representation, it deepens the unequal distribution of political power under the guise of austerity.

The above state policy actions inequitably redistribute economic wealth and political power. Canadian governments help accumulate wealth and power into the hands of economic and political elites while dispossessing the workers and the masses. These policy trends showed that the Canadian governments perpetuated neoliberal capitalism. These findings are hardly surprising. As Banting and Myles (2013) show, Canada has had a 'fading of redistributive politics' as exemplified by weakening unemployment benefits, social assistance, and progressive

taxation, among others. Specifically, Langille (2016) demonstrates that Canada's public policies around the SDH have been increasingly influenced by the corporate class lobbying for neoliberal macroeconomic policies favouring the elite, thus the persistence of health inequities.

The critical realist review of the literature and thematic analysis of the interview data corpus demonstrate that health inequities in Canada are exacerbated by deliberate state actions that veered away from Keynesian to neoliberal public policies. As Albo stated: Canada's "political system from the beginning establishes a series of blockages to provide non-capitalist solutions to any social problem" (Interviewee). Looking beyond Keynesianism and neoliberal capitalism is necessary. In capitalism, existing redistributive healthy public policy and public health policy are highly susceptible to regressive policy reversals.

What is the alternative? As discussed in the previous chapters, socialism is a potential path toward alternative politics and public policymaking to reduce avoidable health inequalities.[42] Canada's universal healthcare system is an example of a socialistic non-maldistributive public policy that is not readily predisposed to reversal because the larger sections of the population support it. One must remember that it is the socialists that initiated this kind of policy reform that lasted for a long time despite intensifying efforts of neoliberal state and corporate actors to deregulate and privatize Canada's healthcare systems and services.

5.2 Factors Sustaining Health Inequities

[42] As mentioned earlier, further details about socialism are beyond this study. The reader is thus directed to some readings. For example, according to Wood (1995), socialism is the antithesis of capitalism. Wood (1995) states: "Socialism can no doubt be understood as building upon the developments of capitalism while resolving its specific contradictions; but to acknowledge the specificity of capitalism is at the same time to insist on the specificity of socialism, not simply as an extension of, or an improvement upon, capitalism but as a system of social relations with an inherent logic of its own: a system not driven by the imperatives of profit maximization, accumulation and so-called 'growth', with their attendant waste and degradation - material, human and ecological - a system whose values and creative impulses are not circumscribed by constricted notions of technological progress." (p.162). See also *The Socialist Manifesto* by Sunkara (2019).

My thematic analysis of the interview data corpus identified five factors maintaining health inequities in Canada. First, power, interest, and ideology in silos or combinations trump evidence-based research and policy ideas that address health inequities. Second, the unequal resources among competing interest groups resulting in unequal policy advocacy fields sustain health inequities. Third, the dominance of the business and corporate sector in political and public policy institutions perpetuates health inequities. Fourth, the neoliberal governing authorities and political parties fail to reduce health inequities. Finally, fragmented and weak labour, civil society, and social movements contribute to Canada's persistent health inequities.

5.2.1 Power, interest, and ideology trump evidence. As discussed in Chapter 4, the informants unanimously recognized that power, interest, and ideology override evidence-based research and policy ideas to reduce health inequities. Moreover, the informants' collective insights demonstrate that the influence of evidence on healthy public policy and public health policymaking is often minimal and rarely substantial.

Power trumps evidence. The balance of power among state and non-state policy actors determines the success or failure of evidence-based research and policy ideas to reduce health inequities. At present conjuncture, the dominant power of governing authorities and big capitalists over other policy actors supersedes evidence about the causes of and potential means to reduce health inequities. On the one hand, the result validates the claims that corporate power dominates Canadian public policies around the SDH (e.g. see Bryant & Raphael, 2020; Raphael, 2014, 2015). Moreover, it confirms *policy process is all about power* (Carey et al., 2016) and that health policy is about *process and power* (Walt, 1994). On the other hand, it contradicts the claim that 'institutionalized ideas' or 'policy paradigms' (Smith, 2007, 2013a,b; 2014; Hall,

1993) fundamentally filter, alter, and obstruct healthy public policy and public health policy. Health politics is more about power than evidence and ideas.

Interest trumps evidence. Aside from power, interest directs the success or failure of evidence-based research and policy ideas to reach the realms of public policy. At present, the interests of the business and corporate sector and neoliberal governing authorities prevail over evidence about the causes of and potential means to reduce health inequities. The result affirms the claims that corporate interests dominate Canadian policies around the SDH (Bryant & Raphael, 2020; Langille, 2016). Again, it contests the claim that 'institutionalized ideas' or 'policy paradigms' (Smith, 2007, 2013a,b; 2014; Hall, 1993) chiefly strain, change, and block healthy public policy and public health policy. Health politics is more about interest than evidence and ideas.

Ideology trumps evidence. Aside from power and interest, ideology influences the success or failure of evidence-based research and policy ideas to reach the institutional public policymaking processes. At present, the dominant ideology of governing authorities aligned with capitalism supplants evidence about the causes of and potential means to reduce health inequities in Canada. The result confirms that political ideologies shape public policies and SDH distribution (Baum et al., 2013, 2020; Exworthy, 2002; Navarro et al., 2006). Again, it challenges the claim that 'institutionalized ideas' or 'policy paradigms' (Smith, 2007, 2013a,b; 2014; Hall, 1993) fundamentally sieve, modify, and hinder healthy public policy and public health policy. Canada is a capitalist society, and the capitalist state upholds market fundamentalism, liberalism, conservatism, and individualism. Health politics is more about ideology than evidence and ideas.

The axis of power, interest, and ideology dominates institutional health politics and public policymaking, relegating evidence-based research and policy ideas into the peripheries. On the one hand, the result corroborates the claims that evidence hardly influences public policy to reduce health inequalities (e.g. see Carey & Crammond, 2015a,b; Petticrew et al., 2004; Smith, 2007, 2013a,b; 2014; Whitehead et al., 2004). On the other hand, it refutes the claim elsewhere that health inequalities reduction fails because of the non-implementation of evidence-based policies (Mackenbach, 2010, 2011). In Canada, it is not evidence, institutionalized ideas, and policy paradigms that influence healthy public policy and public health policy, but rather ideology, interest, and power. Health politics is more about the power-interest-ideology axis.

In Canada, existing document data show that there is no shortage of evidence-based research and research-informed ideas and policy proposals addressing the inequitable distribution of social determinants of health resulting in health inequities, including but not limited to class, gender, and racial health inequities (e.g. see Borras, 2021; Bryant, 2016; Epp, 1986; Lalonde, 1974; Mantoura & Morrison, 2016; NCCDH, 2018; Raphael, 2016, 2020; Raphael et al., 2004, 2020). As discussed in the literature review, Raphael (2012) provided seven discourses tackling health inequalities in Canada: biological, social and health services access, modifiable behaviour and lifestyle, material living conditions, public policy shaping the material living conditions, political and economic structures and ideologies, and power and influence. Indeed, the last three discourses are most helpful for understanding the causes of and ways to reduce health inequities.

Specifically, the findings partly confirm and disconfirm Smith's (2007, 2013a,b; 2014) studies about successful, partial, fractured, recontextualized, weak, or non-journey ideas in health inequalities reduction. Like Smith's informants, unanimously, my interviewees explained that *evidence* insignificantly influences healthy public policy and public health policy. However,

unlike Smith's, this research finds that not *institutionalized ideas,* but power, interest, and ideology reject, modify, or accept *research-informed ideas* and policy proposals. These findings are significant because they strengthen each claim and compensate for their limitations.

The findings suggest that to sufficiently address preventable health inequalities, one must go beyond 'evidence-based policy' or 'policy paradigms' or 'research-informed ideas' to confront the axis of power-interest-ideology. As discussed earlier, ideas, paradigms, and ideologies are distinct concepts. Thus, to strengthen Smith's six journeys of ideas, it may be helpful to emphasize that the abstract-subjective ideas, paradigms, and ideologies are fundamentally based on the concrete-objective material and social conditions of life.

Social relations of power, interest, and ideology shaping health inequities must be acted upon more as an ensemble rather than in silos. As discussed in the previous chapters, the critical political economy theory that accounts for power, interest, and ideology in an integrated way sufficiently explains the causes of and factors sustaining health inequities, neo-pluralism to a moderate degree, and classical pluralism and discursive institutionalism to a lesser degree.

5.2.2 Unequal resources of competing interests and advocacy groups. As discussed in Chapter 4, all interviewees acknowledged that unequal wealth, power, and influence among competing interests and advocacy groups: e.g. politicians, policymakers, and political parties; businesses and corporations; labour, civil society, and social movements; academics, activists, and advocates, results in unequal public policy advocacy field, sustaining health inequities.

The result validates the claim of the pluralists that numerous competing interest groups participate in public policymaking to influence governing authorities' decisions (Dahl, 1961; Kindon, 1984). It further confirms that in a parliamentary and liberal democracy, many centres of power (Mudde & Kaltwasser, 2017) and multiple pressure groups vie to shape state policy

according to their material interests (Dahl, 1961, 1984; Lindblom, 1979, 1982). However, contrary to classical pluralists' claim that political participation is accessible to all citizens, whereby individuals and groups have equal opportunities to influence health politics and public policy (Bryant, 2016; Dahl, 1961; Howlett et al., 2009), the result shows that the governing authorities tend to listen to more powerful and influential individuals, groups, and organizations.

The result shows that state public policies impacting peoples' health may not represent the common interests of various advocacy groups but rather mainly reflect the interests of the most powerful and influential groups. As such, they contradict the view that state policies always follow democratic consultative processes to address social issues like poverty (see ESDC, 2018), housing insecurity and homelessness (see GOC, 2018) and food insecurity (see GOC, 2019). In a neoliberal capitalist state like Canada, the pluralistic approach to addressing unjust health inequalities through consultation, compromise, or consensus may be considered pretentious.

In Canada, competing interests and advocacy groups do not have equal chances to influence public policy to reduce health inequities. The quality and quantity of the distribution of the SDH are shaped fundamentally by the degree and balance of wealth and power among state and non-state policy actors. The result is significant because Canada projects itself as a champion of equity, diversity and inclusivity, a pluralist democratic state offering equal opportunities to develop human potential to the fullest regardless of class, gender, race and other identities.

5.2.3 Dominance of the business and corporate sector. As discussed in Chapter 4, all informants acknowledged that the big capitalists have tremendous wealth, power, and influence

than other competing interests and advocacy groups. In Canada, the dominance of the business and corporate sector in political and public policy institutions maintains health inequities.

The result reinforces the neo-pluralists' contention that the business and corporate sector has considerable power and influence in shaping public policymaking processes (see Cawson, 1978; Lindblom, 1982; Macfarland, 2007; Mills, 1956), adversely impacting population health. Contrary to arguments that since non-state policy actors use their power to shape state policy decisions, power is diffused rather than consolidated in the most powerful competitor (Dahl, 1961, 1984; Lindblom 1979, 1982), the result shows that power is somewhat concentrated in the hands of economic and political elites and oligarchs. Although power is numerous and dispersed in Canada, it is unequally distributed among classes and groups vying to influence healthy public policy and public health policy.

Moreover, the result supports the claims that big corporations dominate healthy public policymaking processes, as also seen in Australia (Baum et al., 2013, 2020), the United Kingdom (Scambler, 2002, 2019a,b) and Canada (Bryant & Raphael, 2020; Langille, 2016; Raphael, 2015, 2016). Specifically, corporate power (Carroll & Sapinski, 2018) eroded Canada's redistributive politics and public policy (Banting & Myles, 2013) and weakened the welfare state system (Finkel, 2018; McBride & Shields, 1997; Peters, 2012), sustaining health inequities. The corporate power elite pushed for public policies satisfying their rapacious needs and interests for profit and wealth accumulation resulting in the inequitable SDH distribution.

In Canada, the dominant power and influence of the business and corporate sector heavily shape public policy that inequitably distributes the social determinants of health, including but not limited to employment, housing, early child development, and healthcare systems and services, resulting in health inequalities (Raphael, 2015), intensifying social and material

deprivation, resulting in psychosocial stress, unhealthy coping behaviours, and health inequalities (Bryant & Raphael, 2020; Raphael, 2014, 2015, 2016). As introduced, among others, the Canadian corporate power elites are represented by the Canadian Chamber of Commerce, C.D. Howe Institute, National Citizens Coalition, and Earncliffe Strategy Group (Langille, 2016). These powerful lobby groups and the governing authorities' ideologies aligned with capital interests largely shape public policy in their favour, maintaining health inequalities (Bryant, 2015a,b; 2016; Bryant & Raphael, 2020; Raphael, 2014, 2015). The dominance of the business and corporate sector in health politics and public policy must be challenged vigorously to reduce health inequities.

Aligned with the politics of *who gets what, when, how* (Lasswell, 1958), the result shows that in Canada, while the less influential workers and masses are marginalized in health politics and public policymaking, the more influential big businesses and corporations primarily direct the distribution of societal resources based on their economic interests. However, accentuating the dominance of the corporate power elite in public policy while ignoring the deeper realities of the conflict-based class structures and balance of power among contending class forces is risky. As discussed earlier, peoples' movements could boost their collective wealth, power, and influence through information, organization, and mobilization. Power asymmetries among social forces could be altered, favouring the less powerful competing interest and advocacy groups when they unite, organize, and mobilize against corporate power, interest, and ideology. Doing so might help reverse the spiralling social and health inequities across and within countries.

5.2.4 Neoliberal governing authorities. As discussed in Chapter 4, all interviewees -- explicitly or implicitly -- explained that the governing authorities and political parties in power, especially the Conservative Party and Liberal Party, through public policy actions and inactions,

primarily serve private interests while decentering labour, civil society, social movement, and public interests, sustaining social and health inequities in Canada.

On the one hand, the result validates the claim of neo-pluralists that the state is not a neutral arbiter of societal and public health affairs because it also acts independently to protect its economic and political interests (Howlett et al., 2009). On the other hand, it contradicts the claim of classical pluralists that under polyarchy, the state acts as an unbiased umpire of societal and public health affairs (Bryant, 2016; Dahl, 1961, 1984; Howlett et al., 2009). Instead, the result corroborates the claims that the oligarchs and political power elites primarily mould public policies to fulfill their private economic and political interests (Mills, 1956; McFarland, 2007), sustaining class, racial, and gendered health inequalities (Hofrichter, 2003; Scambler, 2002, 2019a,b). The historical-political-economic tradition of the neoliberal governing authorities pushes capitalism despite its harmful effects on the workers and masses.

The result further challenges some of the most influential proponents of SDH working from a pluralist framework who suggest cooperation and coordination among multi-stakeholders, including private businesses and corporations, is fundamentally needed to reduce avoidable health inequalities (e.g. WHO, 2008; Marmot et al., 2010, 2020). For these classical pluralists, the solution to health inequities is for numerous state and non-state actors to work on a consensus-based healthy public policy and public health policy satisfying common interests. However, if one ignores capital, colonial, patriarchal, and racial structures, one consciously obstructs the real 'causes of the causes of health inequalities.' Moreover, as the critical realist literature review and thematic analysis of the interview data corpus show, some competing interests are irreconcilable.

There is no common ground among neoliberal governing authorities, corporate class, and peoples' movements. *Common ground* is a fantastic illusion created mainly by the former group assuring the latter that democratic participation of all societal sectors in policymaking is ensured, further legitimizing their actions. In Canada, at the federal level, the political institutions have been ruled alternately by the Conservative Party and Liberal Party. Although these governing authorities also act freely, their policies often support the profit interests of the capitalist class, especially the big businesses and corporations. In contrast, they often send off to the peripheries the interests of the poor and working-class and subordinated groups. Contemporary health politics in Canada are controlled by the neoliberal state players from the same elite economic and political backgrounds, collaborating closely with the corporate class. Pluralism in a capitalist system is a farce. The consensus-based pluralist approach to health inequities in neoliberal capitalism is unsound. The politics of health is often antagonistic and hostile.

5.2.5 Fragmented and weak labour, civil society groups, and social movements. As discussed in Chapter 4, all informants -- explicitly or implicitly -- acknowledged that the divisions within the ranks of the peoples' movements: labour unions, civil society groups, and social movements undermine their power and influence to surmount the dominance of the capitalist class and neoliberal governing authorities that inequitably distribute economic and other societal resources to their advantage, maintaining health inequities.

The result validates the claim that the weak labour unions and weak social democratic movements mirror the weak welfare state systems in advanced capitalist countries, sustaining health inequalities (e.g. see Navarro, 1999). It has been established that in liberal welfare states with lower union density, social security expenditures, public employment, and women's labour participation, health outcomes are not better than in social democratic states (e.g. see Bryant &

Raphael, 2020; Navarro & Muntaner 2017; Navarro & Shi, 2002). Specifically, the fragmented and weak labour movement reflects the low and sustained decline in union density, maintaining health inequalities (Benach et al., 2016; Muntaner et al., 2010; Raphael, 2015), as further shown in Table 7 below, which I constructed.

Table 7. Trade Union Density and Collective Bargaining Coverage versus Low Pay, Poverty, and Infant Mortality

Countries	Trade Union Density (TUD)		Collective Bargaining Coverage (CBC)		Wage Level, Low Pay (WLLP)		Total Poverty Rate (TPR)	IMR
	2000	2018	2000	2018	2000	2018	2018	2018
Liberal								
Australia	24.9	13.7	60.0	61.2	16.35	15.43	12.4	3.1
Canada	28.2	25.9	32.4	30.1	23.25	20.68	11.8	4.7
UK	29.8	23.5	36.4	26.0	20.85	18.96	11.7	3.9
USA	12.9	10.1	13.9	11.7	24.70	24.07	17.8	5.7
Social democrat								
Denmark	74.5	67.5	85.1	82.0	7.36 (2002)	8.73	6.1 (2017)	3.0
Finland	74.2	60.0	85.0	88.8 (2017)	4.60 (2001)	7.32	6.5	2.1
Norway	53.6	49.9	74.0 (2004)	69.0 (2017)	No data		8.4	2.3
Sweden	81.0	65.5	87.7	88.0	No data		8.9	2.0

Sources: OECD (2021a,b,c,d,e).

Table 7 shows the links between trade union density (TUD), collective bargaining coverage (CBC), low pay (LP), total poverty rate (TPR), and infant mortality rates (IMR) in selected liberal and social democratic countries. Again, the liberal states, including Canada, recorded lower percentages of TUD and CBC and higher percentages of LP, TPR, and IMR than the social democratic states. Remarkably, the forerunner of global neoliberal capitalism, the USA recorded the lowest percentages of TUD and CBC and the highest percentages of LP, TPR,

and IMR. The USA's path is not the way to reduce health inequities. Trade union density and collective bargaining coverage have inverse relationships with low pay, poverty, and infant mortality.

Furthermore, the result confirms the claims that the fragmented and weak civil society groups, like the SDH advocates and social movements, like the health movements, sustain health inequalities (e.g. see Baum et al., 2020). Nonetheless, social movements and civil society groups can also improve population health through redistributive public policy advocacy (Baker et al., 2018; Baum, 2007; Baum et al., 2009; Baum et al., 2020). It is common knowledge that together, there are thousands of labour unions, civil society groups, and social movements with millions of members greatly outnumbering the neoliberal state and corporate policy actors. However, since these peoples' movements are not united, they are not strong enough to counter the power elites. This fundamental weakness of the peoples' movements should be addressed decisively amid the global convergence of multiple existential crises: economic, ecology, pandemic, imperialism, authoritarianism, and nuclear war threat.

Social change necessary to reduce health inequities will not be delivered *from above* by the power elites who adhere to the principles of neoliberal capitalism unless compelled by the peoples' movements. World history shows that transformative social change often comes from unified struggles of the peoples' movements *from below*. There is an urgent need to regroup and restrengthen progressive and socialist peoples' movements toward health inequities reduction in Canada. In my mind, this is one of the crucial findings of this research that may inform the reader on how to move forward health inequities research, policy, and practice.

5.3 Moving Forward to Reduce Health Inequities

The preceding results have addressed why and how health inequities or avoidable health inequalities, especially class, race/ethnicity, and gender health inequalities persist in Canada. The following themes answer the question of how to reduce health inequities: 1) pushing for redistributive public policies; 2) uniting and strengthening labour unions, civil society groups, and social movements; 3) engaging in electoral politics; and 4) core strategies toward redistributive public policies, united and strong labour, civil society, and social movements, and alternative politics.

5.3.1 Pushing for redistributive public policies. As discussed in Chapter 4, the collective insights of the informants yielded at least 39 specific policy proposals to reduce social and health inequities in Canada. These policy recommendations include but are not limited to improving employment and working conditions, increasing income support, providing public and social housing, expanding healthcare systems and services, enhancing progressive taxation, intensifying unionization levels, and electoral reform.

Improving employment and working conditions. More than half of the informants proposed policy changes improving employment and working conditions, including but not limited to full-time employment, secure employment, minimum wage increase, a living wage, paid sick days, employment equity, and pay transparency to reduce health inequities. These proposals are crucial because even before the increased losses of jobs and incomes amid the COVID-19 pandemic, about 1.2 million people were unemployed, and 3.6 million were part-time employees in Canada in 2019 (Statistics Canada, 2020). As discussed earlier, unemployment is directly linked with low income, relative poverty, and mortality differences among social classes (Wilkinson, 1989, 1992, 1997), while precarious employment results in significant financial and health risks (Benach et al., 2014, 2016; Matilla-Santander et al., 2021; Muntaner et al., 2010). In

contrast, permanent workers with a living wage show positive results for the workers, employers, and communities (Ivanova et al., 2021; Living Wage Canada, 2013). A secured and well-paying job means stable income plus health benefits and thus fewer health inequities.

Increasing income support. More than half of the informants proposed augmenting income support. It is essential because low income may mean living below the poverty line. Before the COVID-19 pandemic, poverty impacted about 4.4 million people in Canada in 2018 (OECD, 2021c). As discussed earlier, poverty is the single most significant determinant of avoidable health inequalities. In contrast, the "hypothetical impact if Canadians in bottom 4 income levels experienced the same indicator rate as those in highest income level," there would have been one million fewer food insecure households in 2011-2012; 673,700 (32.1%) fewer people living with diabetes in 2013; 580,700 (24.1%) fewer women with obesity in 2013; and 300 (15.1%) fewer infant deaths in 2011 (CIHI, 2015).[43] Higher income improves health outcomes.

Providing public and social housing. Almost half of the informants proposed social and public housing at all government levels. It is imperative because even before the COVID-19 pandemic, housing insecurity impacted 1.7 million households in Canada, of which 55% were women-led in 2018 (GOC, 2018). As discussed earlier, the housing-insecure persons recorded higher physical injury, psychological stress, and cardiovascular-related mortalities than the housing secure (WHO, 2018). In contrast, the "hypothetical impact if Canadians in bottom 4 income levels experienced the same indicator rate as those in highest income level", there would have been 1.6 million fewer housing insecure households in 2011 (CIHI, 2015). Socialized housing can reduce health inequities.

[43] Average annual income in 2011: lowest income (level 1) $16,000; second-lowest income (level 2) $28,400; middle-income (level 3) $39,100; second-highest income (Level 4) $52,000; highest income (level 5) $87,100 (CIHI, 2015).

Expanding healthcare systems and services. More than half of the informants suggested strengthening Canada's universal healthcare system. It is vital because even before the COVID-19 pandemic, the marginalized classes and groups experienced inequitable healthcare access (McGibbon, 2016). Specifically, 3.4 million people over 12 years old reported unmet healthcare needs in which low-income persons were more likely to suffer than higher and middle-income persons in 2014 (Statistics Canada, 2016). In contrast, the "hypothetical impact if Canadians in bottom 4 income levels experienced the same indicator rate as those in highest income level", there would have been 11,000 (14.6%) fewer heart attack hospitalizations; 9,000 (31.6%) fewer alcohol-related hospitalizations; and 40,300 (26.8%) fewer mental health hospitalizations in 2012 (CIHI, 2015). Expanding healthcare systems and services can improve population health and reduce health inequities.

Enhancing progressive taxation. More than half of the informants proposed bolstering progressive taxation. It is central because adequate and long-term funding is required to finance public policies to improve working, living, and health conditions. Most informants proposed that the wealthy and the corporate class be taxed higher. As discussed earlier, corporate income tax declined by 21% between 1980 to 2019, and the income tax for the wealthiest decreased by 10% from 1980 to 2021 (Broadbent Institute, 2021). Notably, if the largest 198 companies paid the same corporate income tax rate of 28% in 2000 rather than 19% in 2009, Canada's governments could have added $12 billion in tax revenue (Mcdonald, 2011). Recently, the Parliamentary Budget Officer estimated that a 1% net wealth tax on 13,800 Canadian families earning over $20 million per annum would add a tax revenue amounting to $5.6 billion in 2020-2021 (Wodrich, 2021). A more progressive taxation system to support redistributive public policies is required to reduce health inequities.

Intensifying unionization levels. About one-third of the informants proposed increasing unionization density. It is essential because de-unionization and concessions around collective bargaining agreements resulted in the rise of precarious employment in Canada (Banting & Myles, 2013; Carroll & Sapinski, 2018; Finkel, 2018; McBride & Shields, 1997; Peters, 2012). In contrast, two decades ago, Navarro and Shi (2002) demonstrated that health is better in social democratic countries with higher union levels than in liberal welfare states like Canada with lower union levels. Recently, although only 1.3% or 33/2433 articles published in the Health Promotion International journal talked about unions, unionization and collective agreements, Muller et al. (2021) reaffirm that higher union density and collective agreements improve health-related public policy and occupational health and safety. There is extensive evidence that unionization improves wages and benefits, job security, working conditions, and health outcomes (Muller & Raphael, 2021). As shown in Table 7, trade union density and collective bargaining coverage are inversely related to low pay, total poverty, and infant mortality. For numerous reasons discussed earlier, the crux of intensifying unionization levels, critical in social and health inequities reduction, is on the workers, not corporations and neoliberal governing authorities.

Electoral reform. About one-fourth of the informants proposed electoral reform. It is crucial because electoral systems "influence the choices that voters and political parties make, and thus play a key role in shaping the political outcomes that emerge from their use" (Pilon, 2016, p.25). In Canada, however, as McKenzie stated: "the first-past-the-post way that we run our government actually makes it fairly difficult for everyday people to make choices that make sense to them." (Interviewee). The first-past-the-post that reflects inequitable representation needs a replacement.

Specifically, the Angus Reid Institute found that 3/5 of the Canadian voters preferred proportional representation. The survey respondents were shown the recent federal election results and seat distributions: Liberal 158, Conservative 119, Bloc Québécois 34, NDP 25, Green 2, People's Party 0, whereas hypothetically, the seat distributions under proportional representation: Liberal 109, Conservative 109, Bloc Québécois 24, NDP 65, Green 11, People's Party 21 (Korzinski, 2020). These data suggest that the Liberal and Bloc Québécois gained 49 and 10 additional seats, while the Conservative, NDP, Green, and People's Party lost 10, 40, 9, and 21 seats. The proportional representation looks democratic than the first-past-the-post and may help realize redistributive public policies that reflect the general population's interests.

Further details on 39 public policies recommended by the informants are beyond this study. However, most of those proposals were forwarded a long time ago. For example, the Lalonde Report (1974) proposed health promotion, regulation, research, healthcare efficiency, and goal setting that integrates 74 proposals forming the 'Health Field Concept.' The Black Report (1992) offered 37 public policies focusing on information and research, social and health services, and strategies beyond the healthcare system. Moreover, the Acheson Inquiry (1998) recommended 39 policies targeting poverty, income, tax benefits; education; employment; housing and environment; mobility, transport, pollution; and nutrition and agriculture. Finally, Wilkinson & Marmot (2003) identified early life, social gradient, unemployment, work, social exclusion, stress, addiction, social support, food, and transport and proposed tackling these SDH through redistributive public policies on income, employment, and education.

In Canada, there is no shortage of research-informed policy proposals that can address the inequitable distribution of social determinants of health to reduce health inequities. For example, Mikkonen and Raphael (2010) and Raphael et al. (2020) outline numerous policy proposals

addressing (un)employment and working conditions, (un)employment security, income and wealth distribution, housing, food (in)security, education, early child development, social safety net, healthcare services, social exclusion, disability, gender, race/ethnicity/indigeneity, immigration status, geography, and globalization to reduce health inequities (see also Raphael, 2016). The authors' books have been downloaded over a million times. Moreover, the NDP incorporated the SDH into its political and policy agenda before. Thus, it is difficult to imagine that politicians and policymakers are not aware of the inequitable distribution of SDH and the resultant health inequities between classes and groups.

However, the critical realist review of the literature and thematic analysis of the interview data corpus show that the problem persists despite vast public policy proposals and interventions to address preventable health inequalities. As discussed earlier, among the leading causes, reasons for policy failures, and barriers to reducing health inequities in Canada are the capitalist system itself, the dominance of corporate power and influence, and neoliberal governing authorities shaping policy to their advantage at the expense of the general public. The following themes offer alternative ways to reduce health inequities.

5.3.2 Uniting and strengthening labour, civil society, and social movements. As discussed in Chapter 4, all informants -- explicitly or implicitly -- acknowledged that since labour unions, civil society groups, and social movements are fragmented and weak at the present moment to prevail over big corporations and neoliberal governing authorities dominating health politics and public policy, they suggested uniting and strengthening these peoples' movements to effect social and policy change. As the informants attested, collective struggles of peoples' movements bring about redistributive public policies necessary to reduce health inequities. To remind the reader of some of their successes, I requote:

Academic-activist Anonymous N19: "I've seen the power of really popular movements… led by the people affected… the fight for $15... It's a very powerful movement that led to significant changes." Moreover, around housing struggles, activist Crowe testified: "It was a very vibrant, popular movement supported by unions… foundations… faith groups… [I]t was a national movement that led to the first national housing program." Anti-poverty activist Clarke: "We took up a fight… to get people access to a benefit called the special diet for people on social assistance… [T]his had gone from a benefit paying $6 million a year to $200 million a year."

Academic-activist-advocate Armstrong expressed: "We need unions that aren't business unions, but unions that are progressive social movement unions." Academic and public scholar Bryant stated: "We do need the labour movement, but it needs to be more radical… Civil society organizations also have to be willing to stick their necks out." Unity is key because "if there were a rainbow coalition of these groups that realize that you can actually rise all boats on the tide, you would do better" (McKenzie: Academic-Activist-Advocate). Carroll, an academic who works with social movements, declared: "there needs to be a kind of movement of movements."

Aside from the above narrative lived experiences, one may also learn lessons from the historic Ontario's Days of Action (e.g. see Darrah, 2020; Kellogg, 2011), Maple Spring (e.g. see Bégin-Caouette & Jones, 2014; Collombat, 2016), and Alberta's Nurses Strike (e.g. see UNA Local 1, 2015), among other collective forms of resistance and struggles to improve peoples' working, living, and health conditions. Furthermore, successful stories of people power over corporate power and state power are well-documented worldwide (e.g. see Transnational Institute, 2017, 2018). Notably, amid the COVID-19 pandemic and the multiple existential crises, some peoples' movements are unifying and strengthening their ranks to overcome the power of big corporations and capitalist states, destroying the ecology, communities, livelihoods,

and lives. Collective peoples' struggles to bring about emancipatory social change are core requirements to reduce health inequities across countries and within Canada.

5.3.3 Engaging in electoral politics. As discussed in Chapter 4, some informants proposed participating in electoral politics. The informants remind the reader: "People have to become more engaged in provincial politics… They have to appreciate that NDP is the official opposition right now" (Crowe: Activist). While Crowe supports the NDP, others are unsure: "I'm doubtful, but it's the party on the left that we have now. So, one possibility is to try to push the NDP in a stronger direction" (Carroll: Academic). Epidemiologist Anonymous N14 suggested, "maybe new political actors… and not through traditional parties." Albo lamented: "We don't have ascended political parties carrying the banners of an alternative society. And an alternative society going into the names of socialism or communism and not even one that carries the banner of historical, social democracy" (Academic-Activist-Advocate).

Engaging in electoral politics is crucial because, in parliamentary democracy, registered voters choose their representatives to legislate laws concerning the distribution of economic, political, cultural, and ecological resources in which peoples' health is shaped. However, voters turnout has been declining in Canada. For example, in the federal elections, the highest voters turnout of 79.4% in 1958 declined to 75.7% in 1968, 75.3% in 1988, and 58.8% in 2008. Then it rose to 68.3% in 2015 and then dropped again to 67% in 2019 (Elections Canada, 2021). There is a need to boost voters' turnout as it is associated with health.

Participating in electoral politics is critical in healthy public policy and public health policymaking processes. For example, Brown et al. (2020) conclude:

> Communities marginalized by disability, mental and physical health, race, and age tend to be the most affected by the positive association between health and voting. Differences in voter participation related to health inequities can have some effect on overall electoral outcomes, shaping overall policy and possibly deepening healthcare inequities. (p.19).

Engaging in electoral politics in Canada may mean supporting the traditional political parties and politicians. Traditional politicians or *Trapo*, coined in the Philippines, means "a politician perceived as belonging to a conventional and corrupt ruling class" (Oxford Lexico, 2021) or "politicians who will say and do anything, including dirty tricks to get elected or get what they want" (Urban Dictionary, 2021). *Trapo* is a Spanish and Filipino word meaning *rag*. Electoral politics strategies may also mean forming an alternative political party. The result suggests that an independent socialist political party may be required to push for redistributive public policies within the capitalist system and beyond capitalism to capture state power and establish socialism to reduce health inequities.

Engaging in electoral politics is one of the forms of struggle within and against capitalism and for socialism. Informed by Wright's (2018) anti-capitalism struggles in the 21st century, I further reflect. First, engaging in the politics and political economy of health can help *smash capitalism* by capturing state power through elections. Second, engaging in health politics and public policymaking can *dismantle capitalism*, a passage to democratic socialism through state-led reforms mitigating the harms of capitalism. Smashing and dismantling capitalism envision replacing capitalism with socialism to reduce health inequities.

Engaging in electoral politics and healthy public policy can *tame capitalism* through social democratic parties and non-revolutionary socialist parties. Social democracy tames and

resists capitalism, although it merely counteracts the effects of capitalism rather than dismantling capitalism. Dismantling and taming capitalism necessitate collective struggles by organizations, expressly political parties, to capture and exercise state power to reduce health inequities.

Resisting capitalism, the primary form of struggle of most labour unions, civil society groups, and social movements, operates outside the state without attempting to capture state power may help reduce health inequities. *Escaping capitalism*, which disengages from politics, may protect one's wellbeing. While resisting and taming capitalism counterbalances the harms of capitalism, escaping, dismantling, and smashing capitalism goes beyond the structures of capitalism to reduce health inequities.

Reducing health inequities by *eroding capitalism* combines state-led efforts to dismantle and tame capitalism with peoples' movements' efforts to escape and resist capitalism. Wright (2018) declared:

> This strategic complex combines the progressive social democratic and democratic socialist vision of changing, from above, the rules of the game within which capitalism operates in order to neutralize its worst harms and create alternatives anchored in the state, with more anarchist visions of creating, from below, new economic relations that embody emancipatory aspirations. No political movement explicitly embraces this strategic complex of resisting, taming, dismantling and escaping capitalism in order to erode, in the long term, its dominance. But impulses in this direction can be found in political parties that have close ties to progressive social movements, such as Syriza in Greece and Podemos in Spain. Eroding capitalism might also resonate with youthful currents within some established center-left parties – for example, Bernie Sanders supporters in the Democratic Party within the 2016 American presidential election or the Corbyn forces within the British Labor Party. (p.28).

Engaging in electoral politics, health politics, and healthy public policymaking processes dominated by the wealthy and capitalist class and neoliberal governing authorities may not be seen as the most feasible way toward socialism to reduce health inequities. However, some developments outside Canada show that some progressive and socialist political parties and non-traditional politicians are winning elections. In the USA, there is The Squad. In Latin America, from the working class and marginalized groups, Brazil's Lula da Silva, Bolivia's Evo Morales, and Peru's Pedro Castillo. In the Philippines, the team of presidential candidate union leader Leody de Guzman, vice-presidential candidate academic-activist Walden Bello, and senatorial candidate labour-lawyer activist Luke Espiritu openly challenge the team of Marcos-Duterte and other candidates representing the interests of the oligarchs, *trapos,* and political dynasties – a historic challenge by socialists countering the dominance of economic, political, and military elites in the country's electoral politics.

In my view, eroding capitalism is a promising approach to reducing health inequities in Canada. Five years ago, I wrote about Newfoundland and Labrador's anti-poverty strategy:

> [T]his *State-Society or Government-Civil Society interactive approach* has produced an anti-poverty strategy which includes, among others, long-term provincial affordable housing and homelessness strategy such as the Social Housing Agreement, income supports such as HST credit and low personal tax, affordable post-secondary education, which include grants and a tuition freeze, a 10-year Child Care Strategy which include Child Care Service Subsidy, major investment in healthcare which accounts for about 36% of the provincial budget, and increasing the minimum wage (Canada Without Poverty, 2015). Consequently, Newfoundland and Labrador [have become] the only province in Canada [with] a continuous decline in poverty levels in the last 10 years. Thus, a *sandwich strategy to my approach* is

> attainable in the Canadian context. [Nonetheless], Fox (1993) reminds us: "Some reforms are initiated from above while others are responses from below, but in both cases, it often takes pressure from below to carry them out – certainly in Mexico" (p.40). (Borras, 2016, p.59, original emphasis).

Based on the findings in the critical realist review of the literature and thematic analysis of the interview data corpus, I agree with Fox. Furthermore, I agree with the final thoughts of Professor William Carroll, who, when asked about how to surmount the structural barriers to reducing health inequities in Canada, categorically stated, and I requote:

> I think it's possible. I'm not all that optimistic. But the only real solution is from below; it's organizing. It's organizing people who are exploited, oppressed, marginalized. Organizing them in a way that recognizes the diversity of different groups that are oppressed, but also recognizes a basis of unity. There needs to be a kind of movement of movements, and I think it needs to be both a social justice movement of movements and an environmental justice movement of movements because the environmental crisis is a major health crisis and will be more and more as it plays out. The climate crisis has enormous implications for human health. The movement has to come from below. Like basically, as I said, this structure is entrenched in terms of class power and connections between the dominant class and the state, so that any kind of real change process can only occur through popular mobilization from below. Bringing together these somewhat disparate, they seem to be somewhat disparate interests, whether they're interested in homelessness or occupational health and safety or the trade union movement there. They all have their own specific agenda, but they all need to

converge on a common agenda. Of course, political parties are important. (Carroll: Academic).

Notably, in the context of global neoliberal capitalism, the struggle within and against capitalism to reduce health inequities should be globalized. As Carroll further stated:

> I think part of the solution also has to be international because capital itself is so internationalized now that there needs to be much more transnational solidarity among progressive movements. That's one of the big problems that we face, the capitalist class has become transnational, and its governance mechanisms are, to some extent, transnational now. But the rest of us are not transnational. And, so there's an enormous strategic advantage that capital has in the era that we live in now. And we need to think about how to address that through organizing, organizing from below. Because as I say, in my view, that's the only solution. Of course, people like me, for example, who are not particularly oppressed need to be active and aligned with progressive movements. So, it's more than just relying on the agency of people who are at the margins and exploited. It's very much a matter of trying to mobilize all the progressive social forces into, as I say, a movement of movements that don't collapse diversity, but that finds a kind of convergence around the need for a social transformation that deals with the ecological crisis, and the crisis of livelihoods, and health and people's wellbeing.

5.4. Core strategies toward health inequities reduction. The following identified themes offer strategies to realize redistributive public policies; united and strong labour, civil society, and social movements; and alternative politics to reduce health inequities whether one wishes to smash, dismantle, tame, resist, escape, or erode capitalism. The core strategies are

interconnected: informing, educating, advocating, organizing, and mobilizing at the family, workplace, community, and state levels. However, as an ensemble of actions in various spaces, the following methods are not a step-by-step prescription for improving the working, living, and health conditions of the poor, workers, and masses to reduce health inequities in Canada.

Informing and educating. As discussed in Chapter 4, all informants believe that research-based evidence is necessary despite the dominance of power, interest, and ideology in health politics resulting in the insignificant influence of evidence in public policy. Logically, the informants unanimously suggested massive information and education campaign to realize their general recommendations and public policy proposals to reduce health inequities.

First, *information* dissemination is essential to raise social awareness about the causes, barriers, and potential means to reduce health inequities, as discussed in this study. For example, it can be done through the mainstream and alternative media in various forms: print, television, radio, and online. Second, related but not similar to information, is *education*. For example, it can be done through academic institutions, which offer lectures, discussions, and practicums. Massive information and education may also occur outside the academe. For example, it can be done by the labour unions, civil society groups, and social movements to make their members politically engaged.

Informing and educating the people about the causes, barriers, and potential means to reduce health inequities is challenging. The corporate capture of the media maintains capitalist ideology, interest, and power. For example, a film shows that corporate media is a powerful ideological institution shaping peoples' thoughts and actions favouring the capitalist class (see Chomsky, 1992). In Canada, the Irving family "controlled all of the daily newspapers in New Brunswick," while the Postmedia has over 120 media brands, and the Black Press has over 170

publications in Canada and the USA – they bankroll Liberal Party and Conservative Party politicians (Smart, 2021). Corporate lobbyists also dominate television news outlets (Horler, 2021).

Nonetheless, despite the dominance of corporate media, as mentioned earlier, Mikkonen and Raphael (2010) and Raphael et al.'s (2020) *Social determinants of health: The Canadian facts* have been downloaded over a million times, meaning there is a critical mass of people who are now probably aware of the causes of health inequities and the potential means of reducing them. Therefore, progressive and socialist forces must use alternative media to counter the corporate media. Informing and educating fall within the discursive institutionalist approach to health and policy change to address health inequities.

Advocating. As discussed in Chapter 4, all informants recognized that unequal resources among competing interests and advocacy groups result in an unequal public policy advocacy field. Nonetheless, the informants unanimously recommended -- explicitly or implicitly -- protracted advocacy efforts to realize their general recommendations and public policy proposals to reduce health inequities in Canada.

Specifically, the World Health Organization (2008) stresses that advocacy is a crucial strategy to influence state policy actions on the SDH. Canada's NCCDH (2015) defines:

> Advocacy is a critical population health strategy that emphasizes collective action to effect systemic change. It focuses on changing upstream factors related to the social determinants of health, and explicitly recognizes the importance of engaging in political processes to effect desired policy changes at organizational and system levels. (p.1).

The NCCDH (2015) identifies four main roles advocates can utilize to address the SDH and reduce health inequalities: 1) framing the issue, 2) data gathering and dissemination, 3) establishing alliances, coalitions, and collaborative work, and 4) utilizing the politico-legal and regulatory systems. The advocates may focus on supporting the individual (*client advocacy*) and community (*community development advocacy*), enhancing the working and living conditions (*social policy reform advocacy*), and pushing for healthy macro-level policies *(community activism advocacy*) to achieve health equity and justice.

In Ontario, some public health units actively advocate for health equity promotion at the local levels because of the lack of governing authorities' policy actions on the social determinants of health (Raphael & Sayani, 2019). However, in Toronto, a qualitative study showed that despite many successes of some community health centres' advocacy efforts to improve healthcare access and actions on the SDH, their capacity to advocate for healthy public policy is limited by their lack of resources and priorities, non-profit restrictions, and funders (Chef, 2017). Moreover, Cohen and colleagues (2015) scoping review and thematic analysis focusing on 'public health advocacy' found:

> Although PH advocacy to address root causes of health inequities is supported theoretically and through professional practice standards, the empirical literature does not reflect that this is occurring widely in PH practice. Tensions within the discourse were noted and multiple barriers to engaging in PH advocacy for health equity were identified, including a preoccupation with individual responsibilities for healthy lifestyles and behaviours, consistent with the emergence of neoliberal governance. If the PH sector is to fulfil its advocacy role in catalysing action to reduce health inequities, it will be necessary to address

advocacy barriers at multiple levels, promote multi-sectoral efforts that implicate the state and corporations in the production of health inequities, and rally state involvement to redress these injustices. (p.309).

My critical realist review of document data and thematic analysis of the interview data corpus demonstrate that individuals, groups, and organizations should engage in political actions and advocacy efforts to improve working, living, and health conditions. Notably, health equity advocates should focus on the causes, barriers, and means to reduce health inequities, as discussed in this study. Social change and redistributive public policy happen when people act and advocate together. Informing, educating, and advocating fall within the pluralist approach but are entangled with the discursive institutionalist and critical political economy approach to health and policy change to reduce health inequities.

Organizing and mobilizing. As discussed in Chapter 4, all informants recognized that preventable health inequalities in Canada persist because the labour unions, civil society groups, and social movements are fragmented and weak to overcome the dominance of big corporations and neoliberal governing authorities in health politics and public policymaking. Corporate and state power prioritize private over public interests. Logically, the informants suggested -- explicitly or implicitly -- organizing and mobilizing to realize their general recommendations and public policy proposals to reduce social and health inequities.

Specifically, *community organizing* can be understood as "a field of practice in which residents collaboratively investigate and undertake sustained collective action regarding social issues of mutual concern" (Christens & Speer, 2015, p.193), like health inequities. It may involve participatory research, mobilization, and reflection. Community organizing attained positive public policy changes around SDH (Christens & Speer, 2015). No doubt, grassroots

community advocacy, organizing, and mobilizing efforts can reduce class, race, and gender health inequalities (Garcia et al., 2020; Pastor et al., 2018; Subica et al., 2016).

Furthermore, health promotion and reducing health inequalities require community empowerment (Labonté, 1993) that integrates *horizontal community-building* and *vertical community-organizing* to challenge power structures (Wallerstein, 2002), which in the Canadian context, dominated by the corporate class and neoliberal governing authorities shaping health politics and public policy to their advantage. Six years ago, I wrote:

> Keefe, Lane, and Swarts (2006) provide evidence on how organized activism managed to build four health-based social movements, namely, Needle Exchange Program, Breast Cancer Activism, AIDS Coalition to Unleash Power, and Women's Health Movement that influenced social and health policy legislation. These movements went to achieve their objectives by undergoing processes, which can be generalized from one social movement to the next. Indeed, activists from these movements have employed common tactics and strategies such as grassroots education, direct action, and involvement in decision-making structures that shaped widespread health and social policy changes. (Borras, 2016, p.60).

Sufficient evidence shows that information, education, advocacy, organization, and mobilization efforts can reduce health inequities, including but not limited to class, gender, and racialized health inequities. As mentioned earlier, Ontario's Days of Action, Maple Spring, and Alberta's Nurses Strike are collective struggles to improve working, living, and health conditions. Sustained collective mobilization is a crucial ingredient toward social change.

Mobilization requires a politically informed, educated, and organized movement that permanently struggles within and against capitalism. Organized activism and mobilization necessitate street protests or electoral politics to elect socialist political parties and candidates.

The core strategies toward health equity, although distinct, are interlinked. Information and education fall within the discursive institutionalist approach, whereas advocacy within the pluralist approach. The pluralists and discursive institutionalists' understanding of tackling health inequities -- especially class, gender, and racialized health inequities -- through public policy is insufficient in a capitalist state like Canada. At best, they offer incremental policy changes highly susceptible to policy reversals. In contrast, without ignoring information, education, and advocacy, critical political economists emphasize the need to unite, organize, and mobilize the exploited and oppressed, progressive and socialist groups and individuals, and the general public to transform society to reduce unjust health inequalities.

Final Thoughts. Based on the critical realist review of the literature and thematic analysis of the interview data corpus, a united front is required to reduce health inequities, especially class, gender, and racialized health inequities. Uniting and strengthening the peoples' movements may require forming new unions for non-unionized workers. It may also mean strategic alliances and coalitions among labour unions, civil society groups, and social movements. It may further mean forming an anti-capitalist movement of movements carrying the banner of socialism. This socialist movement of movements aims to overcome the tandem of the corporate class and neoliberal governing authorities most responsible for maldistributive public policies and health inequities persistence.

Perhaps, it is to the advantage of the peoples' movements to take the liberating processes of criticism and self-criticism. From disciplined criticism and self-criticism, corrective actions

can be taken. For example, the progressive and socialist labour unions, civil society groups, and social movements may refrain from isolating each other. In doing so, they may resolve the division and discontent among and within their ranks to defeat the economic and political elites. Unless the peoples' movements realize that the only way out of the harms of capitalism is a unified struggle for socialism, they have no other to reproach for persistent health inequities.

Overall, the findings show that Canada fails to reduce avoidable health inequalities through public policymaking due to the vast imbalances in wealth and power among contending social forces with conflicting material interests. The major contending social forces are the big businesses and corporations, neoliberal governing authorities, and peoples' movements. Emancipatory social change required to reduce health inequities boils down to altering power distribution among these social forces favouring the workers and masses instead of the capitalists and the elite. Health politics is fundamentally conflict-based.

Post-pandemic, a Canadian socialist state is not only imaginable but realizable. The onus to realize transformative social change to reduce health inequities, especially class-based, gendered, and racialized health inequities, heavily reside on socialist labour unions, civil society groups, and social movements. Finally, in the context of intensifying global neoliberal capitalism cum right-wing authoritarian populism, those five health equity core strategies must be reflected globally. There is a need to internationalize emancipatory struggles toward health justice. Hope and despair oscillate but hope often prevails over despair.

5.5 Chapter Summary

In this chapter, I summarized, analyzed, and discussed further the main findings of the thematic analysis of the interview data corpus by connecting them with the literature review and

existing document data. Then I reflected on the relevance of the results relative to the study's purpose and overarching question. The following chapter concludes the study.

CHAPTER 6
CONCLUSIONS

Social and health inequities are existential societal problems partly shaped by public policies enacted and implemented by the governing authorities. Despite vast public policy proposals and interventions to address social and health inequities among and within countries, the social phenomena persist. This research aimed to answer how and why health inequities, especially class, race/ethnicity, and gender health inequities persist in Canada and how such differences can be reduced.

Theoretical-empirical evidence based on the critical realist review of existing document data and thematic analysis of the interview data corpus showed that health inequities are fundamentally shaped by the macrolevel social structural ensemble of economic, political, cultural, ideological, and institutional forces and factors than by the microlevel individual forces and factors. Compared to pluralism and discursive institutionalism, the critical political economy approach to health and policy change is more useful in examining social and health inequities, as evidenced by the distinct but interrelated findings in this research. A promising approach: applied in an ensemble, pluralism, discursive institutionalism, and critical political economy may prove most helpful in examining social and health inequities.

The answers to how and why health inequities, especially class, race/ethnicity, and gender health inequities persist in Canada are as follows: Health inequities are mainly caused by 1) the capitalist economic system; 2) the co-constitutives of capitalism, namely colonialism, racism, and sexism; and 3) maldistributive public policies. Health inequities are primarily sustained by 1) power, ideology, and interest trumping evidence-based research and policy ideas; 2) unequal wealth and power distribution among competing interests and advocacy groups

resulting in unequal public policy advocacy health field; 3) the dominance of big business and corporate sector hindering redistributive healthy public policy and public health policy; 4) the governing authorities adhering to the doctrines of capitalism; and 5) the fragmented and weak labour, civil society, and social movements were unable to overcome the power and influence of corporate class and neoliberal governing authorities that, through public policy, prioritize their private economic and political interests over public interests.

The answers to how health inequities can be reduced in Canada are as follows: 1) pushing for redistributive public policies; 2) uniting and strengthening labour, civil society, and social movements; and 3) engaging in electoral politics. The core strategies to realize redistributive public policies; united and strong labour, civil society, and social movements; and alternative politics are informing, educating, advocating, organizing, and mobilizing. Reducing health inequities in general and class, race/ethnicity, and gender health inequities, in particular, may involve struggling within and against the capitalist system and for socialism. Socialism offers a plausible alternative way toward health equity.

There has been little research on the understanding of public policy academics, activists, and advocates hold on the importance of the inequitable distribution of social determinants of health that create health inequities and means of addressing them. This research identified the fundamental causes, barriers, and alternative ways to reduce health inequities by inquiring and analyzing their insights. The main contribution of this study is the insights from Canadian public policy academics, activists, and advocates. This study contributes to current scholarly and public debates on reducing health inequities across and within countries. It may provoke social actions toward transformative social change to achieve health justice.

A new world beyond capitalism is struggling to be born!

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APPENDICES

Appendix A:

Participant Recruitment Letter

Dear: [Name of potential participant]

I would like to invite you to participate in the York University doctoral research entitled "Reducing health inequities through actions to improve Canadians living and working conditions".

I am approaching you to participate in a semi-structured interview because I believe you have in-depth knowledge and insights in important areas of this inquiry. Your views are important as they will contribute to matters that impact public health. The purpose of the study is to understand the barriers to addressing health inequities and provide means of improving the living and working conditions of Canadians and others elsewhere. I recognize that your expertise may not be in health inequities, but your work does address many of the factors that create these health inequities.

If you agree, you will be asked to reflect on your experiences and express your views related to the central research question: *Why and how do class, race/ethnicity, and gender-based differences in life circumstances persist in Canada, and how can such differences be reduced?*

The interview will take about 30-45 minutes. For further information, please see the attached informed consent form. I will also bring a printed copy to the interview.

If you have any concerns or questions, please feel free to contact me at borras10@yorku.ca or my doctoral supervisor Dr. Dennis Raphael at draphael@yorku.ca and/or 416-736-2100. You may also contact the Graduate Program in Health at gradhlth@yorku.ca and/or 416-736-2100 ext. 22052.

If you are willing to participate, please suggest some dates and times that work best for you. I look forward to meeting you soon. Thank you very much!

Kind regards,

Arnel Borras, RN
Principal Investigator/Student
Ph.D. Candidate, Health Policy and Equity
School of Health Policy and Management, York University
4700 Keele Street, Toronto ON, M3J 1P3
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Appendix B:

Informed Consent Form

Date: _____

Study Name: "Reducing health inequities through actions to improve Canadians living and working conditions"

Researcher name: Arnel Borras, RN
Principal Investigator/Student
Ph.D. Candidate, Health Policy and Equity
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Committee:	Dr. Dennis Raphael	(Supervisor)
	Dr. Marina Morrow	(Member)
	Dr. Jessica Vorstermans	(Member)

Purpose of the Research: The purpose of the study is to discover ways of understanding health inequities and develop means of improving the living and working conditions of Canadians that lead to these inequities. To address the central research question: Why and how do class, race/ethnicity, and gender-based differences in life circumstances persist in Canada, and how can such differences be reduced? As part of this study, I am interviewing those with expertise related to the sources of health inequities amongst Canadians: their living and working conditions.

What You Will Be Asked to Do in the Research: You are selected to participate in a semi-structured interview because you have been identified as having in-depth knowledge and experience related to this issue. Your view is important as it will contribute to matters that impact public health. If you agree, you will be asked to reflect on your experiences and express your views on specific questions related to the central research question and the purpose of this research. I recognize that your expertise may not be in health inequities, but your work does address many of the factors that create these health inequities. The interview will take about 30-45 minutes. You will not receive any incentives: monetary or any other forms.

Risks and Discomforts: We do not foresee any physical, emotional, economic, or social risks or discomforts from your participation in the research.

Benefits of the Research and Benefits to You: We will share with you the results of the research if you wish. The research can potentially discover alternative ways of understanding health inequities and improve the living and working conditions of Canadians and others elsewhere.

Voluntary Participation and Withdrawal: **Participation in this research study is completely voluntary and you can withdraw/terminate participation at any time or refuse to answer any question during the interview.** If you choose not to participate, there will be no impact on the relationship you have with the researchers or study staff or the nature of your relationship with York University either now, or in the future. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

Confidentiality: Unless you choose otherwise audio-recording and transcribing of any identifying information you supply during the research will be held in confidence, and unless you specifically indicate your consent, your name will not appear in any report or publication of the research.

The interview will be audio-recorded. Your transcribed interview will be safely secured in a locked facility and only the principal investigator and the dissertation committee will have access to this information. The electronic data will be encrypted and protected with strong passwords. The hardcopy data will be secured in a locked filing cabinet in a locked room in the researcher's residence/institutional facility.

All data will be secured and stored until their destruction on September 8, 2025. The electronic data will be deleted from all electronic devices, which means, deletion of all digital files. The hardcopy data will be shredded.

Confidentiality will be provided to the fullest extent possible by law.

Questions About the Research?
If you have any concerns or questions about the research in general or your role in the study, please feel free to contact me at borras10@yorku.ca or my doctoral supervisor Dr. Dennis Raphael at draphael@yorku.ca and/or 416-736-2100. You may also contact the Graduate Program in Health at gradhlth@yorku.ca and/or 416-736-2100 ext. 22052.

This research has received ethics review and approval by the Delegated Ethics Review Committee, which is delegated authority to review research ethics protocols by the Human Participants Review Sub-Committee, York University's Ethics Review Board, and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Sr. Manager & Policy Advisor for the Office of Research Ethics, 5th Floor, Kaneff Tower, York University (telephone 416-736-5914 or e-mail ore@yorku.ca).

Legal Rights and Signatures:

I, _____, consent to participate in "Reducing health inequities through actions to improve Canadians living and working conditions" conducted by Arnel Borras. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature_____ **Date:**_____
Participant

Signature_____ **Date:**_____
Principal Investigator

Additional consent (where applicable)

☐ I consent to the audio-recording of my interview(s).

Signature: Date:_____

_____
Participant: (name)

Consent to waive anonymity

I, _____, consent to the use of my name in the publications arising from this research.

Signature: Date:_____

_____
Participant: (name)

Appendix C:

Semi-Structured Interview Guide and Questions
SET A: Level 1 Participants
(Societal issue but less as an SDH/health issue)

A. Introduction

Introduction of the interviewer
The signing of the consent form
Introduction of the interviewee

Preliminary question: I would like to start by asking you to describe your position, and primary responsibilities in your organization briefly.
Probes: How long you have been in your role?

B. Backgrounder

Health inequities occur among various classes and groups of people among and within countries. Health inequities are a result of the inequitable distribution of circumstances – also called social determinants of health -- such as working conditions, income, housing, early child development, and social exclusion that in large part, are created through public policy. In Canada, these circumstances are not equitably distributed despite many proposed policy interventions to address this issue. Many Canadians are concerned about their living and working conditions.

The central research question of this study is: Why and how do class, race/ethnicity, and gender-based differences in life circumstances persist in Canada, and how can such differences be reduced? The purpose of the study is to discover alternative ways of improving the living and working conditions of Canadians.

C. Guide Questions

Main questions	Probes
1. Based on your experience and in your view, what do you think are the major causes OF (choose one: low employment rate and precarious employment, poverty, income inequality, housing insecurity and homelessness, delayed child development, social exclusion)? Please explain.	Do you think social relations of power such as class, gender, and neocolonial/racial relations play a significant role in shaping social inequities such as (e.g. poverty)? Please explain. Are we moving fast enough in addressing (e.g. poverty)? If not, why? If yes, in what ways? Please provide any examples.
2. What do you think are the major reasons why policy recommendations from policymakers, academics, activists, and advocates that aim to address (e.g. poverty) are enacted and implemented	Do you think various competing interest groups and organizations have equal or the same chance of influencing and shaping public policy? Please elaborate

by the ruling government while others are not? Please describe some of the successes and failures you, or your organization, or others that you know, encountered in addressing (e.g. poverty) through public policy.	on your answer. Who do you think are the forces that primarily influence government policy decisions? Please explain. How about corporations and businesses? In what ways, they influence and shape public policy? Please provide any examples. Do you think civil society groups also influence and shape public policy? In what ways? Please provide any examples. Do you think political ideology and cultural differences play a crucial role in policymaking? Please explain. What do you think are the elements of a successful public policy proposal? Why do meaningful policy proposals to address (e.g. poverty) fail? Do you think evidence-based research influence public policy? If not, why? If yes, in what ways? Please explain. Do you think ideas primarily shape public policy? If not, why? If yes, in what ways? Please explain.
3. What do you see as the key barriers to policy change that aims to improve the living and working conditions of Canadians? Please describe and provide any examples of institutional/governmental, economic, political, cultural, or ecological barriers to addressing (e.g. poverty).	Are we moving fast enough in overcoming those structural barriers? How do we surmount the barriers to policy change that attempts to substantially reduce, if not eliminate (e.g. poverty)?
4. What are your recommendations as to the way forward to improving the living and working conditions of Canadians?	Do you think the government is doing its best to substantially reduce if not eliminate class, race/ethnicity, and gender-based social inequities such as poverty? If not, why? If yes, in what ways?? Please explain.

	Are there any attempts initiated by you or your organization to engage actors from the government, corporate sector, and civil society groups to address class, race/ethnicity, and gender-based social inequities such as poverty? Please cite a particular collaborative project, if any. Did it work out? Why and why not? What public policies or policy actions do you or your organization wish to see in the future?
5. As I mentioned earlier, some people see these issues (e.g. poverty and housing) as health issues through their use of the term social determinants of health. How do you see the framing of these issues as health issues? How might it be useful? How might it be a barrier to having these issues addressed?	Do you think to frame (e.g. poverty) as a public health issue, relevant to facilitating policy change toward effectively tackling this issue? Please elaborate. What do you see as the challenges and opportunities of understanding and tackling (e.g. poverty) as a public health issue?
6. Considering the political, economic, cultural, and ecological tradition in Canada, in your view, how are we going to tackle policy change concerning class- and identity-based differences in life circumstances given the recent politics and policy shifts in Canada, (as exemplified in Ontario)?	Do you think the recent public policies of the (Ford) government related to (e.g. poverty) can reduce if not eliminate class, race/ethnicity, and gender-based social and health inequities? Please provide any examples of those policies. How do you and your organization respond to the recent political and policy shifts (in Ontario)?
7. Are there any other comments that you would like to make?	Please propose specific questions that you think can help answer my research questions. Please suggest ways on how to improve my interview.
8. Would you like us to share our research findings with you? If so, please provide your contact information.	
9. Would you like to remain anonymous? If not, please give your consent.	Thank you very much!

Appendix D:

Semi-Structured Interview Guide and Questions
SET B: Level 2 Participants
(Societal issue as an SDH/health issue)

A. Introduction

Introduction of the interviewer
The signing of the consent form
Introduction of the interviewee:

Preliminary question: I would like to start by asking you to describe your position, and primary responsibilities in your organization briefly.
Probes: How long you have been in your role?

B. Backgrounder:

Health inequities occur among various classes and groups of people among and within countries. Health inequities are a result of the inequitable distribution of circumstances – also called social determinants of health -- such as working conditions, income, housing, early child development, and social exclusion that in large part, are created through public policy. In Canada, these circumstances are not equitably distributed despite many proposed policy interventions to address this issue. Many Canadians are concerned about their living and working conditions.

The central research question of this study is: Why and how do class, race/ethnicity, and gender-based differences in life circumstances persist in Canada, and how can such differences be reduced? The purpose of the study is to discover alternative ways of improving the living and working conditions of Canadians.

C. Guide Questions

Main questions	Probes
1. Based on your experience and in your view, what do you think are the root causes of the inequitable distribution of the social determinants of health such as precarious employment, income inequality, and social exclusion that result in persistent class- and social identity-based health inequities? Please explain.	Do you think social relations of power such as class, gender, and neocolonial/racial relations play a significant role in shaping precarious employment and health inequities? Please explain. Are we moving fast enough in addressing precarious employment and health inequities? If not, why? If yes, in what ways? Please provide any examples.
2. What do you think are the major reasons why public policy recommendations from academics, advocates, activists, and policymakers that aim to address precarious employment and health	Do you think various competing interest groups and organizations have equal chance of influencing and shaping public policy? Please elaborate on your answer.

inequities are enacted and implemented by the ruling government while others are not? Please describe some of the successes and failures you or your organization encountered in addressing precarious employment and health inequities through public policy.	Who do you think are the forces that primarily influence government policy decisions? Please elaborate. How about corporations and businesses? In what ways, they influence and shape public policy? Please provide any examples. Do you think civil society groups and social movements also influence and shape public policy? In what ways? Please provide any examples. Do you think political ideology and cultural differences play a crucial role in policymaking? Please explain. What do you think are the elements of a successful public policy proposal? Why do meaningful policy proposals to address (e.g. poverty) and health inequities fail? Do you think evidence-based research and ideas influence public policy more than the politics of policymaking? If not, why? If yes, in what ways? Please explain.
3. What do you see as the key barriers to policy change that aims to improve the living and working conditions of Canadians? Please any examples of institutional/governmental, economic, political, cultural, or ecological barriers to addressing precarious employment and health inequities.	Are we moving fast enough in overcoming those structural barriers?
4. What are your recommendations as to the way forward to improving the living and working conditions of Canadians? What public policies or policy actions do you or your organization wish to see in the future?	Do you think the government (past and present) is doing its best to substantially reduce if not eliminate class, race/ethnicity, and gender-based social and health inequities? If not, why? If yes, in what ways? Please explain. Are there any attempts initiated by you or your organization to engage actors from the government, corporate sector, and civil society groups to address class,

	race/ethnicity, and gender-based social and health inequities? Please cite a particular collaborative project, if any. Did it work out? Why and why not?
5. How do we surmount the structural barriers to policy change that attempts to improve the working and living conditions of Canadians and reduce health inequities?	
6. Many of us see living and working conditions through the lens of the social determinants of health. Others see them as issues of social justice, fairness, or human rights issues. How do you see the framing of these issues as health issues? How might it be useful? How might it be a barrier to having these issues addressed?	What do you think are some of the reasons why understanding and tackling precarious employment as a public health issue difficult to pursue? What do you see as the challenges and opportunities of understanding and tackling precarious employment as a public health issue?
6. Considering the political, economic, cultural, and ecological tradition in Canada, in your view, how are we going to tackle policy change concerning class- and identity-based differences in life circumstances given the recent politics and policy shifts in Canada, (as exemplified in Ontario)? That is, amid the rise of the right-wing popular groups? What are we going to do?	Do you think the recent public policies of the (Ford) government related to working and living conditions can reduce if not eliminate class, race/ethnicity, and gender-based social and health inequities? Please provide any examples of those policies. How do you and your organization respond to the recent political and policy shifts in (Ontario)?
7. Are there any other comments and thoughts that you would like to make?	Please propose specific questions that you think can help answer my research questions. Please suggest ways on how to improve my interview.
8. Would you like us to share our research findings with you? If so, please provide your contact information.	
9. Would you like to remain anonymous? If not, please give your consent.	Thank you very much!

Appendix E:

Generated Results of MAXQDA Coding System

Code System		No. of Coded Segments	No. of Interviewees
Ableism		3	3
Academics		24	10
Activists		30	8
Advocates		72	18
Age and generational		26	11
Alternatives		47	8
Authoritarian populism		39	18
Balance of forces		26	13
Barriers to policy change		146	23
	Power	66	17
	Structural	16	10
	Jurisdictional	12	8
	Ideological	30	13
	Cultural	2	2
	Systemic	2	2
	Economic	5	4
	Political	39	17
	Institutional	18	11
Biomedical health		15	9
Capitalism and political economy		134	23
	Liberalism	4	4
	Privatization	28	17
	Neoliberalism	35	12
	Liberalization	1	1
	Austerity	38	14
	Deregulation	5	3
Class		53	15
	Class forces and social forces	22	10
	Capitalist class	55	17
	Corporate and business	89	23
	Ruling class	15	7
	Working class	95	15
	Class inequality/inequity	61	19
	Class structure	35	15
	Class struggle	15	9
Colonialism		25	15
Community		35	11
	Engagements	45	10

Consciousness		3	2
Consensus		6	6
Cultural		18	7
Democracy		13	5
Dental care		7	3
Disease of despair		2	1
Evidence, research, knowledge		92	23
Faith community		4	1
Fundamental causes		78	23
Gender		49	21
	Patriarchy or sexism	27	12
	Domestic labour and abuse	3	3
Geography		2	1
Globalization		9	4
Green New Deal		1	1
Health inequality/inequity		61	13
Health policy		38	10
Human development		2	1
Human rights		30	12
Ideas		76	22
Ideologies		40	14
Imperialism		5	3
Incrementalism		13	9
Individualism		15	9
	Blaming	2	2
	Lifestyle and behaviour	2	2
	Attitude	9	6
Institutionalism		19	10
	Institutions	38	14
	Discourse	67	22
	Discursive Institutionalism	74	23
Intersection		10	7
Jurisdictional		6	2
Just transition		2	1
Keynesianism		1	1
Land		1	1
Legitimacy		3	2
Media		5	4
Opportunities and openings		78	19
Pandemic		91	16
	Revelations	21	9
	Food	3	3
	Care	10	6
	Class	4	3

	Homeless	4	4
	Housing	13	9
	Social exclusion	2	2
	Jobs and employment	24	12
	Immigrants	15	8
	Workers	46	13
	People of colour	16	10
	Poverty	11	8
	Income	16	9
	Vulnerable groups	10	6
	Senior care	12	7
	Childcare	6	5
	Planning capacity	3	2
	Public administration	4	1
	Healthcare (cuts)	36	13
Partnership		1	1
Pharmacare		8	6
Pluralism		82	23
	Civil society	50	16
	Kingdon policy primeval soup	21	10
	Neutral state?	82	21
	Corporatism	45	17
	Multiple pressures	62	21
	Advocacy	87	20
	Competing interests	110	23
	Neo-pluralism	70	22
	Classical pluralism	6	5
Policy interventions		57	15
Policy planning		10	6
Policy recommendations		66	19
	Internet	1	1
	Data gathering	4	2
	Retirement and pension	4	3
	Anti-discrimination	7	5
	Food	4	4
	Nationalize banks	1	1
	Urban redesign	1	1
	Public goods and services	13	7
	Living wage	10	8
	Paid sick days	10	5
	Disability benefits	4	2
	Social support or social safety net	19	9
	Anti-poverty	11	7
	Pharmacare	11	8

	Childcare	10	7
	Employment	25	11
	Education	24	15
	Public transit	10	6
	Ecological restoration	27	11
	UBI	12	6
	(De)commodification	8	4
	Universal basic servicing	3	2
	Social provisioning	15	4
	Breaking dominant power	15	6
	Healthcare reforms	39	16
	Government coordination	19	9
	Community clinic	1	1
	Democratic participation	13	5
	Taxation	46	20
	Working condition improvement	38	15
	Unionization	18	13
	Immigration support	17	7
	Permanent status	7	3
	Refugee support	3	2
	Indigenous support	1	1
	Rehabilitation	1	1
	Recreation	3	3
	Housing support	27	17
	Income support	38	16
	Increase minimum wage	23	15
Political economy		44	16
Political party		46	15
	Social democratic	19	11
	Conservative	41	16
	Liberal	38	15
Politics		90	22
	Political will	4	4
	Political struggle	33	11
	Politicians	71	17
	Policymakers	57	15
Power relations		94	22
	Power balance	74	21
	Medical power	13	7
	Capitalist power	60	19
Public and public support		36	13
Public health		30	13
Public policy		143	23
	Policy success	92	21

	Policy failure	131	23
	Policy change	178	23
Race/ethnicity		94	19
	Discrimination / segregation	38	13
	Racism	83	23
Redistribution		11	6
	Distribution	1	2
Reform		7	6
Representation		28	7
Responses		37	9
Revolution		9	4
SDH Framing		45	22
Social change		43	11
SDH		75	21
	Persons with disability and benefits	6	5
	Food	7	4
	Employment or jobs	44	14
	Unemployment	11	10
	Working conditions	47	14
	Precarious employment	36	13
	Early child development	8	7
	Healthcare	104	16
	Public transit	4	2
	Social support and provisions	9	7
	Social exclusion	5	4
	Labour market	43	7
	Immigration	32	10
	Immigration policy	1	1
	Housing	50	17
	Homelessness	34	8
	Education	27	16
	Poverty	28	10
	Income and wealth	66	17
Social inequality /inequity		67	17
Social justice		25	12
Socialism and socialist		7	4
State		137	23
	Government responses	173	23
	Municipal	10	3
	Territorial	1	1
	Provincial	35	16
	Federal	34	15
	Capitalist state	19	6
(De)stigmatization		6	1

Strategies		73	19
	Internationalize struggle	2	2
	Movements	34	16
	Awareness or consciousness	27	13
	Mobilize (Collective)	49	18
	Resist and fight	43	16
	Organize (Unite)	74	22
	Advocate	54	17
	Educate (Train)	41	18
	Inform	31	16
Targeting		7	2
Technology		8	6
Threats and challenges		144	23
Transcending barriers		83	21
	Election and reforms	16	11
Undocumented workers		1	1
Unions		67	20
	Unionization	15	7
	De-unionization	3	3
Universalism		11	6
Wages		31	14
Water		2	2
Welfare state system		23	10
	Retrenchment	3	3
	Socialist democrat	4	4
	Conservative	2	2
	Liberal	3	3
Workplace		35	13
Total coded segments		7695	