Navigating the Health Equity Gap:

Bridging Systemic Challenges in Health Promotion Across Welfare States

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ABSTRACT

This dissertation examines the capacity of public health systems to advance health promotion and health equity within two contrasting welfare state typologies: Anglo-Saxon liberal welfare states and Nordic social democratic welfare states, with Canada as the central case study. Using political economy as the primary theoretical framework, complemented by historical institutionalism and systems theory, this research explores the systemic barriers that hinder health promotion efforts, particularly in addressing upstream social determinants of health.

The dissertation is structured in three parts. The first examines the evolution of health promotion and equity concepts and their integration into public policy frameworks. The second presents findings from a critical literature review, a two-decade analysis of 22 health policies, and thematic insights from 15 in-depth interviews with scholar-practitioners, representing over 250 years of collective public health experience across diverse welfare state contexts. Reflexivity, informed by the author's 15 years of professional experience in public health systems, ensured critical engagement throughout the research process. The final part synthesizes these findings to identify systemic barriers that impede health promotion as an essential public health function and proposes strategies to overcome these obstacles, drawing lessons from both Anglo-Saxon and Nordic systems.

Findings reveal systemic barriers in Anglo-Saxon welfare states, including resource constraints, market-oriented governance, and institutional path dependency, which weaken public health systems' ability to address social determinants of health effectively. These barriers often manifest in a policy drift, wherein focus shifts from structural determinants to individual behaviours, undermining equity goals. In contrast, Nordic social democratic welfare states demonstrate how integrated governance, sustained investment, and equity-driven frameworks can enhance health promotion. However, persistent relative health inequalities within Nordic systems highlight that no welfare model is entirely free from systemic limitations.

This dissertation contributes to health policy scholarship by providing actionable strategic frames to confront systemic barriers, adapt successful strategies, and strengthen health promotion as a core public health function in diverse welfare state contexts through a series of strategic dilemmas.

Dedications

To my mother.

To my grandmothers.

To Jackie, Abigail.

To Jan.

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Table of Contents

Abbreviation List

AI	Artificial Intelligence
APHA	Australian Public Health Agency
ARD	Absolute Rate Difference
BAME	Black, Asian, and Minority Ethnicity (UK specific)
CDA	Critical Discourse Analysis
CEO	Chief Executive Officer
COREQ	Consolidated Criteria for Reporting Qualitative Research
CPP	Community Planning Partnerships
CSO	Civil Society Organization
KPI	Key Performance Indicator
FPE	Feminist Political Economy
HIA	Health Impact Assessments
HiAP	Health in All Policies
NIHR	National Institute for Health Research
NHMRC	National Health and Medical Research Council
NHS	National Health Service
NPHIs	National Public Health Institutions
NGOs	Non-governmental Organizations
PHC	Primary Health Care
PHE	Public Health England
PHAC	Public Health Agency of Canada
PHS	Public Health Scotland
SDG	Sustainable Development Goals
SDOH	Social Determinants of Health
THL	Finland's National Institute for Health and Welfare
UHC	Universal Health Coverage
UK	United Kingdom
WHO	World Health Organization

List of Tables

Table of Figures

“Knowledge develops through critique and is constrained by history and structure.”

(Harvey, 2022).

PART I: FOUNDATIONS OF HEALTH PROMOTION AND WELFARE STATE SYSTEMS

Chapter 1: Introduction And Overview of The Research

1.1 Background and Context

Health promotion has been widely acknowledged as an essential function of public health systems (IANPHI, 2007; Naylor et al., 2003; PAHO, 2020; PHAC, 2021; WHO, 2016, 2022). Recent events, such as the COVID-19 pandemic, underscore the fundamental importance of "promoting health and well-being as well as actions to address the wider determinants of health and inequity across health systems (Squires et al., 2023)." These impacts underscore vulnerabilities in health systems, particularly chronic underfunding, which hampers essential functions like health promotion and delays progress toward achieving health for all (Squires et al. 2023).

Broadly, health promotion is defined as the constellation of processes that societies use to both prevent illness and promote positive health and well-being, including collaboration with communities and other sectors to understand and improve health (Nutbeam 1998; PHAC, 2021). Central to health promotion is health equity, which Whitehead (1992) defines as the absence of unfair and avoidable differences in health across population groups. Braveman and Gruskin (2003) extend this understanding by emphasizing that inequities in health are not only unfair and avoidable but also systematic and unjust, disproportionately affecting socially disadvantaged groups—those disempowered by poverty, gender, or disenfranchisement. These systematic disparities further entrench disadvantage by limiting access to health, which is essential to well-being and overcoming broader social inequities.

This research uses the terms "inequalities" and "inequities" with intention, favouring the term "inequity" to highlight the ethical and systemic dimensions of unjust and preventable health disparities. However, the term "inequality" is occasionally employed for its simplicity and its use in measurement discussions, where it denotes unequal differences without necessarily addressing their systemic or ethical implications, though it does imply a cause for concern (Raphael, 2012). Achieving health equity requires addressing the inequitable distribution of the social determinants of health (SDOH)—such as income, education, and housing—to ensure that everyone has the opportunity to enjoy health as an essential resource for daily life (Braveman and Gruskin, 2003; Whitehead, 2012; WHO 1986).

On the global agenda, health promotion is considered both a standalone priority as well as an essential part of Universal Health Coverage (UHC)— an important target (target 3.8) of the

2030 Sustainable Development Goals (Agyepong et al., 2023). The World Health Organization (WHO) has elevated health promotion as a strategic priority in its draft *14th General Program of Work (2025–2028)*, reinforcing its role in addressing global health inequities (WHO, 2024b). These international commitments build upon the *Ottawa Charter for Health Promotion* of 1986, which emphasized equity as both a "fundamental condition and resource for health," and as a main focus for health promotion (WHO 1986). The Ottawa Charter remains a foundational document in global health promotion, yet its equity-focused vision has often been undermined by difficulties in their implementation, particularly in liberal welfare states (Raphael, 2013a, 2013b; Rootman et al., 2017; Schrecker, 2013).

At the national level, the responsibility for health promotion and other essential public health functions rests with national public health institutions responsible for the delivery of public health such as health departments, public health agencies, and public health institutes (Squires et al., 2023). These national structures, alongside non-governmental organizations (NGO's), community-based organizations, academia, and private sector actors such as private insurance, comprise public health systems (PHAC, 2021). In many countries, national public health institutions are responsible for health promotion and tackling inequality (Squires et al., 2023).

Importantly, the framing of health equity as a public health issue has often placed the responsibility for advancing more equitable health outcomes on public health systems, which often lack the necessary power, influence, and resources to transform the structural determinants of inequities (Lynch, 2020). Political economy and welfare states play a pivotal role in mediating these same conditions that influence health and shape equitable health outcomes, including the public health systems capacity to affect more 'upstream' health promotion efforts (Bambra, 2011; Eikemo et al., 2008; Raphael 2013a, 2013b; Lynch, 2020). Despite this recognition, significant gaps remain in understanding how different welfare state models influence health outcomes and address societal inequalities (Bambra, 2011; Raphael, 2015); and Anglo-Saxon liberal welfare states like Canada, Australia, and the United Kingdom (UK) continue to face scrutiny for their limited approaches and implementation strategies for health promotion (Baum et al., 2018; Carey et al., 2017; Eikemo et al., 2008; Raphael 2008, 2013a, 2013b; Rootman et al., 2017).

The term ‘welfare state’ broadly refers to the state's role in providing essential welfare services and social transfers, including education, housing, social insurance, and health (Eikemo and Bambra 2008). In the Anglo-Saxon liberal type[1], the state provides modest social transfers that are often means-tested and stigmatizing, encouraging market dominance and creating a sharp divide between those reliant on state aid and those able to afford private provision (Bambra, 2007; Eikemo et al., 2008; Esping-Andersen 1990; Ferrera 1996; Navarro and Shi, 2001; Raphael, 2013a, 2013b). In contrast, Nordic social democratic models, such as those in Norway and Finland, emphasize reducing social inequalities through extensive welfare programs supported by stronger progressive taxation (Eikemo and Bambra, 2008; Esping-Andersen 1990; Raphael, 2013a, 2013b). This study bridges globally acknowledged ideals in health promotion and health policy with comparative welfare state analyses, highlighting how systemic barriers and institutional dynamics shape equitable health outcomes.

However, and as a central tenet of this work, welfare state capitalism is not merely a system of social transfers and welfare services but also a mechanism of social stratification, influencing societal economic and social hierarchies (Bambra, 2007:200; Esping-Andersen 1990). The design and implementation of social policies, the level of welfare provision, and the normative functions of welfare systems significantly impact health and its equitable distribution

[1] Building on Esping-Andersen’s (1990) foundational work, Navarro and Shi (2001) identify the UK and Canada as part of the liberal ‘Anglo-Saxon’ typology, characterized by weak labour protections and strong capitalist influence. Integrating Ferrera’s (1996) shift in focus from the overall quantity of welfare provided to the organization and delivery of social benefits, this research extends the typology to Australia, which shares the institutional features of Anglo-Saxon liberal welfare states rooted in colonial governance and the Westminster model. The institutional similarities among these states stem not from the ethnic composition of their populations, but rather from historical governance structures that embedded market-driven policies and residual social assistance into their welfare frameworks.

While the Anglo-Saxon designation has been widely used in comparative welfare state research over the past 50 years, the term ‘liberal-Westminster’ might better reflect the shared institutional characteristics of these welfare states in modern times, particularly as the socio-cultural composition of these countries evolves. However, in keeping with the dominant terminology in the literature, this work continues to use Anglo-Saxon liberal for consistency. This classification is reinforced by Raphael, Curry-Stevens, and Bryant (2008), who highlight that Canada, and the UK have consistently been placed in liberal, basic security, or Anglo-Saxon liberal welfare state typologies across multiple comparative frameworks, though Australia has shown less consistency. Conversely, Finland and Norway are almost always categorized within the social democratic or Nordic welfare state models.

by influencing socioeconomic inequalities and the accessibility of health resources (Bambra, 2011; Eikemo et al., 2008; Raphael, 2013a, 2013b). For example, the institutional similarities among Anglo-Saxon liberal welfare states stem from colonial governance structures that embedded market-driven policies and residual social assistance into their policy frameworks (Eikemo et al., 2008; Navarro and Shi, 2001). This stratification is particularly evident in the privatization of health services and the stigmatization of welfare recipients in liberal welfare states which perpetuate inequities (Baum et al., 2018; Carey et al., 2017).

Meanwhile, though social democratic welfare states have stronger redistributive mechanisms, they do not entirely erase structural hierarchies based on race, gender, and migration status, which continue to shape access to social and health resources. This is evident in the "Nordic Paradox," wherein despite sustained equity-driven policies and strong welfare systems, relative health inequalities persist (Eikemo and Bambra, 2008; Kautto et al., 2001). While absolute health outcomes improve for all social classes in these welfare states, disparities in relative health outcomes remain, suggesting that structural inequalities operate even in highly redistributive contexts (Mackenbach et al., 2018; Popham, Dibben, and Bambra, 2013). Nonetheless, welfare state typologies continue to structure public policy trajectories and shape societal understandings of equity (Coburn, 2004; Lynch, 2020; Raphael, 2012).

Welfare states are defined by the systems, including public health systems, through which nations assume responsibility for the welfare of their citizens, shaping broader social institutions and policy actions (Esping-Andersen 1990). Welfare states, therefore, also play a role in mediating SDOH and addressing health inequities (Bambra, 2011; Eikemo et al., 2008); and importantly, generous welfare states, supported by social democratic and classical conservative traditions, are positively associated with improved population health (Barnish, Tørnes, and Nelson-Horne, 2018; Eikemo and Bambra 2008; Raphael, 2013a).

These are important factors in understanding the persistent challenges faced by public health systems in advancing health promotion and addressing health inequities (Carey et al., 2017; Halsall, Orpana, and Jan, 2024; Lynch, 2020; Popay, Whitehead, and Hunter, 2010; Raphael, 2008). One such challenge is the phenomenon of 'lifestyle drift,' where policy focus shifts from addressing upstream determinants of health inequalities to emphasizing individual lifestyle factors (Carey et al., 2017; Halsall et al., 2024; Popay et al., 2010). This shift risks neglecting the root causes of inequities, such as socioeconomic inequality, thereby perpetuating

inequalities and undermining systemic efforts to strengthen public health systems (Baum et al., 2018; Brookes, 2021; Halsall et al., 2024; Popay et al., 2010; Schrecker, 2013).

Such systemic barriers are particularly pronounced in Anglo-Saxon liberal welfare state contexts such as Canada, Australia, and the UK, despite their robust systems of universal health coverage and explicit commitments to health promotion (Carey et al., 2017; Halsall et al., 2024; Popay et al., 2010; Raphael, 2013a). For example, an exclusive, or over-emphasis on individual behaviour-based interventions—characteristic of lifestyle drift—can detract from efforts to address the broader SDOH (Halsall et al., 2024; Popay et al., 2010). This misalignment between policy objectives and systemic implementation ultimately hampers progress toward equitable health outcomes, a 'north star' of contemporary public health systems.

Comparative studies provide a valuable lens for examining how welfare state models shape health promotion strategies, offering actionable insights for policy reform. Nordic social democratic welfare states like Norway and Finland offer a compelling alternative, although even they are not immune to such challenges. Nordic welfare systems prioritize citizen well-being and consistently demonstrate better overall health outcomes and fewer absolute inequalities in health outcomes (Raphael, 2018; Fosse and Helegsen, 2019; Coburn, 2004; Navarro et al., 2006; Bambra, 2011; Raphael, 2013a, 2013b). For example, Finland's Health in All Policies (HiAP) approach demonstrates how intersectoral collaboration can embed equity considerations across policy processes as a policy tool, though stronger efforts to sustain this momentum at the societal level may be needed (Fosse and Helgesen, 2019).

Moreover, cross-country comparisons offer valuable insights on complex policy challenges as well as the required shifts in practice to facilitate effective action (Rootman et al., 2017). By comparing Anglo-Saxon liberal and Nordic social democratic models, this research seeks to identify thematic tensions and system learnings that can be applied to strengthen health promotion as an essential function of public health systems.

This study contributes to the existing knowledge base by bridging the concept of lifestyle drift with the role of welfare states in addressing this issue through public health systems. By comparing Anglo-Saxon liberal welfare states (such as Canada, Australia, and the UK) with Nordic social democratic welfare states (like Norway and Finland), this research aims to uncover mechanisms through which such systems might effectively address barriers to health promotion, stemming from phenomena such as lifestyle drift, despite the limitations imposed by entrenched

welfare state typologies. This research aims to advance theoretical understanding while providing practical guidance for designing equitable health promotion strategies that address structural inequities within public health systems.

This study employs a robust analytical framework to explore how different welfare state models impact health promotion and equity. Drawing from theories of policymaking, including historical institutionalism, and systems theory, underpinned by political economy, this research aims to understand systemic and institutional interactions, recognizing underlying power dynamics and their reciprocal influence on public health systems and the public policy that shapes the conditions in which people live their lives. This approach not only reveals the tensions of different welfare approaches to health promotion but also delves into underlying structural and organizational factors that influence these outcomes.

1.2 Research Questions, Objectives, Implications, and the Structure of this Thesis

This research is guided by three key questions: (1) How do the features of different welfare states enable or hinder effective health promotion? (2) What can Anglo-Saxon liberal public health systems learn about navigating these tensions from Nordic social democratic models to enhance health promotion and health equity? and (3) What common and strategic dilemmas can be effectively leveraged in Anglo-Saxon liberal welfare state contexts?

This research uses Canada as the primary case to explore tensions constraining effective health promotion strategies and implementation within Anglo-Saxon liberal public health systems drawing from the Canadian, Australian, as well as English and Scottish experiences, as part of the UK. It draws on lessons from the Nordic model to propose strategies for strengthening health promotion efforts. This includes analyzing explicit health promotion commitments in contemporary national health policies and examining implementation experiences across health system building blocks, aiming to enhance public health capacity to advance health equity (Naylor et al., 2003; PHAC, 2021; WHO 1986). Importantly, however, while Nordic models provide valuable insights, they are not without limitations, including their vulnerability to neoliberal restructuring and persistent inequities along socio-cultural lines. Critical analysis of these challenges will help ensure that considerations for public health systems remain robust and inclusive in different welfare state contexts.

Case studies are invaluable for understanding national health promotion efforts, providing insights into recurring challenges, effective strategies, and contextual factors that advance public health systems globally. By adopting a comparative perspective, this research aims to provide a series of strategic dilemmas rooted in systemic challenges to effective health promotion efforts. The findings of this research have significant implications for public health policy. By identifying tensions experienced by decision makers around health promotion strategies and implementation efforts, decision makers across public health systems can identify and act on barriers to upstream action and threats of lifestyle drift, enhancing health equity, and improving overall public health.

This study contributes to the discourse on strengthening public health systems and promoting health equity by examining systemic underpinnings of challenges to these, such as the persistent issue of lifestyle drift, where policy attention shifts from structural determinants of health to a narrower focus on individual behaviours (Carey et al., 2017; Halsall et al., 2024; Popay et al., 2010). Such shifts undermine efforts to promote health by neglecting the drivers of unfair distribution across the SDOH that create inequities in the first place. By comparing how welfare state models exacerbate or mitigate lifestyle drift, this research underscores the importance of systemic interventions in advancing equitable health outcomes. This research contributes to health systems scholarship by providing insights into how public health systems can shift from concern with individual behaviour change to addressing root causes of health inequities, ultimately advancing comprehensive and equitable health promotion strategies.

1.2.1 A Brief Introduction to Theoretical Frames

This research is grounded in critical realism as well as elements of interpretivism, a set of philosophical approaches that reveals the underlying mechanisms driving observable phenomena and individuals' understandings of these mechanisms (Wilson 1983). Critical realism facilitates an in-depth analysis of structural and systemic factors influencing equitable health outcomes, enabling the identification of entrenched barriers and transformative opportunities (Raphael, 2018; Raphael and Brassolotto, 2015). This approach moves beyond surface-level observations, providing a robust foundation for examining the complexities of health promotion and equity.

The interpretivist paradigm complements the critical realist underpinnings of this research by providing a nuanced lens for understanding how social realities and institutional practices are constructed and experienced. It focuses on the meanings and perceptions that individuals and groups ascribe to health policy processes, enabling a deeper engagement with the subjective dimensions of health promotion and equity (Wilkinson 1988; Jamieson, Govaart, and Pownall, 2023). This complementary approach enriches the critical realist analysis by highlighting the interplay between objective systemic mechanisms and subjective human experiences.

This research is guided by three interconnected theoretical frameworks: systems theory, historical institutionalism, and political economy. Systems theory analyzes the interdependence of societal sectors, emphasizing how changes in one domain reverberate across others (Ndumbe-Eyoh et al. 2021; Wilson 1983). Scholars have successfully shown the inextricably linked systems of inequity at the local, regional, national, and international levels, underscoring the importance of understanding how these complex systems act together to produce health and social inequities (McGibbon and McPherson, 2011). Systems theories identify leverage points where public health systems can promote equity, such as by addressing SDOH through coordinated policy action (Brownson et al., 2021; Carey and Crammond, 2015). However, its descriptive nature often overlooks the power dynamics and structural inequalities that constrain systemic interactions.

Historical institutionalism builds on systems theory by examining how past decisions and institutional structures shape current policy trajectories (Hall and Taylor 1996; Peters, 2019). It highlights the persistence of path dependency, explaining why welfare states, particularly Anglo-Saxon models, struggle to shift from individual-focused interventions to structural reforms that address upstream determinants of health (Bambra, 2011). However, while historical institutionalism provides valuable insights into institutional inertia and critical junctures, it does not adequately address the broader socio-economic and political forces that shape institutional behaviour.

Addressing these limitations, political economy serves as the foundational framework for this research, allowing critical examination of how economic systems, power dynamics, and resource distributions shape health outcomes. Unlike systems theory and historical institutionalism, political economy explicitly situates public health within the broader context of

socio-economic inequality and welfare state governance (Raphael, 2013a). By situating health promotion within the political economy of the welfare state, this approach identifies how different welfare models either advance or hinder health equity. Political economy, therefore, uniquely accounts for the structural barriers created by market-driven policies and the absence of explicit commitments to health promotion, offering a pathway to address these systemic constraints.

The intersection of these approaches offers a comprehensive lens for comparing public health systems across different welfare regimes. Systems theory highlights dynamic interactions, historical institutionalism exposes institutional constraints, and political economy reveals structural power dynamics that sustain inequities. Political economy's ability to address the limitations of the other frameworks makes it the central analytical tool for this work, guiding the analysis of systemic barriers and pathways to transformative health promotion policies.

1.2.2 A Brief Description of Methodology and Methods

The case study is one of the most frequently used research methodologies in policy research as an empirical method that investigates a case within its context; particularly when the boundaries between the case and context may not be clearly defined (Yin 2018, 2022). Informed by mixed-methods, the case study offers methodological rigour to explain how, or why, a condition came to be—or why a sequence of events did, or did not, occur (Yin 2018).

The quantitative and qualitative nature of this research aims to describe the real (societal structures and powers with the capacity to promote health and tackle health inequalities, actual (how these societal structures and powers are activated), and empirical (what can be seen or observed through the activation of the real and actual) experiences of health promotion (Raphael, 2012; Sayer, 2002). This research focuses on the Canadian experience, drawing on insights from other Anglo-Saxon Liberal welfare states, Australia, and the UK (specifically England and Scotland), as well as Nordic social democratic welfare states, Norway and Finland. To capture the multitude of factors influencing public health policymaking and health promotion, this study uses three complementary methods of qualitative data collection: (1) a critical realist literature review (2) a document analysis of recent government policies, recent legislative and strategic frameworks from the last two decades (2000-2023); and (3) in-depth interviews with key

informants involved in policy processes. All three of these methods are considered through a reflexive approach.

The critical literature review establishes the foundation for addressing the study's research questions: how different welfare state features enable or hinder effective health promotion. By exploring existing academic and grey literature alongside existing global datasets, drawing on theoretical frameworks listed above, the review sets out the real, actual, and empirical conditions that perpetuate barriers to, or drift within, health promotion efforts. Drawing on comparative analyses of public health systems in Canada, Australia, the UK (namely England and Scotland), Norway, and Finland, the review underscores the influence of welfare state typologies on health promotion strategies. This critical engagement with the literature justifies the study's methodological approach, emphasizing the need to contextualize policy processes to identify barriers, enablers, and actionable pathways for advancing equitable health promotion action.

The documents offer insights into explicit health promotion commitments made by governments as well as the framing of the wider policy problems over the last twenty years. Meanwhile, the interviews provide rich, contextual insights that complement document analysis, allowing for a comprehensive understanding of how welfare policies are shaped and implemented over time. A key component of this research was the application of the Consolidated Criteria for Reporting Qualitative Research (COREQ), which provided a vital framework for ensuring transparency and rigor in the reporting of this study's qualitative components, particularly its in-depth interviews (Tong, Sainsbury, and Craig 2007).

This research uses thematic analysis to identify and interpret patterns in data from document analysis and interviews, complemented by Critical Discourse Analysis (CDA) to explore power relations and ideologies embedded in the discourse (Carroll, 2004). These methods facilitate a nuanced understanding of how health promotion is conceptualized and implemented across different contexts, providing actionable insights for improving public health strategies globally.

This work is informed by a reflexive practice that acknowledges my position as an insider. As such, this scholarship centers around the concept of sociological imagination, first presented by C. Wright Mills, as the interplay between individual experiences and the wider

social environment (Mills 2023). This concept encourages a critical reflection of how societal structures influence people, including policy actors, and vice versa.

Having worked within, and alongside, national and international public health systems and structures across various policy processes for over 15 years, I have witnessed the nuances and complexities of policymaking. This dual role has specifically influenced methodological choices by underscoring the experience and meaning making of those occupying this unique identity. For this reason, I have dedicated this research to highlighting the insights of scholar-practitioners as conscientious actors with diverse vantage points, not easily captured by document analysis and reviews of regulations and legislation alone. Understanding the complex factors that shape policymaking requires interviewing those who have held various roles in policy processes over time. And yet, maintaining objectivity, and understanding the interplay between these experiences, and the wider social environments, as per the sociological imagination, is central to the depth and rigour of this work.

1.2.3 Structure of Thesis

This thesis is structured into three main parts which offer a comprehensive analysis of the challenges and opportunities in advancing health promotion and equity across different welfare state typologies.

Part I: Introduction and Foundations of Health Promotion and Welfare State Systems provides the background and contextual framework for the study. The introduction examines systemic challenges to health promotion and equity. By contrasting Anglo-Saxon liberal welfare states, such as Canada, Australia, and the UK (with specific attention to England and Scotland), with Nordic social democratic welfare states like Norway and Finland, this section highlights common tensions and valuable lessons for public health systems. It also outlines the study's objectives, scope, and overall structure.

This part further examines the historical, conceptual, and theoretical evolution of health promotion, health equity, and public policy. It traces the development of these concepts and their integration into public health frameworks, setting the stage for the theoretical and methodological analysis that follows.

Part II: Theoretical Framework, Methodology, and Thematic Findings integrates the underlying paradigms, theoretical approaches, methodology, and thematic findings into a

cohesive exploration of the study's core concepts and approaches. The second chapter introduces the theoretical underpinnings by presenting the paradigms of critical realism, complemented by interpretivism as well as the theoretical approaches of systems theory and historical institutionalism, underpinned by political economy. These frameworks inform the methodology, which employs an explanatory case study design.

The third chapter provides a critical realist literature review of public health systems in Anglo-Saxon and Nordic welfare states, contrasting the characteristics and challenges of Anglo-Saxon liberal welfare states (Canada, Australia, and the UK: England and Scotland) with the more equity-focused approaches of Nordic social democratic welfare states (Norway and Finland). This critical realist literature review examines key concepts, definitions, and discourses, including the role of welfare state typologies in shaping public health systems, the intersections of health promotion and equity, and the theoretical foundations guiding this research.

The fourth chapter combines results from a document analysis of 22 health promotion-related documents (15 from Anglo-Saxon liberal welfare contexts; and 7 from Nordic social-democratic welfare contexts) spanning over two decades and semi-structured interviews with 15 scholar-practitioners. Reflexivity is central to this approach, emphasizing my own positionality as both an insider and an academic. The thematic findings conclude this section, highlighting key trends in health policy evolution, health equity goals, and practitioner perspectives on barriers and opportunities in advancing equitable health promotion.

Part III: Dilemmas, and Limitations in Health Promotion synthesizes the findings to identify and analyze systemic barriers, draw lessons from Nordic welfare states, and offer a series of strategic dilemmas for public health system decision makers in Anglo-Saxon welfare state contexts. This part examines the systemic barriers to effective health promotion in Anglo-Saxon liberal welfare states, including institutional inertia and constrained resources. It also highlights how Nordic welfare states avoid or mitigate challenges, such as lifestyle drift, through integrated governance and equity-focused policy frameworks. The chapter concludes with a series of strategic dilemmas that can be used to advance equitable health promotion in Anglo-Saxon contexts, informed by the Nordic model.

The conclusion synthesizes the key findings, emphasizing their implications for policy and practice. It reflects on the broader contributions of the research to public health scholarship

and provides recommendations for future research. The conclusion underscores the importance of systemic reforms to strengthen public health systems to promote equitable health outcomes.

1.3 Key Concepts in Health Promotion

Scholars have identified challenges to health promotion, yet few studies have systematically explored how policy processes can be enhanced to mitigate this issue (Popay et al., 2010, Carey et al., 2017, Halsall et al., 2024). Addressing such challenges require an understanding of the core concepts of health promotion, health equity, and their intersection with public policy. This section provides an overview of these key concepts as entry-points to the discourse, across three sub-sections: health promotion, health equity, and public policy. Each concept is central to the understanding, analysis, and critical reflections that underpin this research. Together, these key concepts—health promotion, health equity, and public policy—provide a conceptual foundation for exploring how public health systems can address systemic inequities and foster transformative health promotion practices.

1.3.1 Health Promotion

The conceptual foundation of health promotion is deeply intertwined with broader definitions of health as articulated in influential global health frameworks. Health promotion, as a concept, was defined by the 1986 *Ottawa Charter for Health Promotion* as the "process of enabling people to increase control over, and to improve, their health." The charter was endorsed by participants at the *First International Conference on Health Promotion* held in Ottawa, Canada, in November 1986. Organized by the WHO along with the Canadian Public Health Association and Health and Welfare Canada, this charter for action built upon Canada's 1974 *Lalonde Report*, and the 1978 *Declaration of Alma Ata*, which called for 'health for all' by the year 2000 (WHO 1978; WHO 1986)—a goal that has yet to be achieved, almost half a century later.

The Definition of Health. Both the Alma Ata Declaration (1978), and the Ottawa Charter (1986) re-affirm the definition of health as presented in the WHO's constitution, entered into force in 1948. These emphasize that health is a positive state of complete physical, mental and social well-being, not merely the absence of disease, that encompasses social and

environmental resources, beyond physical capacities (WHO 1978; WHO 1946/8 1986). Crucially, they emphasize health as a fundamental human right, irrespective of race, religion, political beliefs, or socio-economic position (WHO 1946/8).

These global definitions, while influential, often fail to capture localized and culturally specific understandings of health, emphasizing the importance of integrating pluralistic perspectives into health promotion strategies. These conceptualizations are rooted in Western geographical and ideological contexts, with competing definitions existing even within Western societies. For instance, in Canada, a 2016 study among First Nation and Métis youth in the prairies of Canada conceptualized health as centered around resilience, of self and community, interconnected with holistic health, culture, sports, and wellness, and navigating additions (Sasakamoose et al., 2016). Similarly, Inuk scholars emphasize mental health and well-being as holistic concepts encompassing all aspects of daily life, highlighting an interactive process of fostering balance across the social, spiritual, physical, intellectual, and emotional (Healey, Noah, and Mearns, 2016). Healy, Noah, and Mearns (2016) position these defining reflections in the context of the colonial history of Nunavut, and emphasize the central aspect of Inuit identity, and the loss thereof, as causal determinants of mental health and well-being outcomes.

Importantly, health is consistently described as a dynamic quality that is valued both at the individual and social levels and infers control over resources; "a constellation of certain capacities and opportunities, or a potential (Noak 1990, p. 90)." Yet, the prevailing definition used by international institutions, national governments and public health institutions alike, remains the definition of health as a positive concept that includes physical, mental, and social health, beyond the mere absence of disease, presented in the WHO constitution (WHO 1946/8). In actual practice however, even these definitions give way to biomedical and behavioural definitions of health (Halsall et al., 2024; Raphael, 2008).

From Lalonde to Alma Ata to Ottawa: A History of Health Promotion. From this definition, Canada's 1974 *Lalonde Report* recognized that the emphasis on a biomedical health care system was (is) too narrow an approach to health. Instead, it argued that improving the health of the public requires looking beyond care (Lalonde 1974). Four years later, the *Declaration of Alma Ata* was signed by 134 member states of the WHO. The declaration offered radical acknowledgements of the implications of power and political economy on the health of people.

The main goal of the Alma Ata (1978) declaration was to achieve 'health for all' by the year 2000 (Meier and Kastler, 2018). It underscored the need for a radical re-distribution of power and resources within the global economic order, acknowledging the inequitable impacts of colonial expansion and neoliberalism. It emphasized that governments "have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures (WHO 1978, Article V)." Further, it recognized and called out the socio-economic causes of poor health.

The spirit of these seminal documents was again articulated in 1986 in *the Ottawa Charter for Health Promotion*. Building upon the Alma Ata's definition of the problem of gross inequality, the Ottawa Charter assigns the responsibility to national governments (WHO 1978). The Ottawa Charter details health promotion action that governments can use to promote health as a specialized field of practice (Rootman et al., 2017)—leading to the institutionalization of health promoting strategies in public health institutions.

A cornerstone of the 'new public health,' the Charter advocates for actions of developing healthy public policies, fostering supportive environments, strengthening community engagement, enhancing personal skills, and reorienting health services to prioritize inclusivity and cultural sensitivity (Potvin and Jones, 2011; WHO 1986). Further, the Charter calls for efforts at multiple levels—individual, community, and population—across a broad spectrum of potentially supportive areas: educational, political, regulatory, and organizational -- to foster conditions conducive to health (Agyepong et al., 2023; Potvin and Jones, 2011; Raphael, 2008, 2015b, 2015a; Rootman et al., 2017; Schrecker, 2013; WHO 1986). These measures offer a mandate for the health sector to incorporate broader social, political, and economic considerations, striving for health for all through coordinated intersectoral policy actions (Hancock, 2011; Nutbeam 1998; Potvin and Jones, 2011; WHO 1986).

The Ottawa Charter (1986) has significantly shaped the theory and concepts of health promotion. However, its approach is not without limitations. For instance, like the concept of health, as discussed above, it overemphasizes Western and Eurocentric ideas, definitions, and processes. Therefore, it is interpreted in traditional Western and Eurocentric contexts of disease prevention and modifying individual behaviours, further siloing of health from other important aspects of life, ignoring the inequitable power and resource distributions, along the social

conditions that determine health. These critiques underscore the need for inclusive, culturally responsive health promotion strategies that transcend Eurocentric paradigms.

This idea was originally problematized in the Alma Ata (1978), which recognized and called out the socio-economic causes of poor health—even going so far as to boldly call for a 'New International Economic Order.' One that is rooted in equity and a recognition that the current international economic order, enshrined in the Bretton Woods agreement of the 1940s, fostered neoliberalism and was underwritten by colonial expansion and western supremacy. This framework remains the dominant system of international governance, further empowering 'developed' nations through voting and veto rights, and excluding various groups of people from international forms power, and resource distribution (Vastergaard and Wade, 2012; Weaver and Moschella, 2017).

For instance, the exclusion of Indigenous Peoples from international decision-making processes, particularly within the United Nations (UN) is a persistent issue, reflecting these patterns of marginalization and colonialism, and leading to on-going intergenerational health inequities (Bauder and Mueller, 2023; Chin et al., 2018; Higgins, 2018). With health promotion's emphasis on empowering communities and individuals, health equity emerges as its ethical and practical core, addressing the structural causes of inequities across health outcomes.

1.3.2 Health Equity and Health Promotion

Health equity is a foundational goal of health promotion (WHO 1986). As a concept, it seeks to eliminate unfair and avoidable differences in health status (Dahlgren and Whitehead 1991; Kawachi, Subramanian, and Almeida-Filho, 2002). Unlike health inequalities, which are quantitative differences in health outcomes across populations, health inequities imply a judgment about the unfairness of these inequalities, often shaped by social advantage and disadvantage (Bryant, Raphael, and Rioux, 2019; Dahlgren and Whitehead 1991; Kawachi et al., 2002; Link and Phelan 1995). Therefore, definitions of health equity emphasize the absence of unfair and preventable differences in health as well as the social conditions that determine them, reflecting systematic social advantages or disadvantages (Braveman, 2010; Kawachi et al., 2002; Raphael, 2012; Whitehead 1992; WHO 1986).

Unlike health inequalities, which are quantitative differences in health outcomes across populations, health inequities imply a judgment about the unfairness of these inequalities, often

shaped by social advantage and disadvantage (Bryant et al., 2019; Dahlgren and Whitehead 1991; Kawachi et al., 2002; Link and Phelan 1995). Health inequalities do, however, offer a form of measurement, and are therefore an equally important concept to health equity, and health promotion.

The History of Health Inequalities. The systematic collection of mortality and social condition data in 19th-century Europe revealed significant health inequalities. Historical figures such as Louis-René Villermé in France explored the connections between poverty, mortality, and geography. Rudolph Virchow, known as the 'father of pathology' and a Prussian politician, articulated the relationships among health, medicine, and politics. Similarly, Frederick Engels analyzed the impact of socioeconomic status on the health of the working class in the UK (Berkman and Kawachi, 2000; Lynch, 2020).

Indeed, Frederick Engels's concept of "social murder" underscores how societal structures and political choices systematically deprive people of life-sustaining resources, leading to preventable suffering and death. The COVID-19 pandemic exemplifies this concept on a global scale, exposing how neoliberal policies and austerity measures have weakened public health systems, exacerbated health inequities, and disproportionately impacted marginalized communities (Medvedyuk, Govender, and Raphael, 2021). These outcomes are not accidental but are rooted in political and economic systems that prioritize market efficiency over human health, wellbeing, and life.

Understanding health inequality through Engels's stark concept of "social murder" underscores the need for health systems to address inequities not just as technical failures but as moral and structural injustices demanding comprehensive and systemic reform. Such early observations underscore that differences in health outcomes have long been recognized and considered unjust, long before current health systems (Braveman,, 2010; Kawachi et al. 2002; Raphael, 2012; Whitehead 1992). These historical insights lay the foundation for understanding contemporary health equity initiatives, which aim to operationalize social justice within health systems through intersectoral collaboration and systemic reforms.

Health Equity in Contemporary Public Health Systems. Health equity is increasingly recognized as a cross-cutting principle in public health practice. Potvin and Jones (2011) describe how the concept of health equity has been formalized in public health strategies, such as Sweden's "*Health on Equal Terms*" program, which emphasizes social conditions like housing

and community connection rather than specific disease risk factors. Similarly, Canada's 2005 *Pan-Canadian Healthy Living Strategy* aims to improve overall health and reduce health inequities, underscoring a commitment to addressing not just immediate health inequities but broader social determinants (Potvin and Jones, 2011; Smith, Thompson, and Upshur, 2018).

In recent decades, there has been a growing trend to position health equity as an overarching objective for public health systems (Potvin and Jones, 2011; Solar and Irwin, 2010). Acknowledged alongside social justice as a pre-requisite for health—a positive, and everyday resource for life— in the Ottawa Charter (1986), health equity is rooted in the ethical principle of distributive justice (Braveman and Gruskin, 2003). Indeed, it has been well recognized that the distribution of power and resources that determines who has health, and how much (Raphael, 2012; Solar and Irwin, 2010). And yet, thoughtful critique questions not only if the field does fulfill these functions from within the public health system, but indeed if it can (Rootman et al., 2017).

Braveman (2010) and others argue that true health equity must extend beyond these proximal issues to tackle deeper structural and political factors that underpin health inequalities. This approach aligns with social justice, emphasizing that health equity involves not only addressing observable health outcomes but also redistributing power and resources to overcome systemic injustices (Braveman, 2010; Bryant et al., 2019; Lynch and Perera, 2017). So, while policies may recognize the role of social determinants in health inequities, they often fall short of advocating for the necessary systemic changes.

Health equity requires intersectoral policy actions to address the full range of social, economic, and environmental determinants of health (Marmot, 2005, 2020; Raphael and Brassolotto, 2015). The Ottawa Charter provides a framework for these actions, urging sectors beyond health to engage in creating health-promoting policies and practices (WHO 1986). By fostering collaboration across sectors, policies can more effectively tackle the root causes of health inequities, ensuring that all individuals have access to the conditions necessary for good health (Hancock, 2011; Potvin and Jones, 2011).

The Social Determinants of Health and Health Equity. The SDOH refer to the constellation of societal conditions and material resources that influence health outcomes at individual, community, and population levels (Bryant et al. 2019; Marmot, 2005; Solar and Irwin, 2010). These determinants include factors such as income distribution, employment,

education, social exclusion, and access to food and transportation (Bryant et al. 2019; Solar and Irwin 2010). Research since the 1970s has demonstrated that the unequal distribution of these resources leads to inequalities in health outcomes, with those occupying higher social positions having better access to resources and therefore better health outcomes (Diderichsen, Evans, and Whitehead 2001; Link and Phelan 1995). This relationship shows how social stratification, shaped by societal organization, directly affects exposure to risks and access to protective factors against illness.

Conceptual Frameworks of the Social Determinants of Health and Inequity. Of course, the conceptualization of SDOH has evolved over time. Early thinkers like Virchow and Engels successfully identified the connections between health and social gradients, but it wasn't until the 1990s that the SDOH framework gained broader traction in public health (Hankivsky and Christoffersen 2008). A notable contribution to this field is Solar and Irwin's (2010) framework, as part of a discussion series from the WHO, which differentiates between the structural determinants of health and the social factors that distribute these determinants across populations (Solar and Irwin 2010). Scholars of the SDOH and health inequalities have emphasized that this distinction is key, as conflating the causes of health with the causes of health inequities can lead to misguided policy interventions that fail to address root causes, such as socioeconomic inequalities (Graham, 2004; Solar and Irwin, 2010).

In Canada, adopted SDOH frameworks have been mapped along concepts of 'upstream' and 'downstream' interventions to address and reduce health inequities (PHAC, 2021). A parable, often used in public health systems, depicts a witness repeatedly rescuing drowning individuals from a river until they decide to walk *upstream* to investigate why so many are falling in. This story symbolizes entry points of intervention in public health: upstream interventions address the root causes, such as social and structural determinants; midstream interventions reduce vulnerabilities in living conditions; and downstream interventions provide immediate support for those already affected (National Collaborating Centre on Determinants of Health (NCCDH) 2014; PHAC 2021). Together, these approaches have been used to illustrate the need for systemic action to promote health and health equity.

Understanding and addressing the SDOH remains of central importance for shaping public policy aimed at health promotion. By focusing on these determinants, policy actors can work towards intersectoral policies that target both the material and social conditions responsible

for health inequities (Solar and Irwin 2010). This shift from individual behaviours to broader social and economic structures enables more effective and equitable health interventions. Addressing SDOH not only improves population health but also promotes the redistribution resources and power within society, making it a vital component of public health policy (Bryant, Raphael and Rioux, 2010; Graham, 2004).

The Political Determinants of Health. The political determinants of health refer to the power structures, governance systems, and policy decisions that shape the social and economic conditions underpinning health outcomes (Bryant 2016; Bryant et al. 2019; McGibbon 2024; Solar and Irwin 2010). Politics and power are the foundational forces that determine how health is distributed across populations, influencing who has access to the prerequisites for health, such as education, housing, and income, as articulated in the Ottawa Charter (WHO 1986; Solar and Irwin, 2010). By shaping the SDOH, political structures directly impact health, determining who lives well, who struggles, and who is left behind, through public policy processes (Bryant 2009; Bryant et al. 2019; McGibbon 2024; Raphael 2013a, 2013b; Solar and Irwin 2010).

Analyzing the political determinants of health is essential for understanding how welfare state typologies influence health promotion and equity(Bambra 2006). As this research demonstrates, policy is not merely a technical tool but a product of interactions between diverse actors and organizations, reflecting the distribution of power within a society (McGibbon, 2024). Welfare states, with their varying political economies and institutional frameworks, serve as key sites where the political determinants of health are enacted to inform (in)equitable health outcomes (Bambra 2006). These distinctions highlight how the political determinants of health shape not only the social determinants but also the policy frames and governance systems explored in the next section.

1.3.3 Public Policy, Policy Frames, and Welfare States

Public policy plays a role in health promotion because it provides governments with the tools to shape health outcomes at the population level. The Ottawa Charter (1986) represents a pivotal moment in health promotion, setting the stage for integrating health considerations into public policy frameworks at all levels. It emphasizes that health promotion must involve building health-promoting public policy, arguing that health should be placed on the agenda of all policy makers, across sectors and at every level. This approach to health promotion goes beyond

healthcare service delivery, to address broader determinants of health such as income distribution, education, and housing (WHO 1986).

Public Policy and Health Policy. Public policy fosters environments that enable healthier choices and living conditions, promoting overall well-being (Nutbeam 1998). It is a key mechanism through which governments can improve population health and reduce health inequities, as recognized by the WHO Commission on Social Determinants of Health (CSDOH) (CSDOH, 2008; Solar and Irwin, 2010). Understanding the difference between public policy, social policy, and health policy, including public health policy, and healthy public policy, is essential to comprehending how each influences health promotion.

Public policy is anything a government decides to do, or not to do (Dye 1972; de Leeuw, Clavier, and Breton, 2014). Social policy, meanwhile, focuses on redistributing resources to improve societal welfare; and while health policy traditionally addresses access and the provision of healthcare services, health scholars have argued that health policy also encompasses health-related public policies (Bryant, 2009; Nutbeam 1998). While public policy broadly encompasses government actions or inactions, health-related policies can be categorized into several distinct forms, each addressing health determinants in different ways.

Health-related public policies can, in effect, include many different sub-types of public policy. For instance, while *public health policy* focuses on the social conditions that determine population health, the SDOH, and aims to reduce health inequalities through structural interventions (Graham, 2004), *healthy public policy*, as defined by Nutbeam (1998), introduces an explicit concern for health and equity across all areas of policy such as income distribution, employment security and conditions, and access to housing, among others. Lynch (2020) outlines key public policy areas of redistribution, social spending, and managing the market economy. Consistent with this view, *health promotion policy*, as outlined in the Ottawa Charter, calls for coordinated actions like legislation, resource allocation, and organizational change to address social determinants and foster greater equity in health outcomes (WHO 1986). For the purposes of this work, all concepts will be considered part of broader health policy.

Public policy can, therefore, serve as an effective tool for health promotion, particularly across sectors where the SDOH are formed, such as education, labour, and housing. This means that though public health systems rarely ‘own’ the policy levers in these adjacent social sectors,

they are well positioned to recognize and measure the inequitable health outcomes that are produced (Lynch, 2020).

Policy Frames and Responsibility for Action. Policy frames are essential for understanding how political and institutional actors define issues, shape solutions, and influence the policymaking process. Lynch (2020) defines a policy frame as comprising four key elements: defining the problem, crafting a causal narrative to explain its origins, assigning responsibility to actors, and recommending specific solutions. These frames shape how issues are understood and addressed by policymakers, determining the scope of policy debates and the tools deemed acceptable for intervention (Lynch, 2020; Lynch and Perera, 2017).

In the context of health equity, policy frames profoundly impact the prioritization of interventions and the framing of solutions. For example, Lynch (2020) observes that health inequalities are increasingly defined internationally as unjust outcomes of "upstream inequalities in power and resources, which have consequences for how proximate determinants of health are distributed in society (p.82)." This framing invokes a strong moral imperative for action while attributing responsibility primarily to public health systems. However, the solutions proposed differ significantly by context. Nordic welfare states, for instance, often employ redistributive policies aimed at addressing structural inequities, whereas liberal welfare states like Canada and the UK tend to focus on individual behaviour change and lifestyle modifications (Whitehead, 2012; Carey et al., 2017).

The importance of causal narratives in policy frames cannot be overstated. These narratives explain the origins of the issue and justify the need for specific types of intervention. Lynch (2020) highlights that in neoliberal contexts, causal narratives frequently emphasize individual choices over structural factors. This narrows policy priorities, shifting focus away from addressing systemic causes of health inequities and toward modifying individual behaviours. Such narratives obscure the role of power and resource distribution in perpetuating health disparities, reinforcing existing inequities rather than addressing their root causes.

The concept of responsibility within policy frames is equally essential. Assigning responsibility to actors—whether governments, health systems, or individuals—determines who is held accountable for addressing health inequities and shapes the solutions proposed. In liberal welfare states, governments often emphasize individual responsibility for health, supported by narrowly defined public health initiatives like health education campaigns (Smith, 2013;

Whitehead, 2012). Conversely, Nordic contexts place greater responsibility on state institutions to implement policies that reduce socioeconomic inequities, reflecting a broader understanding of the systemic factors driving health outcomes (Fosse and Helgesen, 2018). These contrasting frames underscore the role of institutional cultures and political ideologies in shaping health promotion strategies.

In the case of health equity, public health systems are tasked with addressing the upstream SDOH while simultaneously responding to immediate health needs. This dual role creates persistent challenges in maintaining a balance between systemic reform and targeted interventions. One way of conceptualizing these challenges is through the phenomenon of lifestyle drift, which describes a tendency for health policies to initially focus on upstream determinants, only to narrow their scope to individual behaviours over time (Carey et al. 2017; Halsall et al. 2024; Popay et al. 2010; Raphael 2008). This drift can weaken the ability of public health systems to address the broader structural conditions that underpin health inequities, such as poverty, housing, and education.

For instance, the phenomenon of lifestyle drift is particularly evident in Anglo-Saxon liberal welfare states like Canada, Australia, and the UK, where public health systems often prioritize individual behaviour change and coping mechanisms over upstream interventions (Carey et al., 2017; Halsall et al., 2024; Popay et al., 2010). This reflects broader tendencies in these political economies to emphasize individual responsibility, which Bryant et al. (2011) argue limits the sustainability and effectiveness of health promotion efforts. By contrast, Nordic social democratic welfare states, such as Norway and Finland, offer an alternative approach by integrating structural and individual-level interventions within their public health systems (Bambra, 2011; Bryant, 2016; Raphael, 2012).

The final element of a policy frame—recommendations for action—ties the framing of a problem to tangible policy outcomes. As Lynch (2020) observes, recommendations rooted in structural reform are more likely to address upstream determinants of health, yet such proposals often face significant resistance in neoliberal contexts. Institutions play a mediating role in this process, as they filter ideas through dominant interests, cultural norms, and power dynamics. Smith (2013) illustrates this phenomenon in the UK, where institutional “fractured journeys” limit the translation of knowledge and evidence into actionable policy, particularly for equity-focused health promotion.

Persistent challenges like lifestyle drift underscore the need for public health systems to advance equity-oriented and systemic approaches to health promotion. This involves reframing policy priorities to emphasize structural reforms while ensuring that immediate, individual-level interventions do not detract from broader efforts to address the root causes of health inequities. Of course, domestic realities define what is possible as well as what is feasible, shifting the Overton Windows within the national policy landscape (Lynch, 2020).

Welfare states, public policies and health. Welfare states, through their various models, provide frameworks for how resources and opportunities are distributed within a society, which directly influences health outcomes (Bambra, 2011; Esping-Andersen 1990). A welfare state is a system through which the government assumes responsibility for the well-being of its citizens (Esping-Andersen 1990). Current models of welfare states are important as they represent the unique inclinations of nations to deal with and shape a range of public policy issues, while also shaping the understanding of citizens of the nature of what is possible and feasible in the public policy arena (Esping-Andersen 1990; Raphael, 2012).

The most prominent framework for categorizing welfare states was developed by Esping-Andersen (1990), who identified three primary types: the liberal welfare regime, the conservative-corporatist, and the social-democratic. However, public health scholars like Bambra (2007) encourage those researching health and health inequalities to move beyond this initial model, which was not conceived with public health and the social determinants in mind. However, as Raphael (2012, 2013a, b) has pointed out, there is little controversy around the placing of Canada as a liberal welfare state and likely the same is the case for contemporary Australia and the UK. The same also applied to Norway and Finland as social democratic welfare states, though Finland has been recognized to have some conservative features, similar to Canada (Bambra, 2011; Bergqvist, Yngwe, and Lundberg, 2013; Brennenstuhl, Quesnel-Vallée, and McDonough, 2012; Eikemo and Bambra, 2008; Esping-Andersen 1990; Fosse and Helgesen, 2019; Raphael, 2012). Additionally, as Lynch (2020) emphasized, Finland is, perhaps, further from the socio-democratic ideal than Sweden and Denmark, after a liberalization of the welfare state in the mid-1990's. This reality supports a wider variability in welfare state activities, offering experiences of common tensions across a wide spectrum of welfare contexts.

This research categorizes welfare state models into Anglo-Saxon liberal and Nordic social democratic regimes due to their distinct approaches to social welfare and relevance to

health promotion efforts. Anglo-Saxon liberal regimes, such as Canada, Australia, and the UK, emphasize minimal state intervention, market reliance, and means-tested benefits, often resulting in significant health inequalities, particularly for economically disadvantaged populations (Bambra 2011; Bergqvist et al. 2013; Brennenstuhl et al. 2012; Esping-Andersen 1990). In contrast, Nordic social democratic regimes, exemplified by Norway and Finland, focus on universal welfare provision supported by progressive taxation to reduce social inequalities comprehensively, with strong social security systems that buffer against economic crises and promote better health outcomes(Bambra 2011; Bergqvist et al. 2013; Brennenstuhl et al. 2012; Esping-Andersen 1990).

While these models represent different approaches, both forms have experienced shifts toward marketization and welfare state retrenchment since the 1990s, reflecting broader convergence in Western welfare policies (Popham et al. 2013; Schrecker and Bambra, 2015). Finland, for instance, saw a rapid liberalisation towards market-based policies between 1970 and 1990, and in line with international frames, focused on primary care prevision and the regulation of product markets to affect goods that considered bad for individual health (alcohol, tobacco, saturated fats, salt) (Lynch 2020), an approach not unrecognizable to Anglo-Saxon liberal public health systems. By examining these typologies, including their similarities and divergences, this research explores systemic barriers and enablers to health promotion in diverse contexts. These comparisons provide a critical lens for understanding how welfare state dynamics influence health promotion policies and outcomes.

In summation, welfare states are significant to health equity because of their ability to shape the broader social environment, which determine the distribution of health outcomes. Public policies, such as social security, income redistribution, and healthcare access, are central to ensuring that ***all*** citizens have the means to live healthier lives (Raphael, 2012; Solar and Irwin, 2010). As research suggests, the more redistributive nature of welfare states like those in the Nordic countries leads to better overall health outcomes, particularly during economic downturns, demonstrating the central role welfare states play in buffering against health inequalities (Chung and Muntaner, 2006; Mackenbach et al., 2018). Ultimately, the ability of welfare states to promote health equity depends on the extent to which they implement policies that address both absolute and relative health inequalities (Bambra, 2011; Eikemo and Bambra,

2008).

1.4 Theories of Policy Making

Policymaking is an iterative, complex process shaped by the interplay of institutions, actors, and broader social, economic, and political forces. A range of theories attempts to explain how policies are developed, implemented, and evolve. These include incrementalism, punctuated equilibrium, and multiple streams theory, the lesser considered systems theory, and New Institutionalism (encompassing historical and rational choice institutionalism), political economy, and feminist political economy. Each theory contributes unique insights but also faces limitations in fully capturing the complexity of policymaking processes. While incrementalism, punctuated equilibrium, and multiple streams theories emphasizes the dynamics of policy change, systems theory highlights interdependencies, and New Institutionalism focuses on the constraints of institutional design. Political economy and feminist political economy, in contrast, interrogate the structural forces and power dynamics that shape policy outcomes.

1.4.1 Dynamics of Policy Change: Incrementalism, Punctuated Equilibrium, and Multiple Stream Theory

Incrementalism and punctuated equilibrium offer contrasting views on how policies evolve. Incremental policymaking, as articulated by Lindblom (1959 1979), suggests that policy changes occur through small, gradual adjustments based on consensus-building among policymakers. Similarly, Heclo's (1974) concept of social learning posits that policymakers learn from past experiences, gradually adapting policies over time. However, these theories often assume a linear relationship between knowledge acquisition and policy action, overlooking the institutional and political constraints that can impede change (Bryant, 2002). For instance, Canada's gradual expansion of healthcare coverage in the mid-20th century exemplifies incrementalism, where policy changes built upon earlier reforms rather than pursuing wholesale transformation.

Punctuated equilibrium, by contrast, focuses on periods of stability disrupted by sudden, significant changes when compelling ideas gain attention, and external factors align to create opportunities for reform (Baumgartner and Jones 1993). For example, global health initiatives like tobacco control and malaria eradication have leveraged punctuated equilibriums to achieve

policy breakthroughs (Smith and Katikireddi, 2013). While useful for understanding episodic change, this theory often fails to address the entrenched power dynamics that influence which ideas gain traction.

Meanwhile, Kingdon's (1984) Multiple Streams Theory explains how policy change occurs when three streams—problems, policies, and politics—converge at the right moment. This theory highlights the role of policy entrepreneurs who navigate these streams and seize policy windows to advance reforms. Frameworks based on this theory have been applied to analyze health inequalities in the UK and other contexts (Exworthy, Blane, and Marmot, 2003). However, like punctuated equilibrium, Multiple Streams Theory underemphasizes the role of structural power and economic interests in shaping which policies are feasible or prioritized.

1.4.2 Policy Change and Interdependencies: Systems Theory

Though less considered among theories of policy making, systems theory posits that social, economic, and political systems are interconnected, with changes in one area often creating ripple effects across others (Carey and Crammond 2015; McGibbon and McPherson 2011; Wilson 1983). This is particularly helpful when analyzing the influence of international health systems, rooted in neo-liberalism, on national systems globally. In health promotion, this perspective emphasizes the need to address SDOH—such as housing, education, and income—through coordinated, systemic interventions (Labonte 2010). Public health systems focusing solely on individual behaviour change are unlikely to achieve lasting health equity without addressing these upstream factors.

Despite its strengths in describing interdependencies, systems theory is primarily descriptive and lacks the tools to analyze the power dynamics and structural inequalities that constrain systemic change. This limitation makes it less effective as a standalone framework for analyzing transformative policymaking processes (Carey and Crammond, 2015).

1.4.3 Institutions and Policy: New Institutionalism

Institutions, as societal structures, transcend individual behaviours and influence policy trajectories over time (Peters 2019). This approach examines how institutional design and culture create predictable patterns of interaction among policy actors, shaping which political arguments are feasible and how they influence policy options (Bryant 2016). While there are several

approaches within the umbrella of new institutionalist thought, this section focuses on rational choice and historical institutionalism.

Rational choice institutionalism, for example, examines how actors behave strategically within institutional constraints, driven by cost-benefit analyses (Hall and Taylor 1996). It frames policymaking as a series of collective action dilemmas where actors' behaviours are shaped by institutional rules and the perceived benefits of their decisions (Reich, 2000). While rational choice institutionalism provides valuable insights into individual motivations and strategic interactions, it has been critiqued for oversimplifying human behaviour and overlooking the broader socioeconomic forces that influence institutions (Bryant 2002).

In contrast, historical institutionalism focuses on how past decisions and institutional paths influence current and future policy outcomes. This concept of path dependence explains why policies, once established, persist by creating self-reinforcing mechanisms (Hall and Taylor 1996; Peters 2019). For example, the market-driven focus of liberal welfare states often prioritizes individual responsibility over structural reform, reinforcing lifestyle drift and limiting systemic approaches to addressing health inequities (Bryant 2016). However, historical institutionalism also identifies critical junctures, or moments of significant change, that can disrupt entrenched trajectories. Critical junctures, such as economic crises or public health emergencies, disrupt entrenched policy paths, creating opportunities for transformative reforms. For instance, the COVID-19 pandemic, highlighted vulnerabilities across public health systems and underscored their role as a public good, potentially opening policy windows for structural reforms.

1.4.4 Policy, Structure, and Power: Political Economy Approaches

Political economy provides a comprehensive lens for understanding how power dynamics, resource distribution, and economic systems influence policymaking. This approach highlights the role of welfare state typologies in shaping health outcomes, with redistributive policies in Nordic social democratic states often linked to better overall health outcomes (Bambra 2011). Political economy also explains why liberal welfare states, driven by market-oriented ideologies, often focus on individual behaviours rather than addressing structural determinants of health (Bryant 2016; Raphael 2015b).

By emphasizing the intersection of political, economic, and social contexts, political economy addresses the limitations of other theories, providing a robust framework for analyzing systemic barriers to health equity. However, its focus on macro-level structures can sometimes overlook the nuances of individual agency and institutional behaviour. This approach aligns well with the study's focus on health promotion, offering insights into the structural adjustments needed to shift public health systems toward advancing health equity.

Also noteworthy is feminist political economy (FPE), which builds on traditional political economy by centering gendered labour, particularly unpaid caregiving work, in analyses of policymaking (Armstrong 2013). FPE critiques the systemic undervaluation of caregiving, which is often framed as a labour issue rather than a public health concern. This exclusion limits the practical application of FPE in current policymaking systems.

Despite these limitations, FPE offers critical insights into how gendered power dynamics and social reproduction shape health policies. For instance, during the COVID-19 pandemic, women disproportionately shouldered unpaid care work, exacerbating health inequities (Lokot & Bhatia 2020). By integrating gender and social reproduction into policymaking analyses, FPE highlights pathways for addressing these inequities and informs potential future work on creating more inclusive policies.

Each theory offers valuable insights but has limitations in fully explaining policymaking complexity. Incrementalism and punctuated equilibrium capture change processes but underemphasize structural barriers. Systems theory emphasizes interdependencies but overlooks power dynamics. New Institutionalism explains policy inertia but struggles to account for broader economic contexts. Political economy and FPE address these gaps, offering robust frameworks to analyze power, resource distribution, and gendered labour dynamics.

Ultimately, political economy emerges as the most comprehensive approach for analyzing health promotion policymaking. It highlights the systemic forces driving inequities, while FPE enriches this perspective by addressing the undervaluation of caregiving and its implications for health equity. Together, these approaches provide critical tools for understanding and addressing the structural determinants of health through more equitable policymaking.

1.5 Researcher's Reflexive Statement

A reflexive statement is a critical component of qualitative research, enabling researchers to examine how their social identities, values, and assumptions influence the research process (Gough 2017; Jamieson, Govaart, and Pownall 2023). Reflexivity involves ongoing self-examination and reflection, helping to enhance the transparency, credibility, and rigor of the study (Jamieson et al. 2023; Wilkinson 1988). Wilkinson (1988) argues that there are several types of reflexivity, highlighting that issues relating the identity of the researcher and the form/function of the research constitute one, while "disciplinary" reflexivity involves analysis of the nature and influence of the field of enquiry. The latter, she argues is a "potentially powerful agent for change within traditional academic disciplines (p. 493)." By acknowledging and confronting biases, researchers can better understand how their positionality shapes interactions with participants, data interpretation, and overall findings, contributing to ethically grounded and methodologically robust research (Jamieson et al. 2023).

My positionality as a researcher is shaped by my intersecting social identities, personal experiences, and professional background. I am a white, cisgender woman living and studying in a Western context, which informs both my perspective and potential blind spots in this research. While these identities may lead to overgeneralizations or limited awareness of narratives outside my lived experience, my journey as a breast cancer survivor and the years of disability that followed have profoundly influenced how I understand health as both a resource and a right. These experiences sharpen my focus on the intersections of identity towards health for all, while underscoring the importance of acknowledging perspectives, worldviews, and experiences that diverge from my own.

My familial history also shapes my worldview and academic framing. Although I am not an immigrant, nor do I share the experiences of recent immigrants in Canada, my family's history is one of migration, mixed heritage, and navigating wealth and privilege alongside periods of poverty and survival. These legacies, coupled with professional experiences across different country contexts, have deepened my understanding of governance, resources, and health promotion practices. Working in diverse contexts has ingrained in me a reliance on frameworks that clarify complex systems, particularly the building blocks of health systems, which I use heavily in this work to explain and compare health system functions.

I carry strong values into this work, particularly the belief that health promotion is a core responsibility of states, and that health is an inalienable human right. However, I recognize that this principle is not codified in law across all the contexts studied. In such cases, I report on the divergence between practice and principle, framing this as a gap in systems that cannot leverage legal frameworks affirming health as a human right. This balance of advocacy and observation reflects my commitment to both rigorous analysis and the promotion of equity within public health systems.

I occupy both insider and outsider roles in this study. As an insider, I share professional and cultural touchpoints with participants from Anglo-Saxon liberal welfare states. However, my lack of direct professional experience in Australia, the UK, Norway, and Finland positions me as an outsider to the specific nuances of those systems. This dual positionality requires continuous reflexivity to ensure I neither over identify with participants nor overlook the complexities of their experiences. This professional lens informs the study's emphasis on translating theoretical insights into actionable strategies, while remaining critically aware of potential biases inherent in insider perspectives.

As such, my research fits within the paradigm of "insider research" (Greene 2014), where I, the researcher, share a professional identity and language with the interview participants. This approach fosters a nuanced perspective, credibility, and rapport, while also necessitating careful navigation of potential biases and assumptions (Berkovic, Ayton, Briggs and Ackerman 2020; Jacobson and Mustafa 2019). In recognizing my dual role as both a practitioner and a researcher, this study is underpinned by the concept of reflexivity.

To foster reflexivity, I have maintained a research journal throughout the study, capturing notes, reflections, and ideas from the literature and my interactions. Engaging in discussions with peers, particularly those with differing worldviews or experiences, has also been instrumental in challenging my assumptions and refining my interpretations. These practices, combined with a commitment to critical self-examination, enhance the transparency and rigor of my research, ensuring that the findings are both ethically grounded and methodologically robust.

Owing to this dual role, it is imperative that I approach this work with humility, understanding, and deference to the experiences of my colleagues. Public health systems are powered by people with a wide range of skills, experiences, and perspectives, each contributing to the complex fabric of national public health. Beyond individuals, organizational diversity

plays a role, with civil society, academia, professional associations, government, and research institutes collectively shaping the public health system landscape (PHAC 2021). These varied vantage points offer distinct insights, and while my reflexivity informs this work, my primary focus is on identifying common themes across these broader systems to understand what works, for whom, and in what context.

1.6 Addressing Gaps in the Literature and the Implications of this Research

This research addresses critical gaps in the literature on public health systems, health policy, and effective health promotion, with a focus on Canada's public health landscape and health promotion as an essential public health function. Despite growing evidence of health inequities, Canadian public health systems face persistent challenges in embedding health equity considerations into policy frameworks. As highlighted by Komakech (2022), these challenges are rooted in institutional relations of ruling, where hegemonic biomedical and neoliberal conceptual practices dominate policymaking processes, limiting systemic actions on the SDOH. Similarly, Borras (2022) underscores that health inequities in Canada are perpetuated by power imbalances, the dominance of neoliberal governance, and mal-distributive policies, necessitating systemic reforms and collective action for health justice.

As mentioned above, this research employs a reflexive approach as articulated by Jamieson et al. (2023), which has influenced every stage of the research process—from framing research questions to interpreting findings. My professional experience working alongside international public health systems introduced me to globally accepted frameworks for health promotion, such as Solar and Irwin's 2010 conceptual model, which formed the basis for the WHO's Commission on SDOH conceptual model. These experiences shaped my perception of Canada's domestic public health landscape, particularly when juxtaposed against international systems. This led me to question which domestic influences inhibited some aspects of health promotion while enabling others.

Recognizing that political and cultural biases cannot be entirely removed from the research process, I sought to first acknowledge their presence and then explain them when doing so offered clarity to the reader. The deliberate use of an "international language" of public health versus a "domestic language" provided a conceptual tool that resonated with many of my interview participants. This dual-language approach helped explore tensions between

international frameworks and Canada's distinct socio-political context, framing these differences as navigable tensions rather than outright critiques of governance structures.

This research aims to identify strategic dilemmas within public health systems that can serve as tools for navigating welfare gaps and enhancing equity-driven health promotion. This focus on systemic tensions and their strategic resolution underscores the importance of thoughtful navigation rather than prescriptive solutions.

1.6.1 Very Recent Insights on the Canadian Scene

In recent years, a growing body of research has shed light on the persistent health inequities within Canada's public health systems. These studies explore systemic barriers that hinder effective health promotion that advances health equity, and highlight the influence of institutional, political, and structural dynamics on public health outcomes. Together, they provide critical insights into the challenges faced by Canadian public health systems, while also revealing opportunities for advancing health equity through more strategic approaches.

Recent research highlights the systemic barriers that hinder progress in addressing health inequities within Canada's public health systems. Borras (2022) complements this perspective by identifying broader systemic drivers of inequities, including capitalism, colonialism, and neoliberal governance. Their research emphasizes how power imbalances, the dominance of business interests, and fragmented advocacy efforts sustain disparities, while advocating for redistributive policies and collective action as key strategies to advance health equity. Similarly, Komakech (2022) highlights how institutionalized relations of ruling create systemic hurdles for transformative policy action. These structures constrain efforts to embed health equity within decision-making processes, reinforcing the gaps between stated goals and realized outcomes.

Halsall, Orpana, and Jan (2024) illustrate the challenge by grounding the conversation in the known phenomenon of lifestyle drift. Their scoping review demonstrates how health policies often begin by addressing upstream SDOH, but shift focus to individual behaviours over time. This shift, driven by neoliberal governance and the biomedical model, reinforces systemic inequities by emphasizing individual responsibility and behavioural interventions over structural reforms. However, while Halsall et al. (2024) provide an essential examination of these dynamics, their work does not explore the role of welfare state typologies in shaping health promotion policies and strategies.

This research builds on these recent contributions that situate systemic challenges within the broader context of welfare state structures and governance systems. By examining how different welfare state models shape the capacity of public health systems to advance equity-driven health promotion, this study addresses a critical gap in the literature. It extends the dialogue initiated by scholars like Borras, and Halsall et al., offering new perspectives on how systemic barriers can be navigated to execute the essential public health function of health promotion, within known constraints and challenges.

Contribution to Health Systems Research. Building on these insights, this research uses a critical realist framework to examine how public health policies are shaped by governance structures and welfare state typologies. By comparing Canada's liberal welfare state approach to Nordic models, the study explores how systemic barriers can be addressed through governance innovations. The findings align with Komakech's call for institutional analysis, Borras's emphasis on redistributive policies and collective action, and Halsall et al.'s review of factors contributing to known phenomenon such as lifestyle drift, that result from the under investigated barriers to effective health promotion. This research goes to emphasize the utility of strategic dilemmas as tools to navigate systemic tensions.

By framing these challenges through a reflexive lens, this research contributes to a deeper understanding of public health systems as dynamic and context-dependent entities. It provides policymakers and practitioners with conceptual tools to better navigate the complexities of health equity and health promotion within the Canadian welfare state.

1.6.2 Implications for Research and Action

This study provides valuable insights into the systemic barriers and institutional dynamics shaping health promotion and equity within public health systems in Anglo-Saxon liberal and Nordic social democratic welfare state contexts. By examining these issues through the lens of welfare state typologies, this research offers significant contributions to both academic understanding and practical policymaking. The following sections outline the implications for future research, emphasizing methodological and conceptual innovations, and actionable strategies for policymakers and practitioners aiming to navigate systemic tensions and foster health equity.

Implications for Research. This research highlights critical gaps in the understanding of public health systems, particularly within Canada's Anglo-Saxon liberal welfare state context, by focusing on systemic barriers to health promotion and the advancement of health equity. One significant contribution lies in its reflexive approach, which juxtaposes the "international language" of public health with Canada's domestic landscape, offering a framework for future comparative studies. This conceptual framing, rooted in the role of public health systems in decommodification as a public good, encourages researchers to explore how global frameworks intersect with localized socio-political dynamics.

The use of a critical realist framework also offers a methodological contribution by uncovering the mechanisms and systemic tensions shaping health policy outcomes. This approach encourages future research to move beyond descriptive studies or purely positivist models and instead engage with the deeper institutional and relational dynamics that influence public health systems. Insights from this work could be expanded to explore other welfare typologies, providing a broader comparative understanding of how governance structures impact health equity.

Additionally, the findings underscore the importance of further exploring the strategic dilemmas faced by public health systems. Researchers could build on this study to develop actionable frameworks or refine conceptual tools that better address the dynamic and context-dependent nature of health promotion within different welfare state typologies.

Implications for Action. For policymakers and practitioners, this research provides practical insights into navigating the welfare gaps in Canada's public health system. By identifying systemic tensions and framing them as strategic dilemmas, this work equips decision-makers with tools to engage with governance challenges in a nuanced way. Rather than prescribing one-size-fits-all reforms, it encourages an adaptive approach that considers the unique socio-political and institutional context of the Canadian welfare state.

Public health practitioners can use the strategic dilemmas framework to advocate for equity-driven policy decisions that prioritize upstream interventions while balancing immediate, downstream needs. This study also emphasizes the need for capacity building within public health systems to address governance fragmentation and support a coordinated response to health inequities. Strengthening partnerships between policymakers, community organizations, and advocacy groups is essential for fostering sustainable change. By leveraging experiences from

Nordic models, such as community integration and structural interventions, Canada and other Anglo-Saxon liberal welfare states can reimagine health promotion as a transformative public health function.

1.7 Chapter Summary

Chapter 1 establishes the foundation for this research by framing the critical interplay between health promotion, health equity, and public policy within diverse welfare state contexts. It identifies persistent challenges undermining systemic health policy efforts and situates the research within the comparative framework of Anglo-Saxon liberal and Nordic social democratic welfare states.

Through clearly articulated research questions, the chapter outlines the study's objectives, including the exploration of tensions constraining health promotion efforts in Anglo-Saxon liberal welfare states and the potential applicability of lessons from Nordic models. It integrates a critical realist approach, drawing on theories of systems dynamics, and new institutionalism, underpinned, ultimately, by political economy to examine systemic barriers and opportunities.

The chapter emphasizes the importance of situating health promotion within the broader context of welfare state governance, drawing attention to the structural determinants of health inequities. It sets the stage for the methodological exploration of health policies and practitioner insights in subsequent chapters, ensuring that the study's theoretical and empirical contributions are firmly grounded in public health systems scholarship.

PART II: THEORETICAL FRAMEWORKS, METHODOLOGY, AND THEMATIC FINDINGS

Chapter 2: Theoretical Approaches, Methodology, and Methods

Health promotion, unlike medicine, is almost exclusively about social action (Pederson, O'Neill, and Rootman 1994; Rootman et al. 2017). Because health is socially produced, effective intervention must acknowledge and engage with social context (Kickbusch 1989). My own experiences in my career, in life, and in health, have affirmed this, leading me to question why certain strategies worked so well in some contexts but fell short in others. These questions weren't just practical—they were theoretical, pointing to the need for a framework that could unravel the layers of complexity within public health systems. This reflection became the starting point for the ontological and epistemological assumptions underpinning this research.

This study draws on critical realist and interpretivist paradigms to navigate the tension between structure and agency in public health systems. Critical realism provides a lens to examine the underlying mechanisms and structures that shape public health policies and perpetuate inequalities. This ontological perspective emphasizes the importance of uncovering causal relationships and systemic forces that often remain hidden but have profound impacts on health outcomes. Complementing this, interpretivism brings attention to the subjective meanings and lived experiences within these systems, ensuring that the human dimensions of public health are fully acknowledged. Together, these paradigms form a robust theoretical framework for analyzing how welfare state typologies influence health promotion and address health inequities.

Building on this foundation, the research employs a mixed methods approach to investigate the interplay between welfare state models and public health systems. This methodology enables a comprehensive exploration of both systemic patterns and individual experiences. By integrating qualitative and quantitative methods, the study seeks to illuminate the dual realities of structure and experience within public health, and the contemporary obstacles to effective health promotion faced by public health systems.

This chapter is presented in three main parts. The first part is an in-depth overview of the paradigms and theoretical approaches that underpin this research. The second part introduces the explanatory case study as the methodology and uses a critical realist literature review, document analysis, interviews, and reflexivity as the methods to inform that case study by leveraging thematic analysis and CDA. Finally, the ethical considerations and limitations of this study are presented.

2.1 Paradigmatic and Theoretical Underpinnings

This research is anchored in foundational paradigms and theoretical frameworks that provide critical insights into the systemic barriers and enablers of health promotion as an essential public health function. Critical realism serves as the ontological backbone, offering a way to uncover the often-hidden mechanisms that shape public health policies and outcomes, while interpretivist approaches bring the lived experiences and contextual nuances of public health systems into focus. The theoretical lens is further enriched by systems theory, which explores the interconnected dynamics within public health systems; historical institutionalism, which situates these dynamics within broader welfare state trajectories and reveals how past policy decisions influence present outcomes; and political economy, which highlights structural inequalities embedded in governance and resource allocation. Together, these paradigms and frameworks provide a multi-dimensional perspective for understanding and addressing inequities in public health systems.

Referring to the popular public health parable about a river: upstream efforts address the root causes of health inequalities—like poverty, housing, and education—while downstream interventions tackle immediate, visible challenges, such as healthcare access and individual-level needs (NCCDOH 2014). However, understanding what constitutes "upstream" or "downstream" depends on where you stand on the riverbed. Health promotion spans the entire public health system, with some initiatives best delivered through clinics and well-resourced Primary Health Care (PHC),[2] while others are more effective at municipal, provincial/territorial, regional, national, or even international levels of governance. This work focuses on national health policy levers, examining system-wide efforts through the explicit health commitments of governments and the lived experiences of interviewees working within these systems.

This section is divided into two parts. The first part provides an overview of the paradigms of critical realism and interpretivism, which served as foundational and complementary frameworks for this research. The second part introduces the complementary

[2] PHC is a concept that goes beyond primary clinical care services, recognized globally since 1978. PHC entails comprehensive integrated health services that embrace primary care as well as public health goods and functions; multi-sectoral policies and actions to address the upstream and wider determinants of health; and engaging and empowering people and communities for better social participation in health (WHO 2024).

theoretical approaches that framed this study, including systems theory, historical institutionalism, and political economy

2.1.1 Critical Realism and Interpretivism— Complementary Paradigms

Critical realism, complemented by interpretivist approaches, ground the exploration of how welfare models can support, or inhibit, health promotion efforts in health policy action. Critical realism allows us to uncover the underlying structures and forces shaping health promotion policies, while interpretivism helps to understand how systems, and the people that drive them, interpret and implement these policies within their social contexts. By integrating these paradigms, this research can better explain not just what happens in health promotion, but why certain strategies succeed or fail in different welfare states. This dual lens is essential for examining how Anglo-Saxon liberal and Nordic social democratic models either reinforce or challenge known effective health promotion strategies, directly linking back to the core focus of this study.

Critical realism emphasizes the need to uncover the structure of various realities and the forces that activate them (Bryant et al. 2019; Raphael and Brassolotto 2015). It calls for the examination and analysis of social phenomena, including the structures, mechanisms, and processes that influence outcomes, even where not directly observable (Denzin and Lincoln 2011). As a theoretical framework, it bridges the gap between positivist approaches that emphasize objective observation and interpretivist approaches that focus on subjective meaning. This paradigm serves as the foundation for integrating systemic analysis and structural critique.. However, critical realism has been critiqued for its complexity in operationalization, particularly in multidisciplinary studies, which often require simplifications to bridge epistemological divides.

Interpretivism complements critical realism by highlighting how people understand themselves, and others, inside systems of shared meaning (Wilson 1983). That is to say, the meaning-making process, both individual and collective, around what *is* happening against what *could* happen. It aligns well with socio-environmental paradigms in health promotion research as attention is directed to the larger environments in which people live, recognizing that the organization of communities and societies shape health outcomes (Bryant 2009).

Together, the critical realist and the interpretivist paradigms offer theoretical frameworks that are complementary. In this approach, the interpretivist paradigm guides the exploration and meaning-making of the different levels of reality associated with making, and implementing, health promotion-related policy. In the case of this research, critical realism, therefore, offers a strong perspective through which to examine the *real* power dynamics that contextualize both the public policy processes that determine health, and public health system itself; and the *actual* events and processes that occur across the public policy process. The empirical, on the other hand, are the experiences that can be observed, and represent the manifestation of both the real and the actual (Bryant et al. 2019; Raphael and Brassolotto 2015).

2.1.2 Theoretical Approaches

There are many theories of policy making that are applicable to health policy processes in the context of health promotion. However, to effectively explore systemic barriers and enablers for health promotion across diverse welfare state typologies, this research drew from interconnected theoretical frameworks—systems theory and historical institutionalism—underpinned by political economy. This comprehensive approach allowed deep examination and understanding of various forces driving health promotion and equity experiences.

Systems Theory and Historical Institutionalism. Systems theory framed public health systems as interconnected networks, emphasizing how changes in one domain, such as governance or resources, produced ripple effects across others (Wilson 1983). Systems theories, like complexity science, emphasize that the social, ecological, and structural determinants of heath form a complex adaptive systems (McGibbon 2024; McGibbon and McPherson 2011). It underscores the necessity of addressing SDOH—such as income, housing, and education—through coordinated systemic interventions, particularly in light of drifting focus toward individual behaviours (Labonté 2010; Carey et al. 2017; McGibbon 2024). However, while systems theory offered valuable insights into the interdependence of societal sectors, its descriptive nature limited its ability to interrogate the power dynamics and structural inequalities that constrained systemic change (Carey & Crammond 2015).

Historical institutionalism, on the other hand, complemented systems theory by emphasizing how past decisions and institutional structures shaped current policy trajectories, including the persistence of health promotion practices in liberal welfare states that are largely

ineffective at addressing persistent health inequities (Hall and Taylor 1996; Peters 2019). The concept of path dependency illuminated how entrenched practices, such as market-driven healthcare policies, became self-reinforcing, making it difficult to shift toward equity-focused structural reforms (Bryant 2016). Critical junctures, such as public health emergencies, offered opportunities to disrupt these trajectories, though their transformative potential often depended on broader socio-political contexts (Hall 2016).

Despite their strengths, both systems theory and historical institutionalism shared limitations. Neither adequately accounted for the structural power dynamics, economic ideologies, or resource distributions that deeply influenced institutional behaviour and policy outcomes. For example, rational choice institutionalism, while useful in understanding individual agency within institutions, often reduced behaviour to cost-benefit calculations, ignoring the broader socio-economic forces shaping these decisions (Bryant 2002; Reich 2000). These gaps underscored the need for a more comprehensive framework to analyze systemic inequities in health promotion.

The Utility of Political Economy. Political economy addressed the limitations of systems theory and historical institutionalism by providing a macro-level analysis of how power, resource distribution, and economic systems shaped health policy and outcomes. Unlike the other frameworks, political economy explicitly linked health systems to the broader political and economic contexts in which they operated, offering critical insights into the systemic barriers that perpetuated lifestyle drift in Anglo-Saxon liberal welfare states (Raphael 2013a; Bryant 2016).

This framework revealed how neoliberal ideologies, dominant in Anglo-Saxon welfare states, prioritized individual responsibility over structural reform, thereby inhibiting efforts to address upstream determinants of health such as income inequality and housing security. In contrast, Nordic social democratic states demonstrated that redistributive policies and comprehensive welfare systems could mitigate health inequities, highlighting actionable pathways for reform (Bambra 2011; Raphael 2013a).

The ability of political economy, as an approach, to contextualize challenges like lifestyle drift within broader socio-economic systems aligned directly with research questions, particularly the exploration of systemic barriers and the potential for transformative health promotion strategies. This approach not only accounted for power dynamics and economic

ideologies but also provided a foundation for addressing inequities through systemic interventions.

A Note on Complementary Insights from Feminist Political Economy. Feminist political economy (FPE) enriched this analysis by emphasizing the intersection of gender, race, and class, as contributing to social position, a mediating factor contributing to the distribution of structural determinants of health, in varying degrees (Link and Phelan 1995; Solar and Irwin 2010). Although FPE was not a central framework for this research, it offered critical insights into how intersecting power dynamics shaped health policies and inequitable health outcomes. More than anything, this perspective highlighted avenues for future research.

By integrating systems theory, historical institutionalism, and political economy, this research adopted a comprehensive approach to analyze health policymaking to advance the promotion of health and health equity as an essential function of public health systems globally. This framework addressed gaps in other theories and offered critical tools for understanding and addressing systemic barriers to equity-focused health promotion. Together, these frameworks informed the study's exploration of how systemic interventions could advance equitable health outcomes in Anglo-Saxon liberal welfare states.

By combining critical realism and interpretivist paradigms with systems theory, historical institutionalism, and political economy, this research achieved a nuanced understanding of health policymaking as an essential part of health promotion for public health systems. Systems theory emphasized the interconnected nature of societal sectors, while historical institutionalism illuminated the inertia of entrenched policies. Political economy added depth by situating health promotion within broader socio-economic and political contexts, addressing limitations of the other frameworks. Together, these approaches provided a robust foundation for examining the challenges of promoting health and health equity experienced by public health systems in Anglo-Saxon welfare contexts and proposing systemic considerations to promote equitable health outcomes across diverse welfare states. This framework not only informed the analysis but also highlighted critical areas for future research.

2.2 Research Design

To explore how different welfare state models influence health promotion and equitable health outcomes, this study uses a case study methodology. Case studies are particularly

effective for investigating complex phenomena within their real-life contexts, especially when the boundaries between the case and its context are ambiguous (Yin 2018 2022). This section outlines the effectiveness of the case study, and the methods, including a critical realist literature review, a document analysis, and open-ended interviews. Together, through the lens of reflexivity, the results were used to explore the intricate dynamics of power and policymaking within public health systems, offering insights into health promotion-related policy processes (Rubin and Rubin 2011).

This section is presented in three parts. First, the merits of case study as a methodology are introduced. Second, the study design and data collection methods are explained, including the use of reflexivity that underscores this work. Finally, approaches to data analysis are outlined.

2.2.1 Case Study as a Methodology

Case studies are a strong methodology for this type of research. They offer detailed insights into the underlying mechanisms, and contextual factors, that guide successful health policy, and are commonly used to explore and explain complex phenomena within real-life contexts (Yin 2018 2022). Using multiple sources of knowledge and information, this methodological approach focuses on examining one, or more, specific case(s) to explain the issue at hand; and can be particularly useful in understanding complex systems, unintended consequences, and informing future intervention (Yin 2018). This section explores the utility and application of the case study methodology to this research, including case selection, which reflects their alignment with welfare state typologies, allowing for a comparative analysis that captures diverse approaches to health promotion.

In this study, Canada and its public health system at the federal level is the primary case of interest. Compared to the similarly Beveridge-styled universal health systems in Australia, and the UK, and Nordic countries like Norway and Finland, this approach provides valuable cross-case analysis to explore the role of public health systems in promoting health and health equity. Specifically, the explanatory case study approach facilitates the exploration of '*how'* or '*why'* particular health promotion strategies succeed or fail by drawing on documented artefacts, and the experiences of those working in the public health system in Canada, Australia, England and Scotland, Norway and Finland.

Case studies are particularly well-suited to this type of research because they allow for in-depth exploration of public health systems by connecting the descriptive qualitative and quantitative data from the critical realist literature review, with qualitative data collected through document analysis and interviews. The literature review presents the context of welfare states through an analysis of the real, actual, and empirical. Meanwhile, the document analysis offers insights into formal legal and strategic frameworks that guide public heath systems, and interviews with public health scholar-practitioners reveal how these policies are interpreted and implemented in practice. Together, these methods allow for a rich understanding of the structures and experiences within public health systems, enabling the study to uncover deeper mechanisms that shape health promotion efforts and outcomes.

In comparing Canada with Australia, and the UK (specifically England and Scotland) with Nordic countries, Norway and Finland, the study highlights the potential for policy transfer. Despite varying political and economic contexts, all countries share a commitment to universal health systems, making certain experiences and tensions applicable across contexts. For instance, the comprehensive health promotion policies in Nordic countries, which prioritize upstream SDOH, offer valuable insights for addressing lifestyle drift in Anglo-Saxon liberal welfare contexts. By underscoring these tensions, opportunities to meet the unique needs of various social and political landscapes may provide actionable considerations for strengthening health promotion efforts towards health equity.

Case Selection and Justification. This study compares Canada with other Anglo-Saxon liberal welfare states (Australia and the UK) and Nordic social democratic welfare states (Norway and Finland) to explain how welfare states shape and are shaped by health systems. Importantly, the scope of this work focuses on the national level, rather than regional, provincial/state/territorial, or local levels. An interesting exception is presented through the UK, from which England and Scotland are included in this study due to their distinct approaches within the UK's devolved public health systems, which offer valuable comparative insights into public health governance.

England, as the largest and most influential component of the UK, provides a contrasting model of public health approaches to health promotion and health equity within the Anglo-Saxon liberal welfare state context. Whereas Scotland stands out with its unique institutional reforms, including Public Health Scotland and strategic frameworks like Scotland's Public Health

Priorities (2018), which emphasize systemic collaboration and equity-focused health promotion, further enriching the comparative analysis of institutional strategies and their impact on health equity. This approach offers insights beyond policy effectiveness by revealing underlying structural factors, or mechanisms that empower, or inhibit the effectiveness of public health systems in their health promotion efforts.

The Anglo-Saxon liberal and Nordic social democratic states represent contrasting approaches to health promotion, supporting a rich ground for comparative analysis to move beyond *what* worked (policy effectiveness) towards (1) explaining *how* structural and organizational components act as enablers and barriers to effective health promotion, and (2) key political and economic contextual factors to be considered. The rationale for selecting these countries was rooted in their differing approaches to health promotion and public health policy.

In liberal welfare regimes such as Canada, Australia, and the UK, there is a documented tendency towards lifestyle drift, where public health policies emphasize individual behaviour change over addressing systemic issues (Bambra 2007; Bambra 2011; Carey et al. 2017; Halsall et al. 2024; Lynch 2020; Popay et al. 2010; Raphael 2012). This shift can lead to neglecting upstream SDOH and reinforcing a narrative of individual blame for health outcomes, as recently demonstrated when considering the connection between food, choice, and health in the UK (Burges Watson, Draper, and Wills 2021).

Further, this grouping of Anglo-Saxon liberal welfare states provide varied approaches to health promotion, enriching the comparative study. These states share similar challenges with Canada, such as decentralization and emphasis on individual rights, allowing for relevant cross-case insights. The common underlying values of liberalism and Beveridge-styled universal health systems in these states facilitate a thoughtful comparative framework to consider health policy interventions.

In contrast, Nordic/social democratic welfare states like Norway and Finland are known to implement comprehensive health promotion policies that prioritize preventive measures and address SDOH (Bambra 2011; Kautto et al. 2001; Klepp, Helleve, and Rutter 2022; Raphael 2012). These systemic approaches tend to result in better health outcomes and greater health equity by creating an environment that supports healthy lifestyles through structural changes rather than solely focusing on individual behaviour modification (Kokko, Liveng, and Torp 2018). So, while there is still the Nordic Paradox, wherein countries do not always perform well

on health indicators such as relative health inequalities, the Nordic countries remain leaders in health promotion efforts due to their sustained commitment to equity-driven policies, integrated governance, and structural interventions that prioritize the SDOH (Kokko et al. 2018).

2.2.2 Study Design and Data Collection Methods

This study used the Consolidated Criteria for Reporting Qualitative Research (COREQ) method, as outlined by Tong et al. (2007), to guide reporting. This checklist included details about the research team, study methods, study context, findings, analysis, and interpretations. Overall, COREQ offers a valuable framework for enhancing the quality and transparency of qualitative research reporting, making it a crucial tool in this study. Appendix 1 provides an overview of the 32-item checklist and summary reporting of essential elements of qualitative research (Tong et al. 2007).

Specifically designed for qualitative research involving in-depth interviews, COREQ, like other qualitative reporting guidelines, enhanced the transparency and quality in reporting (Tong et al. 2007). For this reason, the next sections followed COREQ guidelines for interviews closely, with the addition of a qualitative document analysis and associated reporting considerations.

This case study was informed by three data sources: academic and grey literature, document analysis, and open-ended interviews. The critical realist literature review outlines an iterative approach to identifying and gathering literature, emphasizing interdisciplinary sources to explore the real structures, the actual mechanisms, and the empirical outcomes shaping health promotion and equity across different welfare state typologies (Edgley et al. 2014; Pawson et al. 2005; Raphael 2012; Wilson 1983). Setting the institutional context, documents are a source of evidence in our record-keeping society, often through the repetition of dominant discourses (Carroll 2004; Yin 2018). The documents included in this research represent explicit government commitments, or lack thereof, to promoting health and health equity (Raphael 2013a). The document analysis was complemented by in-depth interviews to allow a more comprehensive understanding. This triangulation allowed for the discussion of both the content and context of the documents, thereby enhancing the validity of the findings (Rubin and Rubin 2011). Together, these qualitative methods allow for triangulation, ensuring that policy document analysis is

contextualized by the literature review, and enriched by the lived experiences and insights of scholar-practitioners.

Critical Realist Literature Review. The critical realist literature review for this research followed a systematic yet flexible approach to data collection, emphasizing the integration of diverse sources to capture the complexities of health promotion and equity. The review focused on exploring discourse, ideologies, and the systemic factors contributing to challenges to effective health promotion, such as the phenomenon of lifestyle drift, within health policy processes across Anglo-Saxon liberal and Nordic social democratic welfare states. Using political economy perspectives and welfare state typologies, the review examined the roles of power, influence, and socio-political contexts in shaping health promotion efforts (Edgley et al. 2014; Pawson et al. 2005; Raphael 2012).

The data collection process drew on multiple methods to identify and gather relevant literature interactively and iteratively (Edgley et al. 2014). Sources included an extensive library of academic work previously compiled by the researcher, alongside advanced searches on emerging Artificial Intelligence platforms (Scite.ai, EvidenceHunt.com) and established tools such as Google Scholar™. Martín-Martín et al. (2018) show Google Scholar™ 'finds significantly more citations than the Web of Science Core Collection and Scopus across all subject areas' (p. 1175). These digital searches were complemented by manual reviews and targeted consultations of government websites, such as Canada.ca and Regjeringen.no, to incorporate policy-specific insights. This comprehensive strategy aimed to ensure the inclusion of seminal and contemporary studies, peer-reviewed journal articles, grey literature, and primary, secondary, and tertiary sources.

The literature search used focused keywords to target relevant themes, including "health promotion," "health policy," "social determinants of health," "lifestyle drift," "health equity," and various welfare state typologies that align with "Anglo-Saxon liberal" and "Nordic social democratic". By drawing on interdisciplinary fields such as political science, sociology, philosophy, and political economy, the review captured the interplay between macro-level structures, policy implementation processes, and observed health outcomes. These efforts informed a robust exploration of health promotion's challenges and opportunities, particularly in the contexts of Canada, Australia, the UK (specifically England and Scotland), Norway, and Finland.

Documents. This systematic process was guided by practices outlined by Greenhalgh et al. (2004) and Bowen (2009), ensuring a rigorous approach to document analysis. Documents were sourced from government and public health websites using specific keywords like "public health act," "health inequity," "health inequality," and "health equity." These documents were important to understanding the dominant discourse of (1) the underlying mechanisms that systems rely upon, or have access to, promote health and health equity, and (2) to understand what is considered feasible by system actors guiding successful health policy interventions that withstand challenges to health promotion.

The inclusion criteria focused on documents relevant to the national public health systems approach to promoting health and health equity, published between 2000-2023, in English, and readily available in digital spaces (e.g., Canada.ca, fnha.io). The focus was on legal frameworks governing public health systems, as well as strategic frameworks offering both explicit commitments to health promotion frameworks. Excluded documents were (1) those pertaining to specific populations, such as the *Mental Health Strategy for Corrections in Canada*, which focuses specifically on incarcerated persons in Canada (2) those authored by non-governmental organizations (NGOs) regardless of their location within or adjacent to the public health system,[3] and (3) those requiring travel or translation to access. The inclusion of institutional strategies ensures that the analysis centers on documents with actionable outcomes, defined objectives, general timelines, while excluding preliminary or conceptual documents allows for a more precise examination of realized health policy landscape. This approach keeps the study anchored in tangible, operational frameworks that are actively shaping public health systems and health equity initiatives. **Table 1** details the list of documents reviewed, by country.

This research excluded documents like White Papers, Government Resolutions, and Government Proposals, such as Finland's *Government Proposal for Health and Social Services Reform* (2021), to maintain a focus on binding legislation and operational strategies that have

[3] Note that Canada's Mental Health Strategy (2012), which was authored by the Mental Health Commission of Canada, was included as it is best considered as a federally funded arm's length non-profit organization, rather than an NGO at the time of publication. It is a unique entity that straddles the line between government-supported initiatives and independent advocacy, servicing as a bridge between policy, research, and mental health stakeholders in Canada. However, 10 years after Mental Health Strategy's publication, in 2022, the MHCC became a registered charity, perhaps shifting it further into the NGO realm.

enforceable authority and direct implementation impact. While White Papers, Resolutions, and Proposals provide valuable insights into policy intentions and exploratory frameworks, they do not carry the same legal weight or immediate operational impact as institutional strategies, plans, or enacted legislation. Also excluded were those documents that required travel, or translation, to access, such as the Finnish *Act on Organising Healthcare and Social Welfare Services* (2021), which was due for implementation in 2023). However, such documents may offer a valuable area of future study to understand explicit government commitments within political cycles.

Table 1: Documents Included in Document Analysis

Welfare State	Country	Document Title	Year	Type	Description
Anglo-Saxon/ Liberal	Canada	Pan-Canadian Healthy Living Strategy	2002/5	Strategic Framework	• **Initiated in 2002 and formally endorsed in 2005** by federal, provincial, and territorial governments (excluding Quebec) to address shared health challenges across Canada. • **Primary goal** is to promote healthy living and prevent chronic diseases by addressing key risk factors such as physical inactivity, unhealthy eating, and tobacco use, while also reducing health disparities by focusing on the SDOH. • **Emphasizes creating supportive environments for healthy behaviours,** targeting areas such as physical activity, healthy eating, and achieving healthy weights, with special attention to populations deemed vulnerable.
		Canada Public Health Agency Act	2006	Legislation	• **Established PHAC** to lead national public health efforts and respond to health emergencies. • **Mandated collaboration** with provinces, territories, and international bodies on public health policies. • **Focuses on prevention of disease**, injury, and **promoting healthy living** through research and surveillance.
		Mental Health Strategy: Changing Directions, Changing Lives	2012	Strategic Framework	• **National framework** developed by the **Mental Health Commission of Canada** to improve mental health services and reduce stigma. • **Focus on accessibility**, advocating for better integration of mental health care within existing health systems and improved access for underserved populations. • **Prioritizes prevention** through community-based mental health support and increased mental health promotion efforts.
	Australia	Australian Preventative Health Agency Act	2010	Legislation	• **Established the Australian National Preventive Health Agency (ANPHA)** to lead national efforts in disease prevention and health promotion. • **Focus on lifestyle-related health issues**, including tackling obesity, smoking, and excessive alcohol consumption through public health campaigns and programs. • **Coordinated national prevention strategies** across federal, state, and local levels, emphasizing collaboration for improving population health.
		Australian National Preventative	2011-2015	Strategic Framework	• **National strategy** to lead and coordinate efforts to prevent chronic diseases, focusing on lifestyle-related risk factors such as smoking, obesity, and alcohol consumption.

		Health Agency Strategic Plan			• **Emphasized collaboration** across government, health organizations, and communities to improve public health outcomes. • **Set measurable targets** for reducing the prevalence of chronic diseases and promoting healthier lifestyles through public awareness campaigns and evidence-based interventions.
		Australian Preventative National Health Agency Abolition Bill	2014	Legislation	• **Dissolved the Australian National Preventive Health Agency (ANPHA),** transferring its functions to the Department of Health. • **Shifted focus** from a dedicated national preventive health body to integrating preventive health efforts within broader health systems. • **Signified a policy change away from centralized health promotion**, criticized for reducing national coordination on chronic disease prevention and health promotion.
		Australian Public Health Act	2016	Legislation	• **Establishes the legal framework** for managing public health risks and promoting health and well-being across Australia. • **Empowers state and local governments** to address public health issues, including disease prevention and emergency responses. • **Focuses on modernizing health laws,** ensuring a coordinated approach to public health threats, and promoting equitable access to health services.
		Australian National Preventative Health Strategy	2021-2030	Strategic Framework	• **Long-term national plan** to improve the health of Australians by focusing on prevention and reducing the burden of chronic diseases through healthier lifestyles. • **Sets ambitious targets** to reduce smoking, alcohol consumption, obesity, and improve mental well-being by addressing SDOH. • **Promotes equity** by prioritizing vulnerable populations and integrating preventive health measures into all aspects of policymaking to create a healthier and more sustainable future.
	United Kingdom	Healthy Lives, Healthy People	2010	Strategic Framework	• **Outlined the UK government's vision** for public health reform, emphasizing a shift towards prevention and tackling health inequalities. • **Empowered local governments** to lead on public health initiatives, with a focus on addressing lifestyle-related health issues like smoking, obesity, and alcohol consumption. • **Promoted a cross-government approach**, integrating health considerations into broader policies, and encouraging community involvement to create a healthier population.

		Health and Social Care Act	2012	Legislation	• **Major restructuring of the National Health Service (NHS)**, shifting responsibility for public health to local authorities and creating new clinical commissioning groups (CCGs) to manage health services at a local level. Created Public Health England (PHE) accountable to the Secretary of State for Health. • **Increased private sector involvement**, allowing more competition within the NHS and enabling private providers to bid for contracts to deliver NHS services. • **Promoted patient choice** by expanding opportunities for patients to choose where they receive treatment and increasing transparency in healthcare outcomes.
		Public Health England Strategy	2020-2025	Strategic Framework	• **Focused on improving health outcomes** by addressing major public health challenges such as obesity, smoking, mental health, and reducing health inequalities. • **Prioritized prevention** and early intervention, with an emphasis on tackling the wider SDOH through partnerships with local authorities, the NHS, and other sectors. • **Prepared for future health threats**, including infectious diseases and pandemics, aiming to strengthen public health resilience and response capabilities
		The Public Health England (Dissolution) (Consequential Amendments) Regulations	2021	Legislation	• **Dissolved PHE** and transferred its functions to two new agencies: the UK Health Security Agency for health protection, and the Office for Health Improvement and Disparities for health improvement. • **Amended existing legislation** to reflect these changes, transferring PHE's responsibilities for public health policy, disease prevention, and health surveillance to the new bodies. • **Marked a significant reorganization of England's public health infrastructure,** aiming to improve focus on pandemic preparedness and tackle broader health disparities.
	United Kingdom (Scotland)	Scotland's Public Health Priorities	2018	Strategic Framework	• **Strategic framework** that identified six key priorities to improve health outcomes, including mental well-being, reducing health inequalities, and creating a sustainable, resilient public health system. • **Focused on a whole-system approach**, emphasizing collaboration between local authorities, the NHS, the Scottish Government, and communities to address public health challenges.

					• **Prioritized prevention** and tackling the root causes of poor health, such as poverty, housing, and education, aiming to promote well-being across all sectors of society.
		Mental Health Strategy	2017-2027	Strategic Framework	• **Developed and launched** by the Scottish Government in 2017 to provide a comprehensive framework for improving mental health care and support over a ten-year period. • **Aims to improve mental health outcomes for all people** in Scotland by promoting early intervention, prevention, and recovery, while addressing inequalities and ensuring accessible, person-centered mental health services. • **Focuses on building a mental health system that is equitable and sustainable**, by emphasizing reducing stigma, improving access to care, integrating mental and physical health services, supporting children and young people, and enhancing workplace mental health.
		Public Health Scotland Strategic Plan	2022-2025	Strategic Framework	• **Sets out the vision and goals** for Public Health Scotland over a specified period (2020-2023), focusing on improving public health, reducing health inequalities, and enhancing resilience across Scotland. • **Emphasizes prevention and addressing SDOH,** including poverty, housing, and education, aiming for a more equitable health system. • **Outlines key partnerships** between local authorities, healthcare systems, and communities to implement health strategies, build capacity, and respond to public health emergencies.
	Finland	National Action Plan to reduce Health Inequalities	2008-2011	Strategic Framework	• **Aimed to reduce health disparities** by addressing inequalities in income, education, and access to healthcare, with a focus on vulnerable and disadvantaged groups. • **Promoted intersectoral collaboration**, integrating health equity into various policies, including housing, employment, and social services, to address the root causes of health inequality. • **Set specific targets to improve health outcomes** for lower socioeconomic groups, focusing on disease prevention, early intervention, and equitable access to healthcare services.
		Health Care Act	2010	Legislation	• **Mandates municipalities to lead in promoting public health,** emphasizing preventive measures and addressing SDOH, such as lifestyle factors, housing, and education. • **Ensures equal access** to healthcare services for all citizens, regardless of socio-economic status or geographic location, aiming to reduce inequalities across health outcomes across different population groups.

					• **Reinforces the role of primary care** as the foundation of the health system, focusing on equitable resource distribution to ensure high-quality healthcare across the country.
		Socially Sustainable Finland	2020	Strategic Framework	• **Focused on creating a more equitable society**, with particular emphasis on reducing health and social inequalities through inclusive policies and improved welfare services. • **Promoted sustainable development**, linking public health goals to broader social and economic policies, ensuring that social sustainability was central to Finland's overall development strategy. • **Prioritized well-being for all**, with a commitment to long-term structural changes to enhance the quality of life for vulnerable populations, addressing issues such as aging, employment, and access to healthcare.
		National Mental Health Strategy and Programme for Suicide Prevention	2020	Strategic Framework	• **Launched by the Finnish Ministry of Social Affairs and Health** in 2020 as a framework for improving mental health and reducing suicide rates nationwide over a ten-year period. • **Aims to promote mental well-being,** prevent mental health issues, and provide comprehensive support for individuals in crisis, with a strong emphasis on reducing stigma and addressing the social determinants of mental health. • **Focuses on integrating mental health into all areas of life and policy,** strengthening community-based mental health services, improving crisis intervention and suicide prevention efforts, and fostering collaboration between health, education, and social services.
	Norway	National Strategy to Reduce Social Inequalities in Health	2007	Strategic Framework	• **Focuses on reducing health inequalities** by addressing the underlying SDOH, such as income, education, employment, and housing, to promote overall well-being. • **Emphasizes actions to improve health outcomes** for disadvantaged groups, ensuring that policies are designed to reduce the gap between socio-economic groups in terms of access to healthcare and overall health. • **Calls for cooperation across various sectors**, including health, education, and labour, to ensure that health equity is embedded in all areas of public policy.

		The Norwegian Public Health Act	2012	Legislation	• **Provides a legal framework for promoting public health**, with a strong focus on preventing illness and reducing health inequalities across Norway. • **Emphasizes cross-sectoral collaboration**, requiring that all sectors of government (not just health services) integrate public health considerations into their policies and activities. • **Highlights the importance of addressing social factors** like housing, education, and the environment to improve overall population health and ensure equitable access to health-promoting resources.
		National Health and Hospital Plan	2020-2023	Strategic Framework	• **Outlines strategy to strengthen the healthcare system,** with a focus on improving access to services, particularly for vulnerable populations and those living in rural areas. • **Emphasizes the need to integrate primary care and specialized hospital services**, ensuring continuity of care across different levels of the health system. • **A key feature of the plan is the increased use of digital health technologies** to enhance service delivery, improve patient access**Prioritizes reducing inequalities in access** to healthcare by ensuring that all citizens receive timely, high-quality medical services, regardless of their geographic or socioeconomic status.

2

The selection process resulted in a comprehensive collection of 22 documents (15 from Anglo-Saxon liberal welfare contexts; and seven from Nordic social-democratic welfare contexts). Documents offered valuable information about institutional and organizational frameworks, budget announcements, and formal strategies or communications regarding public health policy. Field notes were taken while analyzing the documents to record initial thoughts and reflections, influencing later stages of analysis. I reached data saturation when new documents no longer added any new insights beyond what had already been analyzed.

Interviews. This research used responsive interviewing, as described by Rubin and Rubin (2011), which supports a conversational approach and recognizes interviewees as conversational partners in the research. In some instances, professional acquaintanceships were already established with interview participants from my various professional roles in the health sector. Participants were informed about my background, goals, and the reasons behind the research.

Shared interviewee and interviewer insider positions, including associated biases and assumptions, were acknowledged to manage potential influences on the research. Indeed, the concept of "scholar-practitioners," has played an interesting role in fields such as healthcare, and social sciences. "Scholar-practitioners" are characterized by their ability to integrate theory, experience, and practice to generate actionable knowledge that benefits both their organizations and the broader academic community (Tenkasi and Hay 2008). This work builds on scholarship that recognizes physicians as exemplary scholar-practitioners in the health care field for their ability to combine clinical work with scientific research to enhance disease control strategies (Kram, Wasserman, and Yip 2012); and the notion that they have a unique role to play in the bridging of theory to practice in public administration (Kernaghan 2009).

The study included 15 participants: five from Canada, two from Australia, four from the UK (three from England; and one from Scotland) and four from Nordic countries (two from Norway and two from Finland). **Table 2** illustrates the range of locations in the various health systems from which interview participants participated and shared their views. Participant characteristics ranged from past and present senior-level advisors and researchers, and leaders from across the public sector, professional associations, and academic institutions that influence policy and practice. Many held experiences from past locations in the same, or different public health systems, leading to deeply differing and interesting experiences. Some focused on

enhancing knowledge and understanding to operationalize key concepts like ‘health equity,’ while others were more involved in policy, organizational strategy, and brokering relationships with academia and other sectors. Anonymity was maintained throughout the study to protect participants' identities and ensure candidness.

In addition to the spread of experience captured across the various scholar-practitioner roles of those interviewed, the cumulative years of experience in public health and health promotion work across all interview participants amounted to over 250 years. Over 180 years of experience was from those working in the Anglo-Saxon liberal welfare contexts, and over 70 years was from those working in Nordic social democratic welfare contexts.

Participants were initially approached via email, or LinkdIn, followed by a snowball method (Appendix 2). Interviewees represented a diverse range of roles within the public health workforce. The inclusion criteria focused on individuals who are conversant in policy processes within the public health system, including researchers, advisors, and leaders. The sampling aimed for saturation, with similar responses emerging consistently. Minimal refusals or dropouts were recorded, ensuring a robust sample size.

Data collection took place through interactions via Zoom, or Teams, allowing participants to join from their preferred locations. Only the participants and I were present during the interviews to ensure confidentiality, and all interviewed adhered to research ethics requirements, including informed consent (Appendix 3). The interviews consisted of open-ended questions and lasted approximately 60-90 minutes (Appendix 4).

Interviews were recorded using password-protected and encrypted software for accuracy and confidentiality, and handwritten notes were taken to capture additional observations. In addition to the reflective journaling exercise, field notes were made during and after the interviews to document additional reflections. Transcripts were not returned due to the length and in-depth nature of the discussions. Instead, direct quotes and high-level summaries of the results were shared with participants.

Table 2 Interview Participant, by country, welfare state typology and Public Health System locations

Interview Participant	Country	Welfare State Typology	Acidaemia/ Health Research Org.	Government Public Health Org.	Other
CI1	Canada	Anglo-Saxon Liberal	❖	❖	
CI2	Canada		❖	❖	
CI3	Canada			❖	❖
CI4	Canada		❖	❖	
CI5	Canada		❖	❖	
AI1	Australia		❖		
AI2	Australia		❖	❖	
UKI1	United Kingdom (England)		❖	❖	
UKI2	United Kingdom (England)		❖	❖	❖
UKI3	United Kingdom (England)			❖	❖
UKI4	United Kingdom (Scotland)		❖	❖	❖
FI1	Finland	Nordic Social Democratic	❖	❖	❖
FI2	Finland		❖	❖	
NI1	Norway		❖	❖	
NI2	Norway		❖	❖	

A Note on Insider Research and Reflexivity. The research undertaken for this dissertation was deeply informed by my lived and professional experiences. With a career that spans multiple jurisdictions and country contexts, my professional work in different health policy landscapes has provided significant insight into the essential functions of public health systems. This has allowed me to engage with decision-makers, policy actors, and the public health workforce from within the systems I studied as part of a PhD in Health Policy and Equity Studies.

As such, my research fits within the paradigm of "insider research" (Greene 2014), where I, the researcher, share a professional identity and language with the interview participants. This approach fosters a nuanced perspective, credibility, and rapport, while also necessitating careful navigation of potential biases and assumptions (Berkovic, Ayton, Briggs and Ackerman 2020; Jacobson and Mustafa 2019). In recognizing my dual role as both a practitioner and a researcher, this study is underpinned by the concept of reflexivity.

Researcher's Intention. Acknowledging that I occupy a unique space as an insider-researcher, and that this brings with it many opinions, ideas, and thoughts that I already use to construct my own daily reality and narratives, this work integrates a needed reflexive approach that requires a statement on my position to this research. It is necessary for readers to understand my identity as a researcher, my commitment to health for all, and my intentions for this project.

My intention for this research is to provide an explanatory case study to assist emerging researchers and policy actors seeking to "re-orient public health systems towards health promotion (WHO 1986)", as so many countries agreed to work towards over forty-five-years ago.

Reflexivity. As defined by Fook (1999), reflexivity involves situating oneself within the broader context of the research and critically examining how one's worldviews and interactions influence the research process. This practice is particularly vital in critical social science research, where tracing the effects of the researcher's position can help avoid the imposition of personal biases on the participants (Fook 1999). Reflexive practice challenges the assumptions within cognitive constructions and acknowledges the impact of the researcher's involvement on the study's outcomes.

To engage deeply in reflexivity, I maintained a research journal using an electronic, password-protected notebook. Scheduled entries, identified in Table included reflections on my identity as an insider aiming to mitigate undue influence on the research (

Table 3). Each entry addressed reflections concerning underlying assumptions, blind spots, and potential influences on the research process. This approach established a reflective relationship with the research, enabling a deeper understanding of both the subject matter and the research process itself.

Table 3: Reflexivity journal schedule

Data Collection Milestones	Planned Reflexivity journalling
Protocol Planning and preparation	✓ 2x during the design and development of study protocols (30 minute minimum each)
Document analysis	✓ 2x during the document search; and 3x during document analysis (30 minutes minimum each)
Interviews	✓ 3x during the design and development of protocols for interviews (30 minutes minimum each)
	✓ After each 90-minute interview (approximately 20 interviews).
Coding and Analysis	✓ On-going/ fluid

2.2.3 Approaches Data Analysis

Data analysis was conducted using two main analytic frameworks: thematic analysis and CDA. The critical realist literature review, the document analysis, and interviews were conducted along six a-priori thematic areas, serving as an entry point for analysis. Originally crafted by the WHO in 2007, and later adapted to amplify the essential public health functions in the Canadian public health system, 6 health system building blocks offer a useful analytic framework to understand and explain public health systems (PHAC 2021; WHO 2007).

Leveraging an adapted version of the building blocks, this framework offers a strong entry point to understand how public health systems are organized to support the essential public health functions. This section is presented in two parts. First, it presents the analytic frameworks of thematic analysis, including an introduction to the adapted public health system building

blocks, and CDA. Next, it explains the application of the building blocks as an analytic tool across all three methods of data collection.

Thematic and Critical Discourse Analysis. Both thematic and CDAs informed the analytic approach to the document and interview analysis. Thematic analysis focuses on identifying themes and patterns within data, and is more descriptive juxtaposed to content analysis, which relies more on data interpretation (Braun and Clarke 2008; Vaismoradi, Turunen, and Bondas 2013). Thematic analysis was used to subject stories of professional experience to specific themes and analyze them through repetitive coding, complemented by CDA, which focused on linguistic markers and contexts to explore explicit and implicit organization of social relations (Carroll 2004). Given the range of approaches to discourse analysis, this study employs a critical realist-informed CDA, which not only examines power, knowledge, and ideology but also situates discourse within broader structural mechanisms that shape public health policy and practice (Carroll 2004). This approach ensures a deeper interrogation of how language reflects and reinforces institutional constraints, making it well-positioned to analyze systemic barriers to health promotion and equity. This method allowed for the identification of recurring themes and patterns in the documents and interview data, providing a descriptive overview of the public health systems' functions and practices across the building blocks, while acknowledging power dynamics that underpin social structure relations.

Thematic Analysis. In the context of health policy, thematic analysis is helpful to explore and understand the complex narratives and experiences of individuals and communities regarding health promotion interventions (Vaismoradi et al. 2013). By identifying common threads across documents and interviews, this research aims to glean insights into the systemic barriers and facilitators of health-promoting policy action. This method allows for an in-depth examination of participants' viewpoints, providing valuable information that can inform the development of tailored health promotion strategies and programs.

There are a variety of approaches to thematic analysis. Braun and Clarke (2008) suggest six phases which were used to guide this research (See Figure 1). In line with this process, and as the sole researcher, I began by familiarizing myself with the data, including reading and re-reading documents and interviews two to three times before coding, noting reflections on both the themes and the discourse. Transcription software was used, and audio recordings were saved for reference and nuance, ensuring accuracy of the transcripts and insights conveyed.

Thematic Analysis (Braune and Clarke, 2006, p.87)

1. **Data Familiarization**: Transcribe, read, and note initial ideas.
2. **Coding:** Systematically code features across the data.
3. **Theme Identification:** Collate codes into potential themes.
4. **Theme Review**: Validate themes and create a thematic map.
5. **Theme Definition**: Refine and name themes clearly.
6. **Reporting**: Select extracts, finalize analysis, and produce a report.

Figure 1. Thematic Analysis 6-steps, Braune and Clark, 2008

Application of the Building Blocks to Health Promotion. This research builds on the 2021 adaptations, which emphasizes health promotion and protection (PHAC 2021). The core components are considered against health promotion, as defined by the Ottawa Charter (1986), and include (1) Leadership and Governance, (2) Financing and Resource Flows, (3) Workforce capacity, (4) Service Delivery and Program Interventions, (5) Knowledge, Evidence, and Information Systems and (6) Medical and Digital Technology.

The foundational building blocks, including Leadership and Governance, Financing, and Workforce Capacity, provide the principal framework for health promotion activities in public health systems. Importantly, these are the building blocks that mediate political economy, and institutional considerations across system processes. **Table 4** provides the definitions used as starting points for the thematic analysis.

Table 4 Thematic Definitions of Building Blocks

Building Block	Thematic Definition
Foundational Building Blocks	
Leadership and governance	Mechanisms to ensure effective health systems through strategic oversight, policy development, and accountability (WHO 2007; PHAC 2021).

Financing & resource flows	Involves generating, allocating, and managing financial resources to ensure the health system's accessibility and effectiveness without financial burden (WHO 2007; PHAC 2021).
Workforce capacity	Focuses on developing a well-trained, motivated, and equitably distributed health workforce through continuous education and training (WHO 2007; PHAC 2021).
Process Building Blocks	
Service Delivery, Policy and Program Interventions	Involves providing accessible, high-quality health policies, programs, and services that address health needs through various health services (such as primary care, community health programs, and regulatory services (WHO 2007; PHAC 2021).
Knowledge, Evidence, and Information Systems	Focus on collecting, analyzing, and disseminating health data to inform decision-making and policy formulation, ensuring high-quality, accessible evidence (WHO 2007; PHAC 2021).
Medical and Digital Technology	Focuses on developing a well-trained, motivated, and equitably distributed health workforce through continuous education and training (WHO 2007; PHAC 2021).

Leadership and governance ensure the creation of inclusive and effective health policies that address SDOH by engaging stakeholders and communities in the policy-making process (PHAC 2021; WHO 2007). Sustainable financing supports the implementation and maintenance of health promoting policy and programming, both as direct and indirect community services, by ensuring accessibility and comprehensive approaches that support all population groups without financial barriers (WHO 2007; PHAC 2021). Workforce capacity ensures that health promotion activities are delivered by well-trained and motivated health workers, who are essential for conducting community outreach, health education, and preventive measures, but also along the policy-making continuum. Empowering health workers with advocacy skills enhances the effectiveness of health promotion efforts (PHAC 2021; WHO 2007).

The process building blocks, including Service Delivery, Policy and Program Interventions, Knowledge, Evidence, and Information Systems, and Medical and Digital Technology, focus on the operational aspects of public health systems, and therefore the operationalization of health promotion efforts. For instance, integrating health promotion into policy and program interventions ensures stakeholder and community participation, ensuring that promoting positive health and wellbeing that meets the contextual needs are at the centre of the intervention. Robust information systems support continuous improvement and tracking progress in health equity (PHAC 2021; WHO 2007). Leveraging medical and digital technologies enhances the reach and impact of health promotion efforts, enabling the use of digital tools, particularly around community participation. These process building blocks ensure that health

promotion activities are efficient, evidence-based, and capable of addressing the diverse health needs of the population (PHAC 2021; WHO 2007).

Coding. Both documents and interview transcripts were coded using the same apriori themes listed above, with sub-themes emerging based on the critical realist literature review and organic patterns of recurrence. Both documents and interview transcripts subject to the same code tree using NVIVO14 software. **Table 5** shows the final codes by type of data, country, and welfare typology.

Table 5. Codes by Welfare typology, Country, Type of Data

Welfare State Typology	Country		Type of data	Codes	Sub-totals	Totals
Anglo-Saxon/Liberal	Canada		Document	86	308	885
			Interview	222		
	United Kingdom	England	Document	107	379	
			interview	132		
		Scotland	Document	84		
			interview	56		
	Australia		Document	111	198	
			Interview	87		
Nordic/Social Democratic	Finland		Document	140	253	453
			Interview	89		
	Norway		Document	109	200	
			Interview	91		

Redefining Themes and Sub-themes. Having started with apriori codes, aligned with the building blocks, I reviewed all content and began to generate sub-codes across categories. I quickly realized that cross-cutting codes such as 'key concepts,' 'enablers,' and 'barriers,' would be supportive, and added this category. I continued to refine and re-define the sub-themes. I then reorganized the themes and data extracts until there was a coherent theme and sub-theme structure, focused on extrapolating the tensions associated with each building block.

Table 6 shows the final codebook, after steps four, thematic review, and five, thematic definition in **Figure 1** were completed (Braun and Clarke 2008).

The final themes represent not just a culmination of re-defined codes, but also central tensions that emerged through this process. The themes and sub-themes are interrelated and address important aspects of the research questions guiding this work. Each theme and sub-theme are presented in a subsequent chapter on results and findings, underscoring the tensions

common across Anglo-Saxon liberal welfare contexts and Nordic social democratic contexts, as well as those that diverge between the welfare state contexts.

Table 6 Original Codebook to Redefined Themes and Sub-themes

Apriori theme	Code level 1	Code Leve 2	Final Parent Code	Final Child Code
Cross-cutting	Key Concepts	Health	Key Concept Frames	Legislative Framing
		Health inequity		
		Health Inequality		
		Health Promotion		Framing Health Equity
		Well-being		
	Enablers			
	Barriers			
Leadership and governance	Governance	Inter-jurisdictional	Governance and Leadership	Governance Structures and Pathways
		Inter-sectoral		
		Social Infrastructure		
	Leadership	Commitments		Intersectoral and Interjurisdictional Collaboration
		Goals and Objectives		
Financing & Resource Flows	Financing		Resourcing and Capacity	Financial Resource Flows
	Funding	Funding Across		
		Funding Down		
Workforce capacity	Health Sector	Capacity		Workforce Capacity
		Core competencies		
		Culture		
	Other Sectors			
Knowledge, Evidence, and Information Systems	Knowledge & Evidence	Knowledge Dissemination	Knowledge and Evidence Use	Operationalizing Knowledge and Evidence in Health Policy Processes
		Knowledge for Policy		
		Learning Systems		
	Information Systems			
		Monitoring and Evaluation		
		Surveillance		
Service Delivery, Policy	Policy and Programme	Conditions that determine health	Health Policy (including Programming)	Health Policy Approaches
		Implementation		

and Program Interventions		Health Systems		
		Healthy Public Policy		Health Policy Action
		Environment		
		Community Action		
		Personal Skills		Examples of Success
Medical and Digital Technology	Digital Technology	Advancements	Medical and Digital Technology	Supportive of policy action
		Digital Determinants of Health		

Critical Discourse Analysis. CCDA goes beyond linguistic analysis to explore power relations, ideologies, and socially constructed relations embedded in discourse. Building upon Bhaskar's 1986 "explanatory critique," Figure 2 illustrates the framework of CDA used is based on Chouliaraki and Fairclough (in Carroll 2004). There are multiple approaches to discourse analysis, broadly categorized as post-structuralist and critical realist approaches (Carroll 2004). While post-structuralist approaches, such as Foucault's genealogy and Denzin's deconstruction, are valuable for interrogating dominant discourses, they have been critiqued for their limitations in social critique and their tendency to reduce social life solely to discourse, leading to what Chouliaraki and Fairclough (1992, in Carroll 2004) describe as a 'discourse of idealism.' In contrast, this study applies Chouliaraki and Fairclough's dialectical critical realism framework, which incorporates the concept of 'explanatory critique' to examine how discourse interacts with material and institutional structures. This allows for a deeper understanding of how public health policy narratives shape, and are shaped, by systems of power.

Thematic analysis and CDA were integrated interactively throughout the research process, ensuring that emerging themes from policy documents and interviews were continually analyzed within their broader socio-political contexts, rather than being treated as isolated textual patterns (Carroll 2004). Integrating the critical realist perspective involved several steps to ensure the philosophical underpinnings of critical realism were consistently applied. Critical realism emphasizes understanding both observable events and the underlying mechanisms that produce them.

Critical Realist Literature Review. In the literature review, I examined the discourse and ideologies that position health promotion as an essential function, and health equity as an objective, of public health systems, the factors that inhibit health promotion efforts, contributing to challenges to health promotion, such as lifestyle drift, in policy processes, as well as the role of public health systems in promoting health and equity. Informed by a critical realist review approach, I explored to what extent the literature is cognizant of the roles that power and influence play in promoting health and equity through social policy and critically examined health promotion efforts in Anglo-Saxon liberal and Nordic social democratic welfare states.

***Document Analysis*.** The document analysis began with an examination of the context in which the documents were produced, considering historical, cultural, and social conditions. This stratified ontology involved analyzing the documents at multiple levels: the empirical (observable events and facts), the actual (events that occur, whether observed or not), and the real (underlying structures and mechanisms).

The analysis identified causal mechanisms or structures hinted at or directly referenced in the documents, such as social norms, power relations, or economic conditions, in relation to the six system building blocks, or themes. Critical analysis assessed biases, assumptions, and underlying ideologies, considering who authored the documents, for what purpose, and what interests they might serve. Findings from the documents were linked to broader theoretical frameworks, relating identified mechanisms to theories of political economy, institutionalism, and systems.

A Critical Discourse Analysis: A Framework (Carroll, 2004, p.265)

1) A problem (e.g. Lifestyle Drift)
2) Obstacles to its being tackled:
    a. Analysis of the conjuncture.
    b. Analysis of the practices(s) re: its discourse moment:
        i. Relevant practices?
        ii. Relation of discourse to other moments?
    c. Analysis of the discourse:
        i. Structural analysis: the order of discourse
        ii. Interactional analysis
3) Function of the problem in the practice
4) Possible ways past the obstacles
5) Reflection on the analysis

Figure 2 A Critical Discourse Analysis: Framework from Carroll, 2004

Interviews. The analysis contextualized interview data within broader socio-cultural and historical contexts, considering the background of interviewees and the circumstances of the interviews. A stratified analysis was conducted, examining what was said (empirical), what was

meant (actual), and what underlay these statements (real). Patterns and themes emerging from the data were linked to broader social structures and mechanisms, focusing on underlying mechanisms such as institutional practices, or cultural norms.

***Reflexive journaling*.** Reflective journaling was a critical component, ensuring that my role and potential biases in the analysis process were considered. This iterative process involved moving back and forth between data and theory, refining the understanding of the mechanisms at play based on new insights. The integration of findings from both documents and interviews aimed to provide an explanation that accounted for both observable events and underlying mechanisms.

The thematic analysis using NVivo software facilitated the integration of qualitative data from both the documents and interviews. Reflexive journal entries were not coded but were referred to throughout the analysis to support CDA. Data saturation was reached when no new themes emerged, ensuring comprehensive coverage of the topics. Direct quotes used in the results section were shared with participants and transcripts were made available to participants, additionally, in acknowledgement of the time constraints voiced by almost all participants, an executive summary document was shared for comment and correction, ensuring high-level participant validation.

2.3 Ethical Considerations

Ethical considerations were met through the Office of Research Ethics for York University. Specifically, an Individualized protocol involving human participants were approved. In addition, written informed consent is to be provided to all participants, and filed away in a locked cabinet. All identifying information was removed prior to transcription, and original researcher notes were also be stored in a locked cabinet and destroyed in compliance with ethical standards. Any electronic data, such as recorded interviews was stored under an encrypted and password protected file until the publication of the research results, at which point it was destroyed in compliance with ethical standards of practice. Given the iterative nature of, specifically, the qualitative research, ethical considerations were revisited throughout the study, particularly during data collection and analysis phases, to ensure ongoing participant consent and confidentiality

2.4 Chapter Summary

Chapter 2 delves into the theoretical frameworks and paradigms underpinning this research, offering a theoretical and methodological foundation for examining health promotion and equity across welfare state typologies. The chapter begins by outlining the complementary paradigms of critical realism and interpretivism. Critical realism serves as a lens to explore the structural and systemic forces shaping health promotion policies, while interpretivism provides a nuanced understanding of how individuals and institutions construct and enact these policies. Together, these paradigms enable a robust analysis of the real, actual, and empirical dimensions of health promotion within public health systems.

Building on this foundation, the chapter introduces three interconnected theoretical frameworks: systems theory, historical institutionalism, and political economy. Systems theory highlights the interdependencies within public health systems, emphasizing the ripple effects of policy decisions across sectors. Historical institutionalism adds depth by exploring how past institutional decisions create path dependencies, shaping current policy trajectories. While these frameworks offer critical insights, their limitations in addressing structural power dynamics are addressed through the political economy approach, which situates health promotion within broader socio-economic and political contexts.

The discussion emphasizes political economy as the central analytical tool of this research. Unlike other frameworks, political economy directly examines how economic systems, power dynamics, and resource distributions shape health outcomes and perpetuate barriers to effective health promotion. This approach underscores the structural barriers to equity-focused health promotion and provides actionable pathways for addressing systemic inequities.

The analytic methods employed in this research combined thematic analysis and CDA to comprehensively examine health promotion policies and practices. Thematic analysis was used to identify and interpret patterns in the data enabling the systematic exploration of key themes related to challenges to effective health promotion. This method allowed for an in-depth understanding of recurring ideas and the nuances within the data, providing a foundation for meaningful insights. Complementing this, CDA was applied to analyze the power dynamics, ideologies, and discursive practices embedded in policy texts and narratives. By focusing on the relationship between language and power, CDA highlighted how certain frames, narratives, and structures influenced health policy decisions and reinforced systemic inequities. Together, these

methods offered a robust analytic framework to uncover both the explicit content and underlying mechanisms shaping health promotion strategies in diverse welfare state contexts.

By integrating these theoretical perspectives, and analytic frameworks, Chapter 2 establishes a comprehensive approach for analyzing health promotion and equity in Anglo-Saxon liberal and Nordic social democratic welfare states. This integration is crucial for addressing the study's research questions, particularly in exploring systemic barriers, enablers, and opportunities for advancing equitable health promotion strategies globally.

Chapter 3: Critical Realist Literature Review

The public health processes that promote health and equity are complex and deeply intertwined with the power dynamics and public policy landscape that define welfare states (Bryant and Raphael 2018; Raphael 2013a 2013b 2015b). In this chapter, I examine the discourse and ideologies that frame health promotion and health equity within public health systems, the factors that inhibit health promotion efforts and contribute to challenges like lifestyle drift, as well as the role of public health systems in promoting health and equity. Informed by a critical realist review approach, I explore to what extent the literature is cognizant of the roles that power and influence play in promoting health and equity through social policy and critically examine health promotion efforts in Anglo-Saxon liberal and Nordic social democratic welfare states. I use a critical realist ontology to consider how existing literature explains *how* and *why* policy processes work or fail, from individual failings to macro-level interventions that include analysis of different forms of the welfare state (Klinberg et al. 2021; Pawson et al. 2005; Shahid et al. 2021).

There is a growing literature dedicated to understanding how the political and economic systems of a country influences the distribution of the SDOH and health inequalities (Bambra 2007; Bryant and Raphael 2018; Chung and Muntaner 2006; Eikemo et al. 2008; Eikemo and Bambra 2008; Mackenbach et al. 2018; Navarro et al. 2006; Popham et al. 2013; Raphael 2013a 2013b 2015b). Building on the contributions of scholars working at the intersections of health policy and political economy in Canada and beyond, this chapter examines the drivers of health inequity and the mediating role of public health systems. It is presented in four parts. First, it introduces an adapted conceptual framework that identifies key political and economic drivers of health inequalities at the *real* level, which influence the *actual* domain of policymaking and, ultimately, shape the *empirical* outcomes observed in health inequalities. Second, it explores the *real* and *actual* dimensions in greater detail, emphasizing their interconnectedness. Third, it discusses the *empirical* through a focus on public policy and decommodification, highlighting how policies impact health outcomes. Finally, it examines the central role of the public health system as both a distributor of resources—through services, policies, and programs—and as a government institution responsible for shaping health within broader governance and policymaking landscapes.

This review narrows focus to Canada as a primary case study, drawing comparative insights from other Anglo-Saxon liberal welfare states—Australia, and the UK (emphasizing England and Scotland)—and Nordic social democracies, Norway and Finland. These contexts offer valuable perspectives on how diverse welfare state models address upstream health policy considerations and systemic inequities. By situating Canada within this comparative framework, the review provides a foundation for analyzing health promotion efforts across welfare typologies and exploring transformative strategies for advancing health equity.

3.1 Factors that Contribute to Effective Health Promotion

Solar and Irwin (2010) argue that policy interventions must address both intermediary and structural determinants of health to effectively reduce inequities. This section uses a critical realist approach to examine how political and economic systems shape the extent and impact of challenges to effective health promotion and the advancement of health equity within health policy frameworks. By focusing on the underlying structures and mechanisms that perpetuate health inequities, this approach allows for a deeper understanding of how welfare state models influence the breadth and depth of health promotion efforts. The critical realist perspective challenges traditional health promotion strategies by revealing the systemic and structural factors that drive health inequity, providing a more nuanced analysis of how these factors intersect with known challenges to health promotion efforts and affect health equity on a global scale (Bambra 2007; Raphael 2012).

For instance, 'lifestyle drift'—where policies originally target broader SDOH narrow to focus on more on individual behaviours—presents challenge and barrier for strong health promotion action (Carey et al. 2017; Halsall et al. 2024; Whitehead 2012). Defined as “well meaning initiatives on tackling inequalities in health that start off with a broad social determinant (upstream) but drift downstream to largely individual lifestyle factors (Whitehead 2012, p. 523),” lifestyle drift undermines the effectiveness of health promotion strategies by focusing on individual behaviours rather than systemic issues. This shift dilutes the impact of health interventions, and can also perpetuate health inequalities by neglecting the structural determinants (Carey et al. 2017). Addressing such challenges is critical to sustaining and maintaining health improvements across populations (Bambra 2011), and researchers have highlighted the need for more empirical research on phenomena associated with barriers to

effective health promotion efforts, such as lifestyle drift, "including research that elucidates the mechanisms that contribute to it" (Halsall et al. 2024, p. 2).

3.1.1 A Conceptual Model

In 2008, the WHO released the final form of the *CSDOH Framework*. Building upon the discussion sessions and resulting frameworks proposed by Solar and Irwin (2010), this framework highlights the socio-economic and political contexts as a structural determinants of health inequalities (CSDOH 2008). It specified Governance, both social and public policy, culture and societal values as the structural determinants of health inequities (CSDOH, 2008).

This framework continues to guide public health actors and decision makers globally. It emphasized the causal pathways through which health is distributed, impacting equity in health; and while the framework did not delve into the political and economic power relations that drive social inequity across the framework resulting in health inequities, the accompanying report did refer to the "social and political mechanisms that generate, configure, and maintain social hierarchies," including social and public policies, and the role of the welfare state (CSDOH 2008, p. :25). The same report offered a framework for tackling SDOH inequalities, which emphasized intersectoral action and social participation and empowerment as cross-cutting themes of policy-based action, warning that interventions and policies to reduce health inequalities must take aim beyond the intermediary determinants to the social and systemic mechanisms that reproduce health inequalities in the first place (CSDOH, 2008).

In this broader context, Raphael (2012) proposed a model of factors contributing to the extent of health inequalities and the willingness to tackle them. This model incorporates ideas from Navarro (2004), Brady (2009), and Coburn (2004) to emphasize the role of the welfare state, and specific structures that shape the extent of health inequalities and the inclination to tackle them at the state level (Raphael 2012). Building on these works, **Figure 3** represents an adapted model that guides the rest of this section to delve deep on public policy action, including through social policy, as mechanisms that reproduce health inequalities, challenging those working towards health equity.

In this model, the welfare state, power relations, decommodification, and importantly, the health system itself, are all considered determinants of health inequalities that inhibit health equity. "The state" and "power relations" are mostly made up of societal structures and

undercurrents of power, the *real*. It is how they are activated, the *actual*, to create public policies that affect the equitable distribution of SDOH, the *empirical*. Importantly, this model emphasizes the role that public health systems play in mediating the conditions and the extent of the outcomes through access to care and negotiating the differential consequences of illness in peoples lives, as well as leadership in intersectoral action (CSDOH 2008; Solar and Irwin 2010).

3.2 Health Promotion and the Real, the Actual, and the Empirical

This section underscores the critical role of structural determinants, including the welfare state, public health systems, and power relations, in shaping health inequities; but presents these as contributing factors to the effectiveness of health promotion. This adapted conceptual model provides a nuanced lens through which to examine the interplay of these determinants, linking the *real*, *actual*, and *empirical* dimensions of health policy, setting the stage for subsequent sections of this review. Further, by emphasizing the mediating role of public health systems and the need for intersectoral action, this model aligns directly with the research questions, particularly the exploration of systemic barriers and enablers for health promotion. This framework not only contextualizes the persistence of health inequities but also guides the inquiry into transformative strategies for advancing equity-focused health policies across diverse welfare state contexts.

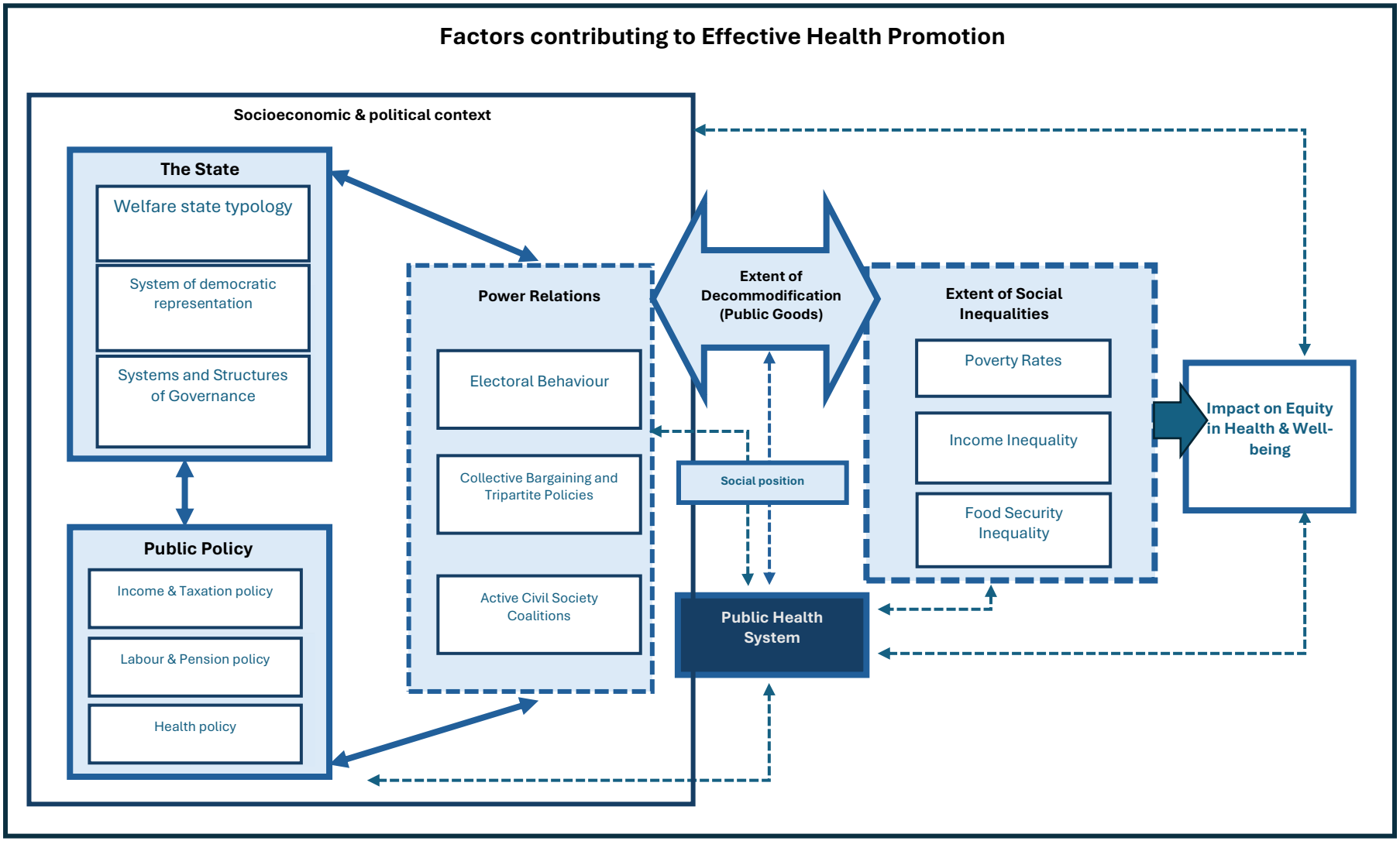


Figure 3: Factors contributing to effective health promotion, adapted from models by CSDOH (2008), Solar and Irwin (2010), and Raphael (2012).

3.2.1 The Possible vs. the Feasible: The Real and the Actual

This socioeconomic political context describes what is *real*, and possible and sets the stage to understand then what is feasible, and the *actual* way that these conditions play out across countries. Following the adapted conceptual model outlined above, this section explores the role of the state, as well as power relations. It sets the stage for an exploration of the empirical public policy, the role of decommodification, and the impact on equitable health in the next section.

The State. The state plays a pivotal role in shaping health outcomes and their equitable distribution through its welfare state type, systems of democratic representation, and governance structures. These dimensions determine the distribution of resources, the focus of public policy, and the mechanisms for citizen engagement (Raphael 2012). This section examines the state's role across liberal and social democratic welfare state models, highlighting the Anglo-Saxon and Nordic models aligned with each, and explores how democratic and governance structures influence health promotion and equity. These discussions directly tie to the research questions by interrogating how systemic structures enable or constrain effective health promotion and equity-driven public health systems.

The Welfare State Typology. In Esping-Andersen's (1990) model, Liberal welfare states such as Canada, Australia, and the UK see state provision of welfare as minimal, and individual responsibility with limited state intervention is emphasized often providing targeted welfare benefits. In Social Democratic welfare states, exemplified by countries like Norway and Finland, welfare provision is universal with extensive welfare benefits funded by high taxation to reduce social inequalities (Esping-Andersen 1990). In contrast, the conservative model, found in countries like Germany and France, see emphasis on traditional family values and reliance on private initiatives, with the state stepping in to support social welfare only when necessary (Esping-Andersen 1990).

Methodological critiques and advancements in welfare state regime theories require scholars in the field of health to think critically about the approach to research relying on welfare state typologies (Bambra 2007; Bambra 2011; Eikemo and Bambra 2008). Acknowledging this critique, and the evolution of welfare regimes through time and space, this work includes considerations from other models of welfare regimes, including the Anglo-Saxon and Nordic models.

The Anglo-Saxon model, which is marked by a liberal approach to social welfare, includes countries such as Canada, Australia, and, naturally, the UK, among others. This model also emphasizes limited state intervention in the economy and a reliance on the market and means testing at the individual and family levels to provide social services. This model leads to significant inequalities in access to welfare services and health outcomes based on socio-economic status (Bergqvist et al. 2013; Brennenstuhl et al. 2012). Studies have consistently shown that the Anglo-Saxon countries have higher levels of health inequalities, particularly among those in conditions of unemployment or poverty (Brennenstuhl et al. 2012; Eikemo and Bambra 2008).

On the other hand, the Nordic model, exemplified by countries like Norway and Finland, among other Nordic countries, is marked by a socio-democratic approach to resource distribution, emphasizing universal access. Nordic welfare states have, in the past, been effective in reducing absolute health inequalities (Bambra 2011). Research suggests that the extensive social security systems that characterize the Nordic model act as a buffer, protecting health during economic crises (Mackenbach et al. 2018). Chung and Muntaner (2006) also showed that countries with a longer history of political parties that ascribe to redistributive ideologies in power (e.g., Nordic countries) have better health outcomes than countries with a stronger liberal history of governments.

Of course, nothing in political economy is static or simple. The evolution of all these models have experienced shifts towards welfare state retrenchment and marketization since the 1990s, leading to a convergence of Nordic welfare policies with those of other Western European countries (Popham et al. 2013). And, importantly, there remains a "Nordic paradox," whereby overall relative inequalities in health do not seem to be smaller in more redistributive contexts, and yet the absolute health of all social classes is better (Eikemo and Bambra 2008; Kautto et al. 2001; Mackenbach et al. 2018; Popham et al. 2013). While neoliberal influences have played a significant role in shifting welfare policies, persistent health inequalities in Nordic states also stem from structural inequities along socio-cultural lines, including gendered labour market stratification and racialized barriers to accessing health and social services (Bambra 2011; Mackenbach et al. 2018; Popham et al. 2013).

Furthermore, as Bambra (2011) highlights, comparative social epidemiology has often focused on relative measures of health inequality, which may obscure how absolute health

outcomes for marginalized groups compare across welfare states. So, although Nordic countries achieve better absolute health outcomes, gender, class, racial and ethnic stratifications continue to shape inequities within these systems.

Despite this, welfare states typologies offer a way of describing the ways of dealing with public policy issues, as well as a path dependency that moves these public policy trajectories into the future (Raphael 2012). Welfare states also shape the understanding of citizens around the nature of society, who then, in systems of democracy, participate in systems of democratic representation based on these understandings (Coburn 2004).

Systems of democratic representation. The relationship between systems of democratic representation, such as electoral processes, and health is important. Democratic governance enhances public health by fostering accountability and responsiveness to the needs of citizens, and groups of citizens. This was evidenced by the sweeping governmental responses to the recent COVID-19 pandemic (Jain, Clarke, and Beaney 2021 2022). Research has shown that democratic principles such as civil liberties, representation, and fair elections create the environment where governments are incentivized to address social and health inequities (Jain et al. 2021 2022; Ruger 2020).

Further, the mechanisms through which democracy influences health are central to good governance. Democratic systems encourage participation and engagement, which are essential for good health policy. A literature review by Marent et al. (2012) shows that the participatory aspect of democracy both empowers citizens and ensure that health policies are reflective the needs of the people, thereby enhancing the effectiveness of the health interventions.

As a way to participate in democracy, there is also evidence to suggest that proportional representation increases the chances of public policy that seeks to reduce health inequalities within a jurisdiction (Raphael 2012). Indeed, Esping-Andersen (1985) argued that the early adoption of proportional representation in the Scandinavians nations was key to the development of their welfare systems. Meanwhile, “first-past-the post” systems, which are used in Canada, the UK, and Australia, could reduce attention to health inequalities, and their underlying social conditions, by favouring certain political parities (Raphael 2012). Notably, both Norway and Finland ascribe to forms of proportional representation the implications of which are provided in later sections.

Another important aspect of democracy and health is gender representation. Scholarship has shown that increasing women's representation in political offices can promote better and more equitable health outcomes (Macmillan, Shofia, and Sigle-Rushton 2018). Specifically, Lin and Yan (2022) showed that higher participation of women in decision-making roles could significantly influence public health policy through the reduced consumption of unhealthy products among children.

In Canada, recent government administrations have sought gender parity in cabinet. However, as of December 2024, Canada ranked 63rd out of 185 countries for women in national parliaments (Parline 2024). Out of the five countries of interest to this study, Finland ranked 11th, with 46% women in the lower or single house, and Norway was 17th with 44.4% (Parline 2024). The UK was 24th with 40.5%, while Australia ranked 33rd with 38% (Parline 2024).

Another important aspect of democratic representation is that of self-determination for Indigenous Peoples, particularly in the context of colonialism. Indigenous self-determination shapes how Indigenous communities engage with state governance structures and advocate for rights and well-being. Across the five country contexts of this study, the recognition and implementation of Indigenous self-determination vary significantly, reflecting distinct historical, legal, and political frameworks.

In Norway and Finland, the Sámi Parliaments serve as structured political institutions through which the Sámi people exercise self-governance in cultural, linguistic, and land-related matters, reinforcing a model of Indigenous political engagement within the broader national framework (Mörkenstam, Selle, and Valkonen 2022; Norum and Nieder 2012). By contrast, Canada, and Australia exhibit ongoing tensions between formal recognition of Indigenous rights and the realities of democratic structures that often limit meaningful self-determination at the national level (Hobbs 2018; Reinders 2019). Meanwhile, the UK presents a more complex and multifaceted challenge to indigenous rights, based on identity, historical, and socio-political dimensions that intersect with broader discussions of national identity and devolution, which is discussed in-depth below.

Self-determination enables Indigenous communities to advocate for culturally relevant health interventions, challenge systemic barriers, and assert control over resources that influence their well-being. The Sámi Parliaments of Norway and Finland provide an example of how Indigenous-led governance structures can enhance democratic engagement and advance SDOH,

offering potential insights for other jurisdictions seeking to strengthen Indigenous representation in decision-making.

This underscores how democratic principles—ranging from participatory governance to proportional representation, gender inclusivity, and Indigenous self-determination—create environments conducive to advancing health equity. These principles foster accountability, empower citizens, and shape public policy to address health inequalities effectively. However, the ability of democratic systems to influence health outcomes also depends on the broader structures and systems of governance within which they operate. Understanding how governance frameworks, including welfare state models and intergovernmental dynamics, interact with democratic ideals is essential for analyzing the capacity of public health systems to promote health and well-being. The next section delves into these systems and structures of governance, exploring their pivotal role in shaping public health outcomes.

Systems and Structures of Governance. The relationship between systems and structures of governance play a strong role in the strength of a welfare state, and can significantly influence equitable health. This is because these systems and structures directly account for the redistribution of resources (Raphael 2012). For instance, there is evidence to suggest that federal systems, which decentralize decision-making and jurisdictional responsibility, are less likely to create public policy that reduces, or addresses health inequalities while unitary, or central, systems put decision-making authority at the centre, though delegation to localities is inevitable (Banting and Corbett 2002; Bryant, Aquanno, and Raphael 2020; Raphael 2012).

Notably, all liberal welfare states, apart from the UK, are federal jurisdiction (Bryant et al. 2020; Raphael 2012).The UK is an asymmetrical decentralised unitary state, but has undergone a devolution of powers to its components, including Scotland, Northern Ireland, and Wales, leading some scholars to classify it as a 'quasi-federal' state (Game 2016). Notably, while the devolution of political powers has happened, to varying degrees, major fiscal policy remains governed by the UK (Raphael 2012). Meanwhile, both Norway and Finland, among other Nordic social democracies, are central, or unitary systems (Raphael 2012).

In summary, the state's influence on health outcomes is mediated by its welfare typology, democratic representation, and governance systems, which shape policy trajectories and the prioritization of health equity. Anglo-Saxon liberal welfare states tend to emphasize individual responsibility, creating disparities in access to social services, whereas Nordic social democratic

systems prioritize universal access and redistribution, often achieving better health outcomes (Bambra 2011; Bergqvist et al. 2013; Brennenstuhl et al. 2012; Bryant and Raphael 2018; Eikemo et al. 2008; Eikemo and Bambra 2008). Governance structures further impact the state's capacity to address health inequalities, with centralized systems demonstrating greater potential for cohesive equity-focused reforms. These insights contribute to understanding how institutional frameworks and state systems can either perpetuate or mitigate health inequities, aligning with the research focus on systemic barriers and enablers to health promotion. However, the effectiveness of these systems is deeply influenced by power relations, which determine whose interests are prioritized in public policy and resource allocation, setting the stage for the next discussion.

Power Relations. Systems of, sometimes, unobservable power distribution underpin the development and evolution of welfare states and their public policies and highlights how different forms of power influence and health policy. Historically, the role of organized labour has played a strong role in this distribution (Esping-Andersen 1985; Raphael 2012). Power dynamics shape decision-making processes, resource allocation, and the implementation of health promoting policies and programs, impacting health outcomes. This section explores three key aspects of power relations: electoral behaviour, collective bargaining and tripartite policies, and active civil society coalitions.

Union density and collective agreements have both direct and indirect roles in health promotion efforts. Directly, unions lead to better wages and benefits, while indirectly, they strengthen working class influence on public policy processes (Raphael 2012). Meanwhile, collective agreement coverage is associated with lower poverty rates, and income inequality (Swank 2005).

Both differ significantly between Anglo-Saxon liberal and Nordic social democratic welfare states, reflecting broader ideological and institutional contrasts. Anglo-Saxon liberal welfare states like Canada, Australia, and the UK exhibit lower union density and weaker collective bargaining structures. In these contexts, unions face a diminished role amid deregulation and market-oriented policies, resulting in fragmented agreements that focus more on individual protections than collective welfare (Kammer, Niehues, and Peichl 2012). In social democratic regimes, such as those in Finland and Norway, union density is high, supported by robust institutional frameworks that enhance collective bargaining and labour rights (Kang

2020). These systems foster comprehensive collective agreements that prioritize social protections often aligned with expansive welfare policies championed by labour-friendly political parties.

The distribution of power within welfare states profoundly influences health policy, shaping everything from resource allocation to the implementation of health-promoting policies. The contrasts between Anglo-Saxon liberal and Nordic social democratic regimes underscore how power dynamics manifest in union density, collective bargaining, and broader labour relations. In liberal welfare states, weakened union roles and fragmented collective agreements reflect deregulation and individualism, while in social democratic contexts, robust union activity and comprehensive agreements bolster social protections and equity. To fully understand these dynamics, this section delves into two key dimensions of power relations: electoral behaviour, which shapes the political context for health equity policies, and collective agreements, which directly influence economic and social conditions. Together, these elements underscore the important role of organized power in advancing or hindering public health goals.

Electorate behaviour. Electorates hold power in democracies. The perceptions, beliefs, and grievances of the electorate drive voter preferences, political narrative and competition, and the accountability of elected officials. These mechanisms influence public policy and equitable health outcomes. Hobolt and Klemmemsen (2005) found that public opinion tended to drive the public poly process but interestingly noted that using a comparative analysis between the UK and Denmark, concluded that in both parliamentary and proportional democracies, public opinion sways public policy, with proportional democracies perhaps more responsive.

This suggests that where voters prioritize equitable health and well-being outcomes, politicians are more likely to incorporate these concerns into public policy. This recently played our in the Canadian context, in the most populous province of Canada.[4] Labert at al. (2023) point to both public demand and political responsiveness on the issue of health equity in the cancer care sector. However, this work was limited to the cancer care as a sub-component of the healthcare system, a determinant of health in it's own right (Lambert et al. 2023). Indeed, the

[4] Noting that in Canada, a federated democracy, provinces and territories have constitutional jurisdiction over healthcare for many citizens, while the federal level has jurisdiction for some such as Indigenous Peoples residing on reserves. The systems for public health, and the social determinants of health, extend across jurisdictions.

Ontario Cancer Plan has been critiqued as falling too short to address the wider conditions that determine health, those that live beyond the control of the healthcare system (Sayani 2019).

This responsiveness can also have a negative impact on health issues. For instance, in the UK, sloganeers claimed that leaving the European Union would increase funding for the NHS. And yet, following the Brexit referendum, research has shown a destabilisation of the UK's NHS as well as trade agreements linked to non-communicable diseases, and notable increase in discrimination based on race and ethnicity, impacting both access to healthcare and overall well-being for many people (Costa-Font 2017; Hackett et al. 2020; Hawkins et al. 2023; Poppleton et al. 2022). And, in Australia, Windle et al. (2023) found that health promotion strategies, once implemented among the Primary Health Networks, often favoured the higher socioeconomic neighbourhoods, further hindering equitable efforts. In Norway and Finland, however, the weight of egalitarian principles in governance often leads to health policy that prioritizes health equity, with examples of both governments stressing their responsibility for health (Vallgårda 2011).

Collective Bargaining and tripartite policies. Labour and production means have long been linked to health and challenges to health equity. Collective bargaining, often through the empowerment of trade or labour unions, has been shown to improve health through enhanced working conditions, job security, wage equity, and improving conditions between labour market insiders and outsiders (Hagedorn et al. 2016; Reeves 2021; Sochas and Reeves 2023). Tripartite policies, on the other hand, involve collaboration among government, employers, and labour unions, and are essential for occupational health. Canada, for instance, employs a tripartite social contract that underpins its health care system, to enhance accessibility and quality of healthcare services (Martin et al. 2018).

Table 7 illustrates the most recent collective bargaining coverage, by country, based on the most recent year of available OECD data (OECD 2024c). Finland and Norway rank higher than all three Anglo-Saxon liberal welfare states listed, with the UK ranking below the estimated OECD average. This underscores the significance of collective bargaining and tripartite policies as mechanisms for advancing health equity by addressing structural determinants such as wage equity and working conditions. By analyzing these approaches within Nordic and Anglo-Saxon welfare state contexts, this research highlights how labour relations influence health outcomes and explores the potential for systemic reforms to promote equitable health policies, directly addressing the research questions.

Table 7: Ranking Collective Bargaining Coverage, by country and year, OECD

Ranking	Country	Coverage	Year
1	**Finland**	88.8%	2017
2	**Norway**	69.0%	2017
3	**Australia**	61.2%	2018
4	**Canada**	31.3%	2020
5	**United Kingdom**	26.9%	2019

Active civil society coalitions. Civil society organizations (CSO) play a strong role in both health governance and driving social change. Civil societies can mobilize communities, raise awareness about health issues, and advocate for policies that prioritize health equity (Smith et al. 2016). They also play a role in responding to health crises, such as the COVID-19 pandemic, and advocate for the needs of underserved communities (Nampoothiri and Artuso 2021; Sahu 2016).

Figure 4 illustrates the civil society participation index across Canada, the UK, Australia, Norway, and Finland. This index is run by the World Bank Group, and considers many conditions, including that major CSOs are routinely consulted by policymakers; how large the involvement of people are; if women are prevented from participating; and the centralization of legislative candidate nomination (World Bank 2024). This index recognizes the role of civil society in the public space between the private sector and the state, and include interest groups, social movements, professional associations, and non-governmental organizations (World Bank 2024). According to the World Bank, Norway (0.98) leads the way on CSO participation, while Canada, and Finland are tied with a score of 0.94. The UK (0.91) and Australia (0.84) lag behind (World Bank 2024).

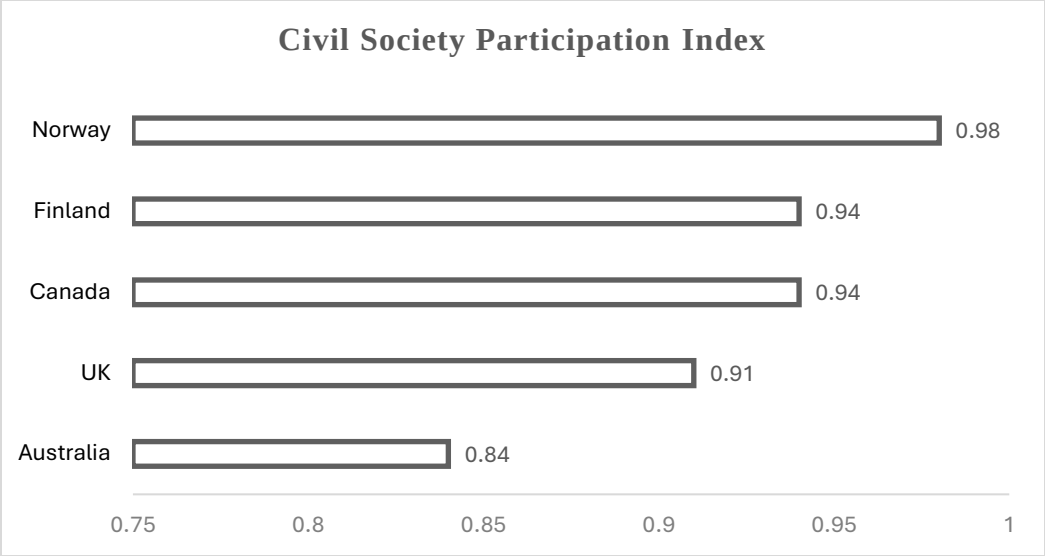


Figure 4. Civil Society Participation Index, World Bank, 2023.

This research highlights the pivotal role of civil society coalitions in advancing health equity by fostering community engagement, advocating for policy change, and addressing systemic inequities. By examining the Civil Society Participation Index across diverse welfare state models, we can see how active civil society involvement can shape health policies and address the research questions regarding systemic barriers and enablers to equity-focused health systems.

Power relations are not static; they evolve within the socio-political and economic contexts of each welfare state. This dynamism underscores the importance of examining how power structures can both sustain inequities and serve as mechanisms for transformative change. As the next section explores the broader structures that influence public policy, this research continues to build on the understanding of how power relations intersect with state governance to shape health equity outcomes.

This section underscores the significance of power relations in shaping health policies and their outcomes, emphasizing the interplay between electoral behaviour, collective bargaining, and civil society coalitions. By examining these dimensions across Anglo-Saxon liberal and Nordic social democratic welfare state contexts, this research illuminates the systemic barriers and enablers to achieving health equity. These findings directly inform the research questions, offering insights into how power dynamics influence policy development, resource allocation, and the broader pursuit of equity-driven public health systems.

The dynamic nature of power relations reveals both the challenges and opportunities for creating more equitable health systems. As we turn to the broader structural and institutional contexts influencing public policy, the discussion builds on these insights to explore how governance systems and institutional frameworks intersect with power to shape health equity outcomes globally.

To conclude, this section has traced the contours of the "*real*" structures—such as welfare state typologies, democratic representation, and governance systems—that underpin health promotion and equity. It has explored the "*actual*" mechanisms by which these structures activate power relations, shaping policies and systems that either enable or constrain health equity. Furthermore, by examining labour dynamics, civil society engagement, and governance approaches, this analysis highlights the contrast between what is "possible" under more transformative equity-focused frameworks and what is "feasible" within the limitations of current systems. This exploration directly aligns with the research questions, illustrating the systemic barriers and enablers to equity-focused health promotion while pointing toward actionable opportunities for addressing these challenges.

3.2.2 The Empirical, Policy, and Health Outcomes

The emphasis and the extent to which different states invest in benefits, or public goods, for citizens is correlated with equitable distribution, or access to several of the pre-requisites for health, as laid out by the Ottawa Charter (1986). These include early childhood education, employment training, pensions, health care, and social services (Raphael 2012). Policy occupies a central role in the empirical because it represents the tangible outcomes of the "real" structures and "actual" mechanisms that shape societal conditions, such as health equity and social well-being. Outcomes—manifested in health indicators, social disparities, and lived experiences—thereby reflecting how theoretical possibilities are realized—or constrained—in practice.

For instance, total public social expenditures as a percentage of GDP provide a concrete measure of a state's commitment to welfare and equity, illustrating how resources are allocated to address SDOH. Countries like Norway and Finland, with higher public social spending, often achieve better health outcomes and greater equity compared to Anglo-Saxon liberal welfare states like Canada, Australia, and the UK, where lower expenditure reflects a reliance on market mechanisms and individual responsibility.

Figure 5 illustrate the total public social expenditures as a percentage of GDP, in 2022. This figure includes pensions, health, income support, among others. Data sets from 2022 were gathered from the temporary OECD database, while 2007 estimates were presented from the OECD database and published in Raphael (2012) (OECD 2023d). Notably, Finland has extended its social spending, and ranks at the top, which Norway has remained steady between 2007 and 2022. Canada and the UK outpaced Norway in 2022. However, this was largely reflective of increased crisis spending, brought on by COVID-19, and both are expected to go down to more traditionally low levels of social spending. Australia lags but has steadily advanced its social spending between 2007 and 2022. However, more comparative research would be needed to understand if these advancements are sustainable, or temporary, due to the recent COVID-19 pandemic, and what longer term impacts there may be to such a punctuated approach, as seen in the Canadian experience.

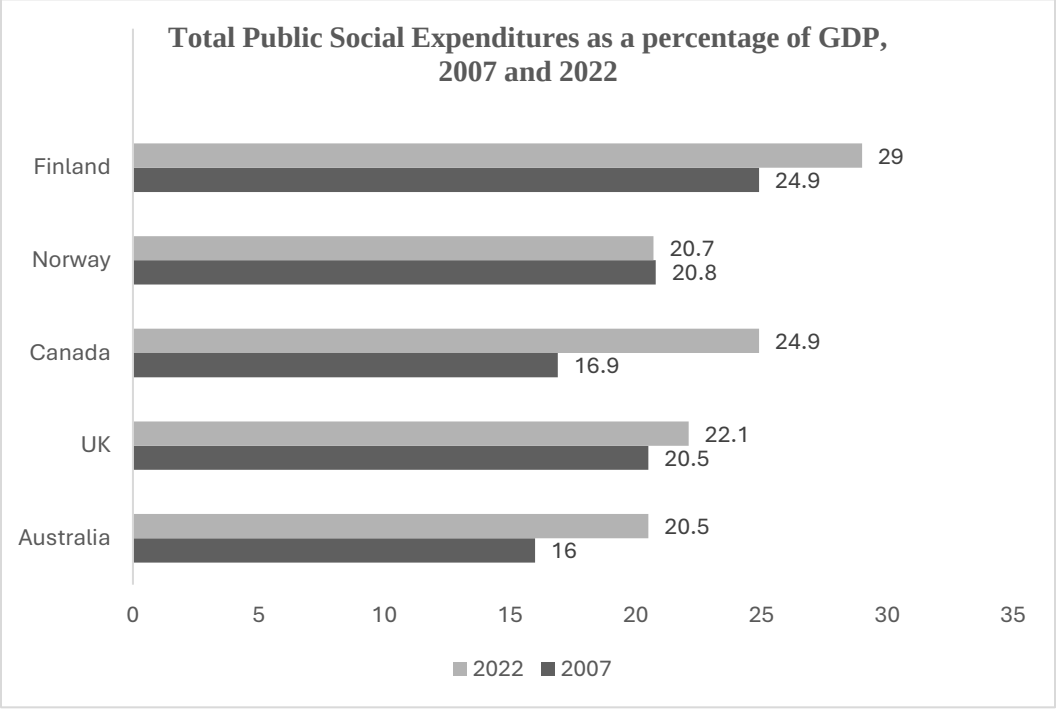


Figure 5 Total Public Social Expenditures as a percentage of GDP, 2007 and 2022, OECD Data

For the purposes of this study, the focus will be on income and tax policy, labour and pension policies, and health policy. This focus is important because these policy domains directly influence the SDOH, shaping the distribution of resources, opportunities, and health outcomes

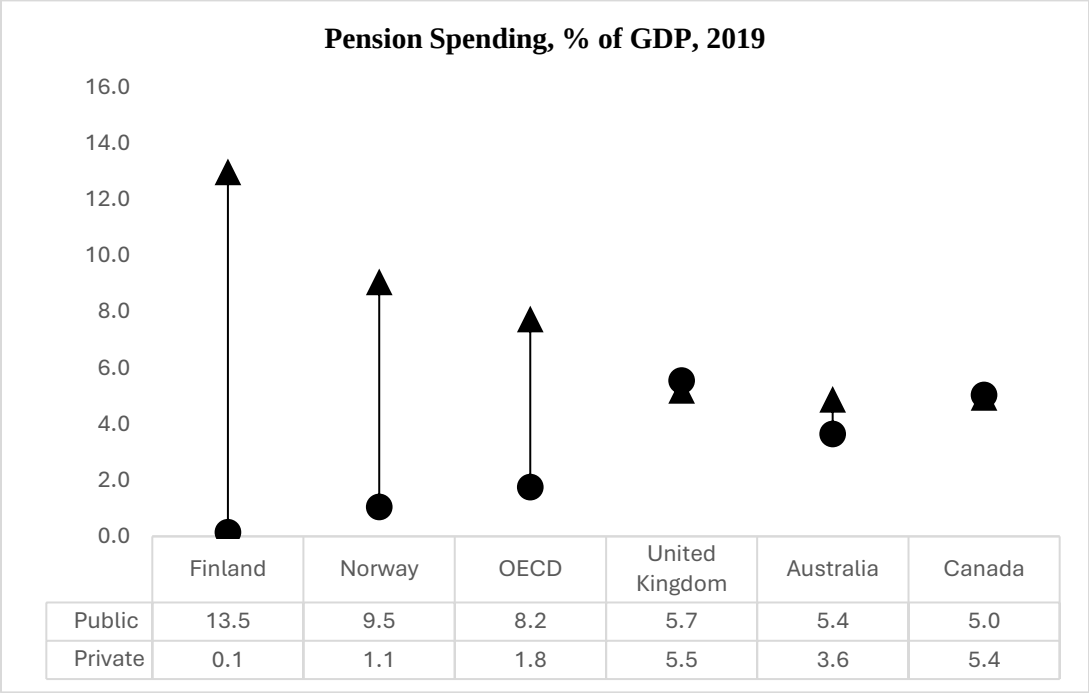
across populations (Raphael 2012). Further, this section will include a discussion on the role of decommodification, which ties directly to the empirical by addressing how policies reduce individual-level dependence on the market for access to essential goods and services, including health, housing, and education. It highlights the tangible outcomes of welfare state policies, demonstrating the extent to which they mitigate health inequities and provide social protections. Finally, this section will conclude with a discussion on social inequalities underlying health inequities. By examining these areas, this review can show how systemic inequities are perpetuated or mitigated, providing insights into the mechanisms through which welfare states address or fail to address health equity.

Income and Taxation Policy. The relationship between income, taxation, and health is multifaceted. Of course, taxation policies offer a redistributive solution, and various uses of tax policy have been explored by health researchers. For instance, Pickett and Wilkinson (2015) highlight that since the 1970s, there has been a global shift to reduce the top tax rates, exacerbating these differences in income, leading to dire health outcomes among those living with lower incomes. In addition to redistributive taxation policies, taxation can also be used to target harmful substances, as a "sin tax," including alcohol, tobacco, or high sugar foods (James, Lajous, and Reich 2020; Meier et al. 2016).

Labour and Pension Policy. Closely related to income and taxation policies are those that shape labour market participation and income security in retirement from the labour market. Puig-Barrachina et al., (2020) showed the active labour market policies had a positive impact on health. These policies include various programs used to mitigate unemployment and address low pay and poverty among those of working-age (Raphael 2012). Their purpose is to give more people access to the labour market, particularly to "good jobs" (OECD 2024a). Reciprocally, research shows that health status directly influences labour market participation, and productivity (Damrongplasit, Hsiao, and Zhao 2019). At the same time, pension policy also plays a key role in equitable health outcomes. Such policies can significantly affect health by creating financial security, or insecurity, in old age.

Figure 6 illustrates pension spending, both public and private, as a percentage of GDP, across all five countries, as well as the OECD average (OECD 2023e). Notable, Finland and Norway have higher rates of public to private spending, while Canada, the UK, and Australia

have less public and more private spending, reflecting higher reliance on private pension plans in both public and private sectors (OECD 2023e).



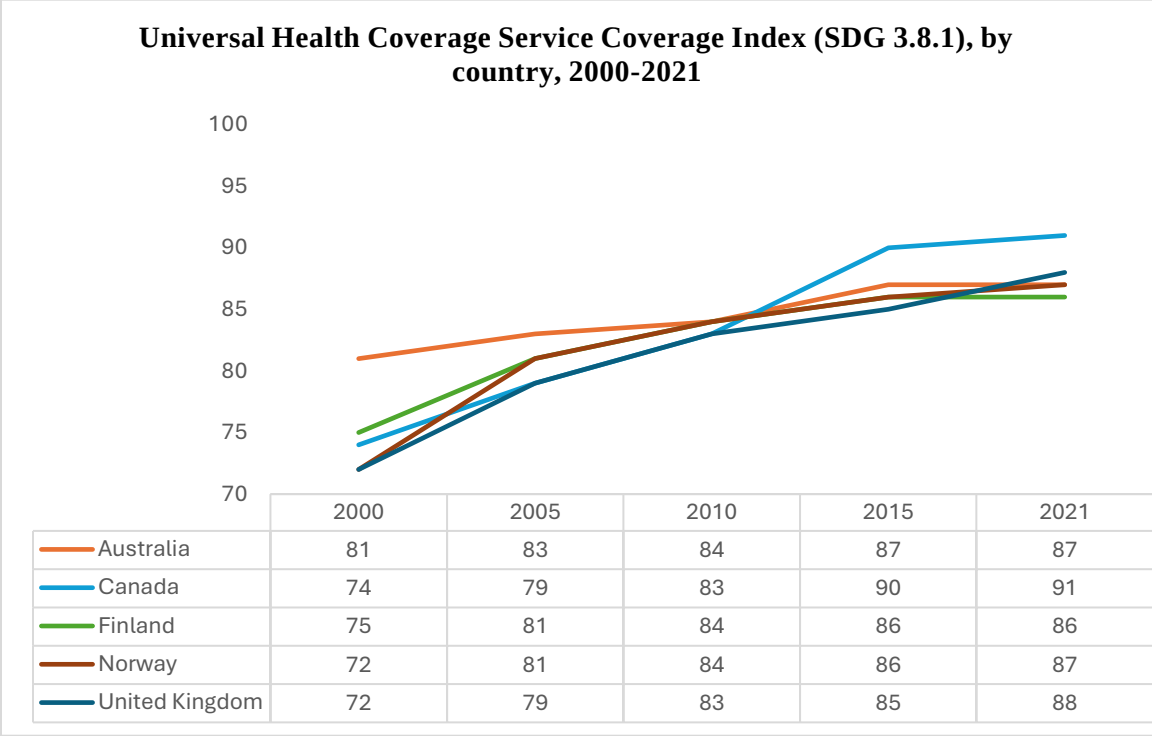
	Finland	Norway	OECD	United Kingdom	Australia	Canada
Public	13.5	9.5	8.2	5.7	5.4	5.0
Private	0.1	1.1	1.8	5.5	3.6	5.4

Figure 6. Pension spending, by GDP, 2019, OECD

Pensions systems are designed to provide a financial safety net to retirees. Public pension spending has been associated with reduced unmet medical needs among older adults across Europe (Reeves 2021). Meanwhile, some researchers note that an over reliance on private pension systems can exacerbate income inequality in old age, as those with her incomes will continue to benefit from tax reliefs associated with private pensions (Hughes 2003).

Health policy. Understanding the role of health policy in health promotion requires a nuanced understanding of how welfare state models influence the implementation and effectiveness of interventions and broader policies that promote equitable health outcomes. As noted earlier, lifestyle drift describes the phenomenon experienced in several Anglo-Saxon liberal countries, whereby health initiatives, initially focused on broad social determinants, narrow to concentrate on individual behaviours, limiting their impact on health inequalities (Carey et al. 2017; Halsall et al. 2024; Popay et al. 2010; Whitehead 1992 2012). To effectively counter this trend, health policies must extend beyond individual-level interventions and address the structural and systemic factors that underlie health inequities.

Universal health coverage (UHC) is on the international health agenda. Linked to the Sustainable Development Goal target 3.8, UHC means that all people are able to access a full range of quality health services, that they need, and when and where they need them, without incurring financial hardship (WHO 2024b). Figure 6 illustrates universal health coverage based on the service coverage index[5]. Notably, as of 2021, Canada had the highest ranking (91), while the UK had the lowest (88). Norway and Finland, expansive countries, like Canada and Australia, were couched in the middle (87, 86 respectively).



	2000	2005	2010	2015	2021
Australia	81	83	84	87	87
Canada	74	79	83	90	91
Finland	75	81	84	86	86
Norway	72	81	84	86	87
United Kingdom	72	79	83	85	88

Figure 7. Universal Health Coverage Service Coverage Index (SDG 3.8.1), by country, 2000-2021, Global Health Observatory Data, WHO

However, it is important to emphasize that the index represented in Figure 7 is made up of two indicators to monitor this target, one focused on health service coverage and the other on health expenditure in relation to a household budget with the aim of identifying financial hardship caused by direct payments for health care services (WHO 2024b). For instance, approximately only 70% of total health expenditures in 2017 were from the public sector, and

[5] The UHC service coverage index combines 14 tracer indicators of service coverage into a single summary measure, including reproductive, maternal, newborn, and child health; infectious diseases; non-communicable diseases; and service capacity and access.

supplementary services not covered under the Canadian Medicare are privately financed, either through out of pocket payment or employer benefits (The Commonwealth Fund 2020). This underscores the financial vulnerabilities still faced by households accessing essential health services, even in publicly funded systems like Canada's.

Notably, the welfare state framework affects how health policies are shaped and implemented. In Anglo-Saxon liberal welfare states such as Canada, the UK, and Australia, the focus on universal healthcare coverage has been pivotal in improving access to medical services. However, these systems often struggle with integrating broader social determinants into health promotion strategies (Bryant 2009; Raphael 2012). For example, while these countries have implemented policies to address health access and coverage, their health promotion efforts frequently emphasize individual lifestyle changes rather than addressing systemic factors that contribute to health inequity (Bryant et al. 2011; Carey et al. 2017; Halsall et al. 2024).

Conversely, Nordic social democratic welfare states, such as Norway and Finland, offer a more integrated approach to health promotion, combining universal social benefits with comprehensive intersectoral actions (Fosse and Helgesen 2019; Kokko et al. 2018; Raphael 2012). These countries have seemingly successfully embedded health promotion into their health policy agendas, addressing a wide range of social determinants and promoting health equity through coordinated efforts across sectors (Klepp et al. 2022). The Nordic model's emphasis on broad social policies, such as universal early childhood development programs and measures to reduce gender inequalities, provides valuable insights for Anglo-Saxon liberal welfare states seeking to strengthen systemic efforts, and overcome barriers to effective population health promotion.

Importantly for Lynch (2020), argues that health inequalities are often framed as the responsibility of the health sector, though the levers for action live across other sectors that influence the distribution of SDOH. So, understanding how health policy efforts can be strengthened must integrate the experiences across welfare state models. This includes adopting a comprehensive approach that balances individual-level interventions with systemic reforms aimed at addressing broader SDOH.

Contemporary approaches in health policy have taken aim at addressing health inequalities, occasionally while acknowledging their social underpinnings. Several approaches have emerged to move health policy action "more upstream" including approaches like HiAP,

proportionate universalism, and well-being frameworks. These approaches have overlapping tenants, and can, and have, been endorsed in varying degrees by various public health systems globally.

For instance, the HiAP approach has bee used in Canada, Australia, the UK, both England and Scotland, as well as both Norway and Finland. According to Canada's National Collaborating Centre for Healthy Public Policy, Institut national de santé publique du Québec, HiAP is "is an intersectoral approach to systematically addressing the SDOH at all levels of government (Institut national de santé publique du Québec 2025)." Though other scholars and organizations have proposed that the approach goes further by acknowledging the impact that public policies have to our health and well-being in our daily lives (McGibbon 2024).

Though each country has leveraged this approach, there are variations in achievements, emphasis, and integration of HiAP principles across public health systems. For instance, in Canada and Australia, HiAP approaches are implemented, largely, at the provincial, or state level. In fact, the Global Network for Health in All Policies (GNHiAP), was launched by several governments, including Finland, the Canadian province of Québec, and the Australian state of South Australia (GNHiAP Secretariat 2017). In the UK, PHE authored a 2016 HiAP resource for local implementation, in collaboration with the Association of Directors of Public Health and the Local Government Associations (Public Health England and Local Government Association 2016). In Scotland, the government website offers support to local entities through both resources and tools, including the Health Impact Assessment (HIAs), but also through a HIA Support unit, which has the mandate to support local partners in the use of the HIAs to enhance HiAP approaches (Public Health Scotland 2024a).

Finland is known for it's HiAP approaches, which are decades-longstanding. In fact, in 1972, Finnish experts and authorities launched a project to change social, physical, and policy environments in a region dealing with high mortality inequalities associated with cardiovascular disease—the North Karelia Project (Puska and Ståhl 2010). This projects emphasized the intersectoral nature of common risk factors associated with most preventable non-communicable diseases, as well as their inequitable distribution (Puska and Ståhl 2010). For this reason, in 2013, after hosting the 8th Global Conference on Health Promotion, the Helsinki Statement on Health in All Policies was issued, building on the Alma Ata (1978) and the Ottawa Charter (1986) before it (WHO 2014).

The Finnish approach to HiAP is rooted in public health science and epidemiology, moving upstream to the linked policy environment (Puska and Ståhl 2010). Basically, it starts with a health problem, like cardiovascular disease, and moves upstream to address drivers, though some scholars have argued that this approach to framing the health issues has led to more mid-stream efforts with this approach (Lynch 2020). Meanwhile, the HiAP approach in Norway, seems to be rooted in integrated intersectoral collaborative planning processes, that legitimize political capacities to act (Amdam 2023).

Similarly, proportionate universalism is an approach that seeks to address health inequities by providing universal services that are tailored in scale and intensity to the varying levels of disadvantage experienced by different population groups. This approach is grounded in the understanding that while health interventions should be available to all, the degree of intervention must reflect the specific needs of those who are more disadvantaged. The term was popularized by the Marmot Review out of the UK, which emphasized that effective health policies must not only be universal but also proportionate to the socio-economic gradients of health needs (Carey, Crammond, and De Leeuw 2015; Marmot 2013).

The principle of proportionate universalism has been applied across various health domains, including maternal and child health, physical activity promotion, and chronic disease management (Carey et al. 2015; Francis-Oliviero et al. 2020). Yet, challenges remain in the operationalization of this approach. Critics argue that while the concept is widely recognized, there is often a lack of clarity regarding how to implement it effectively within existing health systems (Carey et al. 2015; Francis-Oliviero et al. 2020). Proportionate universalism represents a promising framework for addressing health inequities by ensuring that health interventions are both universal and responsive to the varying levels of disadvantage among different population groups. Its successful implementation requires careful consideration of local needs, robust data, and a commitment to equity in health policy design and execution (Carey et al. 2015; Francis-Oliviero et al. 2020).

In Canada, the approach is not as widely incorporated, in favour a targeted universalism, however, it is still mentioned in knowledge to policy resources (NCCDH 2013). In Australia the concept is gaining traction in local health districts and among health scholars (Carey, Crammond, and De Leeuw 2015; Kemp et al. 2024). Meanwhile in England, PHE commissioned a briefing by the Institute of Health Equity in 2014, as a resource for the public health system (

PHE and UCL Institute of Health Equity 2014). Further, Public Health Scotland emphasizes the approach on its website (Public Health Scotland 2024b). Among the Nordic contexts, the principle of proportional universalism has been used to analyze health policy, and is gaining traction, but less so in Finland (Francis-Oliviero et al. 2020; Mehrara and Young 2020).

Well-being frameworks are also gaining popularity for their ability to frame the important role that public policy and structural determinants play in our daily health and well-being, In Australia, the national Treasury has proposed the first national wellbeing framework, called *Measuring What Matters* (Government of Australia 2023). The UK, the Office of National Statistics has a UK Measures of National Well-being Dashboard, while Scotland offers a National Performance Framework as a wellbeing framework (Government of Scotland 2019; Office of National Statistics 2024). Meanwhile in the Nordic context, Finland has released an Action Plan for the Economy of Wellbeing 2023-2025 (OECD 2023a); and Norway announced that it would develop a new national wellbeing strategy in 2021(Wellbeing Economy Alliance 2022).

Lynch (2020) describes emphasis on such policy approaches can also shift the Overton window such that truly upstream, redistributive policies, becomes less feasible for the health system to affect change, resulting in effective, but limited, mid-stream action. Policy processes addressing health inequalities often face challenges balancing complexity with effectiveness. Traditional welfare regimes—liberal, conservative-corporatist, and social democratic—have mechanisms to manage inequality, but these are limited in addressing the farthest upstream determinants of health (Lynch 2020). The shift toward multilevel, multisectoral governance, while promising, often leads to bureaucratic complexity, funding challenges, and a drift toward downstream interventions. However, complexity does not diminish the importance of these efforts.

This section underscores the role of public policy and its processes as the tangible representation of structural and systemic influences on health equity, providing a bridge between the theoretical possibilities of the "real" and the enacted "actual." By examining income and tax policy, labour and pension policies, and health policy, this analysis highlights how welfare states shape the distribution of resources and opportunities, ultimately determining health outcomes. The differences in social spending, pension structures, and health policy frameworks among

Anglo-Saxon liberal and Nordic social democratic welfare states illustrate the varying capacities of these systems to promote equitable health.

These insights are directly linked to the research questions, particularly the focus on systemic barriers and enablers for equity-focused health promotion. By exploring how policies align or diverge with equity goals, this section establishes a foundation for assessing actionable strategies to strengthen health systems. As we progress, the interplay between the feasible and the possible continues to illuminate pathways for transforming public policy to advance health equity across diverse welfare state models.

The Role of Decommodification. The concept of decommodification plays a key role in understanding the relationship between welfare states and population health (Bambra 2006 2011; Eikemo and Bambra 2008; Holland et al. 2011; Jacques and Noël 2022; Raphael 2012). Esping-Andersen (1990) highlighted decommodification as a key feature in his original typology of welfare state regimes, where it refers to the extent to which individuals and families can maintain an acceptable standard of living independent of market fluctuations (Eikemo and Bambra 2008). In other words, decommodification ensures that welfare provisions protect citizens from the uncertainties of market forces, providing security through access to public services, pensions, or healthcare.

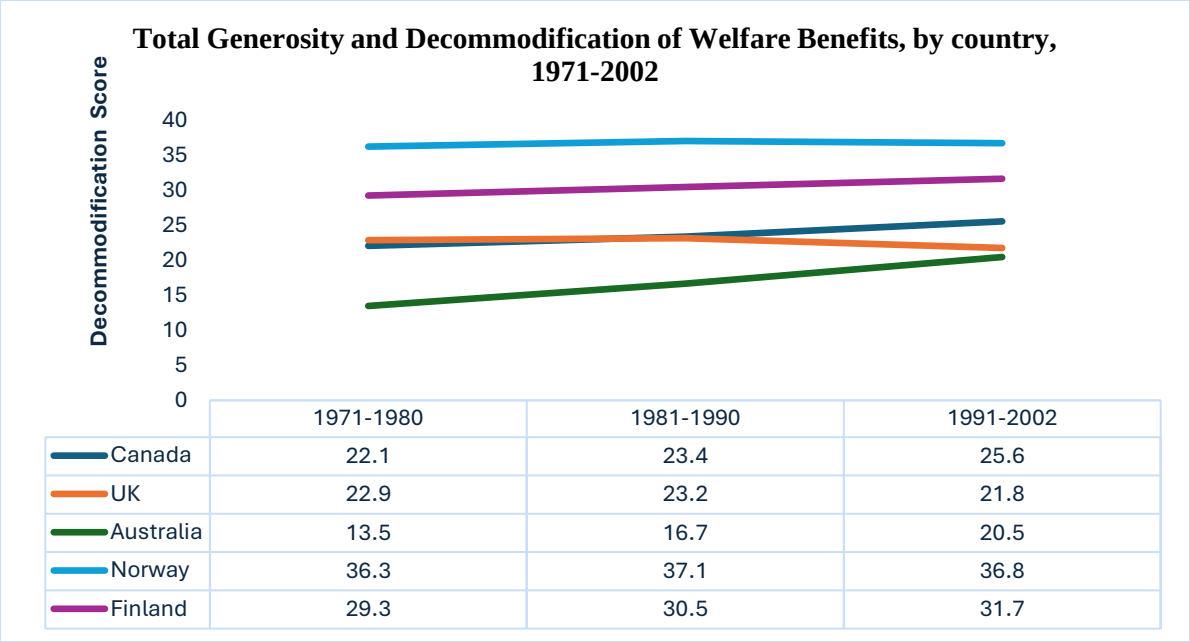
In contrast, commodification reflects the degree to which individuals are reliant on selling their labour in the open market for survival (Eikemo and Bambra 2008). Countries with higher levels of decommodification tend to mitigate the adverse effects of socioeconomic inequalities, thus promoting better health outcomes (Bambra 2006 2011). This is because welfare policies in these countries, such as universal healthcare or income support, reduce the pressures of income insecurity, directly impacting health by addressing key social determinants like poverty and inequality. As we will continue to explore, this dynamic plays out differently across welfare regimes, as welfare states are not static entities but evolve in response to political and social forces.

***Decommodification and Dynamic Welfare States*.** Esping-Andersen's welfare state typology offers a foundational framework for categorizing welfare states into liberal, conservative, and social democratic regimes (Esping-Andersen 1990). However, this typology assumes a degree of stasis, which does not account for the evolution of welfare states over time. Instead, welfare states are dynamic, and influenced by political, social, and economic changes.

This fluidity is particularly visible in Canada, which, despite being originally classified as a liberal welfare state, has adopted certain conservative features in its policies, especially regarding unemployment insurance and pensions (Scruggs and Allan 2006).

Canada's trajectory exemplifies how welfare states can shift over time without fully aligning with a new typology. It has not entirely moved into a conservative regime, but its social policy choices reflect hybrid characteristics that combine liberal foundations with conservative reforms (Scruggs and Allan 2006). This shift highlights the importance of viewing welfare states not as static regimes but as adaptive systems responding to both domestic and global pressures.

Figure 8 demonstrates the evolution of decommodification scores for Canada, the UK, Australia, Norway, and Finland from 1971 to 2002, using data released by Scruggs as part of the Comparative Welfare Entitlement Dataset (CWED2) (Scruggs, Jahn, and Kuitto 2017). Using decadal averages, based on Scruggs et al., (2017) Total Generosity Index[6], which is a valuable proxy for decommodification despite its focus on social spending, which may not fully capture the broader institutional and access dimensions of welfare states.



	1971-1980	1981-1990	1991-2002
Canada	22.1	23.4	25.6
UK	22.9	23.2	21.8
Australia	13.5	16.7	20.5
Norway	36.3	37.1	36.8
Finland	29.3	30.5	31.7

Figure 8 Total Generosity and Decommodification of Welfare Benefits, by country, 1971-2002, CWED2, 2017

[6] Total Generosity Index (TOTGEN) is a comprehensive measure of decommodification as it captures the extent to which welfare benefits—across pensions, unemployment, and sickness—reduce individuals' reliance on the market by ensuring economic security

In it, Canada's decommodification score has increased modestly over the decades, signaling a shift toward greater state intervention in social protection. However, Canada's trajectory diverges from the Nordic countries, where decommodification levels have remained consistently high, illustrating stable welfare systems in Norway and Finland that support better health outcomes.

Scruggs and Allan (2006) critique Esping-Andersen's static typology by recalculating decommodification scores with a more detailed and comprehensive dataset. Their recalibrations reveal that certain countries, including Canada, could have been misclassified in Esping-Andersen's original framework.

Table 8 Esping-Andersen vs. Scruggs and Allen 1980 decommodification scores

Table 8 offers a side-by-side comparison of decommodification scores illustrates the difference between Esping-Andersen's (1990) original classifications and the recalculated scores by Scruggs and Allan (2006). Canada's higher decommodification score under Scruggs and Allan's 2006 framework reflects its increased welfare generosity, aligning it closer to conservative welfare states than previously thought. This recalibration underscores the fluidity of welfare states and the need to consider policy changes over time.

Country	**Esping-Andersen (1980)**	**Scruggs & Allan (1980)**
Norway	38.3	36.2
Finland	29.2	28.9
Canada	22.0	25.0
UK	23.4	22.9
Australia	13.0	16.0

The dynamic nature of welfare states means that they can adopt lessons from other regimes, particularly those with high decommodification. Nordic countries such as Norway and Finland offer important examples of how sustained decommodification can lead to positive health outcomes by mitigating the adverse effects of socioeconomic inequalities.

Decommodification of health as a public good. The concept of decommodification—freeing essential services like health from market reliance—is foundational in understanding how different welfare states address the SDOH. However, framing public health as a public good offers a more inclusive approach to conceptualizing health as a universal right. In essence, it

moves beyond purely economic arguments about welfare provision to highlight the intrinsic social value of health for all.

As Heimburg et al. (2022) argue, viewing universal wellbeing as a public good requires a shift in how we understand the responsibilities of the state and the collective toward health. Public goods can be characterized as non-excludable and non-rivalrous, meaning they are available to everyone, and one person's access does not diminish another's (Heimburg et al. 2022). This framing of health as a public good implies that public health systems should be structured to ensure equal access to care and protections for all, regardless of market dynamics or personal wealth.

In countries like Canada, Australia, and the UK, the move toward decommodifying public health—by ensuring universal coverage, which includes health promotion, and publicly funded health services—reflects this recognition of health as a public good. Decommodification scores for this countries reflect a more market-oriented approach to social protection (Esping-Andersen 1990; Scruggs and Allan 2006; Scruggs et al. 2017). However, challenges remain, particularly when broader determinants of health, and known pre-requisites of health, such as shelter and food, remain commodified. Public health systems, therefore, have a role in influencing and recognizing the broader SDOH as public goods, and supporting policies that ensure equitable access to the resources that influence health, such as nutritious food, housing, and income.

Nordic countries like Norway and Finland, which have higher decommodification scores (Esping-Andersen 1990; Scruggs and Allan 2006; Scruggs et al. 2017), offer examples of systems where public health is more closely aligned with the public good model. Moreover, the Nordic approach integrates public health with other sectors—such as education, housing, and social security—further decommodifying the broader SDOH, leading to better overall health outcomes.

Framing public health as a public good can also serve as a narrative tool to communicate the value of decommodification, health equity, and public wellbeing to policymakers and the public. By highlighting the moral imperative of ensuring everyone has the opportunity to live a healthy life, it aligns with broader societal goals, such as the Sustainable Development Goals, and promotes a more inclusive, equitable, and just approach to public health.

Decommodification emerges as a central concept in understanding the empirical realities of how welfare states shape health outcomes. By reducing reliance on market mechanisms for essential services and goods, decommodification directly addresses the SDOH, mitigating the impacts of socioeconomic inequality. The evolving nature of welfare states, exemplified by shifts in Canada's decommodification scores, underscores the importance of examining these systems as dynamic entities capable of adopting policies that align with health equity goals. Nordic countries such as Norway and Finland, with consistently high levels of decommodification, offer compelling models that illustrate the tangible benefits of treating health as a public good.

The concept of decommodification—freeing essential services like health from market reliance—helps explain why some welfare states achieve stronger UHC and better health outcomes. By reducing individuals' dependence on market forces for essential needs like healthcare, housing, and income security, decommodification strengthens welfare states' capacity to ensure equitable access to health services. This, in turn, leads to more comprehensive public health systems that mitigate health inequalities and reduce avoidable mortality.

This discussion reinforces the centrality of policy in translating the "real" and the "actual" into concrete outcomes. By framing health as a public good, welfare states can transcend economic arguments and focus on ensuring equitable access to resources essential for well-being. This aligns directly with the research questions, as it sheds light on systemic barriers and enablers for health promotion and equity, providing a foundation for exploring actionable reforms in policy and practice across diverse welfare state models.

Social Position as a Mediator. Decommodification is a central mechanism in reducing health inequalities. However, social position mediates the extent to which individuals benefit from decommodification, as access to social protections is shaped by historical and structural inequities (Link and Phelan 1995). Even in highly decommodified welfare states, those with greater social and economic resources are better positioned to access and navigate health and social systems, leading to persistent inequalities in health outcomes.

Institutions serve as conduits linking the political past and present, reinforcing patterns of governance and resource distribution that disproportionately affect racialized, Indigenous, and gender-marginalized communities.

If social position is the "fundamental cause" of health inequalities (Link and Phelan 1995), then the valuation of labour and economic participation must be considered in relation to gendered

and racialized inequities. Welfare states that prioritize decommodification may reduce reliance on market-based health systems, yet they do not inherently disrupt gendered and racialized hierarchies. This aligns with intersectionality, which highlights how race, gender, and ability intersect to compound disadvantage, particularly in health and social policy contexts (Crenshaw 1990).

In the context of colonialism, Indigeneity further mediates the relationship between decommodification and inequality. Historical policies of displacement, forced assimilation, and the exclusion of Indigenous peoples from formal welfare structures have resulted in ongoing disparities in health access and outcomes, even in welfare states with strong social protections (Rootman et al. 2017). While Indigenous self-determination frameworks seek to reclaim governance over health and social services, systemic barriers continue to limit full participation in welfare provisions.

A note on Absolute vs. Relative Health Inequalities. This dissertation primarily focuses on absolute health inequalities, which examine differences in health outcomes in real terms, rather than relative measures. However, relative measures—such as rate ratios—remain a valuable tool for understanding how social position mediates the relationship between decommodification and health inequalities. Rate ratios allow for comparisons across population groups, illustrating the disproportionate burden of disease and disadvantage. Although they do not capture the total population-level impact of inequalities, they help to highlight the systemic inequalities embedded in social structures.

Each of the five countries showcased here have specific dynamics that shape social position and its relationship to decommodification and health inequalities which, ultimately, contribute to absolute health inequalities and population health outcomes at the national levels. For example, in Canada, although many healthcare services are decommodified under the Canada Health Act (1984), there are relative differences in regular access to a health care provider among adults (18+ years old). Specifically, women (RR 1.09) have better access than men (reference 1.00); First Nations (off reserve) (RR 0.95) and Inuit (RR 0.52) have less access than both Metis and Non-Indigenous groups (RR 1.0); and Black (RR 0.92), and Arab/West Asian (0.93) have significantly lower access than the White reference group (RR 1.0) (Pan-Canadian Health Inequalities Data Tool. 2022).

These relative inequalities continue to inequitable health outcomes. For instance, First Nations (RR=1.43), Inuit (RR=1.65), and Métis (RR=1.36) Peoples, had significantly higher rates of heart disease when compared to theNon-Indigenous reference group (RR=1.00) (Pan-Canadian Health Inequalities Data Tool. 2022). Likewise, Black (RR=0.60), East/Southeast Asian (RR=0.71), and Latin American (RR=0.77) also experienced significant inequalities when compared to the white reference group (RR=1.0); and similarly, females experienced difficulties doing activities of daily living at a higher rate (RR=1.13) than the male (reference group) counter parts (RR=1.0) (Pan-Canadian Health Inequalities Data Tool. 2022).

The data presented here illustrate how social position, particularly in relation to gender, Indigeneity, and cultural identity/race, mediates access to decommodified healthcare and ultimately shapes health inequities. While Canada's universal healthcare system provides broad access, persistent inequalities continue to exist in healthcare access and health. These findings underscore the limitations of decommodification alone in eliminating health inequities, as broader structural determinants—historical colonialism, systemic racism, and gendered labour hierarchies—continue to shape health outcomes. Addressing these disparities requires policies that not only enhance decommodification but also actively dismantle the institutional barriers that reproduce social and health inequalities. Future research should further investigate how intersectional approaches to policy design can mitigate these inequities across different welfare state models.

Extent of Social and Health Inequalities. Social and health inequalities are interconnected, with the inequalities in social conditions directly influencing equitable health outcomes at both individual and population levels. *The Ottawa Charter for Health Promotion* (1986) emphasizes the pre-requisites for health, including peace, food, shelter, adequate income, and social justice. These elements are central to addressing the SDOH, which, as demonstrated, affect health across the spaces and places that people are born, live, work, and age.

Health inequalities, as defined by Kawachi et al. (2002), refer to differences, disparities, and deviations in health outcomes across different population groups. However, health inequities represent a distinct concept, as they carry a moral imperative for action, based on the idea that they are unjust and avoidable (Kawachi et al. 2002; Raphael 2012; Whitehead 1992). Addressing these inequities requires a focus on social inequalities, which are the underlying drivers of health

disparities. Ultimately, all health inequalities are inherently social inequalities, reflecting imbalances in income, access to resources, and social justice.

Public health policy, according to Graham (2004), is being reconfigured to tackle these social inequalities through upstream interventions that focus on the social distribution of health. However, as Solar and Irwin (2010) caution, it is important to distinguish between the social factors promoting health and the processes underlying their unequal distribution. Tackling social inequalities, such as income inequality, poverty, and food security, is key to improving public health and achieving equity in health outcomes.

This section will explore three critical dimensions of social inequality—income inequality, poverty rates, and food security inequality—and their impact on health outcomes in Canada, the UK, Australia, Norway, and Finland. Using comparative data from the OECD (2023), Pickett and Wilkinson (2015), and the Global Food Security Index (2022), we will examine how these social determinants contribute to health disparities across welfare states.

Poverty Rates. Poverty is a direct contributor to health inequities, as those living below the poverty line often face significant barriers to accessing healthcare, adequate nutrition, and safe living environments. The OECD (2020) defines the poverty rate as the proportion of the population whose income falls below half the median household income. Table 3 highlights the poverty rates across Canada, the UK, Australia, Norway and Finland, along with a ranking from least (because less poverty is good), to highest (more poverty), with Nordic nations of Norway and Finland again ranking higher thank the Anglo-Saxon liberal welfare states.

Table 9. Poverty Rates and ranking (lowest to highest) by country, OECD Poverty Rates, 2020

Country	Poverty Rate	Rank
Finland	5.7	1
Norway	8.4	2
Canada	8.6	3
UK	11.2	4
Australia	12.6	5

As shown in the OECD 2020 data, the poverty rate varies significantly across welfare states. In liberal welfare states like Canada, the UK, and Australia, poverty rates range from 12.6% to 8.6%, respectively (Anon 2020). These higher poverty rates are associated with less

comprehensive social safety nets and means-tested benefits that fail to protect vulnerable populations from falling into poverty. Canada, however, may have benefited from more recent decadal shifts towards conservative social policy as public goods, as well as increased social spending during the COVID-19 pandemic, resulting in the lowest poverty rate (8.6) of the Anglo-Saxon liberal welfare states included (Anon 2020; Scruggs and Allan 2006; Scruggs et al. 2017). In contrast, Nordic countries such as Norway and Finland have lower poverty rates (8.4% and 5.7%, respectively), thanks to their universal welfare programs that provide more robust income security.

The connection between poverty and health is well established, with poverty in childhood having lasting health impacts into adulthood (Raphael 2011). Those living in poverty are more likely to experience chronic health conditions, face barriers to healthcare access, and live in environments that exacerbate health risks (Loignon et al. 2015; Raphael 2011).

Income Inequality. Pickett and Wilkinson (2015) argue that income inequality is a major contributor to inequitable health outcomes and call for redistributive tax policies to address this gap. **Figure 9** shows the GINI coefficient for Canada, the UK, Australia, Norway, and Finland. As the data illustrates, Nordic countries such as Norway and Finland have lower GINI scores (0.26 and 0.27, respectively), reflecting greater income equality (OECD 2023c). This lower inequality is associated with better health outcomes, as the more equitable distribution of income supports access to universal healthcare, education, and other services that reduce health disparities.

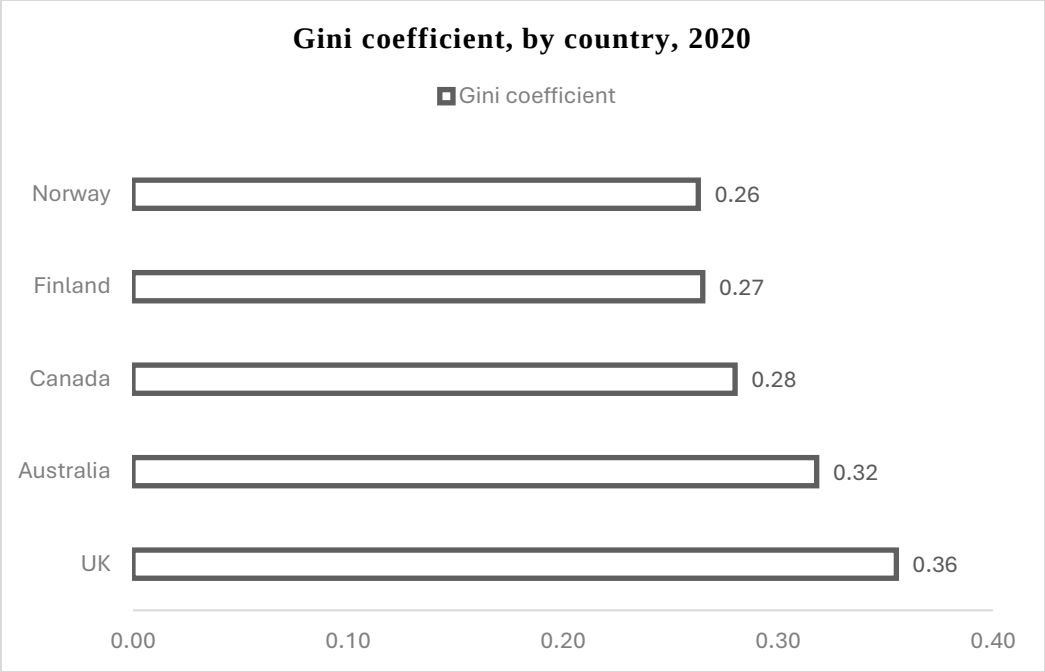


Figure 9. Gini coefficient by country, 2020, OECD data sets

In contrast, in 2020 the UK had the highest GINI coefficient (0.36), indicating higher income inequality. This inequality has significant public health implications, as populations in more unequal societies tend to experience higher rates of chronic diseases and poorer overall health (Pickett and Wilkinson 2015). While Canada and Australia fall between the Nordic and liberal states, their GINI coefficients (0.28 and 0.32, respectively) still reflect a notable level of inequality, which limits their ability to achieve equitable health outcomes.

Food Security. Another important SDOH, and indeed pre-requisite of health, is that of food security (Raphael 2016). Access to adequate and nutritious food is essential to health and health equity. The *Global Food Security Index* (2022) offers a comparative analysis of food security in terms of affordability, availability, and quality and safety across countries (**Figure 10**).

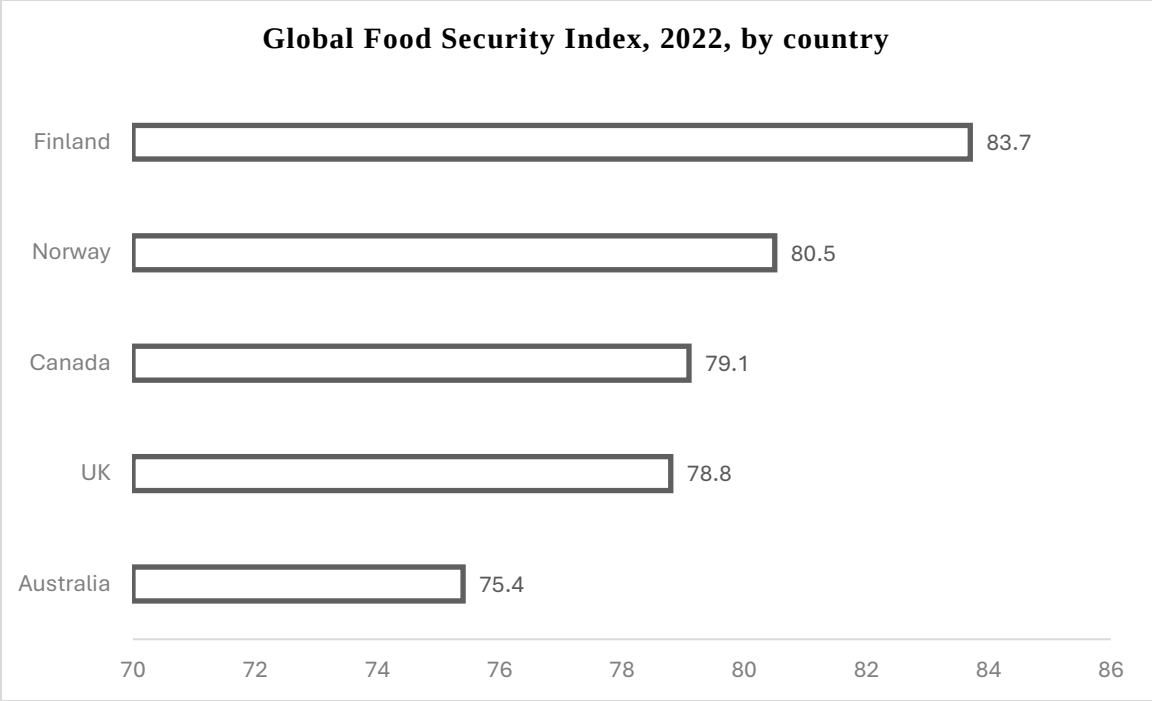


Figure 10. Global Food Security Index 2022, by country, Economist Intelligence Dataset

Based on this index, Canada ranks highly overall in food security, with a score of 79.1 (Economist Intelligence 2022). Similarly, the UK performs well in terms of affordability (91.5) and Australia lags with 75.4. In contrast, Finland and Norway consistently both rank in the top 3 of the indices, with Finland 1st and Norway 3rd, reflecting their resilient food systems and strong social safety nets that ensure universal access to nutritious food (Economist Intelligence 2022).

Food insecurity often arises from poverty, and income inequality, as those with lower incomes face greater challenges in accessing affordable and nutritious food. In Anglo-Saxon liberal welfare states, where market mechanisms dominate food distribution, food security inequality can lead to higher rates of malnutrition, chronic diseases, and overall poorer health outcomes (Raphael 2016). Addressing food security through public policies that promote equitable access to nutrition is therefore critical to improving public health.

Health Outcomes. Health outcomes are intrinsically tied to the empirical because they represent the observable results of policies, systems, and structures. Discussing health outcomes within the empirical framework aligns with a focus on tangible, measurable indicators of how theoretical and structural possibilities (the "real") and mechanisms (the "actual") play out in practice, acknowledging that health outcomes and their inequitable distribution can be complex.

This section presents health outcomes in three, general, parts. First, overall health outcomes noted in the literature of the past two decades. Second, general health outcomes using the rate of reduction of avoidable mortality across the five countries included in this study. Finally, variations in equity between countries will be presented through some select indicators and absolute inequality scores.

First, overall health outcomes noted in the literature in the past two decades underscore the complexities of health. For instance, life expectancy is often considered a comprehensive snapshot of overall population health; and if we were measure by life expectancy (at birth) alone, OECD data from 2020 has Norway and Australia as the top performers at 83.3 and 83.2 respectively, followed by Finland (82), Canada (81.7), and the UK (80.4^{estimated}) (OECD 2020b). However, this measure offers an average and can mask the inequalities within countries.

Infant mortality rates are often used as a compelling indicator of health system access and performance. In the same year, 2020, OECD data on infant mortality rates (1,000 live births, 2020) had Norway (1.7) and Finland (2) with the lowest infant mortality rates of the group, with Australia (3.2), the UK (3.8), and Canada (4.5) lagging behind (OECD 2020a).

Next, avoidable mortality, as an indicator of general health, is an important indicator of how well societies prevent premature deaths, in part through effective public health interventions. Therefore, it is, perhaps, more important to compare the progress made in narrowing the gap by reducing avoidable mortality, rank countries by their rate of reduction in the last 20 years and link these trends to key national and international policy interventions. So, the analysis is based on OECD avoidable mortality rates from 2000 to 2020 (or most recent available year for each country).

The rate of reduction represents the percentage decrease in avoidable mortality between 2000 and 2020 (or the most recent available data[7]). This reflects the effectiveness of health systems and public health policies in preventing premature deaths over time. The rate of reduction is calculated using the following formula:

$$\text{Rate of Reduction (\%)} = \frac{\text{Avoidable Mortality (2000)} - \text{Avoidable Mortality (2020 or most recent year)}}{\text{Avoidable Mortality (2000)}} \times 100$$

[7] Norway only provides data from 2000-2016.

Figure 11 illustrates the ranking of countries, from highest to lowest based on their rate of reducing avoidable mortality between 2000 and 2020[7]. Here, while Australia (39.2%) continued to lead the nations in the rate of reduction, and we also see that Finland has had substantial success in reducing avoidable mortality in the past two decades at 39%. Norway (28%), Canada (25.3%) and the UK (24.3%) have shown slower progress when compared to Australia and Finland by over 10%.

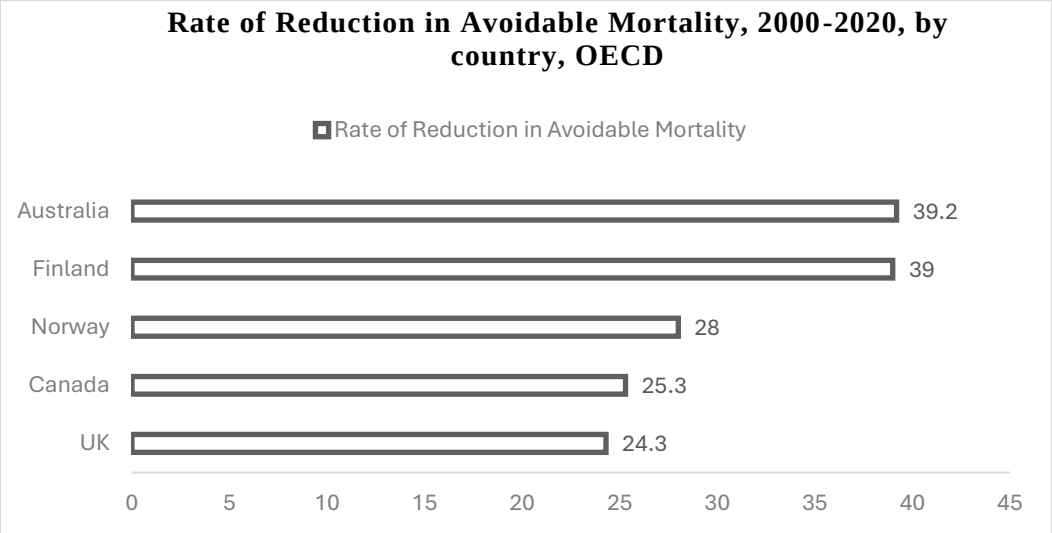


Figure 11. Rate of Reduction in Avoidable Mortality, 2000-2020, by country, OECD. Avoidable Mortality Indicator.

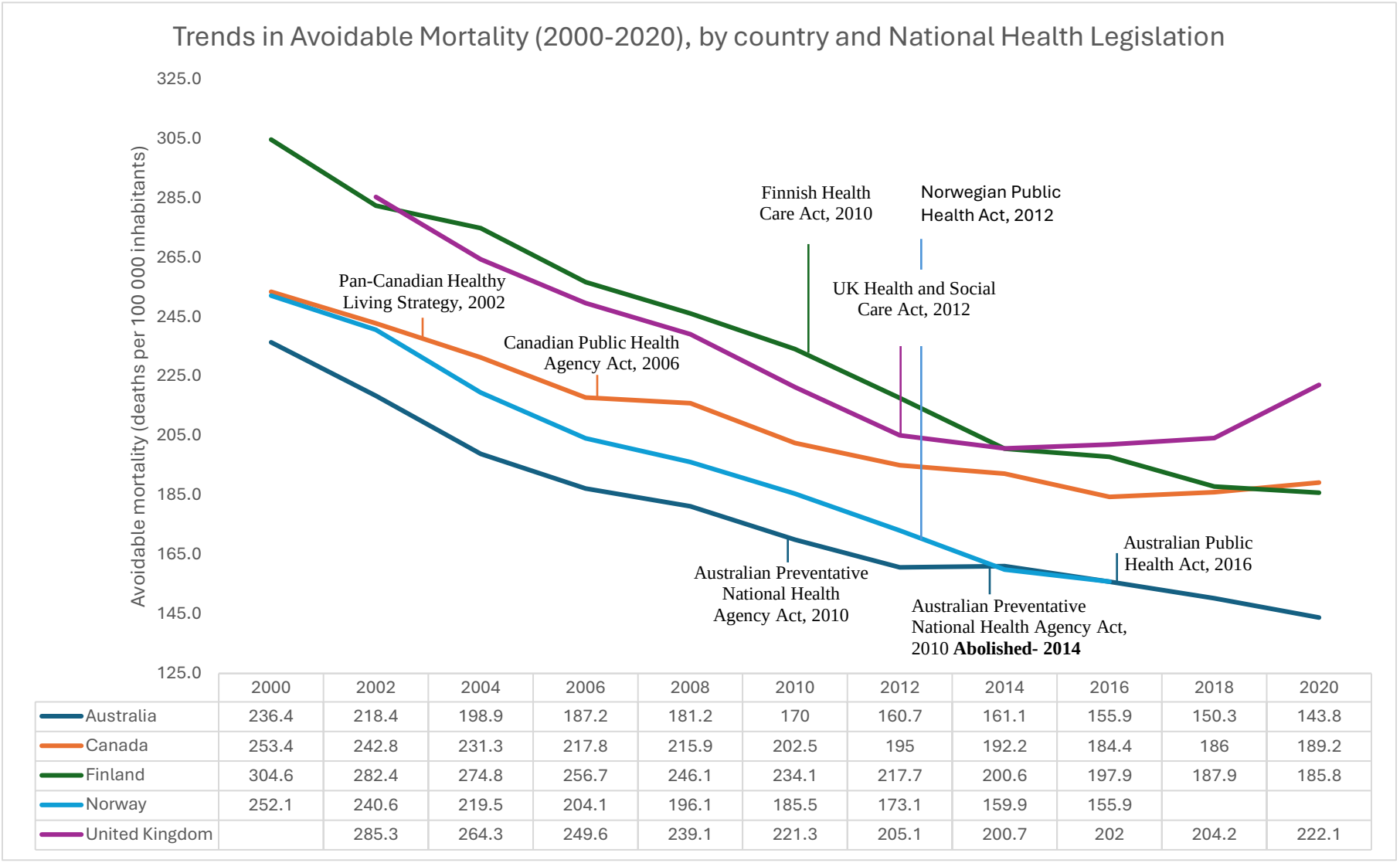
Meanwhile**, Figure 12** illustrates the trends across the last two decades in avoidable mortality, with significant health policies mapped along the timeline. For Australia, we see a clear downward trend from 236.4 in 2000 to 143.8 in 2020. Significant public health reforms in the 2000s, including the Australian Preventative National Health Agency Act (2010), and, interestingly, the Australian Preventative National Health Agency Abolition Act of 2014. In Finland, we saw a similar reduction from 304.6 in 2000 to 185.8 in 2020, reflecting consistent improvements in the health system and social policies. The country's universal health system and health promotion focus likely contributed to this, through a government resolution (2001-2015) and a national action plan to reduce health inequalities from 2008-2011.

Although Norway reduced its avoidable mortality from 252.1 in 2000 to 181.4 by 2018, its progress slowed after 2010, despite the Norwegian Public Health Act of 2007. Both Canada and UK show slower reductions (around 25%), though both passed major legislation pertinent to the public health system between 2005 and 2015.

Importantly, **Figure 12** is for illustrative purposes only, showing the health policy interventions along the trendlines of avoidable mortality across two decades. This is not meant to assume attribution, though it is meant to represent critical interactions between the public health systems and the policy environment of the time. These interactions are just one of the many system inputs, throughputs, and outputs, that contribute to a complex process of promoting health and health equity.

Figure 12 represents a snapshot of the trends in health reform at the national and international levels. In addition to the major legislative and policy pieces listed above, including reforms aimed at tobacco control and chronic diseases, and, of course, policies in place to deal with the global COVID-19 pandemic in 2020. At the international level, the Adelaide Statement of 2010 offered a HiAP framework. This approach aimed to integrate health considerations into "mid-stream" policymaking across all sectors. Australia and Finland were early adopters, and this may have contributed to their significant reductions in avoidable mortality post-2010.

Countries that effectively implemented frameworks to address midstream public policy, like HiAP (like Australia and Finland) show the most substantial reductions, demonstrating the value of cross-sector collaboration in addressing SDOH, and offering valuable examples of successful public health system intervention by both liberal and Nordic



	2000	2002	2004	2006	2008	2010	2012	2014	2016	2018	2020
Australia	236.4	218.4	198.9	187.2	181.2	170	160.7	161.1	155.9	150.3	143.8
Canada	253.4	242.8	231.3	217.8	215.9	202.5	195	192.2	184.4	186	189.2
Finland	304.6	282.4	274.8	256.7	246.1	234.1	217.7	200.6	197.9	187.9	185.8
Norway	252.1	240.6	219.5	204.1	196.1	185.5	173.1	159.9	155.9		
United Kingdom		285.3	264.3	249.6	239.1	221.3	205.1	200.7	202	204.2	222.1

Figure 12 Trends in Avoidable Mortality 2000-2020, by country, OECD Data, and National Health Legislation

welfare states. Meanwhile, Canada and the UK illustrate the challenges faced by Anglo-Saxon liberal welfare states, where market-based systems and uneven healthcare access slow progress in reducing health inequalities. Finland and Norway present different pictures. While Finland achieved significant reductions, Norway's slower progress post-2010 suggests potential weaknesses in addressing evolving health challenges.

This analysis of avoidable mortality trends offers important insights into the role of public health systems as mediators between the socio-political economic context and social and health inequalities across welfare states. Seemingly, countries that adopted comprehensive health promotion approaches to tackle upstream conditions of poor health across sectors (such as Australia and Finland) saw the most significant reductions in avoidable mortality.

Moreover, there is varied literature about the extent of health inequalities across various countries. Burgeoning discussions in social epidemiology and wider social sciences acknowledge that this is a complex and non-linear area of study as relative inequalities in health do not seem to be smaller in more redistributive contexts, and yet the absolute health of all social classes is better (Eikemo and Bambra 2008; Kautto et al. 2001; Mackenbach et al. 2018). Some social epidemiologists and health scholars emphasize the use of absolute measures of inequality, for this reason (Bambra 2011; Raphael 2012). However, those can be complex as well.

For instance, Raphael (2012) highlights one measure of inequality using the OECD's national age of mortality for those older that 10 years from 2010, which showed Norway with the least absolute inequality, but Finland with the most of the group (Raphael 2012). Finland is a similar outlier avoidable mortality (2000-2020) based on the OECD dataset (OECD 2024b). And in 2012, Finland's National Institute for Health and Welfare (THL) reported that health inequalities had not improve and that the measures selected were either lacking nuance, appropriate aim, or ability to address the root causes of health inequalities (THL 2012 p.10).

However, if we look at 2022 data from the Health Behaviour in School-Aged Children (HBSC) study, specifically the mean mental well-being (WHO-5 score) by family affluence, by country, and region, that absolute inequality scores are clear. **Figure 13** illustrates the absolute rate difference (ARD) as a measure of absolute inequality, by gender, using the below formula.[8]

[8] Note that Australia and the UK are not represented in this data set, though England and Scotland are represented separately.

The below formula was calculated based on mean rates of mental well-being from the HBSC survey (Health Behaviour in School Aged Children Survey and Dataset 2023).

$$ARD = Rate\ (_{highest\ affluence}) - Rate\ (_{lowest\ affluence})$$

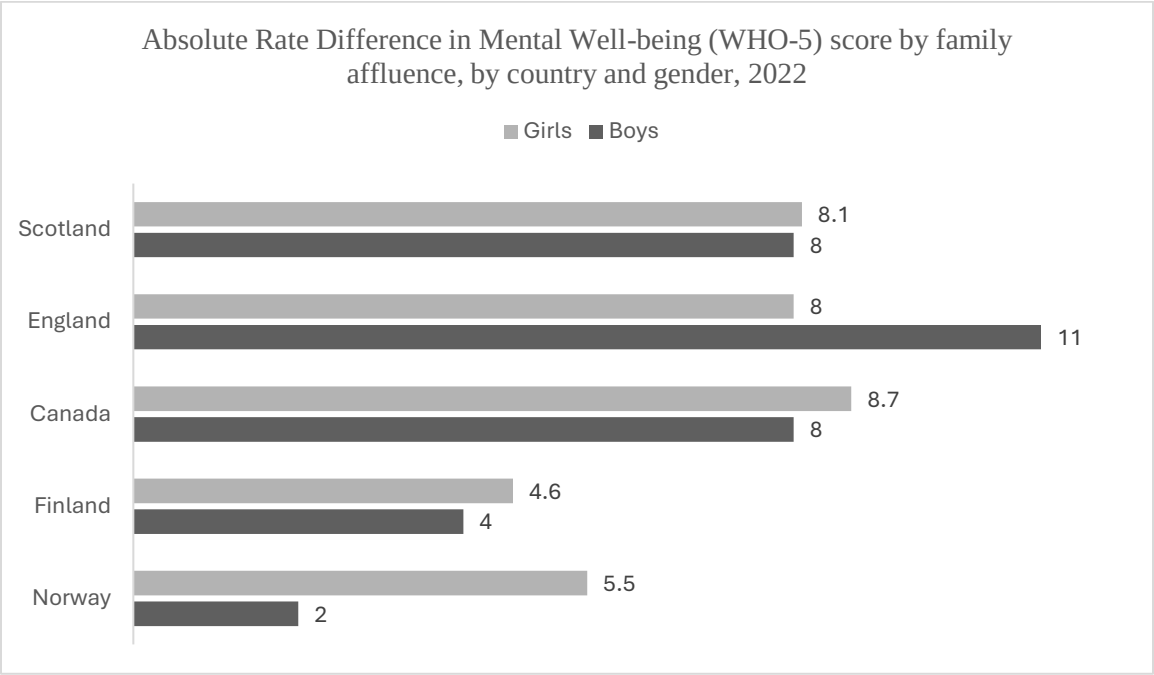


Figure 13. Absolute Rate Difference in Mental Well-being (WHO-5 score) by Family Affluence, by country and gender, 2022 Health Behaviour in School-aged Children Study (2023), Data Browser)

So, while health inequalities are not always smaller than in Nordic nations, there are consistent trends of overall better health outcomes and overall better absolute health inequalities, leading the Nordic nations to offer an interesting comparison for system level policy development and implementation (Raphael 2012). This aligns with this research's exploration of systemic barriers and enablers within public health systems, demonstrating how policy mechanisms rooted in decommodification can mediate health inequities and provide actionable insights for improving policy frameworks across different welfare state models.

3.3 The Role of the Public Health System

Public health systems include all organizations, people, and actions whose primary intent is to promote, restore, or maintain health. This definition extends beyond the traditional pyramid of publicly owned facilities delivering personal health services to include a wide array of

activities, such as health research, occupational health policy, health insurance organizations, and even intersectoral actions around well-established determinants of better health (WHO 2007). Public health systems aim to achieve multiple goals, including improving health and health equity, ensuring financial fairness, and using resources efficiently. As dynamic entities, they continually adapt to address shifting patterns of disease, emerging technologies, and evolving delivery strategies, such as the increasing emphasis on community-based care for mental health and non-communicable diseases. At their core, public health systems are not static but remain central to how countries address new challenges and opportunities, highlighting the importance of leadership, coordination, and responsiveness to ensure health for all (WHO 2007).

Public health systems play a mediating role in the welfare state. The most obvious example would be the implementation of UHC, which promotes equitable access to PHC by providing services as a public good, reducing inequalities in access and quality of care across populations. However, this role is not static or one-dimensional. Public health systems dynamically shape and are shaped by broader welfare state contexts, influencing how policies are designed, delivered, and financed.

At the same time, the tension between what public health systems can achieve within their sector and what requires collaboration across other sectors highlights the complexity of addressing the SDOH. While public health systems may not be positioned for sweeping transformative change, their strength lies in technical precision and strategic engagement. This includes expanding stakeholder participation—building bigger tables to include community partners—or joining discussions in spaces outside of traditional health priorities to effect mid- and upstream interventions that promote lasting health equity.

Recognizing that the health system plays an important role in mediating the differential consequences of inequitable health outcomes, as well as promoting health and well-being, the CSDOH conceptual framework emphasizes the role of the health system as a social determinant of health itself (CSDOH 2008). In **Figure 3**, *Factors Contributing to Effective Health Promotion,* the public health system is located similarly, with a direct mediating relationship to contextual power relations, public policy, and social and health inequalities.

This section will explore these relationships as well as the relationship with the state, drawing on the history of the public health systems in Canada, the UK, Australia, Norway, and Finland. It is presented in two main parts. First, the background and context of national public

health systems. Second, the case of Canada is presented against the comparisons of other Anglo-Saxon liberal welfare states, and select Nordic models, listed above.

3.3.1 The Background and Context of National Public Health Systems

Public health systems are multi-faceted, and complex. While the degree of organizational homogeneity varies across place, time, and space, they can include governmental departments, institutes, and agencies concerned with health, systems of health care, health researchers and knowledge brokers, and CSOs across jurisdictions. In short, public health systems encompass all organizations, people, actions, and resources whose main goal is to promote and protect health while preventing disease and illness (Public Health Agency of Canada 2021).

However, they are important aspects of a welfare state, and the achievement of health equity. Such systems can directly address differential exposure and vulnerability through equitable access to care, mediating differential consequences of disease and illness in people's lives, and the promotion of intersectoral action to improve health (CSDOH, 2008). And, indeed, it is the healthcare component of these systems that most people think about when they consider the public health system, however, the public health system has several essential functions, beyond the clinic or hospital setting.

Benzeval, Judge, and Whitehead (1995) emphasize that health systems have three main obligations: to ensure proportional distribution of resources, based on relative needs; to appropriately respond the different health care needs of various social groups; and to lead in broader, more strategic, approaches to developing and implementing healthy public policies at both the national and local levels to promote equity. Diderichson, Evans, Whithead (1991) went so far as to identify the ways in which the system may address health inequities, including: reducing the inequality level among lower socio-economic groups, focusing on causal factors that mediate the effects of poverty (e.g. nutrition, sanitation, working conditions, and housing; reinforcing factors that, through inequitable exposures, could harm health (e.g. vaccinations, empowerment, and social support); treating and rehabilitating the health problems that constitute the socioeconomic status gap of burden of disease; protecting against social and economic consequences of ill health through health insurance sickness benefits and labour market policies; and of particular importance, strengthening policies that reproduce contextual factors such as social capital that might modify the health effects poverty.

The literature on health systems, particularly in relation to welfare states, commodification, and health equity, reveals a complex interplay of factors that influence and promote equitable health outcomes. Health systems are fundamentally shaped by the characteristics of the welfare state, which determines things like health system governance, financing, and even the workforce. The typology of welfare states, for instance, significantly impacts the structure and performance of health systems, influencing both the availability of services and the equity of health outcomes (Bambra 2011).

Again, a central theme in the literature is the concept of decommodification, which, in the case of public health systems, seems to mostly refer to the extent to which individuals can access health services and programs, or benefit from health policies, independently of their market position. This process seems to be mediated, across time and space, iteratively, by both power dynamics, and the wider public policy landscape, with similar mediating pathways available to national public health systems to affect upstream health promotion efforts outside of health care.

Healthcare and Health Promotion. Countries with strong welfare states tend to provide more comprehensive healthcare services that are less dependent on market mechanisms, thereby promoting health equity. For instance, in Canada, the provision of universal health care is often associated with lower health inequality, as it ensures that all individuals, regardless of socioeconomic status, have access to necessary health services (Pauly et al. 2013). Conversely, the commodification of health, often driven by neoliberal policies, can lead to increased inequalities in health access and outcomes, as marginalized populations may be unable to afford care.

However, this commitment to universal health care can sometimes shield the inequities in health experiences. For instance, in Canada, while healthcare is largely covered under a UHC framework, mental health services are often limited to emergency and in-hospital needs, underpinning a past reliance on patriarchal asylum structures, and limiting community-based mental healthcare initiatives.

Yet, the re-orientation of health services towards health promotion is listed as one of the five main action areas for health promotion in the Ottawa Charter, alongside healthy public policy (WHO 1986). This emphasizes that health promotion can live both at the level of national public policymaking, and in the clinic. Indeed, in many places and spaces, it does. For instance, there is a significant amount of literature on inequitable and unjust practices in health services.

For instance, Morrow and Malcoe (2017) showcase the feminist analysis of patriarchal approaches to psychiatry, with a focus on biomedical and neoliberalism and the ways that they have perpetuated oppression and, ultimately, health inequities. They go on to advocate for a more equitable approach to mental health, rooted in social justice. Likewise, health scholars like McGibbon (2018) call for decolonial practices to be immediately considered at the individual, intermediary, and organizational levels in response to the Truth and Reconciliation Calls to Action. These are just two examples of the role of health promotion within health care systems and health services.

Public health systems play a central role in advancing health equity through their leadership in policy, service delivery, and intersectoral action. However, as this section highlights, their potential is often constrained by the broader welfare state typologies and structural inequities that underpin them. In countries like Canada, while universal health care provides a foundation for equity, limitations in areas such as mental health services expose how commodification and historical legacies continue to hinder comprehensive access and outcomes. This underscores the need for public health systems to exceed traditional roles and actively shape upstream policies that address the root causes of health inequities.

At the same time, critiques from feminist and decolonial perspectives reveal the systemic barriers embedded in both health promotion and healthcare delivery, challenging these systems to adopt more inclusive and justice-oriented approaches from within while advocating amongst other, external, sectors. These insights directly relate to my focus on identifying systemic enablers and barriers to equity-focused health promotion, particularly within the Canadian context. This discussion sets the stage for the next section, which examines Canada as a case study to explore these dynamics in greater depth, offering lessons on how public health systems can evolve to meet their equity-driven mandates.

3.3.2 The Case of Canada

At present, several organisations and governance frameworks across jurisdictions play a role in shaping Canada's public health system (PHAC 2021). As in other countries, Canada's public health system is constantly evolving, interacting with the electorate and other sectors— including public, private, and civil society— to meet the demands of their context. This section explores the evolution of Canada's public health system, drawing comparisons to other public

health systems in similar, and differing, welfare state contexts. Using a modified framework based on the WHO's (2007) health system building blocks as an analytical framework, this work sets the stage for Canada's current health policy landscape, the paradigmatic shifts toward health promotion, and the current system conditions, and known obstacles to meeting health policy objectives enshrined in the Ottawa Chater (1986).

The History of Public Health. This history of public health in Canada is intertwined with socio-political developments, economic considerations, and public health imperatives across time and space. The foundation of Canada's public health systems closely aligns with the UK and Australia, underpinned by a common history that was earmarked by rapid industrialization and colonial expansion, where epidemics— fed by poor and crowded working and housing conditions— raged through European cities (Mold and Berridge 2013). This section emphasizes the historical context, including socio-political and economic conditions, that led to the rise of Canada's current public health system, until the more recent paradigmatic shift towards health promotion, at the end of the 20th century.

Colonial Roots. Contemporary concerns for public health and health equity are rooted in the colonization of what is now known as Canada, with the arrival of European settlers in the 16th century in what is now Gaspé, Quebec. European settlers to the continent introduced infectious diseases such as smallpox and influenza, to which Indigenous peoples had no prior exposure or immunity, leading to catastrophic mortality rates (Montgomery 2020). These factors created conditions for the rapid decline of health among Indigenous populations, and the legacy of these early encounters continues to shape an inequitable distribution of health between Indigenous— that is, First Nations, Inuit, and Métis Peoples— and non-Indigenous groups in Canada.

Historical policies, such as the residential school system and the forced assimilation of Indigenous peoples, have led to intergenerational trauma and ongoing health inequities (Hackett, Feeny, and Tompa 2016; Kim 2019; Wilk, Maltby, and Cooke 2017). Knowledge and research consistently highlight that colonialism is a fundamental determinant of health for Indigenous populations, influencing SDOH such as education, economic stability, and access to health care services (Czyzewski 2011; Kim 2019; Matthews 2017). In 2015, the *Truth and Reconciliation Commission of Canada* emphasized the need for a decolonizing approach in health, advocating

for the inclusion of Indigenous knowledge and perspectives in public health policy and practice (Truth and Reconciliation Commission of Canada 2015).

Similarly, in Australia, Aboriginal and Torres Strait Islander peoples face ongoing health inequities due to colonial policies (Sherwood 2013; Vivian and Halloran 2022). On the other hand, the UK, which perpetuated colonialism through empire expansion around the globe, continues to see inequitable health outcomes among Black Asian and Minority Ethnic (BAME) communities, often tied to historical injustices and socio-economic disadvantages rooted in the country's colonial past (Mullard 2021). This is to say little of the impacts of colonization, including forced migration often to British North America, of Scottish and Irish nations colonized by neighbouring Britian (Geber and O'Donnabhain 2020; Mackillop 2022).

In Canada, First Nations, Inuit, and Métis Peoples, continue to face health inequalities, driven by colonial systems that continue to affect inequitable health outcomes. The contemporary expression of this is seen in mortality by suicide in the general population, using the rate difference[9] in mortality rate per 100,000, based on place-based population metrics, it shows that areas of high concentration of First nations, Inuit, and Métis identity has significantly higher rates of suicide mortality (31.0, CI 28.19-35.01) that those with low concentration of the same identities (0- reference group) (Pan-Canadian Health Inequalities Data Tool 2017).

In Norway and Finland, there is a paucity of knowledge on the extent to which similar colonial strategies have impacted the health of the Sámi people, who live across Sápmi, the traditional lands of the Sámi People, which extend across four countries (Norway, Sweden, Finland and the Kola Peninsula of Russia)(Storm Mienna and Axelsson 2019). In Norway, where the state provides financial support for Sámi health research, it is acknowledged that the Sámi have experienced historical trauma from policies aimed at eradicating their language and culture, contributing to ongoing health inequalities and feelings of cultural unsafety within the Norwegian health care system (Mehus et al. 2019).

Colonial policies and practices are an important context that has left lasting impacts on the health of people around the world. In Canada, policies such as the residential school system and forced assimilation have contributed to intergenerational trauma and ongoing health

[9] Rate Difference: This simple measure calculates the absolute difference in the rates of a health outcome between two groups (e.g., Indigenous and non-Indigenous populations). It is a straightforward and effective measure of absolute inequality.

disparities, seen today in disproportionately high suicide rates among Indigenous populations. While Australia shares similar colonial roots, marked by systemic racism and marginalization of Indigenous health needs, the UK sees health inequities among BAME communities, tied to its colonial history and socio-economic disadvantages. Norway and Finland, although with less well-documented histories of colonial health impacts, have also marginalized the Sámi populations, potentially leading to comparable health challenges.

Understanding these shared and differing trajectories is essential to this research, particularly when approached through systems theory, historical institutionalism, and political economy. Colonialism and colonial ideologies have, and continue to, influence public health systems and perpetuating inequities. These systems have evolved, over time, to continue marginalizing certain groups of people, such as Indigenous Peoples.

Further, past and present economic policies entrench health inequities by limiting access to resources and health services. These frameworks are essential for understanding the root causes of inequities and for developing more effective, inclusive health policies. As we transition to examining the rise of universal health insurance, it is essential to consider how these historical and systemic factors shape public health outcomes and continue to influence efforts toward achieving health equity across these countries.

The Constitution Act, 1867, 1982. It was in this context that Canada was created, by an act of the Parliament of the UK, in 1867, uniting the first of the former British colonies that would go on to become Canada (Government of Canada 2016). First known as the British North America Act, 1867, now known as the Constitution Act, 1867, is the foundational piece of legislation codified many constitutional rules for Canada, with the UK retraining the authority to make any major constitutional changes until 1982, when Canada enacted the Constitution Act of 1982. It is the supreme law of Canada, and it re-affirms Canada's dual legal system, as well as Indigenous rights and treaty rights (Government of Canada 2016). Therefore, it is an essential piece of the state, the welfare state, and public policy in Canada.

In Canada, the Constitution Act, 1867 set out the division of and extent of centralisation and decentralisation of federal, provincial, and territorial governments, as well as the roles and responsibilities for health care. Specifically, there are three sections that most health scholars emphasize, though the legal frameworks, Indigenous treaty rights, and the Chater of Rights and Freedoms all contribute to the interactions of the state and health. These are (1) Section 91,

which emphasizes federal spending power, and Section 92, which sets out the powers of the provincial governments, and importantly, gives responsibility for the administration and delivery of hospitals and asylums, to the provincial governments (Government of Canada 1867). Also notable is Section 102, which gives federal taxation and re-distribution powers. Together, these sections have been interpreted and implemented to improve health, more specifically, health care, since the dawn of the nation.

While the UK and Australia have some similarities due to their colonial underpinnings, there remain some foundational differences that govern their health policy. In the UK a constitution has never been codified in the same way. Instead, various statutes, conventions, judicial decisions and treaties which, taken together, govern how the UK is run are referred to collectively as the British Constitution (UK Parliament 2024). Interestingly, however, the concept of 'devolution' has created a distinct Scottish constitution within the broader Westminster tradition, also composed of statutes, judicial decisions, conventions, and soft law, with the primary source being the Scotland Act 1998 (Page 2020). Under the Scotland Act, 1998, health is one of the devolved areas of public policy, meaning that the Scottish government is responsible for the National Health Service in Scotland, including decisions about public health, healthcare delivery, and health promotion strategies, allowing Scotland the ability to adopt health policies that differ from the rest of the UK (Greer 2004). However, broader economic and fiscal controls, which impact health finding, remain largely under the control of the UK parliament (Greer 2004). Australia, on the other hand, is federated like Canada, and its Constitution grants the Government broad powers to make public health laws, though historically public health has been seen as a state responsibility (Reynolds 1995). Like Canada, Australia, can leverage its control over taxation and financial arrangements to influence state policies, but its powers are increasingly subject to limitations through High Court interpretations of constitutional rights and freedoms (Reynolds 1995).

The constitutional frameworks of Norway and Finland also play a foundational role in shaping their health policies, with both countries prioritizing health as a fundamental right within their constitutional frameworks. In Norway, in addition to a framework for taxation, section 104 authorizes the state to create conditions for children's health, and section 112 of the 1814 Norwegian Constitution states that "every person has the right to an environment that is conducive to health and to a nature environment whose productivity and diversity are maintained

(Kingdom of Norway 1814). In Finland, the most recent Constitution from 2000 explicitly mandates that public authorities provide adequate social, health, and medical services to all residents, ensuring universal health care access (Huikko-Tarvainen, Sajasalo, and Auvinen 2021). These constitutional commitments reflect the distinct historical and cultural contexts in Finland and Norway, influencing their respective health systems and policies.

Constitutional frameworks set the parameters for what is possible within a state's health system, shaping the evolution of public health and welfare policies. In Canada, the UK, Australia, Norway, and to presumably a lesser extent, Finland, these frameworks not only define the division of power but also carry the legacies of colonialism and the historical power dynamics embedded at the time of their drafting. While they have enabled the development of universal health care systems, they also perpetuate structural inequalities, highlighting the ongoing need for reform that promotes equity.

The Rise of Universal Health Insurance. The rise of universal health insurance in Canada reflects a broader international trend during the 20th century, as many nations moved toward establishing healthcare services, emphasizing equitable access to medical care. In Canada, this evolution occurred across its provinces and territories, starting with Saskatchewan's hospital insurance program in 1947 and culminating in the passage of the Canada Health Act in 1984 (Bryant 2016; Bryant et al. 2019). This legislative framework unified the country's healthcare system, ensuring that essential services, such as hospital visits, would be available to all Canadians, regardless of their ability to pay, through a predominantly publicly funded model. Research has consistently linked the enshrinement of universal health insurance with improved health outcomes, including lower mortality rates from treatable conditions and a reduction in health disparities compared to countries without universal coverage, such as the United States (Feeny et al. 2010; McGrail et al. 2009).

The Canada Health Act (1984) has been good for the overall health of Canadians by ensuring access to necessary medical services, contributing to improved health metrics and reduced inequities (Bryant 2016). However, issues persist, such as the inconsistency in coverage for outpatient prescription medications across provinces, leading to a "patchwork" system that affects vulnerable populations (Campbell et al. 2017). While the Act has helped create a more efficient, publicly funded healthcare system with lower administrative costs compared to private

insurance models (Woolhandler, Campbell, and Himmelstein 2004), it has not eliminated all barriers to care, particularly for low-income groups (Blackwell et al. 2009).

Current debates in the Canadian health policy landscape highlight ongoing tensions and challenges. The push for universal pharmacare reflects the demand for more comprehensive coverage, as advocates argue that expanding services and addressing cost-effectiveness are essential to maximize the benefits of universal health care; and Hajizadeh and Edmonds (2019) emphasize that Canada remains the only developed nation with a publicly funded healthcare system that does not include universal coverage for prescription drugs. At the same time, fiscal pressures and calls for reform continue to shape discussions about the future of Canada's health system, with ongoing questions about how to maintain equity in the face of emerging health challenges (Blankenau 2001).

Canada's emphasis on public financing for physician and hospital services was like both the UK, and Australia, as all three countries had roots in the Beveridge model of health care. Named after a British economist and social reformer, the Beveridge system is characterized by universal health coverage provided by the government, funded through taxation. Although each country has adapted the model to fit its unique context, understanding the similarities and differences in how these countries implement the Beveridge model can provide insights into their public health systems.

Canada, the UK, and Australia share a commitment to universal health insurance. These systems are predominantly funded through taxation, ensuring that most services are either free or heavily subsidized at the point of use. The UK's NHS operates a centrally managed system, while Canada's healthcare is, mostly, provincially administered, leading to some regional variation. Australia's hybrid model combines public and private insurance, offering flexibility in provider choice but facing challenges with the affordability of private insurance and out-of-pocket costs.

Despite their shared goals, key differences in structure and private sector involvement affect healthcare access. Australia's greater reliance on private insurance contrasts with the more limited role of private care in Canada and the UK. However, all three countries continue to face disparities in healthcare access, particularly due to socio-economic factors and service availability issues (Adeniran 2004; Bartram 2020). Addressing these policy challenges through

ongoing reforms remains an important part of enhancing health equity and ensuring that universal coverage benefits all citizens.

In the Nordic model, both Norway and Finland have universal health insurance systems funded, mainly, through taxation, reflecting their commitment to equitable healthcare access. Norway's system is characterized by its single-payer model, with public hospitals providing most health services. The National Insurance Act of 1967 ensured that all citizens had access to necessary medical services without cost at point of care (Skorpen and Søndenaa 2024). Finland's trajectory to universal health care became similarly with the Health Care Act of 1972, which established a framework for comprehensive services; notable for its decentralized approach, which allows municipalities to tailor health services to local needs while adhering to national standards (Harjula 2016).

Research has indicated that universal health coverage in these countries has led to increased access to essential health services, and contributed to overall population health improvements (Lyttkens et al. 2016). However, challenges such as long wait times and capacity issues have led to a growing use of supplementary private insurance to bypass waiting lists (Danielsen et al. 2022). Similarly, despite its strengths, Finland faces increasing neo-liberal influence, and reforms of the 1990s emphasized individual responsibility, resulting in more hierarchies of health citizenship (Harjula 2016).

As noted earlier, the rise of universal health insurance in countries such as Canada, the UK, Australia, Norway, and Finland have been transformative, ensuring that healthcare services are accessible to all citizens, as a public good, regardless of ability to pay. These systems, primarily funded through taxation, have contributed to improved health outcomes and reduced disparities, demonstrating the value of universal health coverage in promoting equity (Feeny et al. 2010; Lyttkens et al. 2016). However, each country faces unique challenges, from regional disparities in Canada's provincially administered system to the increasing role of private insurance in Australia and Norway (Danielsen et al. 2022; McGrail et al. 2009).

As we transition to the next phase of healthcare evolution, a paradigmatic shift in health promotion efforts has also emerged. This shift moved beyond access to care and focuses on addressing the underlying SDOH, emphasizing prevention, health promotion, and tackling inequities at their root. The experiences of countries with universal health insurance provide

critical insights into how future reforms can enhance not only access to care but also the broader conditions that affect population health.

A Paradigmatic Shift: The New Public Health. The late 20th century marked a significant shift in public health to a *New Public Health* (Kickbusch 2003; Mold and Berridge 2013). This shift moved beyond traditional notions of health as merely the absence of illness or disease, broadening the concept to encompass mental, social, and environmental well-being (WHO 1978; WHO 1946 1986). The New Public Health framework placed an increased emphasis on prevention, risk management, and the promotion of individual responsibility for health, all while responding to rising healthcare costs and social inequalities in health outcomes (Kickbusch 2003; Mold and Berridge 2013). By reframing health as a multifaceted concept, the New Public Health set the stage for a deeper understanding of how social determinants, such as income, education, and environment, influence individual and community health.

Health promotion is a key element of the New Public Health, signaled by international support for the 1986 *Ottawa Charter for Health Promotion* (Kickbusch 2003; Mold and Berridge 2013; Rootman et al. 2017). The Ottawa Charter defines health promotion as "the process of enabling people to increase control over, and to improve, their health" (WHO 1986). This expanded concept of health promotion recognizes that health extends beyond mere lifestyle choices to include social and personal resources, requiring a comprehensive approach that integrates educational, political, and regulatory supports (Kickbusch 2003; Potvin and Jones 2011). This approach emphasizes the importance of addressing the SDOH, such as peace, adequate income, and social justice, to create conditions conducive to well-being at the individual, community, and population levels (Nutbeam 1998; WHO 1986).

Canada's Advancement in Health Promotion and International Leadership. Canada played a pivotal role in advancing health promotion on the global stage. During the 1990s, Canada adopted the population health approach, which emphasized the need to address health inequalities by focusing on the broader conditions that shape population health (Government of Canada 1999). The Population Health Promotion Model reflected Canada's integration of health promotion strategies with population health approaches, ensuring comprehensive action on the full range of determinants affecting health outcomes (Hamilton and Bhatti 1996). This theoretical underpinning remains a cornerstone of public health programming and policy in Canada, while influencing global public health initiatives.

The Policy Challenge of Health Promotion Implementation. While Canada has made substantial strides in health promotion, critics argue that the emphasis on population health at times sidelined key aspects of health promotion, particularly community development (Rootman et al. 2017); and, as Nutbeam (1998) highlighted over two decades ago, lofty health promotion goals have been challenged by fragmented policy implementation. The rise of lifestyle drift—where public health policies shift from addressing structural determinants to focusing on individual behaviour—has undermined the potential of health promotion to truly address the root causes of health inequities (Carey et al. 2017; Halsall et al. 2024; Popay et al. 2010).

This issue highlights the ongoing struggle between comprehensive upstream interventions and the narrower focus on more downstream, individualized, responsibility for health often associated with Anglo-Saxon liberal welfare state public policies; and indeed, health promotion efforts have evolved differently across welfare state models (Bambra 2011; Bergqvist et al. 2013; Bryant and Raphael 2018; Eikemo and Bambra 2008; Jacques and Noël 2022; Raphael 2013ab). In other Anglo-Saxon liberal welfare states— namely Australia and the UK—health promotion initiatives are closely tied to their Beveridge-style universal health care systems, which aim to provide equitable access to healthcare services. However, similar challenges to those in Canada, such as access disparities and fiscal pressures, persist (Carey et al. 2017; Halsall et al. 2024; Popay et al. 2010; Raphael 2008). Nordic countries, such as Norway and Finland, have been particularly successful in integrating health promotion with their strong social democratic welfare states. Their systems emphasize equity and collective well-being, with Norway's National Insurance Act of 1967 and Finland's Health Care Act of 1972 ensuring universal access to necessary services, though challenges related to waiting times and private insurance have also emerged (Danielsen et al. 2022). These international experiences of public health system efforts, therefore, provide valuable lessons for countries like Canada, seeking to enhance their health promotion efforts while balancing the challenges posed by varying welfare state contexts.

The Building Blocks of the Canadian Health System. Indeed, Canada's health system has continued to evolve since the turn of the century. Building on the WHO 2007 framework for health systems, and PHAC's 2021 adaptations, which emphasized the essential public health functions, the following building blocks help analyze Canada's health promotion efforts in the context of the public health system.

The application of the health system building blocks to health promotion as an essential public health function highlights key areas for improving health outcomes. Leadership and governance focus on creating inclusive policies that address the SDOH, actively involving communities in decision-making, and integrating health promotion across strategies to foster environments that support healthy behaviours. Sustainable financing ensures the availability of comprehensive programs that reach all population groups, reducing health inequities. A skilled workforce is essential for delivering effective community outreach, health education, and empowering health workers to advocate for community action.

Service delivery, policy, and program interventions involve providing accessible, high-quality health services that incorporate preventive measures and health education. These services create supportive environments that target specific health determinants, fostering community empowerment. Knowledge, evidence, and information systems focus on collecting, analyzing, and disseminating health data to inform decision-making and continuous improvement, ensuring that health promotion activities are data-driven, and address community needs effectively. Medical and digital technology enhances health promotion efforts through innovations such as mobile health applications, telehealth, and preventive measures, making health promotion more accessible and effective across diverse populations.

This holistic approach ensures that health promotion is embedded within the public health system, addressing both preventive and systemic health needs (PHAC 2021; WHO (WHO) 2007). This section explores Canada's current public health system landscape using this conceptual framework as a guide for how system organization can mediate the impacts of the state via public policy, power dynamics, decommodification, and social and health inequalities.

***The Foundational Building Blocks*.** The foundational building blocks, including leadership and governance, financing (resource flows), and workforce capacity are integral for promoting health and health equity as essential public health functions (PAHO 2020; PHAC 2021; Squires et al. 2023; WHO 2016 2022; WHO 2007). Leadership and governance set the framework for health policy development and implementation, engaging diverse partners and stakeholders across public, private, and non-governmental sectors (PHAC 2021). Additionally, financing and resource flows are essential for sustainability; public investment is key to supporting health system functionality and resilience, although challenges such as reduced public financing and increased reliance on private sectors can hinder progress (WHO 2007; PHAC

2021). Workforce capacity also plays a crucial role in public health system effectiveness, requiring adequate training and financial alignment to meet current health challenges (PHAC 2021). Further, the interplay between leadership, governance, resource allocation, and workforce development form the foundation for achieving health promotion and equity, as envisioned by the Ottawa Charter (1986).

In Canada, health promotion governance is decentralized, with the federal government, including Health Canada and PHAC, coordinating initiatives while provinces independently manage health services. Indigenous health promotion is led by Indigenous Services Canada's First Nations and Inuit Health Branch (PHAC 2021). This fragmented structure results in regional differences in health promotion (Rootman et al. 2017). Canada's population health approach emphasizes addressing the SDOH, but often drifts towards focusing on individual behaviours rather than systemic change (Bryant et al. 2011; Halsall et al. 2024; Hamilton and Bhatti 1996; Raphael 2008).

The UK and Australia demonstrate more centralized health promotion structures. The UK's NHS operates with consistent health policies across regions, though autonomy exists, in varying degrees, in Scotland, Wales, and Northern Ireland through devolution.[10] Australia blends federal and state responsibilities, but national coordination helps ensure greater uniformity compared to Canada. Both the UK and Australia emphasize equity-focused, centralized health strategies, reducing inequities in outcomes.

In contrast, Nordic models embed health promotion within legal frameworks to ensure equity. Norway's Public Health Act (2011) mandates local authorities to address SDOH (Bekken, Dahl, and Van Der Wel 2017). Finland's Constitution requires equitable access to social, health, and medical services, supporting health promotion through a "HiAP" approach (Puska and Ståhl 2010). These centralized, equity-focused governance models provide consistency in decentralized health promotion efforts, highlighting the limitations of Canada's fragmented system.

Public health financing in Canada relies on a single-payer system funded through federal and provincial taxation, primarily under the framework of the Canada Health Act (CHA)(Bryant

[10] Devolution is the decentralisation of governmental power, such as the powers granted to the Scottish Parliament, the National Assembly for Wales, the Northern Ireland Assembly and to the Greater London and Local Authorities (UK Parliament, 2024).

2016; Martin et al. 2018). Though it is difficult to estimate the spending on public health, including health policy work, federal contributions to health spending have, overall, declined over time, challenging the sustainability of this model and prompting concerns about increased privatization in healthcare, undermining universal and equitable access (Flood, Lahey, and Thomas 2017). Canada also lacks a national pharmacare program, with access to essential medicines largely dependent on private insurance and out-of-pocket expenditures (Martin et al. 2018).

Canada's public spending on health care as a percentage of gross domestic product (GDP) was 8.0 percent in 2022, for a rank of ninth of thirty-eight OECD nations (OECD 2023b). However, this is expected to represent 13.4% of Canada's GDP in 2024, the highest rate ever reached outside of the 2020 and 2021 pandemic periods (Canadian Institute for Health Information 2024). Since public spending on health care is reflected in public health care coverage, it is not surprising that ten of the eleven higher-spending nations, including Norway and Australia, cover a greater proportion of health care costs than the Canadian system. In fact, out of the thirty-eight OECD nations, twenty-four countries' public health care systems cover a greater proportion of total health care costs than does Canada. Canada's Medicare system covers only 71 percent of health care costs (64.9% Provincial and Territorial governments; and 6.2% from other public sectors) (Canadian Institute for Health Information 2024). Notably, mental health services often fall outside of the public sector spending on health in Canada.

The UK's NHS is primarily funded through general taxation, providing free access at the point of use, which helps to maintain consistency in health promotion and healthcare across the regions, although devolved health policy creates some differences between England, Scotland, Wales, and Northern Ireland (Hong and Seog 2023; Sirag et al. 2017). Australia's Medicare also uses a mix of public and private funding, combining taxation with a Medicare levy, and allowing for private health insurance to cover additional services, which contributes to inequities in access (Fox et al. 2019).

Finland and Norway predominantly rely on public funding for their health systems, emphasizing universal coverage and preventive care. Finland's decentralized model allows local municipalities to organize health services, supported by national health insurance, ensuring equitable access across diverse populations (Klavus and Rissanen 2018; Saltman and Teperi 2016). In contrast, Norway has a more centralized system with national funding, ensuring

uniform healthcare access while emphasizing preventive initiatives to maintain public health (Elomäki 2019; Puska and Ståhl 2010). Both countries prioritize health promotion and preventive measures as key components of their financing models, promoting equity and reducing long-term healthcare costs.

In Canada, workforce capacity in health promotion is decentralized, with significant variability in competencies and distribution across jurisdictions (PHAC 2021). Public health workers face challenges related to recruitment, especially in rural and underserved areas, which creates gaps in service delivery (Regan et al. 2014); and there is little information about the health promotion workforce across jurisdictions. Although Canada has made strides through professional development initiatives, such as expanding Schools of Public Health, variations in workforce distribution and competencies hinder the consistent delivery of health promotion programs (Hanusaik et al. 2015).

The UK and Australia have taken slightly different approaches to workforce capacity in public health. In the UK, efforts have been made to create multidisciplinary public health teams, particularly through the now-defunct PHE (Gray and Evans 2018). Despite funding cuts, the UK remains focused on intersectoral collaboration. Meanwhile, Australia has emphasized competency-based training through undergraduate public health programs (Fleming et al. 2009), which may offer a model for improving health promotion capacities in the public health workforce.

In contrast, the public health workforce in Finland and Norway prioritizes well-trained, well-resourced professionals. In Finland, health services are delivered at the municipal level, focusing on preventive care and health promotion, supported by a diverse workforce including public health nurses and health educators (Klavus and Rissanen 2018; Saltman and Teperi 2016). However, both countries have identified challenges related to workforce retention and the need for continuous professional development to adapt to changing public health needs (Elomäki 2019; Puska and Ståhl 2010).

The foundational building blocks—leadership and governance, financing, and workforce capacity—form the bedrock of effective health promotion within public health systems. Canada's fragmented governance and reliance on decentralized structures for both financing and workforce distribution create variability in health promotion efforts across provinces, posing challenges for consistency and equity. By contrast, the UK and Australia demonstrate models

that maintain a stronger focus on equity through national coordination, while still grappling with regional differences and pressures towards privatization. Nordic countries such as Finland and Norway exemplify a more integrated approach, embedding health promotion into legislative frameworks that emphasize equity, universal access, and preventive care.

Each system provides valuable insights into how foundational building blocks, when aligned cohesively, can drive effective and equitable health promotion. To advance public health, Canada, and other Anglo-Saxon liberal welfare models could benefit from exploring strategies that strengthen national coordination, enhance equity, and focus on systemic health promotion initiatives inspired by these international models.

The Process Building Blocks. Different frameworks call these building blocks different things. Some, like the WHO's 2007 framework do not distinguish at all between the foundational and the process, though they allude to inputs, processes, and outputs. PHAC's 2021 CPHO report calls them system-level tools. For the purposes of this research, I will refer to them as system processes, which interact with each other, as well as the foundational building blocks, to deliver outputs. This section focuses on exiting literature in three areas: service deliver, policy and program interventions; Knowledge, evidence, and information systems; and medical and digital technologies.

Canada's decentralized public health system means that health promotion services vary by province and territories, leading to inconsistent delivery and impact (Rootman et al. 2017). As discussed, Canada does have a social safety net that consists of means-tested resources to support people, alleviate poverty, and promote social inclusion. Social safety nets have been shown to play a significant role in mitigating the impacts of economic shocks, such as those experienced during the COVID-19 pandemic. Governments have recognized the necessity of these safety nets to ensure that some income replacement, health services, and other programming is available to those living in Canada, though, due to the federated nature of Canada, this is not consistent across all jurisdictions.

Health promotion in Canada follows the principles of the Ottawa Charter for Health Promotion (1986), which focuses on empowering individuals to take control of their health (Potvin and Jones 2011). This charter guides health strategies across sectors like education, healthcare, and community development. By embedding health promotion within the social

safety net, Canada addresses SDOH—such as income, education, and healthcare access—that significantly impact health outcomes (Hancock 2011).

Various forms of knowledge, evidence, and information are inherent processes in driving evidence-based and wise health promotion practices. In Canada, public health data systems have significantly improved, with initiatives like the Canadian Institutes of Health Research, and six National Collaborating Centres (NCCs) playing a key role in the translation of evidence into actional public health strategies to inform policy action in the last decades (Di Ruggiero, Rose, and Gaudreau 2009; Dobbins et al. 2021). However, the country's decentralized governance has created challenges, especially around the integration of health data across jurisdictions (PHAC 2021).

Despite known challenges, Canada's various surveys and national data collection efforts, such as the Canadian Community Health Survey, and broader data efforts such as the Canadian Network for Public Health Intelligence provide valuable insights into population health trends, informing targeted health promotion policies (Canada 2023). Additionally, a renaissance of implementation science and the integration of Indigenous Ways of Knowing have offered a complimentary and robust knowledge base to support public health system health promotion efforts (Hawe and Potvin 2009; Healey n.d.; Martin 2012; Mundel and Chapman 2010).

In the UK, the now defunct PHE, and the Scottish Health Survey, contribute to a more integrated and centralized approach, which contrasts with Canada’s fragmented model (Gray and Evans 2018). Australia's Australian Institute of Health and Welfare (AIHW) similarly provides a strong framework for data-driven policy, though data fragmentation remains a challenge due to the country’s mixed public-private health system (Smith et al. 2016). Both countries demonstrate a more cohesive system than Canada, particularly in their ability to streamline health promotion through centralized data collection and dissemination.

Norway and Finland present strong models of integrated knowledge and evidence systems, with the Norwegian Institute of Public Health excelling in collecting and analyzing health data to inform health promotion policies (Glavin, Schaffer, and Kvarme 2019). Finland’s HiAP framework emphasizes the use of data to inform cross-sectoral strategies, making it a leader in integrating evidence into public health decision-making (Melkas 2013). Both Nordic countries offer centralized, user-friendly systems that facilitate data sharing across sectors, allowing for more effective monitoring of health promotion outcomes; however, there are still

gaps and challenges, such as implementation evidence concerning health policy governance (Scheele, Little, and Diderichsen 2018).

The integration of medical and digital technologies in health promotion in Canada holds substantial potential for enhancing advancing health equity but also presents significant challenges. This building block includes medical products, vaccines, manufacturing and procurement, health infrastructure such as laboratories, and digitized systems such as early warning surveillance systems, such as GPHIN, and digital health services such as Wellness Together Canada, a digital mental health intervention offered Canada during the COVID-19 pandemic (Basnet and Chaiton 2024; PHAC 2021). Achieving the full potential of medical and digital technologies for health promotion requires systemic solutions, including cohesive e-health policies, enhanced stakeholder involvement, and ethically informed assessments that support equitable and culturally sensitive healthcare initiatives (Giacomini, Winsor, and Abelson 2013; Koh et al. 2021; Mundel and Chapman 2010). And like the other building blocks, the system will have to consider how best to leverage emerging technologies in health promotion to support health and welfare policies.

The UK and Australia have advanced digital health systems that support more comprehensive health promotion strategies. The UK's NHS Digital and Scotland's *Digital Health and Care Strategy* emphasize online health assessments and symptom checkers that enhance self-management (Brice and Almond 2020). Canada may be able learn from these models, particularly in their more structured approaches to digital infrastructure and broader integration of digital tools into public health services.

Meanwhile, Norway and Finland are pioneers in the use of digital health technologies. Norway’s eHealth Strategy has incorporated telemedicine and remote monitoring extensively into its public health promotion, facilitating stronger community engagement through digital platforms (Baardseng 2004)). Finland has made significant strides in using digital tools to address SDOH, integrating health promotion efforts into all sectors, though scholars caution ethical considerations around the use of digital technologies for health decisions (Haverinen et al. 2022).

In summary, Canada’s public health promotion landscape, is characterized by both significant opportunities and ongoing challenges, particularly when viewed alongside other Anglo-Saxon liberal and Nordic social democratic welfare models. For instance, the integration

of medical and digital technologies offers a promising avenue for enhancing service delivery, equity, and health outcomes. However, the decentralized governance structure often leads to fragmentation and inconsistencies in healthcare access, service quality, and health promotion strategies across provinces and territories. By learning from more centralized models like those of the UK and Finland, which demonstrate effective use of integrated digital platforms and cohesive policy frameworks, Canada could develop a more unified and efficient health promotion system. Addressing these challenges will require targeted policy efforts to enhance interoperability, foster stakeholder collaboration, and ensure that health technologies are ethically and inclusively implemented.

Looking ahead, there are numerous opportunities for Canada to strengthen its health promotion efforts by adopting best practices from other countries. Leveraging Scotland, Australia, Norway and Finland's success with the HiAP approach, and the UK's integration of digital health tools, Canada can better address its SDOH through more systemic coordination, but it is crucial to develop cohesive policies and ensure equity in the design and implementation of these measures.

3.4 Chapter Summary

Chapter 3 critically examines the literature to explore the systemic barriers and enablers to effective health promotion within Anglo-Saxon liberal and Nordic social democratic welfare states, aligning closely with the research questions. The chapter begins by presenting a conceptual framework that frames the public health system as a key actor in promoting health and equity, highlighting its role in addressing upstream SDOH in order to advance health equity. Subsequent sections delve into the mechanisms through which public health systems can enact change, such as equitable policy development, intersectoral collaboration, and targeted interventions to reduce structural inequities. Key levers identified include health systems' capacity to mediate differential exposures, re-orient healthcare services towards health promotion, and influence the broader public policy environment.

The review also emphasizes the divergence in health outcomes between welfare models, focusing on avoidable mortality and absolute health inequities. While Nordic social democratic states demonstrate success in reducing absolute inequalities through universal and redistributive policies, Anglo-Saxon liberal states continue to struggle with higher rates of absolute health

inequalities in some measures. These discussions underscore the importance of decommodification and its impact on equitable access to resources, positioning public health systems as both mediators and amplifiers of systemic advancements that promote health and health equity across the population.

Through a critical realist lens, the chapter bridges theoretical constructs with empirical findings, presenting a nuanced understanding of how welfare states influence health promotion efforts. The narrative evolves by connecting these theoretical insights to practical applications, illuminating how public health systems can leverage their governance structures and policies to advance health equity. This sets the stage for subsequent chapters to propose actionable pathways for overcoming lifestyle drift and embedding equity-focused strategies within public health frameworks, directly addressing the research questions.

Chapter 4: Results and Key Findings

This chapter presents the results and key findings from the analysis of 22 documents and 15 interviews across three Anglos-Saxon Liberal welfare states, Canada, Australia, and the UK (focused on England and Scotland)— and two Nordic social democracies, Finland and Norway. The chapter begins by situating the qualitative data within key concepts of health promotion for the 21st century, establishing a shared understanding for analysis. It then explores the mechanisms of health promotion through across the six building blocks of public health systems (see Figure 11), presenting sub-themes that emerged under each building block. The aim of this section is to examine how, and to what extent, features of different welfare states either facilitate effective health promotion or create barriers. The findings are presented with a view to identifying strategic dilemmas that Anglo-Saxon liberal public health systems might address to enhance upstream health promotion efforts.

This chapter is presented in three sections, and acknowledges both preventive measures and systemic health requirements to promoting health equity as an essential function of public health systems globally (PAHO 2020; PHAC 2021; Squires et al. 2023; WHO 2016 2022). Section 4.1 presents key concepts as they apply to this research, specifically, health, well-being, and the pursuit of health equity. Section 4.2 explores the foundational building blocks— *Leadership and Governance, Financing, and Workforce Capacity.* Section 4.3 discusses the process building blocks— *Service Delivery, Policy and Program Interventions, Knowledge, Evidence, and Information Systems, and Medical and Digital Technologies*.

Each section begins by exploring key themes and sub-themes identified through an analysis of legislative and strategic policy documents. These documents provide the foundational policy context by framing how health promotion is conceptualized and operationalized. Themes are then triangulated with insights from interviews which capture the lived experiences of scholar-practitioners working within these systems thereby illustrating the complexities and nuances of implementing these frameworks in practice.

A Note on Reflexivity: Briefing Insights Across Results and Analysis. The research journey for this dissertation was, in many ways, a process of uncovering layers of familiarity. My professional engagement within public health systems, alongside a deep grounding in frameworks such as Solar and Irwin's model and Raphael's contributions to the political economy of health, provided a lens that anticipated much of what I encountered. As a result, the

challenges I faced were less about confronting unexpected barriers and more about navigating a space where my insider knowledge and the academic rigors of inquiry intersected. It was this intersection—this blend of learned expectations and exploratory rigor—that shaped my approach and my findings.

Looking back, the integration of familiar theoretical frameworks might explain why nothing appeared entirely unexpected. Yet, I wonder if this sense of natural progression reflects not a lack of surprises, but rather a process of cumulative learning. Insights gained during the research, while seemingly aligned with my expectations, reshaped my understanding subtly and incrementally, making them feel natural over time. In this way, the research mirrored the systems I was studying—complex, iterative, and deeply influenced by their history and context.

Throughout this journey, a recurring reflection emerged, rooted in the tension between planning and preparing. This dichotomy resonated profoundly: in calm, systems plan; in chaos, they prepare. This research, at its heart, is an effort to equip public health systems for the latter—to transform the often-frenzied fray of policymaking into a structured, meaningful process. In doing so, I aim to provide tools for decision-makers to navigate the constraints and complexities inherent in promoting health, and ultimately, health equity.

The intent is to contribute constructively—to offer a framework that makes sense of persistent daily challenges among and within welfare state contexts and reveals pathways for more effective interventions. This dual role as both a scholar and practitioner emphasize the practical utility of this research, balancing respect for the systems within which I work with a commitment to improving them.

One of the most enriching aspects of this work was the candid, thought-provoking discussions with esteemed colleagues. These conversations brought to life the themes and challenges explored in my research, each a potential “thought piece” on its own. I chose to anonymize these interactions to encourage openness and protect privacy. Yet, I occasionally question this decision, as the distinct voices and perspectives offered by these individuals are themselves a testament to the depth of insight in this field.

Nevertheless, as a collective, these conversations revealed something greater than the sum of their parts. Across diverse contexts and policy landscapes, common themes and sub-themes emerged, weaving a rich tapestry of shared experiences and systemic challenges. Revisiting these interviews, I was struck by their recurring themes and the enduring relevance of

the issues discussed, underscoring the universality of the constraints and opportunities that shape health promotion, alongside the contextual impact that welfare state models can have on what is considered possible, vs. what is considered feasible.

4.1 Common Ground and Jagged Edges—Health Promotion Across Welfare State Models

Common across welfare state models are the aspirations for promoting health and well-being and advancing health equity. However, inconsistencies in their definitions and applications create jagged edges between policy goals and limitations of the policy process. This section highlights shared understandings and aspirations across various welfare models, alongside inconsistencies that may affect equitable health outcomes.

Recalling interpretivist principles, it seems important to start by understanding the key concepts and the jagged edges of collective understandings. These jagged edges manifest as inconsistencies between official policy definitions and the lived experiences of stakeholders. For example, while health policies may converge on a general aim to promote holistic well-being, actual implementation often diverges due to political, economic, or institutional limitations.

Interpretivism values the subjective and contextualized nature of these terms, which means we must acknowledge multiple, coexisting perspectives—both within policy documents and individual experiences. This approach helps reveal how health promotion efforts are conceived and implemented differently by actors within health systems. These differences highlight how concepts are conceived of and understood by those in the systems of policy action, and how they are officially used and implemented.

Overall, key concepts were coded across 13/22 documents, just over half, while all 15 interviews touched on several key concepts, as presented in **Table 10**. The concept of ‘health,’ itself was discussed in all interviews, as a foundational concept to understanding health promotion. The same concept was only coded in 6/22 documents. ‘Mental health’ was also discussed in 5 interviews and found in 4 documents, underscoring the emphasis on mental health alongside health in some Anglo-Saxon liberal welfare contexts, and all Nordic.

Health equity was a topic of discussion in 7 interviews, 4 in Anglo-Saxon liberal countries, and 3 from Nordic countries. Health inequality was defined in documents more often with two documents in Anglo-Saxon liberal and over half (4/7) Nordic welfare contexts defining the concept. Health inequity was, as a concept, not used in any documents in either context,

however 90% interviews in the liberal contexts, and 50% of the interviews from Nordic contexts, touched on the concept. Health promotion and the SDOH were both defined in 2 documents from the liberal context, though they were defined in 11 interviews. Nordic counts differed slightly with all interviews defining these terms, and 3 documents explicitly defining health promotion, and 2 defining the SDOH.

Well-being was defined in relation to health in 2 Anglo-liberal documents and discussed in 8 interviews. Meanwhile, 2 Nordic documents defined the term, and half of Nordic interview participants discussed the definition in relation to health. Public health, interestingly, was defined in the 3 documents from Anglo-liberal countries, and discussed in 11 interviews. In the Nordic context, public health was coded in 2 documents and discussed in all 4 interviews.

Table 10 illustrates the coding matrix of the most frequently discussed key concepts, by welfare state model, to illustrate the trends in discussion. Overall, all key concepts were present in just over half of the documents and were discussed to inform fundamental shared understanding of topics. The exploration of key concepts allowing for an exploration of jagged edges as inconsistencies between official definitions, formal policy frames, and the experiences of health policy processes.

The analysis of key health concepts revealed both areas of areas of alignment and the "jagged edges" where inconsistencies between policy definitions and practical applications emerge. These jagged edges, explored in subsequent sections, underscore the tensions between aspirational goals and the complexities of implementation within different welfare models. The next section, *Theme 1: Framing Health, Well-being, and the Pursuit of Equity*, builds on this foundation by examining how these core concepts are framed in Anglo-Saxon liberal and Nordic social-democratic contexts. Exploring the jagged edges of policy frames around health, health equity, health promotion, and related concepts reveals the nuanced overlaps, gaps, and tensions that shape how these concepts are operationalized, offering insights into how policies can be refined to address inequities more effectively.

Table 10. Coding Matrix for Key Concepts, by welfare state model

	Anglo-Saxon liberal		Nordic social-democratic	
Key Concepts	Documents (n=15)	Interviews (n=11)	Documents (n=7)	Interviews (n=4)
Health	3	11	4	4
Health equity	0	4	0	3
Health inequality	2	10	4	3
Health inequity	0	10	0	2
Health promotion	2	11	3	4
Social determinants of health	2	11	2	4
Well-being	2	8	2	2
Public Health	3	10	3	4

Theme 1: Framing Health, Well-being, and the Pursuit of Equity across Welfare Models

The framing of key concepts like health, health equity, health promotion, and related concepts within public health systems is an important part of assessing the successes and limitations of welfare models in achieving their aspirations. This section explores how these foundational concepts are defined and operationalized in Anglo-Saxon liberal welfare states (Canada, Australia, and the UK, specifically England and Scotland) and Nordic social-democratic models (Finland and Norway). By examining legislative and strategic frameworks, it highlights the ways these concepts are shaped by policy, practice, and contextual influences. Importantly, it investigates the "jagged edges" where official definitions, formal policy frames, and the lived experiences of stakeholders diverge, offering insights into how these inconsistencies impact health promotion and equity outcomes.

The section is organized into three sub-themes to highlight key aspects of these frameworks. First, *Sub-theme 1.1: Legislative Ambiguity— Flexibility or Fragmentation?* explores how gaps in legislative definitions shape interpretation and implementation. Second, *Sub-theme 1.2: Framing Health Equity—From Analytic Lens to Actionable Goal* examines the positioning of health equity in strategic documents, contrasting its role as an analytical tool versus a concrete objective, and considers the practical implementation of health promotion efforts are affected.

Each sub-theme presents the results of the Anglo-Saxon model, drawing out the Canadian experience, followed by results from the Nordic experience. Each sub-section concludes with a short analysis of the commonalities and divergences of experiences between the welfare models. By structuring the results in this way, this section identifies shared aspirations and inconsistencies across welfare models, as well as setting the stage for analyzing how these framings influence implementation challenges and opportunities.

Sub-Theme 1.1: Legislative ambiguity— Flexibility or Fragmentation?

In reviewing the foundational public health legislations across both Anglo-Saxon liberal welfare states, as well as the Nordic social democracies, it was often the gaps—where key terms like health, well-being, and equity are left undefined—that were most revealing. These "negative spaces" reflect a shared emphasis on health measures rather than concrete definitions. This allows for both flexibility and fragmentation of interpretations across different jurisdictions. The following analysis explores the absence of explicit definitions of key terms, and how this affects interpretation and implementation.

In Canada, and across other Anglo-Saxon liberal contexts, public health legislative frameworks emphasize health measures without explicitly defining core terms like health, well-being, or health equity. The Canadian case illustrates how legislative ambiguity can pose opportunities and challenges within a federal system. For example, the Canadian Public Health Act (2006) does not provide explicit definitions of health or health equity, focusing instead on health measures. While this could allow for flexibility across provinces and territories, or even distinct cultural populations, such as First Nations, Inuit, and Métis Peoples, for whom health and well-being have different conceptual underpinnings to western definitions, it also risks creating variability in interpretation and fragmented practices.

As one participant from the Canadian context observed: "In terms of the term health, I think of this in terms of well-being and not only an absence of disease or illness (CI2)." This understanding of health aligns with other western, and dominant institutional conceptual frames, such as the one shared in the WHO's 1948 constitution. However, and more pointedly, another participant highlighted how Indigenous perspectives have shaped their personal definition of health:

> As someone who was, who is, really influenced by Indigenous perspective…I can define health as a kind of […] equilibrium between all different dimensions as a human being like it's not just about, physical health, it's also about mental, spiritual and yeah, and physical health. It's kind of like the balance between this dimension that, is part of us. This is how I define (health) … how it's not just that the absence of illness, of disease (CI4).

These reflections underscore the tension between the inclusivity of diverse perspectives and the risks of inconsistent interpretation in Canada's decentralized public health system.

Likewise, Australia's National Preventive Health Agency Act (ANPHA) (2010), which was repealed just four years later in 2014, emphasizes measures over definitions. Like Canada's Public Health Agency Act 2006, the Australian Act focused on establishing the Agency and delineating its responsibilities, primarily in the realm of preventive health. While it outlined specific functions related to addressing lifestyle-related health risks such as smoking, obesity, and alcohol misuse, the Act notably did not include explicit frames for "health," "well-being," or "health equity." The absence of these definitions reflects a broader focus on operationalizing preventive health measures rather than articulating conceptual frameworks or principles within the legislation.

In this case, the absence of legislated definition also presents the opportunity for some narratives to dominant the landscape, leading to a shared, but confused understanding of the concepts, which may limit the ability of public health systems to implement effective policy options. For instance, one participant from Australia reflected that

> It would be fair to say that it, health, is still considered in a very biomedical way […] rather than that broad social model of health (AI1).

Another participant emphasized that the concepts of health, health equity, and healthcare are interrelated but distinct, though many conflate them, stating that there is still some confusion:

> On those distinctions, because whenever they talk about health, they've often come from medical backgrounds, they're just talking about healthcare. They're talking about

> hospitals and we're quite regularly having to subtly pull things back to a health system where we're talking about the social and economic determinants of health (AI2).

In the UK, the Health and Social Care Act (2012), applicable to England, refers to health in the context of improving both physical and mental health, but similarly does not define "health," "well-being," or "health equity." It does, however, implicitly address health equity, though only in relation to health care services, in Section 1C, stating that the Secretary of State "must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service (Section 1C, p. 3)." Scotland, on the other hand, through the Public Health etc. (Scotland) Act of 2008, does not define these terms, and focuses on inter-jurisdictional efforts and responsibilities, with a focus on managing public health risks, and public health protection.

In the UK, participants recognizing the layered understandings in the English context, stating that:

> You can define health in biological terms, but you can also define it in social, structural, political terms and most public health professionals lean towards the latter, so that the sociopolitical contextualization of the term health as opposed to biological or biomedical contextualization (UKI3).

However, despite this general understanding of health as a broad sociopolitical conceptualization, one interview participant from Scotland offered a decisive insight on the difference between how those in this field understand health, and the general understating in practice, reflecting that:

> Health… and we all talk about the WHO definition of health as a broad concept and that's what we all see and that's kind of the understanding that we all have. But in practice, when you measure it, it tends to be much more biomedical, doesn't it? So, it tends to be the absence of health measure, mortality and drinking …lots of work on mortality… and how we measured disease. I do think often that we talk about health, but we're actually measuring disease (UKI4).

This flexibility in definition does have practical implications. For instance, several Anglo-Saxon liberal participants emphasized the tendency to narrow the function and practice of health promotion because of more narrow and biomedical understandings of health. One participant from Canada noted:

> Health promotion takes different forms depending on the health promoters. Some are just trying to get people to change their behaviour, while others are involved in mobilization. When you take the concept itself and apply it to public health thinking and broader work, such as in the policy and program space, which focuses on more structural aspects in the system, it becomes more of a conceptual framing. This framing is meant to signal the need to pay attention to equity and community voices, supporting a bottom-up approach. However, there's an inadequacy with this term that we want to do many different things. If asked who a health promoter is, I'd say health promoters are everywhere (CI3).

Another participant from England illustrated this point but emphasizing that there is an intrinsic link between how health is defined and how that could contribute to various programs for work for health promotion, or how the health measures in these legislative frameworks are implemented. In speaking about government priorities, they reflected that

> In the UK context, there's more of awareness that we've got lots of people out of work because of long term sickness […] and so I think there's a growing realization that, for example, the treasury that […] some of the social terms of health is important to get people healthy (UKI2).

Further, interview participants across contexts revealed that legislative ambiguity often hinders intersectoral collaboration, as illustrated, again by one UK participant form the English context, who noted that

> Sometimes the term health can be a barrier to partnering with people, because health is perceived in these individualistic forms in these individualized ways. What I (have) found (that) public health practitioners […] try and adopt the language of the people that are talking to, depending on what sort of sphere of government they work in. So, they might talk about, you know, urban and spatial planning and health promotion, more in terms of like having nice places to live or and good transport links, you know, rather than about air quality or about the health outcomes that come about having access to green space. So, I think the framing is really interesting. […] People use different language and take different approaches, but I think yeah, the sort of challenge for public health, and I hear this kind of a lot with in local government, is you know, to what extent being a public health practitioner or working a health promotion is a barrier or an asset when you're trying to work across different portfolios (UKI1).

The legislative ambiguity across Anglo-Saxon liberal welfare states illustrates the dual-edged nature of flexible policy frames, aligning with Hall and Taylor's (1996) historical institutionalism, which underscores how entrenched frameworks reinforce path-dependent practices. Canada's Public Health Act (2006) exemplifies this ambiguity, prioritizing measures over explicit definitions of health, well-being, and equity. This omission allows for adaptability across its decentralized federal system but risks fragmentation, as provincial interpretations may diverge significantly, leading to uneven implementation. These challenges are particularly evident when Indigenous perspectives on health—rooted in holistic and relational understandings—are juxtaposed with dominant biomedical frameworks shaped by Western paradigms. Interview data reflect this tension; while one participant aligned their definition of health with the WHO's conceptualization, another emphasized Indigenous perspectives as a balance of mental, physical, spiritual, and communal dimensions.

Australia and the UK share similar legislative gaps, with Australia's National Preventative Health Agency Act (2010) prioritizing the establishment and operationalization of an agency structure dedicated to public health, and England's Health and Social Care Act (2012) framing equity implicitly without concrete definitions. Canada's decentralized federalism intensifies the potential for policy fragmentation, similarly to Australia, and the devolved systems of England and Scotland in the UK. These findings align with Solar and Irwin's (2010)

critique that intermediary policy measures, such as those that focus on healthy lifestyle and behaviours or access to health services, can perpetuate inequities by failing to address structural determinants.

However, the inconsistency in defining health across these countries reinforces Lynch's (2020) discussion on policy frames, where health is primarily viewed through biomedical and efficiency lenses rather than as a collective societal responsibility, despite a recognition of the socio-political underpinnings of health across the public health systems. While Canada shares these challenges, its context uniquely underscores how legislative ambiguity interacts with federalism, and unique population contexts, highlighting both opportunities for localized adaptation and risks of inequitable outcomes.

From Ambiguity to Action: Nordic Precision vs. Anglo-Saxon Patchwork. Legislation in Nordic social-democratic welfare models reflects a systemic and rights-based approach to health, well-being, and equity, emphasizing collective responsibility. Unlike the Anglo-Saxon liberal contexts, where legislative ambiguity can leave key terms undefined, Nordic legislation embeds these concepts as operational priorities. This section examines the legislative frameworks in Norway and Finland and the experiences of participants regarding how these laws shape their understandings of health, well-being, and health equity.

Norway's Public Health Act (2011) does not define health, however, it does define public health as "the state and distribution of health in a population" and public health work as: "society's efforts to influence factors that directly or indirectly promote the health and well-being of the population, prevent mental and somatic illnesses, disorders or injuries, or protect against health threats" (Chapter 1, Section 3). By framing health and well-being as interconnected and grounded in social conditions, the Act emphasizes systemic interventions to address health inequalities.

Participants highlighted how this legislative approach fosters a broad understanding of health. As one Norwegian participant explained, the idea that health is created by how society is organized is inherent in the Nordic model.

> We have a kind of a common understanding from long before COVID that we organize society in a way that we help those in need. So, I think that it has been very much built

> in […] this is kind of the core of the Nordic model, I would say, at least from the from Norwegian perspective that we take care of those who are in need (NI1).

This framing supports intersectoral collaboration, as the Act mandates local and regional governments to integrate public health considerations into policies across sectors, including transportation, housing, and education.

However, challenges remain. Participants noted difficulties in achieving consistent collaboration, with one respondent stating,

> This is a challenge because the way public policies within public health are created […] there are many policies that are not necessarily framed as being public health policies, but they are if you understand. So, for instance, public health struggles a lot to convince the other sectors that what they are doing is also relevant for public health (NI1).

This reveals a gap between the comprehensive vision set out in the legislation and the practical realities of cross-sectoral governance.

Finland's Health Care Act (2010) articulates a commitment to health, stating its objective as to "promote and maintain the population's health and welfare and reduce health inequalities between different population groups (Chapter 1, Section 2)." Unlike Norway, Finland's legislation takes a more explicit rights-based approach, embedding health equity within constitutional guarantees of equality and social security, and is unambiguous about the role of the state in provisioning health. Reflecting on this responsibility at the highest levels of government, one participant said:

> There's no doubt that in the Finnish Constitution that the public, the state, is responsible for health, responsible to promote health of the population (FI1).

Participants from Finland emphasized the inclusive framing of health in the legislation. One interviewee described health as encompassing "all these different aspects and health inequalities (FI2)," reflecting the holistic perspective that covers "various aspects related to the physical health, mental health, social well-being, and so on (FI2)".

Legislative provisions in Finland also support intersectoral collaboration by requiring municipalities to coordinate health services with broader social and environmental policies. For instance, local governments are legally obligated to develop health, and welfare plans that align with regional and national strategies, ensuring a consistent focus on equity across all levels of governance.

Both Norway and Finland legislate health and equity as collective priorities, but their approaches reveal distinct emphases. Norway's Public Health Act (2011) frames health and its distribution through a lens of social determinants, mandating systemic interventions to address inequalities. Finland's Health Care Act (2010), on the other hand, takes a rights-based approach, embedding equity within constitutional and legal guarantees. Participants' experiences reflect these differences. In Norway, interviewees emphasized the importance of intersectoral collaboration, acknowledging both its necessity and its challenges. Meanwhile, Finnish participants highlighted the legislative focus on equal service provision, which they saw as central to operationalizing health equity.

The ambiguity surrounding the framing of key concepts in health promotion in Anglo-Saxon liberal welfare states reveals both opportunities and limitations. While flexibility allows for localized interpretations, it often results in fragmented approaches that are unable to comprehensively address SDOH. In contrast, Nordic social-democratic welfare states adopt a more integrated legislative approach, explicitly linking health to social and structural factors and embedding equity as a collective responsibility. These distinctions highlight the role of political economy in shaping how health and health equity are framed, implemented, and operationalized.

The next section examines these differences in greater detail, exploring how Nordic frameworks use legislative mandates to systematize intersectoral collaboration and equity-driven action. In contrast, Anglo-Saxon models rely on decentralized governance and flexibility, often at the expense of cohesive health equity frames and strategies. By comparing these approaches, we can better understand how public health systems can balance flexibility with systemic commitments to health promotion.

Margins and Mandates— Comparing Models. The Nordic and Anglo-Saxon models differ fundamentally in their legislative treatment of health, well-being, and equity, reflecting their distinct political economies. Nordic models, grounded in social-democratic principles, frame health as a collective responsibility, embedding equity within legislative mandates as both

intrinsically and systemically tied to social inequalities, and human rights. By embedding intersectoral collaboration and equity mandates into law, these countries address structural determinants of health more systematically. This contrasts with the Anglo-Saxon liberal welfare states, where legislative ambiguity often allows for decentralized and inconsistent interpretations.

Despite their strengths, Nordic models are not without challenges. Norwegian participants pointed to the difficulty of securing consistent collaboration across sectors, while Finnish participants highlighted the complexities of balancing individual rights with collective responsibilities. For Anglo-Saxon systems, adopting elements of Nordic legislative frameworks—such as mandating intersectoral collaboration and explicitly defining health equity—could provide a pathway to addressing aspects of lifestyle drift and advancing upstream health promotion.

In summary, Nordic legislative frameworks offer a model for embedding health and its equitable distribution as both a legal mandate and an operational principle. By comparison, the Anglo-Saxon liberal approach relies more heavily on flexibility and decentralized governance, often at the expense of cohesive equity-driven policies. This analysis underscores the importance of political economy in shaping legislative approaches, with Nordic models providing valuable insights into how health and equity can be legislatively operationalized within public health systems.

Sub-Theme 1.2: Framing Health Equity—From Analytic Lens to Actionable Goal

The framing of health equity in strategic public health documents further underscores significant ideological and operational differences between Anglo-Saxon liberal welfare states and Nordic social democratic models. While Anglo-Saxon systems often conceptualize health equity as an analytical "lens," Nordic models embed health equity as both a societal goal and a systemic process, acknowledging the social inequality roots of health inequality. These framings influence how equity is prioritized in strategic policies and operationalized in practice, reflecting the sociopolitical and economic contexts of these welfare states.

In Anglo-Saxon liberal welfare states, health equity is frequently framed as a lens—a diagnostic tool to evaluate disparities within health outcomes—rather than as a foundational societal goal. This approach aligns with broader liberal welfare ideologies that balance individual

responsibility with selective state support, often emphasizing prevention-focused strategies over structural reforms.

In Canada, the Mental Health Strategy (2012) developed by the Mental Health Commission of Canada exemplifies the use of health equity as a lens. Priority 4.1 of the strategy emphasizes that "New mental health policies and programs should always be evaluated using tools such as 'health equity lenses,' to make sure that everyone benefits and that the gap decreases between those who are best and least well off (p. 80)." This positioning reflects an implicit understanding of equity as central to policy evaluation but stops short of embedding it as a systemic or societal goal. Further, when juxtaposed to the document's definition of mental health, "a state of well-being in which the individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his own community (p. 14)," there is a clear emphasis on individual well-being that does not explicitly connect equity to structural determinants.

Canadian participants also highlighted the challenges of defining and operationalizing health equity. One participant noted,

> Health equity and health inequality... I think that within public health in Canada these are sometimes used interchangeably, however, they do have different meanings […] health inequality is really about different status […] but then when you have these unequal states, there's the question of whether it is inequitable or unjust, and this is what I think of as health equity or inequities. (CI2).

Emphasizing the operational challenges presented by this approach, another participant articulated the operational challenge presented by the concept of health equity in public health systems.

> People […] really do see health equity as like this epi(demiology) outcome, like get the numbers to match them (and we) are all good...but the numbers are never going to match because the numbers are attached to individual disease indicators, and those diseases indicators are all related to the social determinants. So again, they're markers, but they're markers for what we have to address underneath and structurally. Anyway,

> there's a frustration around the inadequacy of these terms…and in a […] classically public health trained environment […] it makes sense to people because its outcome driven but when you're trying to achieve these broader goals across public health indicators it feels inadequate (CI3).

Another participant emphasized the complexities of addressing health equity within Canada's multijurisdictional system, particularly in the context for Indigenous Peoples and devolution:

> Equity [...] is very much about the ability to have self-determination that is meaningful and useful to the specific community [...] but from a systems level, it's very hard (CI1).

These reflections underscore the challenges of translating health equity from strategic frameworks into systemic reforms.

Similarly, Australia's National Preventative Health Strategy (2021–2030) acknowledges fairness as a guiding principle, again using the 'lens' framing, stating that "a health equity lens must be applied to all preventative health actions, with the needs of these groups prioritized for action" (p. 6). In fact, this strategic document refers to health equity as an essential lens 3 out of 7 mentions for health equity. It also refers to the achievement of health equity as a goal, where "health equity is achieved for priority populations (p. 9)." However, the targets focus on incremental reductions in health inequalities for overall life expectancy across populations identified as experiencing health inequalities. So, while the document ties health equity to a lens, to be applied to policy initiatives aimed at identified populations experiencing health inequalities, this framing does not translate into a systemic commitment to equity.

These observations were reflected in insights from Australian interview participants, who highlighted the limitations of health equity framing in policy and practice. One participant noted,

> The language of health equity or health inequities is used in Australian policy and practice quite a bit, rather than health inequalities or health disparities. I think it would be fair to say that it's operationalized in a way that is about …I'll put an inverted comma, 'vulnerable groups.' There is attention to the health of Indigenous peoples in Australia. We have "CALD groups," 'Cultural, and Linguistically Diverse', that's

> another way that's more towards ethnicity and race….and that gets used as a way of sort of operationalizing this attention (AI1).

This perspective underscores the operational focus on specific populations rather than systemic inclusivity. Another participant put a finer point on this reflection, stating that both health equity and health inequality, which are often used interchangeably, are "often discussed within the frame of populations, often described as 'vulnerable,' and it's not always clear how the strategies address the systemic barriers creating those vulnerabilities (AI 2)." These reflections highlight a recurring tension in Australian public health strategies: while health equity is framed as both a lens and a goal, its application often centers on incremental improvements for predefined groups, without addressing the structural determinants that perpetuate inequities.

Meanwhile, in the UK, there is a contrast between that strategic approaches to health equity in England and Scottish systems. For instance, in England, the Healthy Lives, Healthy People Strategy (2010) frames health equity through the lens of tackling health inequalities in the context of economic productivity and social determinants, stating, "the health and wellbeing of people of working age is critical to supporting the economy and society (p. 21)." Uniquely among other Anglo-Saxon liberal models, this emphasis reflects a framing of health equity that links it to workforce participation and economic outcomes. One UK participant from the English context reflected on the political challenges of addressing equity: "health equity is being avoided nationally now... the term disparities is now favored as less politically charged (UKI1)." Recent documents, such as Public Health England's Strategic Plan (2020–2025), reinforce this trend by focusing on social determinants such as housing and employment while avoiding direct references to systemic inequities.

Similarly, Scotland's strategic public health documents, such as Public Health Scotland's Strategic Plan (2022–2025): A Scotland Where Everybody Thrives, the Mental Health Strategy (2017–2027), and Public Health Priorities for Scotland (2018), reflect a systemic approach to addressing health inequalities. These strategies emphasize the importance of tackling structural and systemic drivers of disparities, with health equity implicitly framed as a guiding principle. However, the explicit emphasis remains, overwhelmingly, on the reduction of health inequalities caused by the SDOH, rather than the unfair distribution of resources across these conditions.

For instance, Public Health Scotland's Strategic Plan (2022-2025) identifies reducing health inequalities as central to its mission, stating that "putting reducing health inequalities at the heart of all we do (p. 37)" is key to creating environments where communities can thrive. The Mental Health Strategy (2017-2027) highlights the interconnectedness of systemic inequities and mental health outcomes, endorsing "Good Mental Health for All" as a foundational document for partnership action. The strategy states, "integration Authorities, Local Authorities, NHS Boards, the Third Sector and other community planning partners can use that document and plan partnership action to tackle the determinants of mental health and the causes of inequalities in mental health (p. 20)," signalling a clear recognition of the social determinants of mental health and the need for collaborative, systemic approaches to address them. Finally, Public Health Priorities for Scotland (2018) explicitly emphasizes principles of fairness, equity, and equality in its approach to public health reform. It declares:

> "Our approach will be based on the principles of fairness and equity, taking account of the avoidable differences in health among groups of people and providing access to the resources needed to improve health. Everyone has the right to the highest attainable standard of health, and everyone should have equal opportunity to realize this right without discrimination (p. 45)."

This language not only aligns with rights-based frameworks but also underscores Scotland's approach to addressing avoidable inequities through equitable access to opportunities.

Despite this systemic framing, Scottish participants noted significant challenges in operationalizing health equity, particularly in how inequalities are conceptualized and measured. One participant explained,

> We conceptualize inequalities very much as about deprivation measured by the index of multiple deprivation... but that's very imperfect (UKI4).

This reliance on the Scottish Index of Multiple Deprivation (SIMD), while practical, limits the broader understanding of health equity, particularly in addressing intersectional inequalities. The participant noted a disconnection between how socioeconomic inequalities and

inequalities related to protected characteristics are addressed in public health work in Scotland, stating:

> In public health, we do a lot of stuff on socioeconomic inequalities, using SIMD, which I said is very imperfect. And then we've got this legal sort of procedurally driven requirement to look at things by the equality characteristics, and you need to bring them together (UKI4).

However, while acknowledging legal efforts to bridge this gap through Scotland's Equality Act, the participant reflected,

> There's a bit of a disjunction... we do sort of understand about intersectionality. But again, that's a very difficult thing to operationalize, isn't it? People find it very difficult to think about more than one thing at a time (UKI4).

The participant also reflected on differing definitions of inequity, highlighting the challenges of integrating value judgments into the operationalization of public health work. They explained,

> So, some colleagues will use the Margaret Whitehead definition of health and health inequity as being avoidable and unjust, and you've gotta decide if it's unjust or not. I think that's a value judgment and I've always resisted placing that value judgment on it. But there are other people, and that I can completely see their point of view, and they're right to a large extent that you can't avoid value judgments. […] So, you might as well be explicit about them, but I still don't feel very happy about that. (UKI4).

Instead, they expressed a preference for the Braveman and Gruskin definition of equity and health about being the absence of systematic differences between health of different populations with different levels of advantage, describing it as "more helpful when you're trying to use it in practice (UKI4)."

The pervasive influence of neoliberalism shaped much of the context within which this research unfolded. While not the central focus of my analysis, it was an omnipresent backdrop, influencing the frameworks, policies, and realities encountered by public health professionals. For many participants, neoliberalism was so deeply embedded in their day-to-day work that it felt inseparable from the systems themselves—almost unremarkable in its ubiquity. Yet, some participants directly acknowledged its impact. One UK participant noted how the concept of health equity, often central to public health discourse, "feels like it's aspirational in a neoliberal context." This sentiment highlighted the tension between the ideals of health equity and the practical constraints imposed by systems grounded in market logic, privatization, and austerity measures.

Another participant from the UK offered a particularly incisive reflection on the structural determinants of health under neoliberalism. They remarked:

> I often ask rooms full of people what are the four biggest risks to health […] and then they think I'm gonna say tobacco and alcohol and obesity and the like, but my answer is (1) neoliberal economic policy and its discontents. So (for) about 100 years or so, and (2) the commercial influence on our health, medicine has the third biggest influence on our health […], by which I mean the answer isn't in a shiny gizmo, or a drug that you can't pronounce the bloody name of…that's where the money gets spent, and then the 4th one is public sector finances themselves because they are your AKA determinants of health. […] So, and they all think, well, what do I need to do tomorrow and hang on […] well, the answer to that is quite hard (UKI3).

This insight underscored the profound interplay between economic policy, commercial interests, and public sector resources in shaping health outcomes. It also reflected the practical challenges faced by policymakers and practitioners tasked with addressing these systemic barriers within a neoliberal framework.

The analysis of Anglo-Saxon liberal welfare states—Canada, Australia, and the UK—reveals a general reliance on framing health equity as an analytical lens rather than as a fully integrated systemic goal. Across these contexts, strategic documents frequently emphasize the application of health equity lenses to address disparities for specific populations, such as those

labeled ‘vulnerable.’ However, this framing often limits equity to a diagnostic tool, focusing on inequalities tied to individual or group characteristics rather than systemic inequities. Canada’s use of health equity lenses in its Mental Health Strategy (2012) exemplifies this approach, signaling equity as a priority for evaluating programs without embedding it as a societal commitment.

Similarly, participants from the UK noted the difficulty of operationalizing public health work that moves beyond socioeconomic inequalities to address intersectionality. This tension, compounded by the focus on qualitative metrics highlights the challenges of translating strategic framings into meaningful systemic change. Together, these cases reflect a fragmented approach to health equity that, while committed to addressing disparities, struggles to fully incorporate equity as a transformative goal.

Framing Health Equity—From Societal Goal to Systemic Practice in Nordic Models. In contrast to Anglo-Saxon liberal approaches, Nordic social democratic welfare states frame health equity as both a societal goal and a systemic process. These models embed equity within broader frameworks of social sustainability, reflecting rights-based welfare ideologies that prioritize inclusivity, participation, and equitable access. By integrating health equity into strategic frameworks, Nordic welfare states aim to address structural inequities through systemic reforms that promote societal health and well-being.

Norway’s strategic frameworks further emphasize health equity as a central objective within public health initiatives, though still implicit. One interview participant explained the linguistic challenges in translating “equity,” noting that “the Norwegian language doesn’t actually have a perfect translation of equity (NI2).” However, they stressed that governmental strategies explicitly address health inequalities as consequences of “unfair social arrangements,” often involving “quantifying health inequalities... and addressing inequalities resulting from societal risks (NI2),” reflecting Norway’s data-driven approach to embedding equity into public health initiatives.

For instance, the National Health and Hospital Plan (2020–2023) stresses equitable access to high-quality services, stating, “patients should have equal access to good-quality health services, no matter where they live (p. 3).” While the term “health equity” is not explicitly defined, Norway’s focus on reducing social inequalities and regional disparities reflects a

commitment to systemic equity. This emphasis builds on the foundation of the National Strategy to Reduce Social Inequalities in Health (2006–2007), which outlines:

> The primary goal of future public health work is not to further improve the health of the people that already enjoy good health. The challenge now is to bring the rest of the population up to the same level as the people who have the best health—levelling up. Public health work entails initiatives to ensure a more even social distribution of the factors that affect health (p. 6).

This systemic framing was echoed by Norwegian participants, one of whom highlighted the intersection of social inequalities with public health goals in reference to a recent governmental White Paper in the Norwegian context:

> The first goal is that Norway should be one of the countries with the highest life expectancy which it should be just reflected […] and the second one is that the population should experience more years with good health and well-being and reduce the social inequalities. And then finally, we should create a society that is promoting health in the whole population (NI1).

Importantly, a distinctive feature of Norway's approach is the application of proportionate universalism, which seeks to balance universal benefits with additional support for those in greater need. As one participant explained:

> So, you know, because it's this idea of how we can organize the society in a way that, you know, we offer something for everyone, but you want to lift someone more […] instead of just targeting the ones in who really need something. Then so our parallel for the school food program. This will also be one of the arguments politically, then, that you are fully aware that majority of the kids, they have their own lunchbox, and they eat the well, but you want to introduce it because you know there are also those who don't eat and they don't eat well. So that's why we offer it to everyone, and you hope that it will benefit for the few, perhaps (NI1).

Proportionate universalism thus reflects Norway's commitment to fostering health equity as both a societal ideal and an actionable framework embedded within public health strategies. Similarly, in Finland, Socially Sustainable Finland (2020): A Strategy for Social and Health Policy explicitly articulates its commitment to structural equity, stating, "everyone has the right to social wellbeing, participation and the best health possible" (p. 4). The strategy integrates health equity into its principles through a "health and welfare in all policies" approach, emphasizing multi-sectoral collaboration to address systemic inequalities. This commitment extends to Finland's National Mental Health Strategy 2020–2030, which grounds its approach in universal human rights and the Finnish Constitution. The strategy underscores the systemic and rights-based dimensions of health equity, highlighting that:

> Mental health rights are founded on universal human rights and the fundamental rights under the Constitution of Finland, based on principles of equality of all, language rights, the right to work and education, the right to an adequate standard of living… and the right to social security and adequate health services. Fundamental and human rights safeguard societal conditions which promote mental health and protects against risk factors of mental health disorders… These mental health rights cover the entire population as well as those living in vulnerable or difficult circumstances (p. 25–26).

The strategy also acknowledges ongoing systemic inequities, noting that "fundamental rights are not implemented in an equal manner for all," particularly for individuals with mental health disorders who face "discrimination, stigma and prejudice […] in social interactions, at work, in studies, in housing and within services (p. 26)." One Finnish interview participant emphasized the clarity of these goals as part of recent reforms: "equity issues were one of the key aims... to guarantee that the service provision is equal for different population groups (FI2)."

Together, these examples illustrate how Nordic social democratic welfare states transition health equity from a societal ideal to systemic practice. Proportionate universalism exemplifies Norway's innovative approach to embedding equity into public health policies, ensuring that systemic efforts balance inclusivity with targeted support. Similarly, Finland's rights-based

frameworks reflect a commitment to addressing inequities in both access and outcomes. While these models emphasize structural reforms and inclusive practices, operational challenges such as balancing systemic approaches with growing individualization remain central to the ongoing pursuit of health equity.

Targeted Measures vs. Systemic Goals— Comparing Strategic Approaches. The differing approaches to health equity between Anglo-Saxon liberal welfare states and Nordic social democratic models stress the influence of political economy in shaping public health strategies. Anglo-Saxon models, reflecting liberal principles of individualism, frame health equity primarily as an analytical lens applied to evaluate inequalities in targeted populations. This approach aligns with a focus on individual responsibility, selective state intervention, and incremental improvements, as seen in Canada's reliance on health equity lenses and Australia's prioritization of certain groups in preventive health strategies. However, these frameworks often struggle to address structural determinants of inequity or to operationalize equity as a systemic goal, leading to fragmented efforts that inadequately confront intersectionality and entrenched inequalities.

In contrast, Nordic social democratic models embed health equity within broader rights-based frameworks, treating it as both a societal goal and a systemic process. These models emphasize structural reforms and collective responsibility, operationalized through approaches like proportionate universalism, as in Norway, which balances universal benefits with targeted support for those in greater need. Similarly, Finland integrates health equity into its strategic frameworks through a "health and welfare in all policies" approach, grounded in universal human rights and constitutional principles. These systemic strategies prioritize equity not only in addressing inequities but also in promoting inclusivity, participation, and the redistribution of resources.

While both welfare types aim to promote health equity by addressing inequalities in health outcomes, the Nordic model's systemic and rights-based orientation stands in stark contrast to the Anglo-Saxon focus on targeted interventions and measurable outcomes. This divergence reflects broader ideological differences: the Nordic commitment to social sustainability and collective well-being versus the Anglo-Saxon emphasis on individualized solutions and economic productivity. However, challenges persist in both contexts, from the operationalization of intersectionality in the Anglo-Saxon models to the increasing pressures of

individualization within Nordic frameworks. These comparative insights underscore the importance of aligning public health strategies with structural and systemic approaches to achieve transformative outcomes toward health equity.

4.2 The Foundational Building Blocks of Public Health Systems

Public health systems are built on foundational elements—leadership and governance, financing and resource flows, and the public health workforce—that shape their ability to promote health and well-being and advance health equity. These building blocks create the structural conditions necessary for health systems to engage effectively in health promotion strategies. This section examines these foundational components, highlighting their role in enabling or limiting equitable health outcomes across Anglo-Saxon liberal and Nordic social-democratic welfare states.

As established in Chapter 2, these building blocks were chosen as entry points for analysis due to their critical role in shaping the capacity of public health systems to address health inequalities. This approach reflects an iterative process of familiarization with the documents and interview data, noting both similarities and differences within and between welfare state models. Leadership and governance were coded across all documents and interviews in both Anglo-Saxon liberal and Nordic contexts. Financing and resource flows were discussed in over 85% of documents in both contexts and in over 90% and 100% of interviews, respectively. Meanwhile, the public health workforce was discussed in 100% of interviews and over 70% of documents in both contexts. These findings, presented in Table 11, illustrate the prominence of these themes across the datasets and their centrality to the analysis by welfare state model.

The analysis revealed both shared challenges and distinct tensions within and between the welfare state models. Leadership and governance emerged as critical areas of divergence. Nordic social-democratic systems, such as those in Finland and Norway, integrate decentralized governance with robust national oversight, striking a balance between local adaptability and systemic accountability. For example, Norway's Public Health Act (2012) conceptualizes public health as "a shared societal responsibility," mandating municipal leadership while ensuring national consistency. Conversely, Anglo-Saxon liberal welfare states, including Canada, Australia, and the UK, often grapple with governance fragmentation. Canada's voluntary

collaboration model, for instance, lacks enforceable mandates, creating coordination challenges for public health and social policy integration. Similarly, Australia's post-ANPHA dissolution governance vacuum and England's fragmented structures weaken sustained intersectoral efforts.

Resource flows and workforce capacity also highlight tensions between resources, capacity, and aspirations. Anglo-Saxon models frequently exhibit funding constraints and short-term political priorities, eroding the infrastructure necessary for sustained health promotion. Participants from Canada and the UK, specifically England, noted the prevalence of temporary pilot projects and austerity-driven reductions, which undermined long-term equity efforts. Nordic models, by contrast, embed equity-focused policies within regulatory frameworks, yet face challenges in ensuring consistent implementation. For instance, Finland's HiAP approach reflects a comprehensive policy framework, but regional disparities in healthcare capacity reveal an "implementation gap" that limits its full realization.

These findings underscore the shared tension between centralized aspirations and localized feasibility in both welfare state typologies. Anglo-Saxon systems often devolve responsibilities without adequate oversight or resources, while Nordic systems grapple with maintaining consistency across diverse local contexts. However, the Nordic emphasis on integrating health equity into all areas of policymaking and embedding collaboration within legislative mandates offers actionable lessons for addressing systemic challenges.

Table 11 Coding matrix for foundational building blocks of the public health system, by welfare state model

	Anglo-Saxon liberal		**Nordic social-democratic**	
Code	Documents (n=15)	Interviews (n=11)	Documents (n=7)	Interviews (n=4)
Leadership and Governance	15	11	7	4
Financing and Resource Flows	13	10	6	4
Public Health Workforce	11	11	5	4

Theme 2: Governance at the Crossroads—Leadership and Limits in Health Promotion

Governance frameworks and leadership structures are fundamental to the success of public health systems in advancing health promotion and equity. These foundational elements shape the ways policies are implemented, how interjurisdictional and intersectoral collaboration

is realized, and how systemic challenges are addressed. This theme explores the governance frameworks and leadership approaches of Anglo-Saxon liberal welfare and Nordic social-democratic models to assess how these systems build a sustainable foundation for health promotion.

The section is organized into two sub-themes to reflect the intersections of governance stability, leadership dynamics, and systemic challenges. First, *Sub-theme 2.1: Pathways of Power— Federated and Devolved Governance?* examines how governance structures across welfare models balance centralized authority with localized responsibilities, highlighting the impact of political and fiscal shifts on institutional stability. Second, *Sub-theme 2.2: Navigating Intersectoral Challenges—Collaboration or Compromise?* explores how governance frameworks embed intersectoral collaboration and how systemic challenges, such as jurisdictional complexities, influence the operationalization of health promotion and equity.

Each sub-theme presents the results of the Anglo-Saxon liberal welfare states, with an emphasis on the Canadian experience, followed by findings from the Nordic social-democratic contexts. Each sub-section concludes with a comparative analysis, highlighting shared aspirations and persistent tensions between governance ideals and practical constraints. By structuring the results in this way, this section addresses key research questions on the systemic enablers and barriers within governance frameworks, offering insights into the ways leadership and collaboration shape public health outcomes across different welfare state models.

Sub-theme 2.1: Pathways of Power— Federated and Devolved Governance

Leadership and governance frameworks are foundational to promoting health and equity. Yet, in Anglo-Saxon liberal welfare states, these frameworks often struggle with tensions between centralized authority and more localized responsibilities, exacerbated by jurisdictional roles and responsibilities. These dynamics were particularly evident in the federated systems of Canada and Australia and the devolved governance model of the UK, where interjurisdictional collaboration navigated entrenched institutional constraints.

Canada's governance framework reflected its historical institutional roots as a federated system, requiring coordination between federal leadership and provincial or territorial autonomy. PHAC, as established under the Public Health Agency Act (2006), demonstrated how national oversight could accommodate decentralized collaboration. In this Act, the CPHO was tasked

with “advising the Health Minister” and fostering partnerships across “provincial and territorial governments (Section 6).” This structure allowed PHAC to maintain institutional stability despite political changes. However, another participant, reflected that “collaboration is often easier on paper than in practice, particularly when priorities differ across provinces (and territories) (CI3),” underscoring the tensions between what is possible and what is feasible in such systems. The Mental Health Strategy (2012) echoed Canada’s emphasis on interjurisdictional collaboration, advocating for “engagement across federal, provincial, and local governments (p. 15).”

In Australia, the governance framework similarly reflected the challenges of federated systems. The ANPHA, established in 2010, aimed to centralize preventive health leadership through interjurisdictional collaboration, as outlined in the ANPHA Act (Preamble). However, its dissolution in 2014 through the National Preventive Health Agency (Abolition) Bill exposed governance vulnerabilities, leaving responsibilities fragmented across local authorities and creating gaps in coordination (Abolition Bill, Section 3). In response, the National Preventive Health Strategy (2021–2030) sought to reestablish coherence, emphasizing “cross-sectoral action to create an authorizing and supportive environment (p. 36).” Yet, as one participant noted, operationalizing equity remained narrowly focused on specific populations, particularly through Indigenous health initiatives, noting that

> There are a few health promotion foundations within Australia that are really very good […] and they really try to operationalize health promotion in its very broad sense. You know, really the Ottawa Charter and broader. […] However, at the federal, the national level there is little attention given to health promotion. It's the language of preventative health that gets used and we still see a large proportion of the implementation is at the project and program level, so that's still the doing things to populations, as the way I describe it, rather than tackling the […] real structural reforms (AI1).

Canada’s governance framework also intersected with colonial realities through nation-to-nation relationships with Indigenous Peoples. The Mental Health Strategy (2012) included a strategic direction to “work with First Nations, Inuit, and Métis to address their distinct mental health needs, acknowledging their unique circumstances, rights, and cultures (p. 96).” As one participant highlighted, there are over 600 First Nations in Canada and:

> Each (First) Nation has their own health models…and so do the different groups within Métis and Inuit. […] It's really about self-determination and supporting that self-determination or working in partnership to develop some health promotion frameworks. It's our role is to support that, not so much to be the decision makers (CI1).

They further explained the tensions between flexibility and accountability of the public health system, reflecting that reporting structures are flexible to respect cultural sensitivities and self-determination while ensuring accountability for taxpayer funds (CI1).

However, this approach is complicated by Canada's colonial reality, rooted in historic colonial institutions that still form the basis for governance systems today. One interview participant offed the example of "the *2016 Daniels v. Canada* decision, which expanded federal responsibility to include Métis and non-status First Nations under section 91(24) of the Constitution (CI1)," which addresses one historical inequity, but also adds complexity to the devolution process:

> While we're trying to not exist anymore and for communities to have that self determination it's kind of complex because how do we do that when we're bringing more people into this thing […], so it's a really big discussion and there's a lot of work being done to see what that will look like and how to best to start in a way (CI1).

Australia has faced similar challenges in addressing the health needs of Indigenous populations, referred to as Aboriginal and Torres Straight Islanders. Despite frameworks like the National Partnership Agreement, governance structures remain inconsistent across states and territories. One participant explained that despite these structural gaps, there are organizations that continue the effort, albeit, with less power and mandate than governmental structures and mechanisms may:

> There is a momentum, but some of those formal institutions are not in place yet. There are a few bodies, we have the Lowitia institute in Australia, and that is a health focused research organization, which is marvelous (AI1).

Meanwhile, in the UK, governance approaches reflected a tension between centralized control and more formal devolved authority. PHE, established in 2012, initially provided centralized oversight of health promotion efforts, collaborating with local authorities and the NHS (Health and Social Care Act, Part 1). The PHE Strategy (2020–2025) highlighted the goal of "cohesive health promotion strategies that address social determinants of health (p. 10)" across all levels. However, PHE's dissolution in 2021 fragmented health promotion leadership, narrowing its focus to health security under the UK Health Security Agency, while the Office for Health Improvement and Disparities addressed remaining equity issues (PHE Dissolution Regulations, Section 2). One participant highlighted the tension between national mandates and local discretion, reflecting that centralized policies often lack the flexibility to adapt to local contexts. While national mandates can be effective, local councils need more discretion in implementation to suit their communities' realities (UKI3).

Scotland's devolved governance structure enabled a more integrated model. The Fairer Scotland Duty complemented the UK-wide Equality Act by adding socioeconomic status to the legal framework for policymaking. However, as one participant noted, devolved powers had their limits:

> [The] Scottish Government has got an ambition to be a 'well-being economy,' but […] we have something called the national strategy for economic transformation which talks about well-being economy, but then you look at what they're doing it doesn't really fit with that, you know. It doesn't really suggest that there's been a whole change in mindset which is what a well-being economy should be. […] The point is not just for economic growth for its own sake that is going to enrich large transnational corporations, but not actually benefit people. […] There's a bit of a sort of cognitive dissonance almost when you do it, when you read that they haven't, they can't get beyond that (UKI4).

The implications of governance fragmentation are stark: while centralized leadership can establish consistency, overly rigid structures may stifle local innovation and fail to address context-specific needs. Conversely, decentralized governance risks uneven implementation and

diminished national coherence, particularly when fiscal and political constraints undermine collaborative efforts. Together, these dynamics illustrate the complex interplay of governance structures, equity goals, and the enduring influence of political economy in shaping public health outcomes.

Navigating Decentralized Governance with National Oversight in Nordic Models. In contrast, Nordic social-democratic welfare states prioritized governance frameworks that combined decentralized leadership with strong national oversight. Norway's Public Health Act (2011) similarly framed public health as "a shared societal responsibility (Section 1)," assigning municipalities a proactive role in health promotion while maintaining national regulatory support. Norway's Strategy on Social Inequalities in Health further reinforces this governance structure by advocating for "formalized partnerships and coordination mechanisms (p. 23)" to align health objectives across jurisdictions. One interview participant from the Norwegian context emphasized the importance of this balance, stating,

> Local governance ensures that initiatives are tailored to community needs, but national frameworks provide the accountability and consistency necessary for systemic changes (NI2).

A similar stance is exemplified by Finland, where Finland's Health Care Act (2010) mandated that municipalities ensure "equal access to services that promote health and well-being (Section 7, p. 4)." To support interjurisdictional collaboration, Finland employs national-level steering mechanisms, such as the Government Resolution on the Health 2015 Public Health Program (2001) and the National Action Plan to Reduce Health Inequalities (2008-2011). These initiatives provide guidelines for municipalities, encouraging collaboration across sectors like education, housing, and employment.

For example, in Socially Sustainable Finland (2020), it is explicitly stated that "Municipal leaders are responsible for strategic decisions to promote health and social wellbeing in their respective municipalities (p. 7)." However, this national strategic document authored by the national Ministry of Social Affairs and Health, does not shy away from an oversight role. The emphasize that "Basic health care does not function well enough in all municipalities, and there are considerable regional differences in the quality and availability of services" and that "the

reform is falling short of its goal (p. 10).” Recently, however, Finland’s reforms shifted health and social care responsibilities to regional well-being services counties, aiming to reduce disparities while maintaining municipal responsibilities for population-level initiatives. As one Finnish participant noted,

> We had a year ago a major reform. Now our health and social services are run by 21 welfare areas, not by municipalities anymore. They are responsible not only for healthcare and social care, but also for health promotion in the area, but the law also says that the municipalities do have also a role in health promotion […] on a population level, like traffic safety and education, schools and so on (FI1).

In addition to the strong national level and local level public health organizations, Finland also boasts a strong civil society sector in their public health system. One participant emphasized this, and their role in health promotion: So that's the formal part, but then I must say that in Finland we have very rich network of health NGO's and they do actually (a lot) of the very important health promotion work (FI1).

In Norway and Finland, governance frameworks do reflect an explicit commitment to integrating Sámi perspectives through parallel parliament structures, contrasting with the approach of devolution to Indigenous Peoples in Canada. Finland’s Sámi Parliament actively participates in national decision-making, supported by targeted initiatives within the Finnish Institute for Health and Welfare. One Finnish participant mentioned that

> There is a small group in the Finnish Institute for Health and Welfare, like an equity excellence center […] that looks after these aspects, by providing the evidence to policy making and legislation. So, these kinds of measures are embedded in the decision-making process (FI2).

However, despite these institutional mechanisms, equity challenges for the Sámi persist, such as ensuring adequate health access across remote regions and addressing historical inequities. These frameworks, while notable for their systemic inclusion of Sámi governance,

also highlight the ongoing need to bridge gaps in achieving health equity for Indigenous populations—like the tensions seen in Canada's nation-to-nation.

Diverging Paths: Comparing Governance for Health Equity across Welfare Models. Anglo-Saxon liberal welfare states and Nordic social-democratic welfare models present distinct approaches to governance and health equity, marked by tensions between centralized authority and localized autonomy. Political economy frameworks highlight the contrasting dynamics, with liberal models grappling with governance fragmentation that often undermines coherence in health equity initiatives. For instance, Canada's nation-to-nation relationships with Indigenous Peoples reflect the tension between the possibilities of self-determination and the feasibility of navigating entrenched colonial institutions, such as those governing federal accountability. Similarly, Scotland's devolved governance prioritizes upstream health promotion but remains constrained by economic levers, like taxation and welfare policy, much of which is controlled by Westminster. These constraints illustrate Hall and Taylor's (1996) historical institutionalism, with past structures limiting health policy, and perpetuating challenges in policy coherence.

In contrast, Nordic models, exemplified by Finland and Norway, integrate decentralized governance with robust national oversight, seeking a balance between local adaptability and systemic accountability. Norway's Public Health Act (2011) conceptualizes public health as "a shared societal responsibility (Section 1)," mandating municipalities to lead health promotion efforts while maintaining national regulatory frameworks to ensure consistency. Finland's Health Care Act (2010) similarly emphasizes equal access through municipal leadership, supported by national mechanisms like the National Action Plan to Reduce Health Inequalities (2008-2011). This structure allows for tailored local solutions while upholding national equity standards, an approach largely absent in Anglo-Saxon models, where governance fragmentation can exacerbate inequities.

A critical distinction lies in the treatment of Indigenous governance. Finland and Norway explicitly incorporate Sámi perspectives through mechanisms like parallel parliaments and dedicated equity initiatives within health institutions, fostering systemic inclusion in national policymaking, though inequitable health outcomes continue. Conversely, Canada and Australia's devolution processes remain encumbered by historical colonial frameworks, which complicate the realization of self-determination and consistent health equity for Indigenous populations. These differences underscore the inherent tension between what is possible—achieving equity

goals—and what is feasible within historically constrained systems, illuminating the critical role of governance structures in shaping public health outcomes.

Sub-theme 2.2: Navigating Intersectoral Challenges—Collaboration or Compromise?

Intersectoral collaboration is essential for addressing the structural determinants of health and advancing equity. Governance frameworks in both Anglo-Saxon and Nordic models reflected shared aspirations for systemic integration, yet systemic challenges often constrained their implementation. This sub-theme presents the results, underscoring, again, the tensions between aspirational possibilities and constraints of feasibility when working across sectors to promote health and advance health equity.

Importantly, Canada's Public Health Act (2006) did not include collaboration across sectors. Instead, it emphasizes "collaboration within the field of public health to coordinate federal policies and programs in the area of public health (Preamble, p. 1)." It provided powers to the CPHO to communicate with public, voluntary organizations, and the private sector. However, this is limited to "the purpose of providing information, or seeking their views, about public health issues (Section 6(3), p. 4)." Again, this language was couched in "may" rather than "shall," and does not include sectors in the public domain. However, as noted above, there were allowances for provincial and territorial cooperation, which hold jurisdiction over many social sectors such as education.

Meanwhile, both Canada's 2005 Integrated Pan-Canadian Healthy Living Strategy, and 2012 Mental Health Strategy emphasized the importance of intersectoral collaboration and promoted "whole-of-government" approaches across federal, provincial, and local levels. The Integrated Pan-Canadian Healthy Living Strategy emphasized that:

> Intersectoral cooperation and collaboration are critical, as action to address healthy living goes beyond the mandate of the health sector alone; success requires that all sectors work together to effect change. As well, success entails using all appropriate levers of influence at all possible levels of intervention: this includes public education; policy, legislation and regulations; fiscal measures; advocacy; social marketing; and community action (p. 12).

The 2012 Mental Health Strategy continued this emphasis and recommended the establishment of "whole-of-government and pan-Canadian mechanisms to oversee mental health related policies" alongside "strengthening data, research, knowledge exchange, standards and human resources related to mental health, mental illness and suicide prevention (Strategic Direction 6, p. 17)." So, while there is no legal framework, at least at the organizational and strategic level, intersectoral action acknowledged as a potential, if not expected action for the public health system.

However, interview participants reflected on the scoping challenges. One participant from the Canadian context reflected that lofty intersectoral action such as income and housing may be considered "beyond our scope," emphasizing that

> It really also depends on how you see the boundaries of public health, because I personally think that these types of things, universal childcare, guaranteed income and housing, these are public health issues, and they are levers to improve people's health and well-being. […] Maybe in the future there will be more kind of more movement in that direction, but I sense the way the federal government is organised in Canada, […] there are specific roles and responsibilities, and some of them that would be really helpful to public health, they sit outside (CI2).

Another participant reflected on the same initiatives:

> We see initiatives that align with what we think from a public health perspective should improve population health and reduce inequities. Often, if not most of the time, those policies have very little influence from public health…So like, I'm thinking about housing […] I think there have been attempts for public health to reach out and work with other federal government departments, so I'm thinking about Employment and Skills Development Canada or Employment and Social Development Canada, I think it's called now, especially from the inequities or inequalities perspective, trying to sort of bridge that gap between public health and employment. But those initiatives, from what I've seen, really don't…there's not a lot

> of staying power, so they'll be a short period where there's intense activity to do some sort of a pilot project (CI5).

These reflections underscore the awareness of intersectoral action, but a general lack of direction or empowerment for the public health system to lead and scale initiatives. Importantly, this phenomenon aligns with the language of "may" and "communicate" found in the Public Health Act (2006).

In Canada, the absence of a robust legal framework for intersectoral collaboration highlights the tension between the promise of public health leadership and the structural limitations imposed by its decentralized governance. While the Mental Health Strategy (2012) calls for "whole-of-government" approaches, the lack of enforceable mandates restricts their implementation. This reflects a broader trend where public health is positioned as a supportive player rather than a driving force in cross-sectoral action.

Australia mirrors Canada in its reliance on decentralized collaboration, but the dissolution of the ANPHA further fragmented leadership in preventive health. While subsequent strategies like the National Preventive Health Strategy (2021–2030) emphasize collaboration across portfolios, the absence of a stable, centralized leadership body has left intersectoral efforts vulnerable to shifting political priorities. As one participant noted, the lack of continuity post-ANPHA has made it difficult to achieve the level of intersectoral integration needed for preventive health (AI2). This vulnerability underscores the challenges of embedding long-term health promotion goals in governance systems that prioritize cost efficiency and political expediency.

Like it's Canadian legislative counterpart, the APHA (2010) listed the functions of a Chief Executive Officer (CEO). These included encouraging initiatives "relating to preventative health matters through partnerships with industry, non-governmental organizations and the community sector (Section 11 (1h)," stopping short of requiring such intersectoral programs of work. It did, however, set out objectives and functions that included generating "new partnerships for workplace, community and school interventions (Section 2A (2(c))." The Agency reflected this intention in its 2011-2015 Strategic Plan. In it, it named 'collaboration' an Agency value, including building and strengthening effective and lasting partnerships across all

levels and all relevant portfolios of government and with the health system (p. 13)," among others previously listed.

However, the 2014 dissolution of ANPHA left a leadership gap that impeded systemic collaboration. As one participant reflected, that the fragmentation following ANPHA's dissolution made it difficult to achieve the level of intersectoral and interjurisdictional integration needed for preventive health, stating that

> Often, it's the Commonwealth that sets the agenda, and the jurisdictions are committed, but then it takes far too long for the Commonwealth to actually set a process. So, the jurisdictions each go ahead. But everyone's doing something differently (AI2).

Later, Australia's National Preventive Health Strategy (2021–2030) which came into being 5 years after the dissolution of APHA, emphasized a HiAP approach to governance, the strategy recommended a mechanism "within government, and across relevant portfolios, that have an influence on health and wellbeing of Australians (p. 36)," stating that a "systematic and structured approach" is required "to achieve the best possible outcomes for Australians (p. 37)."

In the UK, significant contrasts between England and Scotland highlight how political economy shapes governance approaches to public health. England's fragmented structures, particularly following the dissolution of the PHE, and reliance on locally driven efforts, contrast sharply with Scotland's cohesive HiAP framework. These differing approaches reveal tensions between centralized authority, local autonomy, and systemic health promotion objectives.

England has faced increasing fragmentation in public health governance. The dissolution of PHE redistributed responsibilities to the UK Health Security Agency and the Office for Health Improvement and Disparities, narrowing the focus of health promotion and undermining intersectoral collaboration at the national level, and shifting efforts to localities with little national oversight or guiding frameworks. One participant noted the challenges of balancing centralized policies with local discretion:

> The central government can't mandate everything in a health improvement space. Local councils know what will work in their specific contexts. [...] We do tend to be too centralized about our approach to implementing and schemes, initiatives,

> programs and projects…. and tend not to allow creativity and flexibility in how things actually play out because it has to be one size fits all (UKI3).

However, without that national oversight role, headwinds from Westminster remain, challenging local efforts. For instance, austerity measures have further constrained local governments' capacity to address the social determinants of health. Over the past decade, local councils faced reductions in spending power, eroding the infrastructure (UKI3).

By contrast, Scotland's devolved governance allows for a more integrated approach to intersectoral collaboration. Public Health Scotland's Three-Year Plan (2022–2025) explicitly calls for public bodies to prioritize health equity goals across sectors, promoting consistent and equitable policies (p. 18). Structures such as Community Planning Partnerships facilitate collaboration between councils, NHS boards, public sector organizations, and voluntary groups. One Scottish participant emphasized the importance of building trust and relationships in these partnerships, reflecting that a lot of work initially involves "loss-leading"—going to meetings, building relationships, and not trying to change anything right away but building trust (UKI4).

By embedding health equity within broader governance frameworks, Scotland has created a foundation for systemic collaboration, though structural barriers tied to its devolved powers remain. Westminster's control over critical economic levers, such as taxation and welfare, limits Scotland's ability to address upstream determinants of health comprehensively.

The governance challenges observed in Canada, Australia, and the UK reflect the broader characteristics of Anglo-Saxon liberal welfare models, where market-oriented priorities and decentralized governance frequently shape public health systems. These models tend to rely on short-term, reactive strategies rather than sustained, systemic efforts to address the SDOH. The resulting fragmentation undermines intersectoral collaboration and limits the capacity of public health systems to advance equity.

In the UK, the contrast between England and Scotland illustrates how governance fragmentation impacts health equity efforts. England's reliance on localized implementation without national oversight has weakened its ability to address systemic inequities. The dissolution of PHE redistributed responsibilities to new entities with narrower mandates, leaving local councils to navigate complex social determinants with diminished resources. One participant highlighted the impact of austerity measures, noting that cuts to local government

spending had eroded the infrastructure necessary to empower communities and address health disparities (UKI3). These challenges are emblematic of England's neoliberal approach, where public health is deprioritized in favor of cost containment and short-term gains.

By contrast, Scotland's devolved governance offers a more integrated model for intersectoral collaboration. Structures like Community Planning Partnerships (CPPs) exemplify a coordinated approach, bringing together public sector organizations, NHS boards, and voluntary groups to address shared health priorities. One participant explained, effective collaboration often hinges on building trust and aligning goals across sectors (UKI4). However, Scotland's ability to tackle upstream determinants remains constrained by Westminster's control over critical economic levers, such as taxation and welfare. This structural limitation highlights the broader tension within devolved systems, where ambitions for health equity are tempered by the realities of centralized fiscal control.

Across these Anglo-Saxon liberal welfare states, governance structures have struggled to operationalize intersectoral collaboration as a means of advancing health equity. Fragmented leadership, short-term political cycles, and the decentralization of responsibilities create systemic barriers to cohesive action. While initiatives like Scotland's CPPs or Canada's nation-to-nation efforts with Indigenous Peoples signal progress, their potential is often curtailed by the structural priorities of liberal welfare states, which emphasize individual responsibility and cost efficiency over sustained investment in equity-driven public health systems. Addressing these challenges will require a fundamental re-evaluation of how governance frameworks can align intersectoral efforts with long-term goals for systemic health promotion and equity.

***Structured Collaboration and Local Integration in Nordic Models*.** Intersectoral action was foundational to the health promotion frameworks of both Finland and Norway, reflecting their emphasis on promoting health and addressing systemic health inequities through integrated governance structures. These models shared leadership commitments to embedding health considerations across sectors, established robust governance and accountability mechanisms, and addressed the structural determinants of health. However, their implementation efforts revealed common challenges and important divergences, offering lessons on leveraging collaboration to achieve health equity.

Both Finland and Norway emphasized the critical role of intersectoral collaboration as a core principle in their public health documents. Finland's Health 2015 Public Health Program

and Norway's Public Health Act (2011) both advocated for multi-sectoral approaches to address social determinants of health, including education, housing, and transportation. Norway framed public health as "a shared societal responsibility (Section 1)," while Finland's program highlighted the need for "comprehensive policies that integrate various sectors (p. 10)." These shared commitments underscored the recognition that systemic health inequities could not be addressed solely within the public health system.

Finland's National Mental Health Strategy 2020–2030 underscored the importance of integrating mental health into broader policies, stating that:

> This 'Mental health in all policies' approach emphasises the significance of mental health as part of general health. This approach systematically accounts for mental health impacts in all decision-making across all sectors, seeking common interests and avoiding harmful mental health impacts. Mental health impact assessment is a way of accounting for mental health in all decision-making all administrative sectors and throughout all levels of decision-making (p. 36).

Similarly, Norway's Strategy on Social Inequalities in Health called for "formalized partnerships and coordination mechanisms" to align objectives across sectors and governance levels, ensuring a cohesive approach to public health (Part 1b, p. 23). Both frameworks shared a commitment to addressing the SDOH, with Finland relying on the HiAP model to guide voluntary collaborations, and Norway embedding intersectoral mandates in legislation through the Public Health Act (2011), which defined health as "a shared societal responsibility (Section 1)." Together, these strategies demonstrated the Nordic commitment to reducing health inequities by operationalizing intersectoral action at both policy and governance levels.

Governance and accountability structures further illustrated a shared emphasis on collaboration across levels of government. Finland's Health Care Act (2010) assigned municipalities a leadership role in aligning local actions with national goals, encouraging partnerships with sectors like social welfare and education. Similarly, Norway's Strategy on Social Inequalities in Health advocated for formalized coordination mechanisms to align public health efforts across sectors and governance levels (Part 1b, p. 23). Both countries leveraged these frameworks to prioritize equity-focused policy integration. For example, Finland's Socially

Sustainable Finland 2020 called on municipal leaders to incorporate equity considerations into all policymaking (p. 7), while Norway's legislative mandates ensured that public health considerations were embedded across sectoral policies to address vulnerabilities.

Despite these commonalities, both countries struggled with implementation challenges. Finland's Socially Sustainable Finland 2020 report highlighted regional disparities in municipal healthcare capacities as a significant barrier to intersectoral governance, noting that "basic health care does not function well enough in all municipalities (p. 10)." Similarly, Norway's Strategy on Social Inequalities in Health acknowledged that aligning sectoral priorities and resources was difficult, particularly when local authorities varied in their capacities (Part 1a, p. 15). These challenges underscored the tension between policy aspirations and practical feasibility in achieving consistent implementation across regions and sectors.

While Finland and Norway shared overarching goals, their approaches revealed distinct governance strategies and operational challenges. Finland's emphasis on national oversight, such as interagency committees to monitor progress (National Action Plan to Reduce Health Inequalities, p. 12), contrasted with Norway's stronger reliance on central regulation and local leadership. Norway's Public Health Act (2011) mandated municipalities to coordinate public health initiatives, integrating local knowledge and priorities into the broader public health agenda.

Norway further ensures local agency while maintaining alignment with national guidelines, embedding equity into decision-making processes at all levels. For instance, one participant in Norway reflected on the institutionalization of these efforts, which are embedded into municipal health systems and integrated with broader welfare efforts stressing that:

> The Public Health Act is defining some of the key terms, they define public health and the social determinants of health and the systematic— how you do public health work systematically in in different governmental bodies. For example, how the governmental bodies should work at the regional level and the municipalities, and there is this wheel describing that…you have to get an overview of the challenges, then you assess the different political efforts you want to do, and then you evaluate… so this kind of cycle (sic). […] This way of bringing public health to the surface at the different levels, which I think is has been a success. (NI1).

Additionally, Finland's approach integrated health considerations across diverse policy areas, such as agriculture, environment, and education. A Finnish participant reflected on the HiAP approach leveraged in the Finnish context:

> The assessment of health consequences needs to be done in the system […] so, this health in all policies approach doesn't only cover public health and health services related issues, but it really covers everything. All these decisions making and these kind of health consequences assessment is required […]. In some sectors it's better and in some sectors it's worse, but it's really like if we are doing legislation related to the financing, or whatever, there's always to be taking into account the health aspects as well. (FI2).

Yet, challenges remained in bridging policy aspirations with action, as another interview participant from Finland reflected:

> This country, your country, WHO—everywhere is full of good reports, unlike 50 years ago when we didn't have them. We have fantastic strategies, absolutely fantastic strategies. But are they implemented? Only a small part (FI1).

While both Finland and Norway provided models for integrating health into broader governance frameworks, they also revealed the tension between policy aspirations and systemic constraints. As one Finnish participant succinctly observed, "our problem is how can we overcome the implementation gap (FI1)." These insights suggested that achieving health equity required not only formal collaboration structures but also a sustained commitment to operationalizing these strategies in practice. By addressing structural barriers and fostering local leadership within cohesive governance frameworks, Nordic welfare states offered valuable pathways for advancing health equity through intersectoral collaboration.

The comparative analysis of Anglo-Saxon liberal and Nordic social democratic welfare models revealed key contrasts in how intersectoral collaboration was conceptualized, governed, and operationalized to address health inequities. Anglo-Saxon models, typified by Canada,

Australia, and the UK, demonstrated fragmented governance structures that often-limited systemic integration and sustainability. In contrast, Nordic models, represented by Finland and Norway, embedded intersectoral action into cohesive governance frameworks, enabling a more comprehensive approach to health promotion. Yet, across both welfare state typologies, persistent challenges highlighted the tension between aspirational policy goals and the systemic constraints of implementation.

Collaboration and Compromise: A look at Anglo-Saxon and Nordic Models. Anglo-Saxon models reflected a tendency toward decentralization, short-term political priorities, and market-oriented governance. Canada's reliance on voluntary collaboration without enforceable mandates underscored the challenges of coordinating public health with broader social policies. Similarly, Australia's governance vacuums post-ANPHA dissolution and England's fragmented structures following the dissolution of Public Health England weakened the capacity for sustained intersectoral efforts. As one Canadian participant noted, public health systems often lacked "staying power," with initiatives relegated to temporary pilot projects (CI5). Meanwhile, austerity measures in England further eroded the infrastructure necessary to address social determinants of health, as illustrated by local councils struggling to sustain community-led initiatives (UKI3).

Nordic models, in contrast, employed regulatory frameworks and governance mechanisms to embed health promotion across sectors. Finland's HiAP approach and Norway's Public Health Act (2011) reflected deliberate efforts to integrate health considerations into all areas of policymaking. However, implementation challenges persisted even within these structured models. Finland, for example, faced regional disparities in healthcare capacity, with one participant lamenting the "implementation gap" that left many strategies only partially realized (FI1).

Resource allocation also emerged as a critical tension across models. Nordic systems demonstrate a commitment to systemic redistribution, with Finland leveraging a gambling monopoly to fund health promotion initiatives and Norway providing block grants to municipalities. These mechanisms foster local autonomy while maintaining alignment with national equity goals. Conversely, Anglo-Saxon models relied on targeted funding and partnerships, which, while fostering community engagement, often struggle to address broader structural inequities. Participants in Canada and Australia highlighted how siloed funding

structures and accountability measures hindered intersectoral collaboration and the implementation of upstream equity strategies.

Despite these contrasts, both welfare state typologies shared a common tension between centralized aspirations and local feasibility. Anglo-Saxon models often devolved responsibilities without sufficient oversight or resources, while Nordic models struggled to ensure consistency across local contexts. However, the Nordic emphasis on equity-focused policy integration and robust monitoring systems provided actionable lessons for addressing these systemic challenges. Embedding intersectoral collaboration within legislative frameworks and ensuring accountability through regulatory mandates emerged as critical strategies for aligning health promotion with systemic equity goals. By addressing operational barriers and fostering collaboration across governance levels, both typologies could advance more sustainable and equity-driven public health outcomes.

Theme 3: Resourcing Health Promotion—Balancing Capacity and Constraints

Resources, both financial and human, are foundational to the capacity of public health systems seeking to advance health promotion and equity. Not only do these building blocks shape the ability of systems to implement policies effectively, but they also determine the sustainability and scalability of health promotion efforts across diverse governance contexts. This theme explored the resourcing of health promotion efforts and the wider systems in which these efforts resided across Anglo-Saxon liberal welfare models and Nordic social-democratic models to understand how intentional resourcing could promote or weaken these efforts.

The section was organized into two sub-themes to reflect the intersections of financial investment, workforce capacity, and systemic challenges. First, *Sub-theme 3.1: Resourcing Health Promotion—Following the Money* examined the tension between the ambition to promote health (capacity) and the practical limitations imposed by governance structures, fiscal policies, and political priorities (constraint). Second, *Sub-theme 3.2: Workforce Capacity—Strengths and Limitations in Public Health Systems* explored how public health workforce capacity was built, distributed, and supported, focusing on the operational challenges and strategies for sustainable workforce development.

Each sub-theme presented the results of the Anglo-Saxon liberal welfare states, with an emphasis on the Canadian experience, followed by findings from the Nordic social-democratic

contexts. Each sub-section concluded with a comparative analysis, highlighting shared aspirations and persistent tensions between those aspirations and resource constraints. By structuring the results in this way, this section spoke to the key research question on the systemic enablers and barriers to effective health promotion, offering insights into the ways resources, both financial and human, shaped public health outcomes across different welfare state models.

Sub-theme 3.1: Resourcing Health Promotion—Following the Money

The Anglo-Saxon liberal and Nordic social-democratic welfare states revealed distinct approaches to resourcing health promotion. Anglo-Saxon models often emphasized local adaptability but struggled with fragmentation and underinvestment. Nordic models prioritized equity and systemic integration but faced challenges in balancing flexibility with consistency. These findings underscored the importance of aligning financial and workforce strategies with health promotion goals while addressing the systemic barriers that impede equitable and sustainable resourcing.

Anglo-Saxon liberal welfare states, including Canada, Australia, and the UK, grappled with distinct approaches to financing health promotion, shaped by decentralized governance structures and shifting political priorities. Each country demonstrated varied strategies for both raising resources (financing) as well as allocating resources (funding) for health promotion, reflecting their unique political economies but also revealing persistent challenges in sustainable health promotion, and health equity.

In Canada, financing for health promotion remained largely decentralized. The Public Health Agency Act (2006) aimed to "support cooperation across provincial and territorial governments" but did not explicitly ensure consistent financial investment across regions (Preamble, p. 1). This decentralization often led to variability in service quality and health promotion efforts, depending on local priorities and resources. One Canadian participant highlighted the underappreciation of health promotion, and reflected that infectious diseases are often prioritized, where as health promotion efforts "kind of goes on quietly in the background," and while health promotion as an essential function of the public health system "is appreciated by people who work in public health," it is also "underappreciated by the government more largely (CI2)." This was explicitly stated in in Canada's 2005 Integrated Pan-Canadian Healthy Living Strategy, which stated that "chronic underfunding of prevention research and public

health systems for surveillance, knowledge synthesis, and exchange means that there is limited capacity for this work in Canada (p. 42)."

Later, in 2012, The Mental Health Strategy underscored the need for resource allocation through funding mechanisms that reflected variables contexts and needs across Canada as a matter of equity. For instance, the higher costs of services in northern and remote regions, advocating for locally designed and implemented solutions. It stated, "Programs developed in cities in the south cannot simply be transferred to northern and remote places and be expected to work. Communities should have access to funding and support to develop, implement, and evaluate their own solutions" (p. 86); and indeed, there were some federal funding levers to allocate resources directly to communities to promote health and health equity identified. For instance, one participant from Canada explained that "contribution agreements" allowed funding to align with self-determined priorities for First Nations, Inuit, and Métis governments and communities:

> For example, just say the budget gives us a certain amount of funding for […] health, as an example, would be supported through contribution agreements. So that would be, again, through self-determination of what is needed, as long as that funding is being used for mental wellness (CI1).

However, Australia's experience only a few years later revealed vulnerabilities in sustaining health promotion financing with the dissolution of the ANPHA in 2014. disrupted this continuity, leaving financial resources dedicated to health promotion susceptible to political changes. Despite this setback, subsequent strategies like the National Preventive Health Strategy (2021-2030) sought to re-establish cohesive frameworks for financing preventive health initiatives and introduced a "long-term prevention fund," which would provide stable financial support for health promotion initiatives, which intended to shift focus from "an illness system to a wellness system (p. 38)."

The strategy acknowledges the role of fiscal policies in health promotion, and emphasized the role of taxation and pricing policies as effective tools to promote health:

> By introducing tax increases on tobacco (30% increase), alcohol (30% increase) and unhealthy foods (10% increase), alongside mandatory salt limits on processed foods, it was estimated that $6 billion of net savings could be made to the health system through a reduction in direct healthcare costs (p. 25).

This approach aimed to embed health promotion goals across various policy areas, creating a cohesive foundation for preventive health, and suggested that this fund could be financed through revenues from national excise tazes, such as the ones listed above.

Like in Canada and Australia, in the UK public health is financed through general taxation. In England, financial resources primarily flowed through the NHS, which ensured some consistency in health service delivery. However, the NHS focused on acute care over upstream investments in health promotion and addressing social determinants. As one participant explained:

> The NHS does a great job of fixing people when it breaks, and it does an amazing job at that. But my stock response is if you're not talking child poverty, you're not talking air quality, you're not talking the, the, the, the consequences of lack of access to green space, you're not talking health (UKI3).

In 2012, the Health and Social Care Act, which created PHE, transferred many public health responsibilities to local authorities, aiming for an "equitable distribution of resources" while supporting local adaptability (Part 1). One participant from England reflected on these shifts, which often lack adequate resourcing to match the responsibility and task at hand:

> Shifting the responsibility without giving people the power (and) resources to do it and ultimately, they'll never be able to have the power and resources to change some of the social determinants of health, which influence local health and inequalities (UKI2).

Further, with the dissolution of PHE in 2020, mid-COVID-19, coupled with austerity policies, this model was significantly impacted. The impact of funding cuts was described thusly:

> Public spending at the local level […] has been slashed. The spending power of local government is 50 percent less than it was a decade ago […] we've cut our investment into the determinants of health by half (UKI 3).

These challenges eroded the infrastructure necessary to address SDOH and undermined the long-term goals of health promotion.

In contrast to other Anglo-Saxon liberal models, Scotland's approach differed significantly from England's austerity-driven model. Scotland emphasized collaborative financing mechanisms to pool resources across sectors, as seen in its HiAP model, integrated into Public Health Scotland's Priorities (2018). This model prioritized and committed to embedding health considerations across policy areas and promoted partnerships, such as equitable education attainment, a priority determinant of health:

> This is supported by £1bn of investment in the expansion of early learning and childcare which the Scottish Government and local government are jointly delivering from 2020 onwards. This will deliver quality early learning and childcare in an effort to reduce the poverty-related attainment gap and to provide additional support to families. In addition, £750m has been committed to the Attainment Scotland Fund (ASF) over the lifetime of this Parliament. This includes £120m Pupil Equity Funding, which provides resources direct to schools intended to help tackle the attainment gap through targeted improvement activity in literacy, numeracy and health and wellbeing (pg, 17).

This type of collaborative financing across sectors, recognized inside of a health promotion framework that prioritizes equity support a more robust governmental approach to upstream action.

Scotland's devolved governance allowed for a more equity-focused approach to financing, supporting the redistribution of resources to underserved areas. However, structural limitations tied to broader UK fiscal policies constrained the extent to which Scotland could address upstream determinants of health, highlighting the tension between local autonomy and centralized fiscal control.

Across these Anglo-Saxon liberal welfare states, financial resource mechanisms for health promotion revealed shared aspirations but diverging strategies. Canada and Australia grappled with decentralization and fragmentation, which limited their ability to sustain cohesive public health financing. Though Australia's proposal for a centralized prevention fund, may provide a model for stability, though it was only launched in 2024, and impact and longevity through political shifts remains to be seen.

England and Scotland demonstrated the impact of divergent governance models. England's reliance on local funding was weakened by austerity measures, while Scotland's collaborative frameworks offered a more integrated approach. However, both countries were constrained by political priorities in addressing the upstream, structural, determinants of health. Reflecting broader systemic challenges inherent in liberal welfare models, an interview participant form Scotland succinctly summarized the dependence of resource allocation to promote health and equity on alignment with government priorities and plans, emphasizing the influence of political shifts on operational autonomy:

> There's a kind of circular thing […] we need Scottish Government to agree with our annual plan so that we can (work) on the part that we really want them to ask us to do… the things that we want to do, so that we can make sure it's in the plan (UKI4).

However, addressing these challenges required aligning financing structures with long-term health promotion goals, ensuring that funding mechanisms supported not only healthcare services but also the broader SDOH. Lessons from these countries highlighted the need for stable, equity-focused funding to advance health promotion effectively.

Capacity and Constraints in the Nordic Context. The Nordic social-democratic welfare models of Finland and Norway exemplified innovative approaches to financing health promotion, embedding equity and resource flows into their governance frameworks. These models prioritized financial redistribution and systemic investments to address structural determinants of health, leveraging mechanisms such as taxation and public monopolies. By tying resource allocation to broader health equity objectives, Finland and Norway sought to align public health financing with societal goals. However, tensions between centralized oversight and municipal autonomy revealed persistent challenges in achieving uniform outcomes. This section

explores how these countries approached health promotion financing, emphasizing the integration of income distribution and targeted investments to address inequities while navigating the complexities of decentralized governance.

In Finland, a government monopoly on gambling profits provided a key funding source for health promotion efforts. One Finnish participant explained,

> In Finland, the gambling is a governmental monopoly, and all the profits of gambling for the lotteries and things like that are used to fund nongovernmental organizations (FI2).

This mechanism integrated societal behaviours into public health financing, specifically for the purpose of health promotion, channeling revenues into NGOs focused on addressing SDOH. Similarly, Norway employed its alcohol monopoly system to regulate consumption while generating public revenue. As one participant noted, "we sell alcohol at, we have this monopoly that is, governmental shops and it's a government institution (NI1)." This dual-purpose approach demonstrated the alignment of regulatory measures with public health objectives.

Norway's reliance on taxation also extended to broader structural determinants. The National Strategy to Reduce Social Inequalities in Health (2006) explicitly tied resource redistribution to equity goals, emphasizing that "the government has set itself the goal of further strengthening the general allocation of resources in the taxation system, and the Government's taxation policy has therefore been designed so that people with high incomes and wealth contribute more to the community" (p. 34). These policies mapped out a taxation framework that created "more space for public welfare services" (p. 34). Additionally, the Directorate for Health did occupy a role in providing evidence and recommendations on strategies such as progressive taxation and housing access to address inequities. As one participant explained

> This Directorate for health that I mentioned, they have an Independent Advisory Board that looks at healthy inequities and what to do about it. And they produced the revision of (a) report that they regularly release, and they had, I think ,10 recommendations which included progressive taxation and enabling access to housing and other things that aren't really within the remit of healthcare system. (NI2).

Indeed, income redistribution emerged as a central theme in Nordic health promotion strategies, linking financial equity to public health outcomes. Finland's Socially Sustainable Finland 2020 underscored the importance of maintaining robust income support systems during extraordinary times, stating that the aim was "to ensure that the income support and insurance systems can continue to function […] by creating sufficient unemployment insurance and social insurance buffer funds (p. 15)." This policy highlighted the Finnish government's recognition of economic security as fundamental to health equity, particularly during periods of societal disruption.

Both Finland and Norway demonstrated tensions between centralized oversight and local flexibility in resource allocation. For instance, in Finland, there is a strong integration of NGOs, all of which require funding to support their work. Recent changes to a "sin tax" structure on gambling has supported the important work of the NGOs in the public health system. One interview participant reflected:

> So, they (NGOs) are relatively well funded. History is complicated because we had this kind of gambling machines system which collect the local money, and then the Minister of Health distributed the money. Now because of this problem with the addiction and gambling, the system has been removed so that, actually, the money is completely now in the budget […] so part of the money is for permanent support and part of the money is for is project based. So, you have to apply for certain projects, but part of the money very often about half of the money is just for the permanent functions of the organization (FI1).

Somewhat similarly, Norway relied on block grants to support municipal health promotion efforts, leaving decisions on resource allocation to local governments. As one participant explained,

> For public health and health promotion, most of the resources for whatever they do at the municipal level is probably the municipal resources. Obviously, every municipality

> in Norway gets a block grant that's not tied to public health [...] it's not a federal transfer earmarked for public health (NI2).

This funding approach allowed municipalities autonomy but risked amplifying disparities between regions with differing capacities. Another participant described the variability in municipal size and capacity, stating,

> We have municipalities like Oslo, which has maybe 1/2 million people, while there are municipalities in Norway with less than 1,000 people. All of these have the same expectations...A large share of the funding from the national level is not earmarked but allows municipalities discretion (NI1).

This decentralized approach fostered flexibility but also underscored potential regional disparities in capacity and outcomes. While wealthier municipalities were often able to allocate more substantial resources to health promotion, smaller or less affluent regions faced challenges in meeting national expectations.

The Nordic approach to financing health promotion illustrated a strong commitment to aligning resource flows with health equity goals, leveraging both innovative mechanisms and structural redistribution. Finland's gambling monopoly and Norway's taxation policies exemplified their ability to use societal and economic behaviours to fund health initiatives. However, both countries encountered challenges in achieving uniform implementation due to decentralized governance structures and regional disparities.

While Finland's reliance on regional and municipal flexibility allowed for tailored approaches, it also risked inequities where local resources were insufficient. Norway's centralized mandates sought to mitigate these disparities but faced logistical challenges in ensuring equitable distribution and capacity building across municipalities. Together, these approaches underscored the critical role of integrating financial resource allocation into broader governance frameworks to address structural determinants of health effectively. By prioritizing redistribution and leveraging targeted financial mechanisms, Nordic welfare states offered valuable lessons for embedding equity into public health systems.

Funds and Fault Lines: Resource Allocation in Liberal and Social-Democratic Models. The allocation of financial resources for health promotion highlighted significant contrasts between Anglo-Saxon liberal and Nordic social-democratic welfare models, revealing tensions between decentralized flexibility and centralized equity efforts. Anglo-Saxon systems often emphasized local adaptability, with limited centralized oversight. In contrast, Nordic models, including Finland and Norway, explicitly embedded equity into their financial strategies, leveraging systemic investments and redistributive mechanisms to address structural determinants of health. These divergent approaches reflected broader tensions within each welfare model's governance framework.

Anglo-Saxon liberal systems demonstrated the challenges of decentralization in achieving equitable health promotion funding. In Canada, the absence of enforceable mandates for interjurisdictional resource allocation allowed regional disparities to persist. The emphasis became around federal funding mechanisms, while flexible, lacked the systemic consistency necessary to address inequities across regions effectively. Similarly, in England, austerity-driven policies exacerbated these disparities, as local councils faced significant cuts to spending power, undermining investments in SDOH at the local levels. Scotland offered a partial counterpoint, with its devolved governance enabling collaborative financing mechanisms to prioritize upstream determinants such as education and childcare. However, Scotland's ability to fully address structural health inequities remained somewhat constrained by centralized UK fiscal policies.

Nordic social-democratic models illustrated a more integrated approach to financial resource allocation, prioritizing equity through innovative mechanisms like monopolies and progressive taxation. Finland's gambling monopoly directed revenues to NGOs central to health promotion, demonstrating how societal behaviours could be leveraged to allocate financial resources in a way that promotes health and equity. Norway adopted a similar approach with its alcohol monopoly, aligning regulatory measures with fiscal sustainability. Both countries further embedded health equity into resource allocation through income redistribution policies. These models highlighted the potential of redistributive financing to align health promotion with societal goals.

Despite their strengths, Nordic systems also faced challenges in ensuring consistent outcomes across regions. Finland's reliance on municipal funding for population-level initiatives risked inequities, particularly in less affluent areas, despite recent reforms to consolidate health

and social care at the regional level. Norway's block grant system similarly allowed for local discretion but introduced variability in resource allocation between municipalities with vastly different capacities. These structural tensions underscored the complexities of balancing centralized oversight with local adaptability, even within equity-focused systems.

Together, the experiences of Anglo-Saxon liberal and Nordic social-democratic welfare states underscored the importance of aligning financial resource allocation with health equity objectives while addressing systemic barriers. While Nordic models leveraged innovative mechanisms and redistribution to prioritize equity, Anglo-Saxon systems seemingly struggled with underinvestment and fragmentation. The contrasting approaches illustrated the tension between flexibility and consistency in resource allocation, offering critical lessons for embedding equity into public health financing frameworks.

Sub-theme 3.2: Workforce Capacity—Strengths and Limitations in Public Health Systems

Workforce capacity is a cornerstone of effective public health systems, directly influencing the ability to advance health promotion and address equity goals. Across welfare state models, workforce strategies revealed varying approaches to resourcing, training, and intersectoral collaboration. Anglo-Saxon liberal models, such as Canada and Australia, often emphasized adaptability but struggled with workforce fragmentation due to political shifts and decentralized governance. By contrast, Nordic social-democratic approaches, exemplified by Scotland within the UK's devolved system, highlighted more cohesive strategies that integrated workforce efforts into broader equity-driven frameworks. This section examines the workforce strategies employed in Canada, Australia, and the UK, focusing on the interplay between structural constraints, political priorities, and intersectoral collaboration.

Public health workforce strategies revealed varying, but similarly limited, approaches between Anglo-Saxon liberal welfare models, revealing tensions between sustainability of core capacities, and susceptibility to political decisions around public health systems and structures. Anglo-Saxon models, exemplified by Canada, Australia, and the UK, prioritized adaptability but faced systemic fragmentation and political disruptions. Canada's decentralized governance emphasized training through the 2005 Integrated Pan-Canadian Healthy Living Strategy and the 2012 Mental Health Strategy but lacked mechanisms to ensure consistent application across provinces and territories, exacerbating regional disparities. Similarly, Australia's workforce

strategies were undermined by the 2014 dissolution of ANPHA, disrupting planning and intersectoral integration. While the National Preventive Health Strategy (2021–2030) sought to address these gaps by emphasizing training and capacity-building, long-term sustainability remained uncertain amidst shifting political priorities.

In Canada, the decentralized governance structure shaped public health workforce strategies, enabling local flexibility but exacerbating regional disparities. The Public Health Agency Act (2006) emphasized continuity during institutional transitions by mandating the transfer of personnel to the newly established PHAC. This ensured workforce stability, maintaining institutional knowledge critical for public health operations (Section 17(2)).

At the strategic level, most references to workforce capacity were tied to strategic calls for training and competencies. For instance, Canada's 2005 Integrated Pan-Canadian Healthy Living Strategy highlighted workforce capacity as a cornerstone of effective health promotion and emphasized training and skills. For instance, the strategy called for "physical activity training and continuing education for community health service providers," equipping front-line workers with the skills necessary to deliver equitable health promotion services (p. 38). In 2012, the Mental Health Strategy did the same, emphasizing the importance of "education and training for all types of service providers (from mental health to health, education, justice, and social services) include a focus on recovery and well-being while also helping everyone to learn how to build genuine partnerships (p. 36)."

Australia's approach to the public health workforce reflected the tension of sustainable capacity for health promotion action, and political shifts. Under the Australian Public Health Agency Act of 2010, ANPHA was responsible to "assist in the development of the health prevention workforce (Section 2(d))." However, in 2014, with the dissolution of ANPHA, workforce initiatives were disrupted, leaving gaps in training and recruitment. One interview participant emphasized the consequences of this fragmentation, particularly on the peoplepower that drives systemic health promotion efforts:

> Basically, it's goodwill, so it's the investment in time for people like me in the (research) side and my counterparts in the government side. So, investment of time. Other academics are [also] more than happy to supervise joint students and have meetings and round tables in their current salary time. But (when) every new project, a new research

> project, is instigated, we need to have some funding to bring on new staff to be able to do that, so that's where some resourcing is needed and that tends to be a longer-term project where we need to then either (see if) the government can find some money to invest or we go to a granting body, which of course that is a bit more hit and miss (AI2).

Despite the challenges, Australia's emphasis on intersectoral collaboration and capacity-building demonstrated a commitment to aligning workforce strategies with long-term health promotion goals, and six years later, the National Preventive Health Strategy (2021–2030) underscored "enabling the workforce" as a key principle, where common themes around training, education, and competencies emerged. It stated that:

> Action must enable the health workforce to engage in promoting health and preventing illness through multi-disciplinary health care and utilising the full scope of practice for all health professionals. This includes ensuring that the workforce is available, educated and capable of providing evidence-based, culturally safe and responsive care (p. 10).

A key aspect of this approach included a health workforce that has "improved cultural safety (p. 39)," and is "supported in building the health literacy capacity of themselves, their communities, patients and clients (p. 41)."

Again, the UK revealed contrasting approaches to workforce resourcing between England and Scotland. In England, like Australia, the 2020 dissolution of PHE eroded workforce capacity, and disrupted targeting planning to enhance workforce training and learning, as captured in the 2020 Public Health England Strategy, which emphasized workforce capacity, stating objectives for intersectoral collaboration such as "work with Health Education England and other system partners to improve the capabilities of the public health workforce to promote mental health, prevent mental health problems and prevent suicide (p. 25)."

Scotland's approach, in contrast, emphasized collaboration and pooled resources through its HiAP framework. This model, integrated into Public Health Scotland's Three-Year Plan (2022–2025), aimed to address workforce shortages by establishing a "fully sustainable service within Public Health Scotland with an appropriately skilled workforce (p. 23)." In the context of

intersectoral partnership and action, one participant reflected that the workforce effectively becomes a valuable in-kind budget line item, stating, “I don’t have a budget, and so the main resource is in kind and it’s staff time, so it’s staff time from within PHS and in our partners to do the pieces of work that we’ve done (UKI4).” By leveraging workforce strategies to enhance intersectoral action, Scotland demonstrated a more cohesive approach to addressing public health challenges while navigating structural constraints tied to its devolved governance.

The UK’s devolved governance presented a contrasting dynamic between England and Scotland. England’s workforce strategies, particularly after the dissolution of PHE in 2020, were constrained by austerity and fragmented coordination, limiting intersectoral training initiatives outlined in the 2020 Public Health England Strategy. Scotland, by contrast, embedded workforce development into its HiAP framework, pooling resources and emphasizing collaboration through Public Health Scotland’s Three-Year Plan (2022–2025). By leveraging staff time as an in-kind resource and integrating intersectoral action, Scotland demonstrated a cohesive model for addressing workforce shortages and promoting health equity.

In comparing these approaches, Anglo-Saxon models highlighted flexibility but struggled with sustaining systemic workforce investments, while Scotland’s integrated framework emphasized collaboration and equity-focused training. These contrasts underscore the importance of aligning workforce strategies with long-term public health goals, balancing adaptability with systemic coherence to address health promotion and equity challenges effectively.

Nordic Approaches to Workforce Capacity and Associated Limitations. Public health workforce capacity played an important role in the Nordic social-democratic welfare models of Finland and Norway, reflecting their commitment to integrating training, equity, and intersectoral collaboration. Both countries emphasized workforce development as central to their health promotion strategies, with structured policies aimed at aligning workforce goals with broader public health objectives. However, implementation challenges and structural disparities highlighted areas of tension and opportunity in their respective approaches.

Finland demonstrated a proactive approach to workforce capacity, embedding training and expertise within its governance frameworks. Specialized units, such as those within the Finnish Institute for Health and Welfare, concentrated expertise on key health challenges like tobacco and alcohol use. As one participant explained, this workforce not only conducted

research but also provided evidence to policymakers, reflecting Finland's commitment to evidence-based health promotion. They emphasized that

> We are able to […] influence the policy making legislation making, providing proper research evidence, and we are also listened in that sense, and […] quite often, before, new legislative chances are made (FI2).

Norway took a similarly structured approach, stressing workforce integration across health services. The National Health and Hospital Plan (2020–2023) described systematic workforce planning involving hospitals, municipalities, and educational institutions. This collaborative approach aimed to meet staffing needs while addressing rural disparities, with efforts to increase education capacity and create flexible training models for health workers (p. 33). By aligning workforce strategies with national health goals, Norway worked to ensure equitable access to health promoting policies and services across diverse regions.

Both Finland and Norway demonstrated strong commitments to workforce development, yet their approaches reflected different governance priorities. Finland's decentralized model provided adaptability but risked uneven resource distribution, particularly during the early stages of its regional reforms. Norway's centralized approach offered greater consistency but faced challenges in aligning national goals with local capacities. Together, their experiences underscored the importance of balancing workforce flexibility with systemic coherence, ensuring that public health systems are equipped to address equity and health promotion objectives.

Comparative Insights on Workforce Capacity and Development between Welfare Models. The comparative analysis of Anglo-Saxon and Nordic approaches to workforce capacity highlighted fundamental differences in how these welfare models prioritized adaptability, equity, and systemic coherence. Anglo-Saxon models demonstrated the advantages of flexibility in addressing local needs but struggled with fragmentation and sustainability. Political shifts, exemplified by the dissolution of ANPHA in Australia and PHE in the UK left workforce initiatives vulnerable to changing priorities. Meanwhile, Canada's approach allowed for more contextual precision but had limited mechanisms to ensure equitable workforce capacity nationwide.

By contrast, Nordic models, such as Finland and Norway, embedded workforce strategies into broader equity-driven frameworks, prioritizing systemic integration and evidence-based policymaking. Norway's centralized planning effectively reduced regional disparities, leveraging collaborations across sectors to align workforce goals with public health objectives. Similarly, Finland's specialized units within the Finnish Institute for Health and Welfare concentrated expertise on key health issues, ensuring that policymaking was informed by robust evidence. However, both countries faced challenges in balancing centralized oversight with local autonomy, as demonstrated by Finland's uneven resource allocation during regional reforms and Norway's difficulties in addressing rural workforce shortages.

4.3 The Process Building Blocks

Just as the foundational building blocks offer the structural underpinnings for public health systems to promote health and equitable health outcomes, the process building blocks emphasize the procedural mechanisms that operationalize these goals. This section explores how process building blocks— service delivery, policy, and programming; knowledge, evidence, and information systems; and medical and digital technologies—enable, or limit, the implementation of health promotion strategies aimed at advancing health equity.

The coding analysis revealed significant differences in how these elements are emphasized across welfare state models. Knowledge, evidence, and information systems were present in 12 of 15 Anglo-Saxon liberal documents and 100% of interviews in both Anglo-Saxon and Nordic contexts, underscoring their central role in shaping public health strategies. Service delivery and policy and program interventions followed a similar pattern, highlighting their shared importance in public health efforts across both welfare models. However, medical and digital technologies were significantly less emphasized, appearing in only 4 of 15 liberal documents and 1 of 11 interviews, and in 3 of 7 Nordic documents and 1 of 4 Nordic interviews.

Table 12 illustrates the distribution of these themes across the welfare states.

Public health systems are at the forefront of addressing health inequities, and their ability to bridge the gap between evidence and equitable policy outcomes is vital. *Theme 4: Evidence and Equity in Public Health Policy*: *Building Knowledge-Driven and Inclusive Systems* explores the role of evidence in shaping health policies and the structural frameworks that enable equity in health promotion. Tensions consistently arose about the role of public health systems and the use

of knowledge and evidence, including which knowledge is valued, and how it is used to inform policy and practice.

Key tensions emerged regarding the privileging of certain evidence types, misalignment of policy priorities with equity goals, and the capacity for intersectoral collaboration. While Anglo-Saxon systems emphasized community-driven initiatives constrained by siloed funding and neoliberal governance, Nordic models demonstrated more cohesive integration of equity into national frameworks, albeit with their own challenges in maintaining local adaptability and systemic alignment. These sub-themes emphasize the complexities of advancing equity through public health systems and provide valuable insights into the interplay of evidence, governance, and resources in shaping health policy outcomes.

Table 12 Coding matrix for process building blocks of the public health system, by welfare state model

	Anglo-Saxon liberal		**Nordic social-democratic**	
Code	Documents (n=15)	Interviews (n=11)	Documents (n=7)	Interviews (n=4)
Knowledge, Evidence, and Information Systems	12	11	7	4
Service Delivery, Policy and Program Interventions	12	11	7	4
Medical & Digital Technologies	4	1	3	1

Theme 4: Evidence and Equity in Public Health Policy: Building Knowledge-Driven and Inclusive Systems

Public health systems play a mediating role in addressing health inequities, and the effectiveness of various approaches is rooted in their ability to translate knowledge and evidence into policy. Across Anglo-Saxon liberal and Nordic social democratic welfare states, tensions emerged between the ambition to integrate knowledge and evidence into policymaking and the practical realities of resource constraints, governance models, and competing policy priorities. A recurring challenge was the privileging of certain types of evidence—such as epidemiological and economic data—over social sciences, community knowledge, and Indigenous ways of knowing. These tensions were compounded by the difficulty of aligning research outputs with policy cycles, as well as by disparities in how equity-focused frameworks were operationalized.

Theme 4: Evidence and Equity in Public Health Policy: Building Knowledge-Driven and Inclusive Systems explores these dynamics through two sub-themes. *Sub-Theme 4.1: From Knowledge to Action—Operationalizing Evidence in Health Policy* examines how evidence is mobilized to inform health policies, focusing on examples from Anglo-Saxon liberal and Nordic contexts. It highlights shared aspirations and divergent approaches in embedding evidence systems within public health structures. *Sub-Theme 4.2: Equity in Health Policy Action—Synergies, Frameworks, and Implementation* shifts the focus to health-driven policies, analyzing the interplay of governance, resource allocation, and community agency in addressing health disparities. Together, these sub-themes provide a nuanced understanding of how knowledge and policy action intersect within public health systems, offering insights into the systemic enablers and barriers that shape equitable health outcomes.

Sub-Theme 4.1: From Knowledge to Action—Operationalizing Evidence in Health Policy

This sub-theme examines how knowledge and evidence were operationalized in health policy, focusing on Canada as the primary case while drawing trends from other Anglo-Saxon liberal welfare states. Anglo-Saxon liberal welfare states emphasized efforts to bridge research and policymaking, reflecting the challenges and opportunities in mobilizing evidence within public health systems. This sub-theme examines the operationalization of knowledge and evidence in health policy, highlighting shared aspirations but diverse approaches across Anglo-Saxon liberal welfare states. It focuses on how evidence systems were systematically resourced and structured, while exploring key differences in the prioritization, generation, and integration of evidence within public health systems. Nordic systems demonstrated a focus on embedding evidence into national frameworks through varying approaches. Both approaches aimed to bridge the gap between research and practice, yet institutional structures, governance models, and resource allocation influenced their efficacy.

In Canada, the Pan-Canadian Healthy Living Strategy (2005) and the Mental Health Strategy (2012) emphasized the need for knowledge exchange systems to bridge research and policy gaps. As one participant reflected on their training to professional reality:

> I always assumed that policy was really solidly grounded in the best evidence when they talked about knowledge translation and that usually, it takes like 10 to 17 years for

> evidence to translate into action. I didn't really believe that, but now that I work in a policy setting, I can see that there's all sorts of different drivers. That means that policy is not always fully aligned with the evidence base (CI5).

These goals were supported by formalized partnerships with academia, exemplified by the Canadian Institutes of Health Research (CIHR), Canada's federal funding agency for health research. In 2005, CIHR was identified as a key partner to collaborate with universities and government agencies, such as PHAC and Health Canada, among others adjacent to the health portfolio, such as Social Development Canada and Transport Canada, to foster evidence generation and use across sectors to support evidence-based, or evidence-informed, healthy public policy action (Healthy Living Strategy, p. 45). This partnership was not emphasized in the 2012 Mental Health Strategy, however.

Australia's National Preventative Health Strategy (2021–2030) underscored academic-government partnerships, framing prevention as a shared responsibility across all sectors, highlighting research and academia (p. 7). Investments in specialized research centers, such as the National Centre for Immunization Research and Surveillance, exemplified rapid evidence mobilization for policymaking (p. 46). However, similar systemic barriers persisted across all Anglo-Saxon liberal welfare contexts. One participant from Australia articulated the challenge fluently:

> The development of policy and practice, we do have some relationships between the policy and practice systems and the research world, and for that type of evidence exchange. There's no systematic way of that happening. That's a bit ad hoc at the national level (AI1).

In the absence of a systematic approach, another participant emphasized relationship building to support this work, in their role in facilitating evidence use in policymaking: "we work quite closely with the [state] government department […] to build those connections so that we can work on research together to improve the use of evidence in policymaking (AI2)." This approach emphasized collaborative relationships to enhance evidence integration into policy processes, especially for preventive health initiatives. However, as another participant from Australia

reflected, this can lead to a valuing of some expertise and evidence over others, as "a bit ad hoc at the national level," they described their experience by reflecting that:

> There are a number of people in favour with the Ministers, or the bureaucracy, and they get called on…. But what it means is you get both a privileging of pet issues and types of evidence […] I believe strongly it's part of the reason why we see epidemiology and economics as the main type of evidence used to inform health policy making and implementation. […] The inclusion of the social sciences, I think, is limited (AI1).

There were notable discussions about the types of evidence and knowledge that is valued. In Canada, participants noted a persistent misalignment between evidence and political priorities, where competing interests shaped policy outcomes. One participant reflected,

> There seems to be more of a valuing of science and evidence on the more biomedical side of public health, I'm primarily thinking infectious disease as opposed to health promotion, chronic disease prevention, addressing health inequity, and that's problematic because there's no reason why something like infectious diseases should be more evidence based than health promotion or chronic disease prevention (CI5).

This reality contributes to tensions between scientific knowledge and real-world feasibility. In Australia, one participant emphasized that while Australia's national funder, National Health and Medical Research Council (NHMRC) has, in recent years, funded more social science inclusive research, the challenges remained:

> The understanding of the social sciences, I think, is limited to psychology. Psychology is great, but it's not the only social science. It's also part of the reason why we don't see real action on the social and commercial determinants of health. Trying to get that sort of evidence into those discussions often leads to the response, 'Well, we don't have the evidence.' No, we don't have that type of evidence, but we've certainly got other types of evidence. So, the prioritization of numbers still exists (AI1).

This valuing is an important tension that plays out in health policy processes as well, with both Canadian and Australian interview participants reflecting on how Indigenous knowledge is beginning to be incorporated into policy considerations. In Canada, the value of including Indigenous perspectives, and lived experience, as integral to health equity efforts were commonly discussed. However, it was emphasized that the process of coming to knowing, or creating knowledge for policy, was just as important as the knowledge outcomes. One participant reflected that

> It's more about the social part of public health, without the statistic prevalence and incidence… but it's I think it's complementary […] giving more value to the incidents and prevalence. […] People will do their policy recommendation, or the decision, based on the incidents and the prevalence of a disease […] but sometimes we forget (to ask) 'what is the cause of that? What is the need? What are the social determinants of health that contributing here and making people more vulnerable to this? I feel like it's kind of it's not a new concept (CI4).

In Australia, similar sentiments were considered, and one participant emphasized that: "the other thing I would say is that finally, there has been a much greater recognition of Indigenous knowledge into […] to policy and practice (AI1)." However, while other overall reflections on the move towards valuing Indigenous knowledges and ways of knowing were seen as overwhelmingly positive, operationalizing these principles required careful navigation of data sovereignty and cultural sensitivity, with one participant reflecting on the importance of respecting data sovereignty and reconciliation, they explained:

> we don't want to be asking for any kind of cultural information that doesn't belong to us or that communities don't want us to know (CI1).

Similar reflections were found in the UK. For instance, England's NHS also provided significant infrastructure for evidence and knowledge mobilization through the National Institute for Health Research (NIHR), ensuring that health and care research is closely aligned with the

priorities of the NHS. One interview participant from England lamented the tendency for prioritizing acute care over upstream determinants:

> Institutional setting matters and how governments will take and use evidence, local or national, is wildly different to how a medical professionals will view evidence. So, for a councillor, what Mrs. Smith said is evidence…. and that kind of matters, that really, really matters…Mrs. Smiths' lived experience and all the collated lived experience of the people, that's a perfectly legit form of evidence. Whereas if I'm a medic, that's sort of soft intelligence and doesn't really matter, and the only thing that matters is the randomized control trial and then the systematic review. There's all that kind of evidence hierarchy thing. Which kind of works in sort of the type of interventions where the unit is the individual but just doesn't work where the type of intervention is a population of people. So, there's a legit the there's a very legit alternative way of looking at evidence whereby different models of evidence and different hierarchies and different paradigms of evidence matter. For me, I'll spend an awful lot of my time <u>not</u> looking at biomedical types of paradigms of evidence, but social and political science, types of paradigms and types, paradigms and evidence. (UKI3).

However, other participants reflected on the complex nature of knowledge and evidence for policy action on the SDOH. One participant from England reflected:

> On reflection […] public health can sometimes overpromise and under deliver in terms of the kind of data driven, evidence based […] maybe its people's expectations are raised a lot when public health promised to take a data driven, evidence-based approach…people think there's gonna be this [..] silver bullet (UKI2).

In Scotland, this tension was considered thoughtfully:

> There's a kind of tension, isn't there, in public health that we're really interested in evidence and data, and I have a lot of colleagues who think if you've only got enough

> evidence and data that is the answer, and I don't think that at all. I think you need to know the question before you go looking for answers and I have too many colleagues who have lots of answers, but they don't know what the question is (UKI4).

The findings reveal both commonalities and divergences in how evidence systems were designed and operationalized to support health policy across Anglo-Saxon liberal models. A shared theme was the emphasis on integrating evidence into policymaking to address health inequities, yet each country faced barriers to aligning research outputs with political priorities and policy cycles. In Canada, participants highlighted efforts to foster intersectoral knowledge mobilization through initiatives such as the Pan-Canadian Healthy Living Strategy (2005). However, limitations in capacity to analyze data rapidly enough to meet policy demands and the privileging of certain types of evidence, such as prevalence data, were recurring challenges. Similarly, in Australia, systemic barriers persisted in formalizing partnerships between research and policy systems. Participants described this as "ad hoc," with some types of evidence—particularly epidemiological and economic—being favored over social sciences or Indigenous knowledge, limiting the scope of health equity work.

Divergences emerged in how knowledge types were prioritized, reflecting underlying political and structural influences. Canada and Australia have increasingly recognized the value of social sciences and Indigenous knowledge in addressing SDOH, yet the process of operationalizing these perspectives has required navigating complex issues of data sovereignty and cultural sensitivity. In Australia, participants described recent shifts toward incorporating Indigenous knowledge into policymaking, though these efforts remained constrained by broader systemic biases.

A recurring tension across all contexts was the struggle to prioritize upstream determinants of health within evidence systems often centered on immediate, acute care needs. In England, participants critiqued the NHS's tendency to focus on acute care, despite its robust infrastructure for knowledge mobilization. Scotland's approach through its HiAP framework attempted to address this by integrating evidence into cross-sectoral policy discussions, but participants highlighted a philosophical tension between relying on data-driven solutions and ensuring the right policy questions were being asked.

These findings emphasize how evidence systems enable or constrain health promotion and health equity efforts by suggesting the answers to questions that may have not been asked, as one participant astutely observed. While formalized partnerships and institutional frameworks exist to support knowledge mobilization, systemic barriers such as privileging certain evidence types, misaligned policy priorities, and capacity constraints impede progress. Lessons from Canada, Australia, and the UK suggest that to move beyond these tensions, health systems must adopt more inclusive, context-sensitive approaches that prioritize upstream determinants, value diverse knowledge systems, and balance the political realities of policymaking with the need for equitable health outcomes.

Nordic Approaches to Operationalizing Knowledge and Evidence for Policy Action. This section explores how Nordic countries operationalize evidence to inform health policy that promotes health and health equity, focusing on the experiences of Norway and Finland. Both countries exemplified a commitment to embedding research into actionable policy frameworks, albeit through distinct approaches.

Norway and Finland provided distinct yet complementary approaches to embedding evidence into health policy. Norway emphasized structured research-to-policy pipelines to ensure actionable interventions. A Norwegian participant explained, “my work is focused very much on epidemic interventions research—research to understand the effects of different kinds of infection prevention and control measures (NI2).” This focus on epidemic research highlighted the role of targeted studies in developing practical solutions, particularly in infection prevention and control.

Norway’s Strategy on Social Inequalities in Health further illustrated the country’s commitment to aligning evidence with policy actions. The strategy emphasized formalized partnerships as a mechanism to strengthen the connection between knowledge generation and public health decision-making (Part 1b, p. 23). These partnerships provided the infrastructure for translating research into equitable policies, reflecting Norway’s integrated and collaborative approach.

Finland’s evidence system emphasized the consolidation of public health institutions and the development of cohesive, data-driven policies. The Health 2015 Public Health Program captured this focus, stating that “health promotion requires comprehensive policies that integrate various sectors, underpinned by reliable data and research to inform actions (p. 10).” This

approach underscored Finland's emphasis on integrating evidence across sectors to inform strategic decision-making, a nuanced approach to emphasizing the roles, i.e., providing date to inform action, in a framework of shared responsibilities.

Institutional consolidation emerged as a hallmark of Finland's strategy. One Finnish participant noted efforts to streamline public health institutions, explaining,

> instead of many small institutes, there should be a broader public health institute because the public health issues, they relate to each other (FI1).

This initiative aimed to centralize expertise, enhance coherence in public health policies, and align national practices with international standards.

Both Norway and Finland highlighted the importance of diverse evidence types in shaping health policy. Norway's focus on epidemic interventions and infection prevention reflected a prioritization of targeted, biomedical research to inform specific public health challenges. Finland, by contrast, emphasized comprehensive, population-level data as the foundation for health promotion strategies. The National Action Plan to Reduce Health Inequalities (2008–2011) underscored this, stating that "sustained collaboration across sectors is necessary to address systemic health disparities, guided by evidence-based strategies (p. 12)." This demonstrated Finland's holistic approach to identifying inequalities and developing targeted interventions.

While both countries valued collaborative frameworks, Finland's strategy reflected a more systemic orientation, leveraging broad institutional reforms to integrate evidence into national policies. Norway, in contrast, seemed to focus on specific policy areas, such as infection control, where targeted research could drive measurable outcomes. These differing emphases highlighted the adaptability of Nordic models in aligning evidence priorities with national health goals.

Finally, equity emerged as a unifying theme in the Nordic approaches to operationalizing evidence. Norway's Strategy on Social Inequalities in Health and Finland's National Action Plan to Reduce Health Inequalities both underscored the importance of addressing systemic health inequalities through evidence-informed interventions. This approach fostered a knowledge-based

centred on promoting health where collaboration across sectors was central to these efforts, enabling both countries to target the SDOH effectively.

However, experiences of these approaches differed between the Nordic contexts. One Norwegian interview participant emphasized that the public health system in Norway is not afraid to weigh in on the challenges through knowledge and evidenced-based recommendations. Referring to a report produced in the last few years by the Directorate of Health, they emphasize that there were 10 recommendations, which included progressive taxation and access to housing (NI2). However, they noted that:

> The problem is that focus doesn't translate attention in the sectors that actually have to drive that. And this I think he's the fundamental challenge with health inequalities like those who really have energy to bring attention to the issue aren't those that have the access to the most important levers for change (NI2).

In Finland, knowledge and evidence are integrated into regional and municipal planning practices. Though this approach is not without challenges. One Finnish participant reflect:

> The problem, of course, is to implement all this […] the Institute (THL) gives information on the situation or regional level. Not so much on local level because they say the sample size doesn't allow. […] Information on the regional level is given to the regions and of course […] we have the school health surveillance system with information come from all the schools and that is very much used by municipalities concerning the improvement of policies at schools. […] Every four years, they must make a report on what has been accomplished and what is the plan for the next few years. […] Usually, they based the report very much on the evidence that are given to them, at least the regional level, from THL (FI1).

The participant went on to emphasize the role of a national public health institution in knowledge and evidence dissemination, clearly defining the roles and responsibilities at the national level in Finland:

> The role of the Institute is to provide all this information to the government, to the public, to the politicians, to the NGO, to the health services source service and to the public. But that does not mean that the institute that the role of the Institute is to try to influence. I mean, you know, there's a whole literature and science of persuasion and so on, and that's not the role of the institutes really to translate that information to actions. Of course, you say that they can say that this means this and this and this, but it is very much the NGO and health services, municipalities that use and try them to persuade the people to follow accordingly (FI1).

The Nordic systems of Norway and Finland demonstrated a strong commitment to embedding evidence into health policymaking, with an emphasis on equity and collaboration. Norway's approach emphasized targeted research-to-policy pipelines, particularly in epidemic interventions and infection prevention, underpinned by formalized partnerships to align evidence with actionable public health decisions. Finland complemented this with a focus on institutional consolidation and systemic strategies to integrate population-level data into cohesive national policies.

Despite their strengths, both models faced tensions in balancing specialized and systemic approaches. Norway's emphasis on specific policy areas like infection control demonstrated measurable impact but risked under-prioritizing broader social determinants. Finland's focus on institutional reforms and data-driven frameworks enabled comprehensive strategies but required sustained collaboration and resource alignment to maintain effectiveness.

Together, these models illustrate the Nordic commitment to operationalizing evidence as a cornerstone of public health action. They underscore the importance of aligning evidence systems with national health priorities while addressing systemic disparities through collaborative, equity-focused strategies. These findings also reveal that tensions between targeted and systemic approaches, as well as the challenges of cross-sector collaboration, remain critical considerations for advancing evidence-based public health policies.

Comparing Approaches: Common Tensions and Divergences in Operationalizing Evidence for Health Policy. Both Anglo-Saxon liberal and Nordic welfare states demonstrated a strong commitment to bridging research and policy in public health systems, yet they differed

significantly in their institutional structures, governance models, and approaches to prioritizing evidence. A recurring theme was the tension between systemic health equity goals and the operational realities of embedding evidence into policy frameworks. Across these contexts, competing priorities—such as resource constraints, political considerations, and sectoral silos—often impeded the translation of research into practice.

In Anglo-Saxon systems, formalized partnerships between academic institutions and government agencies were key in fostering knowledge mobilization. For instance, Canada's Pan-Canadian Healthy Living Strategy (2005) identified research organizations, CIHR, to enhance cross-sectoral collaboration. However, capacity limitations and the privileging of specific evidence types, such as prevalence and incidence data, remained. Similar dynamics were observed in Australia, where reliance on relationships rather than systematic frameworks led to the ad hoc prioritization of epidemiology and economics over social sciences and Indigenous knowledge.

Nordic systems exhibited a more centralized and cohesive approach, with Finland emphasizing institutional consolidation and Norway prioritizing targeted research pipelines. Finland's consolidation of public health institutions and reliance on population-level data reflected a systemic orientation aimed at addressing SDOH. Norway's focus on epidemic interventions and infection control, supported by its Strategy on Social Inequalities in Health, demonstrated the efficacy of targeted research-to-policy pipelines but risked under-emphasizing broader equity-oriented determinants.

A shared tension across both models was the challenge of prioritizing upstream determinants of health within evidence systems traditionally oriented toward acute care and immediate policy demands. Participants in Anglo-Saxon systems, particularly in England, critiqued this focus, but Nordic approaches appeared to navigate this tension more cohesively through cross-sectoral collaboration.

Finally, the value and integration of diverse knowledge types emerged as both a point of progress and contention. In both Anglo-Saxon and Nordic contexts, there was increasing recognition of Indigenous knowledge and lived experiences as critical to equity-focused policy. However, participants highlighted the complexity of operationalizing these perspectives. Nordic systems, while embedding evidence into policy more systematically, faced similar challenges in ensuring that diverse knowledge types were meaningfully integrated into national frameworks.

In conclusion, the experiences of Anglo-Saxon liberal and Nordic welfare states illustrate the complexities of operationalizing evidence in health policy. Common tensions—such as competing priorities, resource limitations, and the privileging of certain evidence types—shaped the efficacy of these efforts. While Nordic models demonstrated strengths in systemic integration and institutional coherence, Anglo-Saxon systems highlighted the importance of flexible, cross-sectoral partnerships. Moving forward, these findings suggest that health systems must navigate these tensions by prioritizing upstream determinants, fostering inclusivity in knowledge systems, and ensuring sustainable collaboration across policy domains to achieve health equity goals.

Sub-Theme 4.2: Equity in Health Policy Action—Synergies, Frameworks and Implementation

This section examines examples of approaches to implementing equity-driven health policies, focusing on HiAP and proportionate universalism as illustrative strategies. Despite shared aspirations to advance health equity, systemic barriers, including market-driven priorities, centralized control, and rigid funding structures, frequently undermined community agency and broader equity goals. At the same time, the economic and societal benefits of reducing inequities and promoting health equity were widely recognized, framing equity as both a moral imperative and a pragmatic approach to reducing systemic costs and improving population well-being.

Canada's public health system, while increasingly influenced by HiAP principles, continues to grapple with the challenges of moving upstream. As one participant noted,

> There's broad acknowledgment that you need these upstream policies [...] but when it comes to funding, it feels like it's a downstream approach to trying to address the impacts of health inequities. So, do we do we support policies that really address those structural determinants? […] Are we talking about working across sectors to do that, and are there some initiatives that we support? Yes, for sure, here and there, like the some intersectoral partnership funds. (CI3).

For instance, Canada's experiences underscore the tensions between top-down power dynamics and a growing emphasis on community action and autonomy. This was particularly emphasized in Canada's approach to self determination in Indigenous health strategies, an acknowledgement of the inequities born out in health outcomes for centuries due to colonial

policies and practices. In other Anglo-Saxon liberal contexts, like Australia and the UK, approaches such as HiAP and Health Impact Assessments (HIAs) were also considered instrumental in addressing structural determinants. However, challenges related to implementation such as resource allocation, siloed funding, and rigid accountability systems persisted across contexts, limiting the potential of these initiatives to achieve transformative change. By critically examining these dynamics, this section explores barriers to implementing health policies.

Centering community voices and respecting cultural contexts were consistently viewed as pivotal to effective and equitable health policy. Participants from Canada emphasized the necessity of empowering communities to define health priorities, illustrating how the mechanisms by which national funding programs can make engaging in health promotion policy processes more accessible, highlighting the tension around evolving institutional norms and community empowerment. One participant noted:

> But I feel like one things that is really annoying for community organization is when you receive the funding from […] and the evaluation is provided by the funder […] and sometimes those question need to be with you because it's not necessarily and the question is not related to how they spend the money or how they use it to address their reality. So, I feel like there's still like a kind of vertical relation pattern based on that. […] The pandemic helped a lot to […] to balance this institutional versus community work. We find a way to have to work closely together (CI4).

In particular, Canada had to navigate the implementation of health policy approaches in tandem to horizontal approaches to good governance such as truth and reconciliation and self-determination for First Nations, Inuit, and Métis communities. For instance, one participant reflected on the impact of the recent COVID-19 response from public health, and how that tension between institutional and community work played out, emphasizing the value of partnership and agenda alignment in health promotion efforts:

> For me the pandemic COVID-19 pandemic really helped that balance because there was more visibility first for public health work, and more visibility for community work,

> and we find out we need each other. So, this really helped […] between the institutional and community level work, […] and still today you can see that we he was like this was a good lesson learned, how to work with community and show their impact related to implementing goals and objectives. […] Related to indigenous people, even to take any decision if you are not sure, we will always go back to them, and we are working with some national organization that […] are key partners (CI4).

Another participant reflected on the intricacies of working with Indigenous communities in the context of devolution, cultural safety, and prominent government roles in health promotion efforts, and recent shifts towards more flexible approaches to evaluation that take community experience into account:

> Because part of accountability is results, right? So, we tried to have a very flexible approach to how results are given […] and that's because of self-determination. So, accountability of funding, and accountability to some of these goals being reached. […] (Without a flexible approach centered on self-determination) we're not going to get good results because we're missing what is actually going on in the community. […] So, it is very complex, especially with evaluation, because of colonisation there is a tension between what the federal government wants to see, and accountability and sort of a proof of what is working compared to what that means in community (CI1)."

Interestingly, across Anglo-Saxon liberal models, equity was framed not only as a moral obligation but also as a pragmatic strategy to reduce societal costs and improve economic outcomes. A Canadian participant articulated this perspective:

> Promoting positive health, reducing inequities, promoting equity, it's good for everyone [...] less taxes, less resources needed from the healthcare system, from the justice system, from the education system (CI5).

This framing linked equity-driven policies to broader societal benefits, such as increased productivity and reduced strain on public systems, and went on to frame how equity as an economic asset could appeal even to individualistic or neoliberal priorities: "even if you're being

selfish...it's a good thing because[...] there'll be less resources needed from the healthcare system, […] we will have a more prosperous economy […] it's a win-win (CI5)." These arguments underscored the intersection of equity and economic efficiency, reframing health promotion as both a social good and a cost-effective policy goal.

Another theme that emerged was an emphasis on education as a policy tool to drive behaviour change. Building out on that assumptions that if people know the healthy choice, they will make the healthy choice, one participant astutely described the following scenario around healthy lifestyles and physical activity:

> Oh, we've got a problem. We'll educate the population about it. From a health equity perspective, that's most likely to help the most educated people. […] I see a lot of people coming up with ideas for how to address a health problem from personal experience, especially in the physical activity world. The challenge there was that you had a lot of people all the way up the chain who were really into personal physical fitness, which was great for them. They had a car, so they drove to work. They had a gym on site. They had all these structural supports so that they could be physically active. And so, some of what I saw coming from physical activity policy was just like educating people about how active they should be (CI5).

Another emerging trend included frameworks like HiAP and HIAs as pivotal in operationalizing equity, particularly in addressing SDOH. In Canada, intersectoral collaborations reflecting HiAP principles such as partnerships with housing, education, and social services, were inherent in population-based health promotion efforts. One participant, emphasized the barriers to Indigenous population health in a system that silos sectors that determine health:

> When it comes to, specifically, Indigenous views on health (the) social determinants of health, (are) very siloed, so we're working on making them not siloed because we realise that it's holistic health means that they aren't siloed. They all impact each other if you're working from a siloed perspective, then you're not really doing justice to the view of holistic health and intersectionality (CI1).

However, in Australia, which is often considered a key player in the HiAP approach, however, the implementation seems to live more at the state jurisdiction levels, with their own enablers and barriers to broader implementation. This approach often lives along side, and even in tension, with other approaches attempting to achieve the same health promotion goals. One participant reflected on the implementation of this approach, stating:

> You know the health and all policies approach, and some governments have brought in the well-being in all policies, frameworks and the [state-level] used the New Zealand model a bit (AI2).

Another participant emphasized this recent shift towards wellbeing approaches:

> When the well-being discussions came in, and the well-being framework work was developed, the well-being framework people didn't think to talk really closely to this whole-of-government initiative that was (already) addressing so many of the same things and then […] there was a change of Chief Minister and the new Chief Minister loved the well-being framework and well-being budget… and so the all-of-government initiative(s) fell to the side (AI1).

However, non-health sectors like education and urban planning continued to be increasingly engaged as partners in health policy. One participant highlighted how these frameworks translate to workforce and people power resources at the system level, reflecting that "by engaging those settings as partners, we've been able to address broader determinants of health, which I think aligns with that more integrative view of health policy (AI2)." However, accountability measures, such as Key Performance Indicators (KPI), often constrained flexibility. A participant observed, "when everything is tied to a KPI, it can limit creativity and the willingness of partners to take risks or explore innovative approaches (AI2)."

In the UK, England and Scotland grappled with differing by similar experiences of devolution. In England, local government networks have a strong desire to implement HiAP approaches in the last few decades. However, these initiatives require resources, time, and, of course, the political conditions to really achieve midstream results, while the more upstream

levers of control remain at the national level, out of reach for most local initiatives. One participant from England reflected on the limitations faced be localized public health systems, and local government actors in particular, stating that there have been:

> So little resource that they've not, I think, been able to grasp the whole intersectoral HiAP work, even though there's a lot of desire to from what I can tell them through like local government networks and things so. Yeah, you can't get away from resource time and resource needed to do equity work well. […] And yeah, moving it from the big "P" politics it is important to have a stability that you need to build that equity focus, like going back to right at the beginning just agreeing on an a routine language as well as a way of communicating maybe better communications training for us as public health practitioners would be beneficial, and maybe building back some other positivity around health promotion […] not the kind of deficit stuff […] and not forgetting the politics. You know, recognizing, acknowledging the politics of public health rather than pretending that it's mostly a science, when in fact the art is partly the art of politics and not so hiding that underneath the bed covers actually, you know, openly talking about politics and acknowledging it and then moving on, you know, sort of like how we in this context, what are we able to do, what we're not able to do and working within those sort of realistic boundaries (UKI1).

Scotland provided a strong example of HiAP implementation, embedding equity into multi-sectoral policy design. A participant explained,

> Since I have been in public health training, I've been really interested in and done a lot of work on health impact assessment because I think that's a that's a good way to […] take what we now call a health in all policies approach. […] It was before the term health and all policies was used, but it was kind of what we've been trying to do sort of throughout my career. A lot of my work is about trying to work with people who are not health people and to work alongside them and learn their language. […] It's about learning a different language with transport colleagues or whatever it might be so that you can work out what they're planning to do and how that will affect health and hopefully amend it to get better outcomes for health. (UKI4).

While this model fosters integrated governance, achieving meaningful collaboration requires navigating sectoral tensions. A Scottish participant explained further:

> Health in all policies, is about starting where your partners are. It's not about starting with your public health problem and saying, let's have a partnership that's about obesity and invite everybody to the table… because they're not gonna show up. Why would they? It's about seeing, you know, we're about to write a local transport strategy and public health showing up to that table…but that's not traditionally what we've done in public health. We've tended to identify our public health problem and expect everybody else to want to help us fix it, and that's, I don't think that's (what) health in all policies is about, I think it's very explicitly about the broad holistic range of health effects of other people's policies and working alongside them…and you do have to be quite kind of humble (UKI4).

However, this approach had identifiable barriers to implementation, anchoring the work to a more mid-stream approach where levers for economic redistribution policies live more federally. The same interview participant reflected on the political momentum and understanding to address health inequities at the national level:

> They'll talk about fundamental causes and they'll sort of understand that that's what really drives health inequalities, but then they'll place the responsibility for health inequalities on local authorities and local authorities, they deliver services to local areas, but they don't hold the any of the fiscal or tax or benefit or other levers that could make a difference in income inequalities, for example, the so and it's a way of sort of ducking responsibility […] there is still a feeling that you are going to solve inequalities by, I don't know, by doing a few targeted interventions at the poorest people completely ignoring fundamental causes and the gradient and all the other things that we know about […] we also of course live in a very neoliberal sort of environment and that is the predominant framing of, well everything…. So, we have very individualistic framing of just about every issue you can think of, and that inevitably seeps into what people are able to understand (UKI4).

Resource allocation emerged as a key factor in equity-driven health policy. In Canada, federal funding supported equity initiatives but was often constrained by sector-based silos. One participant critiqued these structures: “the way that our funding […] works in this country is siloed and sector based. So, you have to make it about health because that's what your funding looks like, and you can't really go too far from that (CI3).”

In the UK, interview participants also emphasized the siloed ways of working as prohibitive, and requiring a different approach to resources, including human resource capacity for partnership development and maintenance beyond just government funding mechanisms. Indeed, pockets of success have been seen, including in crises like the pandemic, which demonstrated the potential of coordinated resource allocation. One participant from England reflected that, the coordinated effort between public health, housing, and social care to shield vulnerable populations showed what can be achieved when sectors work together (UKI3). In Scotland, the approach to the same resource challenges necessitated reliance on in-kind contributions and staff time. A participant stressed that “the main resource is in kind and it’s staff time, so it’s staff time from within PHS and in our partners to do the pieces of work that we’ve done (UKI4).”

The operationalization of equity in health policy demonstrated both successes and persistent challenges across contexts. Canada’s emphasis on self-determination provided a compelling model for community-driven health strategies, but systemic barriers, including colonial and siloed funding practices and rigid accountability systems, often undermined progress. Scotland and Australia demonstrated the potential of integrative frameworks like HiAP and HIAs, yet resource constraints and compartmentalized funding structures limited their impact.

Neoliberal governance models emerged as a recurring obstacle, emphasizing individualism and bureaucratic efficiency over structural reforms and community agency. However, examples of cross-sectoral collaboration and flexible funding mechanisms illustrated the potential for transformative change. Achieving sustainable and inclusive health policy requires a critical re-evaluation of power structures, resource allocation, and governance frameworks to prioritize equity at every level of policymaking.

The findings highlight the need for governance models that dismantle entrenched power structures and prioritize both community agency and systemic alignment. By reframing equity as both a moral and economic imperative, health systems can advance transformative policies that not only address social determinants but also improve societal well-being and economic resilience.

Equity in Action and Policy Approaches in Nordic Models. Equity is a foundational principle of Nordic public health systems, which actively integrate fairness and justice into policy frameworks. These systems use a combination of national and local strategies to address health inequities. However, Norway and Finland offer interestingly different approaches with Norway embedding a more upstream focus and integrating approaches such as proportionate universalism to do so, while Finland leverages an HiAP approach. This analysis examines how these principles manifest in Nordic models, drawing mainly from participant insights.

Norway's Strategy on Social Inequalities in Health highlighted intersectoral action as essential for addressing health disparities and achieving systemic equity. It emphasized that reducing inequalities required "formalized partnerships and coordination mechanisms" to align health objectives across sectors, such as housing, education, and employment (Strategy, Part 1b, p. 23). Further, the strategic proposed a review and reporting system, stating that:

> The Government will: (1) Establish a review and reporting system to monitor developments in the work on reducing social inequalities in health; and (2) report on developments in the work on reducing social inequalities in health in the Minister of Health and Care Services' annual budget propositions (pp. 84).

Norway further recognizes the need for cross-sectoral tools and emphasizes the utility of HIAs at both the national and local levels (p. 85). This approach is further bolstered by critical governance infrastructure and a reliance on partnerships such as county administrations, particularly in their capacity as regional development actors, emphasizing the balance between centra cohesion and local autonomy. In it's Strategy on Social Inequalities in Health (2007), the rationale provided was clear:

> County planning is done across sectoral and hierarchical boundaries and is therefore

> ideal for raising public health issues that require a broad approach and that depend on the central government, county administration, local government, and voluntary sector all pulling in the same direction (p. 87).

In Norway, when health policy approaches are considered against the available mechanisms, the various levels, jurisdictions, and organization have a clear role to play. Jurisdictional levers were used towards the national goals of health for all. One interview participant reflected that:

> So maybe, for instance, to influence people(s) diet, then you have some of the measures would be at the national level like the, you know, the fiscal policies or the taxes and so on. While for physical activity, I think that may be most of the important measures would be at the local level. You know, because the national can't do anything but the municipality can decide, OK, we built this bicycle lanes there (NI1).

More recently, Norway has been flirting with approaches like the well-being approaches of Australia, and proportionate universalism from the UK. One participant reflected on these different burgeoning approaches, juxtaposing their limitations and strengths. They emphasized that with the more recent approaches like the politically palpable well-being economy approaches there is a "risk in just talking about well-being (NI1)." They gave the example of:

> You say OK, we have a lot of poor people in the country where a lot of people are unemployed, but who cares, they've they tell us that they are feeling OK. So, I feel there's a risk there that you, you kind of underplay some kind of the role. When you combine them (and) someone say, 'health and well-being,' OK, that's better, but when you only focus on well-being it maybe put the focus on the individual instead of the structural level (NI1).

Proportionate universalism, on the other hand, was recently introduced by Sir Michael Marmot of the UK, through an assessment that informed a recent White Paper on the topic.

The same participant reflected on what the implementation of this approach looks like from a public health perspective in Norway:

> Because it's this idea of how we can organize the society in a way that we offer something for everyone, but you want to lift someone more than others instead of just targeting the ones who really need something. For example, the School Food Program, this will also be one of the arguments politically, then, that you are fully aware that (the) majority of kids have their own lunchbox and they eat well, but you want to introduce it because you know there are also those who don't eat and they don't eat well. So that's why we offer it to everyone, and you hope that it will benefit for the few, perhaps (NI1).

Meanwhile, Finland emphasized the utility of it's HiAP framework, which integrates health considerations into all areas of policymaking, based on voluntary collaboration guided by shared goals. This approach is deeply embedded in Finnish public health systems. One participant reflected on this approach which has been in Finland since the 1990s, stating that:

> We have had for a long time also the concept of intersectoral work already on the ministerial level, so it's not only the Ministry of Health and Social Affairs, but also the Ministry of Education and Culture, and Ministry of the Environment, and so on, that this kind of health promotion aspects are taking into account in in all policy making like in health in all policies approach (FI2).

However, these approaches are not without their challenges to implementation. Another participant emphasized that, for Finland:

> Our problem is how can we overcome the implementation gap […] In health promotion, health inequities *should* drive the policies, but the question is what *is* driving policy. Is it just health and welfare? There are economic issues. Deployment issues. Of course, there are a lot of lobbying (FI1).

Yet, despite this ‘implementation gap’ described by interview participants, the HiAP approach remains the dominant approach with documents as recent as the 2020 Socially Sustainable Finland, emphasizing it as a strategic choice (p.4). An example of a successful implementation of this approach was considered by the same participant who reflected on the economic and domestic production challenges that can underpin change towards population-level healthier behaviours, including consumer behaviour.

> How can we solve the problem (and) have people to eat more fruit? Because it's important that they are domestically produced and we approached Ministry of Agriculture, Ministry of Commerce and they said yes that's a good idea and we got we got money. The farmers are happy to make change because they're farming is a difficult business, but the key is that there must be there must make profit I mean you must make your living with that too (FI1).

The Nordic approaches to health equity—exemplified by Norway and Finland—demonstrate both shared principles and distinct strategies for addressing social determinants of health through public health systems. Both countries emphasize intersectoral governance and systemic equity as central tenets. Norway’s model is favourable to approaches like Proportionate Universalism, emphasizing equitable access through policies that target structural determinants of health while ensuring benefits for all. In contrast, Finland’s long-standing HiAP approach integrates health considerations across all policy domains, relying on voluntary collaboration among ministries to achieve shared goals. Despite their differing frameworks, both approaches recognize the critical role of national oversight in aligning local efforts with overarching equity objectives.

However, the implementation of these strategies reveals notable divergences. Norway’s structured governance and legal mandates foster clear accountability but face challenges in addressing regional disparities and ensuring consistent local-level application. Meanwhile, Finland’s HiAP relies on voluntary collaboration, which, while fostering flexibility, is susceptible to the “implementation gap” caused by resource constraints and competing sectoral priorities. Both systems grapple with balancing upstream health promotion efforts against economic, political, and institutional pressures, yet their experiences underscore the importance

of robust frameworks and sustained collaboration to advance equity-focused health initiatives effectively.

Implementation Tensions Between Anglo-Saxon and Nordic Models in Equity-Driven Health Policy. The Anglo-Saxon and Nordic models of health policy reflect fundamental tensions in implementation, exacerbated by tensions uncovered across the foundational building blocks. While both aspire to address health inequalities, their approaches are both similar, and, at the same time, very different.

Anglo-Saxon systems, such as those in Canada, Australia, and the UK, often prioritize localized, community-driven initiatives framed around market-driven principles, voluntary partnerships with other social sectors and individual responsibility. In contrast, Nordic systems, exemplified by Finland and Norway, both emphasize systemic redistribution, collective societal responsibility, and national frameworks that integrate health and health equity into all levels of governance.

Nordic models are characterized by structured governance frameworks and legal mandates, providing clear accountability mechanisms to ensure equity objectives are met. Norway's approach reflects a structural emphasis where policies benefit the entire population while there is a benefit to those most in need. Finland's HiAP approach similarly integrates health into all policymaking sectors but relies heavily on lifestyle and individual-level risk factors, and voluntary collaboration. While this fosters flexibility, it creates challenges in ensuring consistent policy implementation across sectors.

In contrast, Anglo-Saxon systems often face fragmentation due to decentralized governance and siloed funding mechanisms. While frameworks like HiAP and tools like HIAs have gained traction in countries like Canada, and Scotland, their success is constrained by limited resources, de-centralized accountability measures, and political conditions that prioritize midstream or downstream interventions over systemic reforms. One participant from the UK noted the need to balance the "art of politics" with the science of public health, reflecting on the inherent challenges in navigating liberal governance structures to achieve transformative equity outcomes.

Both models grapple with the complexities of translating national equity policies into local action. Finland's HiAP relies on voluntary ministerial collaboration, creating vulnerabilities to resource constraints and competing priorities. Similarly, Norway's structured mandates face

challenges in addressing regional disparities and ensuring equitable implementation at the municipal level. Anglo-Saxon systems, particularly in Scotland and England, have demonstrated pockets of success with localized HiAP initiatives and intersectoral partnerships. However, these efforts often remain midstream, with upstream policy levers, such as economic redistribution, controlled at higher governance levels.

A recurring tension is that of balancing upstream health promotion with the immediate demands of downstream interventions. Anglo-Saxon systems frequently address inequities through community-based programs that respond to existing health inequalities but struggle to tackle the root causes. Nordic models aim for a systemic approach, integrating equity into all levels of governance, yet still encounter challenges in bridging the "implementation gap." Participants from both contexts emphasized the importance of sustained collaboration, robust monitoring, and adaptive governance to overcome these barriers.

In conclusion, the Anglo-Saxon and Nordic models highlight different philosophies and practicalities in equity-driven health policy. Nordic systems offer a blueprint for systemic redistribution and collective responsibility, while Anglo-Saxon systems underscore the value of localized flexibility and community engagement. However, both models face persistent challenges in ensuring that equity policies translate into meaningful, sustainable change. Bridging these approaches—leveraging the strengths of structural frameworks and community-driven initiatives—offers a pathway to advancing equity-focused public health systems.

4.4 Chapter Summary

Chapter 4 explores the dynamics shaping public health systems and their capacity to promote health equity across Anglo-Saxon liberal and Nordic social democratic welfare states. The analysis is structured around four major themes and their respective sub-themes, each addressing core elements of governance, resource allocation, evidence use, and equity-driven policies. These themes provide insights into systemic enablers and barriers to achieving equity-focused health promotion, directly linking to the research questions.

Theme 1: Framing Health, Well-being, and the Pursuit of Equity Across Welfare Models

This theme examines how health and equity are conceptualized and operationalized within welfare state frameworks. *Sub-theme 1.1: Legislative Ambiguity—Flexibility or Fragmentation?* explores the tensions between legislative flexibility, which can foster adaptation

to local needs, and fragmentation, which often undermines cohesive public health strategies. *Sub-theme 1.2: Framing Health Equity—From Analytic Lens to Actionable Goal* addresses how equity is framed as both an analytic tool and an actionable goal, highlighting the discrepancies between policy aspirations and practical implementation. This theme emphasizes the importance of clear and consistent framing to support systemic alignment in achieving equitable health outcomes.

Theme 2: Governance at the Crossroads—Leadership and Limits in Health Promotion

Governance structures are pivotal in determining the effectiveness of public health initiatives. *Sub-theme 2.1: Pathways of Power—Federated and Devolved Governance?* examines the complexities of federated and devolved governance models, particularly their impact on policy coherence and accountability. *Sub-theme 2.2: Navigating Intersectoral Challenges—Collaboration or Compromise?* investigates the role of intersectoral collaboration in addressing the SDOH, highlighting both the opportunities and compromises inherent in cross-sectoral policymaking. Together, these sub-themes underscore how governance arrangements shape public health leadership and the ability to implement equity-focused strategies effectively.

Theme 3: Resourcing Health Promotion—Balancing Capacity and Constraints

This theme explores the critical role of financial and human resources in public health systems. *Sub-theme 3.1: Resourcing Health Promotion—Following the Money* focuses on the allocation of financial resources, examining how funding structures and budget priorities influence the scope and sustainability of health promotion efforts. *Sub-theme 3.2: Workforce Capacity—Strengths and Limitations in Public Health Systems* highlights workforce challenges, such as skill shortages and capacity constraints, that limit the effectiveness of health promotion initiatives. This theme draws attention to the importance of aligning resource allocation with systemic goals to advance health equity.

Theme 4: Evidence and Equity in Public Health Policy—Building Knowledge-Driven and Inclusive Systems

The final theme addresses the use of evidence and knowledge in shaping health policy and equity initiatives. *Sub-theme 4.1: From Knowledge to Action—Operationalizing Evidence in Health Policy* examines the pathways through which evidence is generated, prioritized, and integrated into policymaking, emphasizing the tensions between political priorities and evidence-informed strategies. *Sub-theme 4.2: Equity in Health Policy Action—Synergies, Frameworks,*

and Implementation explores how frameworks like HiAP and intersectoral collaborations address structural inequities, while also highlighting the challenges of siloed funding and rigid accountability systems.

The themes and sub-themes reveal the tensions around how public health systems navigate structural, financial, and governance challenges to address systemic health inequities. By analyzing framing, governance, resourcing, and evidence use, this chapter provides a nuanced understanding of the mechanisms that enable or constrain equity-driven health promotion. It also illustrates how these dynamics vary across welfare state typologies, offering insights into the comparative strengths and limitations of Anglo-Saxon liberal and Nordic social democratic models. These findings directly address the research questions by highlighting the systemic enablers and barriers to effective health promotion and equity-focused public health systems.

PART III: DILEMMAS, AND LIMITATIONS IN HEALTH PROMOTION

Chapter 5: Discussion Notes and a Series of Strategic Dilemmas

The previous chapter presented the results and initial analysis of the findings from the document analysis and 15 interviews from Canada, other Anglo-Saxon Liberal welfare states, Australia, and the UK with a focus on England and Scotland, as well as Nordic social democracies, Finland and Norway. In this chapter, I reflect on the relevance of the results presented in Chapter 3 and Chapter 4 to the main research questions. The critical literature review in Chapter 3 provides a foundational lens through which the systemic barriers and enablers discussed in this chapter are analyzed. Chapter 4 offers thematic tensions across legal and strategic frameworks, and the experience and insights of scholar-practitioners working within the systems. This chapter offers four strategic dilemmas unique to the policy landscape and institutional frameworks of public health, with a particular focus on Anglo-Saxon liberal welfare contexts. This discussion is presented in two main sub-sections, including the utility of strategic dilemmas to public health systems and the welfare state context in which these dilemmas are fostered; and, finally, the four strategic dilemmas and the underlying tensions that emerged from the results that create each one.

5.1 Decision-Making Under Pressure: Strategic Dilemmas for Health and Health Equity

Issues of public health and health equity are usually quite complex, with decision-makers often facing challenging choices that go beyond technical or logistical considerations. These choices involve what are known as strategic dilemmas—situations where every available option comes with significant trade-offs, and where moral justifications of “rightness” or “wrongness” or “justice” are seen as subjective. In health, a strategic dilemma involves a situation where public health decision-makers across public health systems must balance conflicting priorities, values, or goals, often under conditions of uncertainty.

By using strategic dilemmas, I borrow and build on an approach used in emergency and risk communications for health as presented by John Rainford, a former colleague, and his work on the 'stigma dilemma (Rainford 2015).' His thinking on communicating the complexity of health challenges while simplifying decision-making through dilemma frameworks has profoundly influenced my approach. Inspired by his work, I have adopted the use of dilemmas in my professional practice, applying this approach to tackle 'wicked' public health problems and implement knowledge-based solutions. Rainford’s legacy in shaping public health decision-

making through dilemma-based language remains a guiding principle in my own professional, and now academic, work.

Strategic dilemmas require decision-makers to choose between seemingly mutually exclusive alternatives, each with potential benefits and risks, and trade-offs. The practice exposes the underlying complexities of policy, especially in areas of public health like health promotion that aim to improve public welfare. This method enables effective interdisciplinary problem-solving and decision-making in policy processes that live both internally, and externally, to the public health system of any given country or welfare context, translating complexity into clear, actionable pathways

Strategic dilemmas show the tension between competing values such as efficiency and equity, or short-term relief versus long-term resilience. In public health systems, these tensions are ever-present. Leaders must weigh the need to address immediate health crises against the imperative to build sustainable systems that address root causes of health inequalities. By examining these dilemmas, we gain a better appreciation for the difficult choices' decision-makers face and the delicate balance required to achieve both immediate and longer-term health and well-being. Acknowledging these dilemmas helps clarify the stakes involved and the trade-offs that come with different policy directions and offer an important entry-point for reflection about decisions that will have downstream implications on both public health systems, as well as the populations that they serve.

For those shaping public policies, including health policies, understanding strategic dilemmas is crucial because it provides insight into the multifaceted nature of policy. These dilemmas reveal often-hidden trade-offs inherent in different choices, helping decision-makers anticipate potential conflicts and understand the diverse, sometimes conflicting, interests of stakeholders and partners. As such, strategic dilemmas serve as an analytical tool, allowing leaders to navigate the competing goals that define complex policy environments and to make more informed, transparent decisions.

Strategic dilemmas have several key features. First, they involve mutually exclusive options, each with trade-offs that require decision-makers to prioritize one path while forgoing others. For instance, one choice may maximize efficiency, while another may prioritize equitable access to health resources, making it impossible to fully achieve both goals. Second, they involve competing values or objectives. In health, this often means balancing immediate health outcomes

against long-term structural improvements or choosing between policies that benefit the majority and those that target marginalized groups. The need to balance conflicting priorities is central to public health systems, where values like efficiency and equity frequently pull in different directions.

Uncertainty and complexity also define strategic dilemmas. Decisions involve layers of interdependent social, institutional, economic, and political factors, which create uncertainty about the impact of each choice. This complexity makes it difficult to fully assess the implications of any given decision and increases the risk that even well-intentioned choices may have unintended consequences. Furthermore, these decisions are typically high stakes with long-term impacts, often inequitably borne by populations already facing conditions of vulnerability. Choices made within, and by, public health systems can shape outcomes and inequalities for years, if not decades, underscoring the importance of carefully weighing options when the stakes are so high and the consequences so lasting.

Finally, strategic dilemmas are marked by multi-stakeholder interests and ambiguity. Different stakeholders—including government bodies, healthcare providers and practitioners, community groups, and citizens—may have different perspectives on what constitutes a "successful" outcome. This multiplicity of interests adds layers of ambiguity to every decision, requiring a nuanced approach that seeks balance amid differing, sometimes incompatible, demands. By framing the challenges faced by decision-makers in public health systems as strategic dilemmas, we gain a clearer understanding of the complexities in health policy and the difficult choices required to promote health and health equity.

By using these strategic dilemmas in decision making, public health systems can further reorient the health sector to one that promotes health, aligning with the spirit of the Ottawa Charter (1986), which states:

> The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.

This approach provides a lens to view the competing goals, constraints, and uncertainties that shape public health efforts, encouraging a more informed and transparent decision-making process. Through this framing, we acknowledge the inherent trade-offs and move toward outcomes that are not only effective in the short term but equitable and sustainable in the long term.

5.1.1 Why Welfare State Context Matters

Acknowledging and understanding the welfare state context is essential for identifying both the limitations, and potential policy opportunities in promoting health and health equity. Welfare state models—whether Anglo-Saxon liberal or Nordic social democratic—shape policies, through resource allocation and governance structures, that influence health outcomes. Welfare state models determine what health promotion strategies are considered possible and feasible, which strategies and actions are prioritized, and implemented; and, ultimately, how effectively public health systems can address structural determinants of health. By examining the interplay between welfare state typologies and health systems, we can better understand the systemic constraints and opportunities that create strategic dilemmas faced by public health system actors.

This analysis underscores why context matters: it determines what works, for whom, and in which environments equity-driven health promotion can survive and thrive. This section is presented in four parts. The first part frames the Anglo-Saxon Liberal Welfare Context, reflecting on the results detailed in Chapter 4. The second part offers learnings from the Nordic Social Democratic Welfare Context, again, rooted in reflections of the results offered in Chapter 4. The third section reflects on the results, anchored in the theoretical frameworks of this research. Finally, the fourth part summarizes these reflections, building towards the strategic dilemmas offered in the subsequent section.

Framing the Anglo-Saxon Liberal Welfare State Context. Anglo-Saxon liberal welfare states, such as Canada, Australia, and the UK, are characterized by minimal state intervention, modest social transfers, and market-driven approaches to welfare. These states provide means-tested benefits that often stigmatize recipients and emphasize individual responsibility for health outcomes over systemic reforms (Esping-Andersen 1990; Raphael

2013a; Bryant 2016). Public health policies in these contexts are shaped by fiscal constraints and political priorities that privilege efficiency and cost-effectiveness, often at the expense of equity and comprehensive health promotion strategies (Bambra 2011; Carey et al. 2017).

A significant challenge that has been identified across these systems has been termed 'lifestyle drift,' where health promotion policies shift from addressing structural determinants of health, such as income inequality and housing, to targeting individual behaviours like diet and exercise (Carey et al. 2017; Halsall et al. 2024). This drift undermines efforts to address root causes of health inequities and aligns with neoliberal ideologies that prioritize personal responsibility over collective action (Popay et al. 2010; Carey et al. 2017; Raphael 2013a). Scholars have noted that lifestyle drift reflects a broader failure to align public health initiatives with systemic approaches to health equity, as these systems lack the structural capacity to support upstream interventions (Bryant et al. 2019; Raphael 2018; Halsall et al. 2024).

Public health governance within Anglo-Saxon systems exacerbates these challenges. Common across these public health systems are decentralization coupled with fragmented resource allocation, and limited workforce capacity, which collectively undermined consistent implementation and distribution of equity-driven policies across the SDOH. While these challenges manifest differently in Canada, Australia, and the UK, their shared reliance on market-oriented approaches further compounds systemic barriers to achieving long-term health equity goals (Bryant 2016; Raphael 2013b).

Devolution and Decentralization: Governance Challenges and Opportunities. Governance structures present important enablers, and barriers, for public health systems to promote health and health equity. In Anglo-Saxon liberal welfare states, decentralized governance models frequently create fragmentation in resource allocation, policy implementation, and workforce capacity. These governance gaps directly impact the ability of public health systems to address systemic inequities and deliver equity-driven health promotion.

This section explores the effects of decentralization and devolution in Canada, Australia, and the UK, highlighting common themes and strategic opportunities. Specifically, this section reflects on three common themes that emerged from the Canadian case, and other Anglo-Saxon liberal welfare state contexts. The first explores how decentralized governance can create patchworks of health strategies that fail to address systemic inequities comprehensively. Second, considers how a lack of cohesive oversight weakens the ability to align equity-focused goals with

policy implementation. Finally, the third reflects on resource fragmentation, which often reinforces existing inequalities, with wealthier regions better able to sustain public health initiatives compared to resource-constrained areas.

In Anglo-Saxon systems, decentralization delegates health governance responsibilities across jurisdictional governments. While this can enable tailored responses to local needs, it can, and often seems to, result in fragmented resource flows and inequitable outcomes across regions. In Canada, the federal government provides funding and strategic guidance, both to provincial, territorial, and Indigenous governments, as well as directly to community-based organizations. Meanwhile, provinces and territories independently design and execute public health initiatives. This creates variability in implementation and perpetuates inequities (Bryant 2016). Similarly, in Australia, public health responsibilities are largely decentralized to states and territories, leading to inconsistencies in resource allocation and policy cohesion. The lack of national oversight exacerbates these disparities, with state-level differences driving inequitable health outcomes (Baum et al. 2018).

Further, devolution in Canada and the UK offers contrasting perspectives on how governance structures impact public health equity. In Canada, devolution is primarily framed through the self-determination of Indigenous, namely First Nations, Inuit, and Métis, communities. In this context, devolution operates through self-determination frameworks that grant First Nations, Inuit, and Metis Nations greater control over health governance and service delivery. These agreements allow communities to design culturally relevant health programs that incorporate traditional knowledge alongside Western medical practices, addressing unique local needs (Truth and Reconciliation Commission of Canada 2015). However, progress can be constrained by colonial constitutional powers, including fragmented federal-provincial responsibilities, inconsistent funding, and structural barriers that perpetuate inequities in access and outcomes.

In the UK, devolution enables Scotland, as well as Wales, and, to some extent Northern Ireland, to design policies independently from England, creating opportunities for innovation. Scotland has leveraged its devolved powers to adopt upstream, equity-focused public health strategies. Initiatives like the HiAP framework and Community Planning Partnerships integrate health equity considerations into education, housing, and poverty reduction efforts (Public Health Scotland 2022). By contrast, England’s public health system has been weakened by

austerity measures and the fragmentation caused by the dissolution of Public Health England in 2021, which left local councils underfunded and overburdened with devolved responsibilities (Marmot et al. 2020). These examples illustrate how devolution can either advance or undermine equity-driven health promotion, depending on the alignment of governance, resources, and accountability structures.

Resource Constraints: Financial and Workforce Limitations. Results from Anglo-Saxon liberal welfare states emphasised chronic underfunding is a defining barrier in Anglo-Saxon systems, with financial resources fragmented across governance levels. In Canada, federal transfers for health are often tied to health care and treatment services, and are often considered insufficient to meet provincial needs, particularly in remote or underserved areas (Bryant et al. 2019; Raphael 2013a). In Australia, financial constraints were magnified by the dissolution of the Australian National Preventive Health Agency (ANPHA) in 2014, which left states to shoulder the burden of preventive health initiatives without sufficient federal support (Baum et al. 2018). Similarly, in England, austerity measures following the 2008 financial crisis slashed public health budgets, disproportionately affecting marginalized communities and weakening councils' capacity to deliver health equity programs (Marmot et al. 2020).

Further, results pointed to both workforce shortages and varying capacities across systems and jurisdictions, further compounding financial constraints. Anglo-Saxon liberal models, such as Canada and Australia, often emphasized adaptability but struggled with workforce fragmentation due to political shifts and, again, decentralized governance. In Canada, public health workforce challenges include recruitment and retention issues, particularly in rural and underserved regions. These shortages directly limit the system's capacity to address health inequities where they are most acute (Bryant 2016). Australia faces similar challenges, with state and regional health services often overburdened due to a lack of skilled public health professionals (Baum et al. 2018).

Policy Focus on Individual Behaviours and Lifestyle. Anglo-Saxon systems often prioritize behaviour change interventions over upstream strategies targeting structural determinants of health. Some participants went so far as to name this policy orientation as a neoliberal ideology emphasizing individual responsibility, entrenching systemic barriers to effective health promotion, perpetuating phenomena like lifestyle drift, and limiting systemic reforms (Raphael 2013a; Carey et al. 2017). For example, smoking cessation and physical

activity campaigns dominate public health programs in Canada and Australia, while issues like poverty, housing, and income inequality remain inadequately addressed.

Scotland offers a partial counterexample for how public health systems in Anglo-Saxon liberal context can begin to move incrementally upstream, leveraging its devolved powers to adopt upstream-focused policies. The country's HiAP framework integrates health equity considerations into broader policy domains, addressing systemic factors such as education and housing. Scotland's example underscores the potential for equity-focused governance when central goals and resource allocation align with local implementation (Public Health Scotland 2022). Devolution in Scotland highlights the benefits of coordinated frameworks that align central equity goals with local delivery, showcasing the benefits of cohesive policy frameworks.

Strategic Implications. The comparative analysis of decentralization and across Anglo-Saxon liberal systems highlights persistent governance challenges that undermine equity-focused public health efforts. The analysis of devolution and decentralization in Anglo-Saxon liberal welfare states reveals critical governance challenges and opportunities for advancing health equity. Fragmentation in resource allocation, workforce capacity, and policy implementation underscores the tension between localized adaptability and the need for cohesive national strategies. Canada's decentralized model and devolution to Indigenous communities highlight both the potential of culturally tailored, community-driven approaches and the barriers imposed by inconsistent funding and jurisdictional ambiguities. Similarly, Scotland's equity-driven policies demonstrate the value of aligning upstream public health goals with cohesive frameworks, contrasting with the fragmented and austerity-weakened systems in England and Australia. These findings emphasize the necessity of recalibrating public health systems to prioritize equity through stronger integration of resources, workforce investments, and intersectoral collaboration.

Learning from Nordic Social Democratic Welfare States. In contrast, Nordic social democratic welfare states, such as Norway and Finland, emphasize redistributive policies, progressive taxation, and universal access to health and social services (Esping-Andersen 1990; Raphael 2013a). These systems embed health equity into legislation and policy frameworks, viewing health as a collective societal responsibility rather than an individual burden. This approach allows Nordic states to achieve better population health outcomes and reduce inequities

by prioritizing upstream interventions that address structural determinants of health (Bambra 2011; Fosse and Helgesen 2019).

For example, Finland's Health Care Act mandates equitable service provision, while the Norwegian Public Health Act (2011) integrates upstream interventions into national policy. These frameworks reflect a societal commitment to reducing disparities through legal mandates that align local implementation with central oversight (Raphael 2013a; Kokko et al. 2018). Moreover, innovative resource allocation mechanisms, such as Finland's gambling monopoly, fund non-governmental organizations to promote health equity (Bryant et al. 2019).

However, Nordic systems are not without challenges, as interview participants emphasized. Fragmented financial resources between health systems variability in regional implementation, and tensions between local and central governance highlight the complexity of balancing universal health goals with contextual adaptability (Bambra 2011).

Strategic Insights: Locating Public Health Systems on the Riverbank. The well-known parable of walking upstream to investigate the root causes of people drowning in a river provides a compelling metaphor for understanding the interplay of upstream, midstream, and downstream interventions in public health. However, in my professional experience, this story also underscores the importance of locating one's work and institutional context on the riverbank.

What constitutes upstream, midstream, or downstream is inherently relative, shaped by the specific position of a system, or actor, within the broader landscape of public health systems, and broader still, their welfare state context. For instance, a clinician implementing lifestyle interventions may be engaging in upstream work relative to the downstream provision of acute care, even though these interventions would still be considered midstream in broader structural terms. Without recognizing this contextual relativity, efforts like HiAP risk halting midstream, offering both targeted and universal solutions to improve living conditions while ultimately aiming for population-level behaviour change rather than addressing the structural determinants of health (Lynch 2020). This gap in perspective and action exemplifies the broader welfare gap that public health systems must navigate to promote health effectively.

This distinction is critical when considering the building blocks that enable systems to move upstream. Welfare state contexts provide the foundational resources, governance structures, and policy frameworks necessary for public health systems to situate themselves

along the riverbank and define their scope of action. Nordic welfare states, for instance, prioritize redistributive policies and progressive taxation, enabling systems to address structural determinants like income inequality and housing security. In contrast, Anglo-Saxon systems, with their market-driven approaches and decentralization, often focus on targeted or universal midstream interventions such as social triage through lifestyle education. These systems are constrained by governance fragmentation and limited redistributive capacity, widening the welfare gap that prevents a cohesive and sustained upstream focus.

By using welfare state contexts as a comparative lens, public health systems can better situate their position along the riverbank and learn from others' strategies to incrementally move upstream. Nordic models offer valuable insights into how centralized oversight and universal welfare frameworks create the conditions for addressing root causes, while Anglo-Saxon systems highlight the potential for public health systems that encourage more upstream approaches, such as Australia and Scotland, but experience barriers and risk known phenomena like lifestyle drift. Understanding and navigating these gaps is essential for public health actors working to close the welfare gap. Ultimately, recognizing where a system stands in its journey upstream—relative to welfare context and historical trajectories—can guide more strategic and sustainable health promotion initiatives.

5.1.2 Anchoring in Theoretical Frameworks

Chapter 4 highlighted the significant barriers and enablers within Anglo-Saxon liberal welfare states against those of the Nordic social democratic welfare states, highlighting the contextual considerations that influence the capacity of public health systems to promote health equity. Drawing on political economy, historical institutionalism, and systems theory, this section reflects on how these theoretical frameworks deepen our understanding of the results. These perspectives provide critical insights into the structural and governance-related factors that shape health promotion efforts, setting the stage for the subsequent discussion on strategic dilemmas.

Political Economy: Neoliberalism and Structural Inequities. The political economy of Anglo-Saxon welfare states reveals the pervasive influence of neoliberal ideologies, which prioritize market efficiency and individual responsibility over systemic reform that promotes health and well-being. Raphael (2013b) and Bryant (2016) argue that resource allocation in these systems reflects political and economic structures designed to optimize cost-effectiveness rather

than equity. This market-driven orientation manifests in chronic underfunding of public health systems, which struggle to address upstream determinants such as poverty, housing, and income inequality.

The results from Chapter 4 illustrate how this dynamic perpetuates inequalities in health outcomes, furthering the chasm towards achieving health for all. For example, lifestyle drift—a phenomenon where policies initially aimed at structural reforms shift toward individual behaviour changes—aligns with neoliberal governance priorities (Carey et al. 2017). These results underscore the critical need for redistributive policies that address systemic inequities through public health interventions, such as those seen in Nordic welfare models. Political economy frameworks, therefore, emphasize the importance of aligning governance structures with equity-focused objectives to disrupt entrenched inequalities and both recalibrate and resource public health priorities.

Historical Institutionalism: Path Dependency and Critical Junctures. Historical institutionalism highlights the role of entrenched policies and norms in creating barriers to systemic change within Anglo-Saxon welfare systems. As Bryant (2016) notes, path dependency limits the scope for transformative reforms by reinforcing established practices and ideologies. For example, the persistent emphasis on individual behaviour change over structural interventions has become deeply embedded, shaping the design and implementation of public health policies.

The results of this research further demonstrate how this path dependency constrains health promotion efforts. For instance, decentralized governance and fragmented resource allocation are legacies of institutional frameworks that prioritize regional autonomy over national coherence. However, interview respondents from across Anglo-Saxon liberal welfare contexts emphasized that critical junctures, such as the COVID-19 pandemic, offer opportunities to disrupt these patterns and realign public health systems toward equity-focused. These moments provide a window for adopting more integrative governance models that address systemic inequities, particularly through investments in upstream interventions and intersectoral collaboration.

Systems Theory: Interdependence and Integrative Approaches. Finally, systems theory offers a complementary lens by emphasizing the interconnectedness of societal sectors in achieving health equity. Results presented above emphasize the systemic nature of the welfare

state context, leading to the constrained roles and responsibilities of public health systems within them. Labonté (2010) highlights the importance of addressing structural determinants, such as income and education, alongside intermediary factors like access to healthcare. However, as discussed by Lynch (2020), these structural determinants and the social inequalities in their distribution that lead to health outcome inequalities are often outside of the public health system's levers of control, despite health equity being touted as its responsibility. Chapter 4's results illustrate the challenges of fostering such integrative approaches within fragmented and siloed governance structures. For example, decentralization in Canada and Australia creates jurisdictional barriers that hinder intersectoral collaboration between siloed sectors that live at different jurisdictions, limiting the ability to implement cohesive public health strategies.

However, and somewhat cautiously optimistically, the findings also point to the potential of systems-based solutions to address these challenges. Scottish and Finnish approaches to integrating national HiAP frameworks, as discussed in the results, demonstrates how integrative approaches can align local implementation with national equity goals. This example underscores the value of fostering cross-sector collaboration and embedding equity into broader policy frameworks, providing a roadmap for other Anglo-Saxon liberal systems to move more upstream to promote health efficiently and effectively.

These theoretical reflections illuminate the structural and governance challenges that shape health promotion efforts, and health equity outcomes in Anglo-Saxon liberal welfare states. Political economy emphasizes the need for redistributive policies to disrupt inequities, while historical institutionalism highlights the significance of critical junctures in fostering systemic reform. Systems theory underscores the importance of integration and cross-sector collaboration in achieving equity-focused public health goals. Together, these frameworks provide a comprehensive understanding of the barriers and opportunities identified in Chapter 4, underscoring tensions that underpin the following strategic dilemmas.

5.2 Building Strategic Dilemmas for Health Promotion and Health Equity

The welfare state context directly informs the strategic dilemmas faced by Anglo-Saxon liberal public health systems, by influencing their governance structures, resource allocation priorities, and policy approaches. These systems, characterized by limited state intervention and a focus on market-driven efficiency, create tensions between short-term cost-effectiveness and

long-term investments in health equity. These tensions are emphasized when juxtaposed against the public health systems of Nordic social democratic welfare states to construct strategic dilemmas that present situations where a decision must be made between two (or more) equally compelling but conflicting options. Each dilemma offering a scenario that highlights a conflict, where any choice has significant consequences to the decision-maker, the wider public health system, and the present and future health outcomes across populations.

This section presents four strategic dilemmas: (1) The Autonomy-Coherence Dilemma, (2) The Distribution Dilemma, (3) The Knowledge Integration Dilemma, and (4) The Upstream Dilemma. Each strategic dilemma is underpinned by tension identified across Anglo-Saxon liberal welfare state contexts, when compared to those in Nordic settings. Dynamics, such as decentralized governance prioritizing local adaptability against central oversights enforcing coherence and shared equity goals, how limited resources balance short-term individual interventions and long-term structural reforms and what mechanisms can refocus public health systems on upstream determinants to address root causes of health inequities, illustrate how the welfare state context informs these dilemmas. These dilemmas are deeply rooted in the political, economic, and institutional structures of the Anglo-Saxon welfare state, drawing lessons from Nordic models and adapting solutions to the unique constraints of liberal welfare systems.

By viewing the Autonomy-Coherence, Distribution, Knowledge Integration, and Upstream Dilemmas as interdependent rather than isolated, health promotion efforts can form a cohesive feedback loop where each dilemma both shapes and is shaped by the others. Local adaptability can reinforce—or undermine—long-term equity and system-wide coherence, while knowledge integration informs resource distribution decisions that ultimately strengthen or weaken upstream interventions. In this dynamic interplay, tensions highlighted through Nordic comparisons help spotlight structural misalignments, prompting more intentional navigation of trade-offs that bring each dilemma into productive conversation with the rest.

Strategic Dilemma 1: The Autonomy-Coherence Dilemma

This dilemma is rooted in the strategic need for public health systems and wider government initiatives to balance autonomy and oversight. It is underpinned by a consistent tension across Anglo-Saxon liberal welfare states that question how decentralized systems can adapt to regional needs while maintaining national coherence in health equity goals. Anglo-

Saxon liberal welfare states like Canada, Australia, and the UK, face a common structural challenge: balancing regional autonomy with national coherence in health equity goals.

These systems, shaped by their market-oriented and decentralized governance models, often struggle to implement uniform equity-focused policies (Bambra 2011; Raphael 2013b). Nordic social democratic welfare states, by contrast, exhibit centralized governance mechanisms that prioritize equity while still accommodating regional adaptation. These divergent approaches underscore how political economy and welfare typologies shape health outcomes and institutional capacities (Eikemo and Bambra 2008). This dilemma invites key questions for decision-makers: (1) how can decentralized systems maintain flexibility to address local needs while ensuring consistent national progress on equity goals; and (2) what governance structures can effectively balance accountability and autonomy without exacerbating health inequalities? By framing the dilemma through these questions, one may systematically assess trade-offs and guide more coherent approaches to equity-driven public health initiatives.

The autonomy-coherence dilemma reflects a conflict between tailoring health policies to local needs and maintaining consistent national standards for equity. In Canada, for instance, provinces and territories control healthcare delivery, leading to variation in access and health outcomes, though the Canada Health Act (1986) offers some centralized guardrails as a governing legal framework (Bryant 2009; Raphael 2013a). Similar challenges are observed in Australia, where state-level autonomy complicates the implementation of national equity-focused frameworks (Carey et al. 2017). Nordic systems, such as Norway's, avoid these variations by embedding equity mandates into national governance, ensuring coherence across regions (Bambra 2011). This divergence highlights the tension between decentralization's flexibility and centralization's equity-driven coherence.

Key stakeholders in this dilemma include governments across jurisdictions, and communities advocating for more equitable conditions. Across Anglo-Saxon contexts, regional actors often prioritize autonomy, citing local needs and political autonomy. In Canada, this can manifest in resistance to federal equity initiatives, such as conditions tied to federal health transfers (Rootman et al. 2017). Nordic models mitigate similar tensions by ensuring robust resource redistribution and fostering shared accountability mechanisms. Interview participants emphasized that addressing these power imbalances requires redefining governance structures to align local autonomy with national equity goals, and vice versa.

Failing to balance autonomy and coherence risks perpetuating health inequities, a challenge that Anglo-Saxon welfare states have struggled to overcome. For example, research findings illustrate how lack of centralized oversight exacerbates phenomenon like lifestyle drift, as various jurisdictions favour immediate, behaviour-focused interventions over structural reforms (Carey et al. 2017; Halsall et al. 2024). Nordic systems, on the other hand, ensure coherent action on upstream determinants of health, demonstrating how centralized oversight can sustain equity goals without undermining regional needs (Raphael 2018). The opportunity lies in adapting these lessons to liberal contexts.

Addressing this dilemma requires reconciling decentralization with equity by leveraging hybrid governance approaches. For Anglo-Saxon liberal states, opportunities lie in adopting conditional funding tied to equity benchmarks and establishing shared accountability frameworks. Nordic examples illustrate how investment in redistributive policies and robust data systems can sustain coherence without stifling local innovation. Research findings presented in this work suggest that aligning fiscal incentives with measurable equity outcomes could serve as a viable starting point.

The autonomy-coherence dilemma underscores the shared constraints of decentralized systems in Anglo-Saxon liberal welfare states while highlighting the successes of Nordic models in harmonizing local and national equity goals. Addressing this dilemma requires leveraging hybrid approaches to governance that align roles and responsibilities across jurisdictions. Incremental actions—such as tying funding to measurable equity outcomes, fostering collaborative accountability frameworks, and promoting redistributive policies—offer a practical starting point. By confronting this dilemma, public health systems may navigate the tension between autonomy and coherence in Anglo-Saxon liberal contexts, advancing equity without sacrificing regional flexibility or innovation.

Strategic Dilemma 2: The Distribution Dilemma

Decentralization is a feature of many health systems, including both Anglo-Saxon liberal and Nordic social democratic welfare states. However, its outcomes depend heavily on governance structures and the mechanisms used to balance local autonomy with equitable resource distribution. In Anglo-Saxon systems like Canada, decentralization often amplifies inequities as provinces and territories are responsible for allocating resources across many of the

key SDOH, including education, labour, and health care systems, creating disparities between regions (Raphael 2013a; Rootman et al. 2017). By contrast, Nordic systems like Norway and Finland achieve equitable distribution through decentralization combined with robust national oversight, ensuring that underserved regions receive adequate support (Bambra 2011; Eikemo and Bambra 2008).

The distribution dilemma reflects a tension between preserving decentralized decision-making and ensuring consistent, equity-driven resource allocation. This dilemma raises important questions for those seeking to systemically promote health, including equitable health outcomes: (1) how can decentralized systems preserve regional autonomy while ensuring equitable resource allocation across underserved populations; and (2) what governance mechanisms are needed to align local decision-making with national health mandates, considering the social inequalities that are known to drive health inequalities? These questions offer a framework for systematically navigating the tensions that decentralization creates, particularly in Anglo-Saxon systems where resource fragmentation often exacerbates inequities.

Anglo-Saxon systems, such as Canada and Australia, prioritize provincial and state autonomy, which often results in uneven funding for rural and Indigenous communities (Bryant et al. 2019). Nordic systems, while also decentralized, rely on national frameworks that align local resource allocation with equity goals, demonstrating how decentralization can coexist with consistent redistributive policies (Raphael 2018). This tension highlights the divergent ways decentralization shapes equity outcomes in different welfare regimes.

Key stakeholders include regional and local governments, national authorities, and underserved populations. In Anglo-Saxon systems, decentralization frequently pits regional autonomy against national priorities, as seen in Canada, where provinces resist conditional federal funding aimed at addressing inequities (Rootman et al. 2017). Nordic systems address similar dynamics by embedding equity mandates into national governance, empowering regions to act while ensuring accountability (Bambra 2011). Research participants noted that addressing resource disparities requires rebalancing power dynamics to ensure that equity takes precedence over political and fiscal autonomy.

Poorly coordinated decentralization risks perpetuating resource inequities, particularly in underserved regions, or among communities seeking more equitable conditions that determine health outcomes. For example, findings indicate that in Anglo-Saxon liberal frameworks,

uncoordinated decentralization or devolution efforts can exacerbate lifestyle drift, as underfunded areas lack the capacity to address upstream determinants of health effectively (Halsall et al. 2024). In Nordic contexts, however, decentralized systems operate within a framework of redistributive policies, enabling underserved regions to receive resources proportional to their needs (Eikemo and Bambra 2008). These contrasting outcomes underscore the importance of governance mechanisms that prioritize equity in resource distribution efforts while considering and supporting autonomy of geographical regions as well as communities seeking more equitable conditions.

This dilemma is further complicated by the intersection of health funding with other sectors like housing, education, and labour. In Anglo-Saxon systems, siloed governance structures often prevent integrated responses to known inequities, as seen in Canada's limited coordination between health and social policies (Carey and Crammond 2015). Nordic systems address these intersectoral challenges through centralized frameworks that align funding and policy priorities across sectors, enabling a more holistic approach to resource distribution. The research findings of this dissertation suggest that similar integrations of intersectoral strategies could strengthen Anglo-Saxon systems' capacity to address inequities.

Nordic systems illustrate how redistributive policies, supported by robust knowledge and information systems, can ensure that resources flow proportionally to underserved regions, communities, and groups of people. For example, conditional funding tied to equitable outcomes incentivizes local governments to align their resource allocation with national equity priorities. Anglo-Saxon systems could strengthen their governance frameworks by adopting similar mechanisms, leveraging information systems to monitor health inequalities and guide equitable resource distribution. This approach enables decentralized systems to retain flexibility while ensuring that equity remains a central mandate.

Resolving the distribution dilemma requires a combination of incremental strategies and intersectoral governance mechanisms. Aligning resource allocation across sectors like health, housing, and education can address the systemic inequities perpetuated by siloed governance structures, as demonstrated in Nordic models, particularly Norway. In Anglo-Saxon systems, leveraging conditional funding to incentivize intersectoral collaboration to inform policy processes offers a practical starting point. By embedding equity mandates into governance frameworks and prioritizing integrated resource allocation, public health systems can ensure that

underserved regions, and populations, receive the support they need without compromising local autonomy. These incremental actions provide a roadmap for Anglo-Saxon systems to close the gaps created by uncoordinated decentralization.

Strategic Dilemma 3: The Knowledge Integration Dilemma

This dilemma addresses how public health systems can balance the valuation of diverse knowledge type with the need for timely, actionable evidence in policy processes— a common challenge to evidence-based decisions. This dilemma prompts 3 key considerations: (1) how can governance structures support the systematic integration of diverse evidence into policymaking without compromising responsiveness to urgent needs; (2) what mechanisms can be developed to ensure equitable valuation of social sciences, Indigenous knowledges, and other underrepresented evidence types; and (3) how can policy cycles accommodate both actionable, short-term evidence and the complex relational processes required to address upstream determinants and inequities?

The knowledge integration dilemma highlights the systemic barriers that prevent various evidence types from informing equitable health promoting policies. Across Anglo-Saxon systems like Canada and the UK, fragmented governance and resource flows create institutional filters that shape how evidence and ideas circulate within policymaking processes (Smith 2013). These filters favor ideas that align with existing policy paradigms while limiting or distorting more challenging, equity-focused ideas. In Nordic systems, centralized oversight mitigates some of these barriers, enabling the integration of upstream and social science evidence into policy, despite also operating within decentralized governance models (Raphael 2018; Bambra 2011).

The dilemma reflects competing priorities between timely, actionable evidence and broader, institutional and systemic perspectives that are harder to measure. Anglo-Saxon systems often privilege quantitative data—such as epidemiological or economic metrics—over social science insights, lived experiences, and Indigenous knowledges. This creates a tension between what is easily measurable and what is essential for addressing structural inequities (Carey et al. 2017). In contrast, Nordic systems incorporate broader definitions of evidence into governance frameworks, prioritizing health equity through systemic and long-term interventions (Bryant 2016; Raphael 2015a).

Institutional filters function as gatekeepers, favoring research that aligns with departmental priorities or short-term political goals (Smith 2013). For example, Canada's decentralized health system prioritizes metrics tied to provincial autonomy, sidelining evidence addressing systemic inequities (Rootman et al. 2017). The findings of this research emphasize the difficulty of incorporating Indigenous knowledge into policymaking due to institutional biases, rooted in colonial structures, alongside the acknowledged need for cultural sensitivity and data sovereignty. Nordic models, meanwhile, address similar challenges by fostering more integrated, collaborative governance mechanisms that facilitate evidence translation across sectors.

The exclusion of upstream and equity-focused evidence exacerbates health inequities, particularly for communities experiencing inequitable health outcomes, by way of inequitable conditions. As highlighted in Smith (2013), when institutional filters favor medicalized and individualized approaches, upstream interventions remain underfunded and deprioritized. These research findings echo this, showing how lifestyle drift in such contexts leads to behaviour-focused policies while neglecting structural determinants (Halsall et al. 2024). In contrast, Nordic systems ensure upstream evidence is consistently translated into action, demonstrating how central coordination can align policy priorities with systemic health equity goals (Raphael 2013b).

The dilemma raises concerns about whose knowledge is valued and how evidence is integrated to promote equity. Smith (2013) underscores how institutional hierarchies and siloed governance structures marginalize alternative knowledge systems. This sentiment was exemplified by interview participants who emphasized that integrating diverse evidence requires respecting cultural sovereignty and relational accountability while balancing timeliness with process-oriented approaches. Nordic systems offer practical insights, demonstrating how redistributive policies can operationalize ethical commitments to equity by embedding upstream evidence into decision-making frameworks.

Fragmented governance in Anglo-Saxon systems exacerbates tensions between sectors, impeding the flow of evidence across policy domains. As Smith (2013) notes, silos within institutions prioritize narrow, department-specific ideas, limiting their capacity to address cross-cutting issues like health inequities. For example, Canada's focus on health services often sidelines evidence related to housing or income policies, despite their critical role in addressing

inequities (Carey and Crammond 2015). Nordic systems, on the other hand, integrate intersectoral policies through centralized frameworks, offering a model for improving evidence translation across governance levels.

Addressing the knowledge integration dilemma requires, acknowledging, and in some cases dismantling, institutional filters to ensure diverse evidence—particularly upstream and equity-focused research—can inform policy. As Smith (2013) suggests, improving vertical and horizontal connectivity within institutions can challenge existing filters and foster the flow of complex, systemic ideas. In Canada, adopting participatory processes, such as knowledge co-production with Indigenous communities and local stakeholders, could help integrate relational evidence into policy. Many interview participants further emphasized the importance of creating mechanisms for evidence brokerage to overcome gaps in institutional memory and fragmented policymaking.

The knowledge integration dilemma underscores how institutional filters, fragmented governance, and entrenched policy paradigms hinder the translation of diverse evidence into actionable strategies. While Anglo-Saxon systems face significant constraints, Nordic examples demonstrate that upstream, systemic evidence can inform policy when supported by integrated governance mechanisms. Public health systems can benefit from dismantling institutional barriers, fostering intersectoral collaboration, and operationalizing culturally sensitive frameworks to honor diverse ways of knowing. In doing so, systems can align knowledge integration processes with equity-focused health goals.

Strategic Dilemma 4: The Upstream Dilemma

The upstream dilemma helps to understand how public health systems balance health promotion strategies that address structural factors, often requiring quite a bit of time and money to do so, and the pressing downstream needs voiced by communities facing imminent health risk factors. This dilemma encompasses several tensions inherent to public health systems across Anglo-Saxon liberal contexts, including the ensuring pressure on public health systems to: (1) reconcile systemic reforms targeting long-term inequities with the urgency of meeting immediate, community defined priorities; (2) balance the coherence of top-down frameworks with the flexibility needed to empower communities to address both structural barriers to positive health and well-being, and immediate health needs, particularly within rigid and siloed

funding frameworks; and (3) balancing epidemiological data on health outcomes with diverse knowledge systems to address both structural and enduring inequities alongside immediate community priorities.

The upstream dilemma captures the tension between addressing systemic determinants of health inequities and responding to immediate, acute needs. Public health systems must reconcile the triage mentality—common in moments of crisis, like COVID-19—with the transformative, systemic work necessary for health equity (Lynch 2020). This dilemma presents strategic questions for consideration across public health systems: (1) how can public health systems balance immediate community-defined needs with long-term structural reforms that address systemic inequities; (2) what governance frameworks can effectively align short-term interventions with sustainable, equity-driven outcomes; and (3) how can funding mechanisms support upstream action while maintaining flexibility for community-driven priorities? By framing the dilemma through these questions, public health systems can clarify trade-offs and identify incremental steps toward balancing urgent needs with systemic change.

Such dynamic highlights the contrasting policy frames of Anglo-Saxon liberal and Nordic social democratic welfare states. Anglo-Saxon liberal states, such as Canada, Australia, and the UK, apart from Scotland, adopt prevention-focused, cost-efficient strategies that often treat health equity as a *lens* rather than a foundational goal, limiting long-term structural work (Bryant 2016). In contrast, Nordic systems were grounded in rights-based principles and collectivism, embed health as a fundamental right and a core government mandate, driving systemic reforms to tackle root inequalities (Lynch 2020; Solar and Irwin 2010).

A core tension lies in balancing long-term upstream strategies—addressing root causes like income inequality, housing, and education—with downstream interventions responding to urgent needs. As Solar and Irwin (2010) caution, intermediary solutions that emphasize individual behaviours risk perpetuating inequities by neglecting structural determinants. Research findings highlighted this dynamic during COVID-19. While vaccine distribution and emergency responses dominated priorities, systemic equity work, such as addressing transit policies for essential workers in high-density urban areas, was deprioritized (CI4). This prevention-driven, reactive approach mirrors the Anglo-Saxon reliance on individual responsibility, which reinforces *lifestyle drift* (Solar and Irwin 2010; Lynch 2020). By contrast, Nordic systems view

health equity as both a process and a goal, integrating upstream action into governance frameworks to reduce long-term inequities (WHO 1986).

The Autonomy-Coherence Dilemma, presented above, further intensifies this dilemma, revealing tensions between top-down national alignment and community-driven autonomy. While top-down strategies ensure coherence, they often fail to account for unique local contexts and community-defined priorities. This is particularly evident in Canada, where Indigenous health strategies emphasize self-determination and culturally grounded approaches but are constrained by colonial funding mechanisms that prioritize bureaucratic efficiency over relational, equity-driven solutions.

Participants in Scotland, on the other hand, described HiAP as a promising framework for embedding upstream goals into localized policies, such as adjusting transportation systems for low-income populations. However, they critiqued national governments for "ducking responsibility" by devolving equity challenges to under-resourced local authorities (UKI4). Nordic systems align community-driven approaches with strong national frameworks, demonstrating the potential for integrating equity goals across governance levels (Lynch 2020).

Policy frames play a critical role in determining whether systems prioritize urgent, measurable outputs or long-term reforms. As Lynch (2020) and Hall and Taylor (1996) explain, Anglo-Saxon welfare states' historical path dependency has entrenched a biomedical, efficiency-focused paradigm, limiting structural action. This dynamic is evident in Canada, alongside other Anglo-Saxon liberal contexts, where funding mechanisms remain siloed and sectoral, leaving little room for integrated upstream approaches: "The way that our funding works in this country is sector-based (CI3)." Australia's reliance on KPIs further constrains innovation, prioritizing quick, quantifiable outcomes over complex, transformative policies (AI2). In contrast, Nordic systems apply rights-based frames aligned with the Ottawa Charter, treating health equity as a collective responsibility that necessitates holistic, system-level solutions (WHO 1986).

Balancing structural reforms with immediate community needs raises ethical questions about fairness and sustainability. Public health systems play an important role in advancing decommodification by reducing dependence on market-driven solutions for health and social services, ensuring that essential resources—such as housing, healthcare, and food—are treated as public goods rather than commodities. By embedding decommodification within upstream strategies, public health systems can more effectively tackle systemic inequities and address the

root causes of poor health outcomes (Bambra 2006 2011; Eikemo and Bambra 2008). Public health systems must decide whether to prioritize quick, cost-effective interventions or commit to transformative, rights-based approaches (Lynch 2020). Yet rigid accountability measures and bureaucratic funding structures continue to undermine this balance. Solar and Irwin (2010) argue that failing to address structural determinants perpetuates systemic inequities, highlighting the ethical imperative to shift policy priorities upstream, particularly in communities most affected by inequitable conditions.

Moreover, the privileging of certain evidence types further perpetuates the upstream-downstream divide. In Australia, participants critiqued the dominance of epidemiological and economic evidence, which prioritizes short-term, measurable outcomes while sidelining qualitative insights and social science research essential for addressing root inequities (AI1). Similarly, in Canada, participants emphasized the need for decision-makers to value *how* knowledge is created, not just its outcomes, recognizing that relational and community-driven processes are integral to achieving equity, particularly alongside First Nations, Inuit, and Métis communities (CI4). Scottish participants stressed that evidence must address "the right questions," challenging policymakers to align research with lived realities and long-term systemic needs (UKI4; Lynch 2020). Decommodification complements this emphasis by reinforcing the idea that access to health services and resources should not depend on market dynamics or individual economic capacity. Instead, public health systems must prioritize upstream investments that treat health as a collective responsibility, ensuring equitable outcomes across diverse communities (Heimburg et al. 2022).

To resolve the upstream dilemma, public health systems must adopt governance frameworks and funding mechanisms that balance structural reforms with immediate community needs. This requires shifting policy frames to prioritize equity as a core mandate, not merely a lens for action (Lynch 2020; WHO 1986). Framing public health as a public good aligns with the principles of decommodification, emphasizing non-excludable and non-rivalrous access to health resources. This approach strengthens the capacity of public health systems to lead upstream efforts by embedding health equity within structural reforms, addressing inequities in income, housing, and social determinants holistically (Heimburg et al. 2022).

In Canada, participants emphasized the value of flexible, community-driven funding structures that empower communities to define their priorities while holding systems accountable

for structural reforms. Nordic examples demonstrate the feasibility of aligning upstream goals with strong national frameworks, integrated funding, and cross-sector collaboration, providing actionable insights for Anglo-Saxon systems. These systems operationalize decommodification by integrating health as a public good into governance structures, exemplified by universal policies that address the broader determinants of health through guaranteed access to housing, education, and healthcare (Esping-Andersen 1990; Scruggs and Allan 2006). This contrasts with Anglo-Saxon liberal welfare states, where reliance on commodified systems limits the reach of upstream reforms (Raphael 2012).

Confronting the upstream dilemma, public health systems can adopt incremental strategies that prioritize equity as both a core mandate, as well as a less tangible guiding principle. Leveraging relational knowledge systems, as emphasized by participants in Canada, ensures that community voices inform decision-making and align interventions with lived realities. Integrating cross-sector collaboration into governance frameworks further strengthens upstream efforts, addressing social determinants such as housing, education, and income inequality holistically. Finally, embedding equity benchmarks into funding mechanisms provides accountability and ensures that upstream reforms are sustained over time. Nordic models offer a roadmap for these actions, demonstrating how rights-based frameworks and integrated funding structures can create the conditions for transformative, equity-driven reforms. For Anglo-Saxon systems, aligning governance structures with these principles is not merely a strategic opportunity but an imperative to successful upstream intervention.

5.3 Looking Forward: Implications for Research and Practice

Systemic tensions experienced across and within Anglo-Saxon liberal and Nordic social democratic welfare states underscore challenges to equitable health promotion. As noted, fragmented governance, resource constraints, and market-driven priorities inhibit public health systems' ability to address upstream determinants of health effectively. These barriers, compounded by phenomena like “lifestyle drift,” shift the focus from structural reforms to individual behaviours, perpetuating inequitable health outcomes, even in the presence of universal health coverage.

Building on this study’s comparative approach, future work should explore how lessons from other welfare state typologies can inform actionable strategies in Anglo-Saxon liberal

contexts. This includes examining the adaptability of integrated governance and equitable policy processes in environments. Expanding comparative analyses across additional welfare typologies, particularly conservative, or corporatists typologies, would enrich understanding of the nuanced ways governance systems influence public health outcomes.

For policymakers and practitioners, the findings call for a renewed focus on embedding equity as a core mandate within health promotion frameworks. By addressing the governance fragmentation identified in this research, decision-makers can better align policy objectives with systemic implementation strategies. Research-informed tools, such as strategic dilemmas, can facilitate adaptive decision-making that balances immediate needs with long-term structural reforms.

Finally, this study emphasizes the importance of interdisciplinary approaches in advancing health promotion and equity. Future research directions would benefit from integrating political economy, systems theory, and historical institutionalism to deepen understanding of the systemic barriers identified here. By bridging academic insights with practical policy applications, researchers and practitioners can collectively address the institutional inertia that impedes transformative public health action. These efforts will be important in health system strengthening efforts, emphasizing health promotion as an essential function of public health systems globally.

5.4 Limitations of this Study

This study has several limitations that shape the scope and interpretation of its findings. The reliance on English-language publications poses a significant constraint, embedding Anglo-Saxon worldviews more prominently within the analysis. This linguistic limitation inherently excludes non-English perspectives that could provide alternative or complementary understandings of health promotion and its policy processes. To mitigate this, I sought translated materials and engaged in reflexive practices to interrogate my own framing, particularly by exploring systemic barriers and definitions from other worldviews, including those shaped by colonial histories and the perspectives of Indigenous Peoples across all country contexts included in this study. However, the dominance of institutional and systemic narratives remains a limitation, as these voices do not represent the entirety of experiences within diverse public health systems.

The small sample size for interviews further limits the generalizability of the findings. Although the integration of a literature review and document analysis was intended to provide broader context and strengthen the triangulation of data, the limited representation of Nordic experiences within the interview sample constrained the comparative depth of this typology. This imbalance highlights the need for future studies to engage a more diverse range of participants, particularly those embedded in Nordic and other welfare state contexts, to better capture the nuanced interplay between policy and practice.

Another limitation lies in the comparative framework itself, which focuses exclusively on Anglo-Saxon liberal and Nordic social democratic welfare states. While this comparison underscores systemic differences and shared tensions, it risks presenting a false binary between these typologies. Recognizing this, the study intentionally emphasized the overlaps, and hybrid features of welfare states, such as the corporatist elements in Canada and Finland, to illustrate that these typologies are neither rigid nor universally applicable. Expanding future analyses to include mixed welfare state models could provide a more comprehensive understanding of how different systems navigate health promotion challenges, offering more dimension to the strategic dilemmas faced by decision-makers.

The study's reliance on policy documents and publications from 2000–2020 also introduces a limitation, as more recent debates and post-COVID-19 policy shifts were not included. Significant developments, such as the abolition of the Australian Preventive Health Agency and Public Health England, underscore ongoing shifts in public health governance and strategy. While these were acknowledged as part of the evolving nature of health systems, the study did not delve into their conditions or implications, leaving opportunities for future research to explore these critical junctures in greater depth.

Finally, this work adopts the position that health policy is an ever-evolving field, shaped by shifting priorities and systemic challenges. While it highlights transformative moments, such as the Ottawa Charter and strategic dilemmas in public health systems, it does not fully account for how emerging pressures, such as climate change or technological advancements, may alter the landscape of health promotion. These limitations reflect the complexity of the field and invite further exploration to expand and refine the insights presented here.

5.5 Chapter Summary

In summation, Chapter 5 reflects on the findings presented in Chapter 4, analyzing their relevance to the research objectives and key questions. Specifically, it introduces four strategic dilemmas as analytical tools to help those within public health systems to work through the trade-offs and complexities faced when navigating health promotion as an essential public health function in Anglo-Saxon liberal welfare states. The dilemmas are grounded in the systemic challenges of their welfare state contexts—such as decentralized governance, resource constraints, and the persistence of systemic barriers to effective health promotion efforts—and contrasted with insights drawn from Nordic social democratic systems, which are seen to effectively prioritize upstream, equity-focused interventions.

The chapter is organized into three main sections. First, it examines the utility of strategic dilemmas as tools for understanding and addressing tensions between competing policy priorities, such as efficiency versus equity and short-term outcomes versus long-term resilience. Second, it contextualizes these dilemmas within the broader welfare state frameworks, exploring how institutional structures, governance mechanisms, and resource allocation impact public health systems' capacity to promote health equity. Finally, the chapter introduces four key strategic dilemmas that emerged from the analysis:

1) The Autonomy-Coherence Dilemma – Balancing regional autonomy with the need for national coherence in achieving health equity goals.
2) The Distribution Dilemma – Addressing inequitable resource allocation across regions and communities within decentralized systems.
3) The Knowledge Integration Dilemma – Navigating the tension between diverse knowledge systems (e.g., social science, Indigenous knowledges) and the demand for timely, measurable evidence to inform policy.
4) The Upstream Dilemma – Reconciling immediate, downstream health priorities with long-term, structural interventions that target root causes of inequities.

These dilemmas underscore the inherent trade-offs that policy actors must weigh when attempting to align public health systems with health equity goals. By framing these challenges as dilemmas rather than definitive solutions, or lessons, the chapter provides decision-makers with a reflective lens to navigate complex policy environments more transparently and strategically.

In summary, this chapter highlights that Anglo-Saxon liberal welfare states face systemic constraints that often undermine equity-driven public health efforts. The lessons from Nordic social democratic welfare states further demonstrate the potential for aligning governance structures, resource flows, and evidence integration processes to advance equity and resilience in public health systems. So, by understanding and engaging with these strategic dilemmas, policymakers can adopt more nuanced, informed approaches to address the tensions that shape public health outcomes.

Conclusion

This dissertation investigated the role of public health systems in promoting health and advancing health equity within two contrasting welfare state typologies—Anglo-Saxon liberal welfare states (Canada, Australia, and the UK, with a specific emphasis on England and Scotland) and Nordic social democratic welfare states (Norway and Finland). At the heart of this research lies the pressing challenges faced by contemporary public health systems, and barriers to effective health promotion as an essential public health function.

This research focused on uncovering the systemic and institutional tensions that perpetuate such barriers, and drift, while also offering practical recommendations to mitigate it through the development of four strategic dilemmas. These dilemmas offer conceptual tools to guide decision-makers in navigating the complexities of health policy and implementation. To address these challenges, this study was guided by three key research questions that sought to explain (1) How do the features of different welfare states enable or hinder effective health promotion— including the emergence of barriers, and conditions leading to policy drift? (2) What can Anglo-Saxon liberal public health systems learn about navigating these tensions from Nordic social democratic models to enhance health promotion and health equity? and (3) How What common and strategic dilemmas can these lessons be effectively adapted and leveraged in Anglo-Saxon liberal welfare state contexts?

Methodologically, this research used an explanatory case study, which was particularly suited for explaining complex policy processes, such as health promotion, within their real-world contexts. Canada serves as the primary case within the broader framework of Anglo-Saxon liberal welfare states, offering both depth and specificity, while comparative insights from

Australia, and the UK (specifically England and Scotland) and Nordic countries (Norway and Finland) augment the analysis. Data were gathered through three complementary methods.

First, document analysis of health policies, including legal and strategic frameworks from the last two decades, revealed the formal framing, priorities, and evolution of health promotion efforts across the studied welfare states. Next, fifteen in-depth interviews with scholar-practitioner public health experts from both Anglo-Saxon and Nordic contexts. These interviews offered rich, contextualized perspectives on the barriers, enablers, and lived realities of health promotion policy processes. Finally, all data was considered through a reflexive lens, leveraging my own experiences as a public health system insider with almost two decades of experience across several different systems and contexts.

The findings highlight a clear tension within Anglo-Saxon liberal public health systems, where resource constraints, market-oriented priorities, and institutional path dependencies collectively undermine efforts to address upstream SDOH. These systems often prioritize cost-efficiency and individual responsibility, which results in a drift toward behavioural interventions. This narrowing not only weakens the potential impact of public health strategies but also perpetuates inequities by failing to address structural drivers such as income inequality, housing insecurity, and labour conditions.

In contrast, the Nordic social democratic welfare states provide a compelling counter-narrative. Their health promotion strategies demonstrate a sustained commitment to intersectoral collaboration, comprehensive governance, and equitable resource allocation. The comparative analysis reveals that Nordic systems are better positioned to integrate health equity considerations into policy processes, fostering systemic solutions that address root causes of health disparities. This success stems from robust institutional arrangements, shared societal values around collective well-being, and a more redistributive approach to social policy.

From these insights, this research identifies and develops four strategic dilemmas that act as both analytical tools and practical recommendations for decision-makers seeking to strengthen public health systems: (1) The Autonomy-Coherence Dilemma; (2) The Distribution Dilemma; (3) The Evidence-Integration Dilemma; and (4) The Upstream Dilemma. These dilemmas offer decision-makers a framework to confront the tensions and trade-offs inherent in health promotion policymaking. They are particularly relevant in Anglo-Saxon liberal contexts like Canada, where public health systems must navigate constrained resources, institutional inertia,

and competing political interests. By engaging with these dilemmas, policymakers can identify opportunities to move beyond lifestyle drift, prioritize structural interventions, and build public health systems capable of addressing systemic inequities.

In conclusion, this dissertation underscores the importance of learning from Nordic social democratic welfare states while acknowledging the unique challenges and opportunities present in Anglo-Saxon liberal contexts like the Canadian case. The findings contribute to both theoretical understanding and practical application, navigating the gap between comparative welfare state analysis and actionable public health policy recommendations. By confronting systemic tensions, public health systems can better fulfill their commitments, through the Ottawa Charter of 1986 and the many declarations since, as vehicles for health promotion and equity, ultimately advancing progress toward health for all.

REFERENCES

Adeniran, Rita. 2004. “The United Kingdom and United States Health Care Systems: A Comparison.” *Home Health Care Management & Practice* 16(2):109–16. doi: 10.1177/1084822303258617.

Agyepong, Irene, Neil Spicer, Gorik Ooms, Albrecht Jahn, Till Bärnighausen, Claudia Beiersmann, Hannah Brown Amoakoh, Günter Fink, Yan Guo, Lisa Hennig, Mahlet Kifle Habtemariam, Bocar A. Kouyaté, Rene Loewenson, Angela Micah, Suerie Moon, Mosa Moshabela, Sonja Lynn Myhre, Trygve Ottersen, Walaiporn Patcharanarumol, Malabika Sarker, Gita Sen, Yasuhisa Shiozaki, Francisco Songane, Devi Sridhar, Freddie Ssengooba, Jeanette Vega, Deisy Ventura, Maike Voss, and David Heymann. 2023. “Lancet Commission on Synergies between Universal Health Coverage, Health Security, and Health Promotion.” *The Lancet* 401(10392):1964–2012. doi: 10.1016/S0140-6736(22)01930-4.

Amdam, Roar. 2023. “‘Health in All Policies’ in Norwegian Municipalities-Dilemmas and Lack of Legitimacy and Capacity.” *The International Journal of Health Planning and Management* 38(5):1345–59. doi: 10.1002/hpm.3664.

Anon. 2007. “Framework for the Development and Creation of National Public Health Institutes.”

Anon. 2020. “Poverty Rate.”

Baardseng, Thomas. 2004. “Telemedicine and eHealth in Norway: Administration and Delivery of Services.” *International Journal of Circumpolar Health* 63(4):328–35. doi: 10.3402/ijch.v63i4.17750.

Bambra, C. 2007. “Going beyond The Three Worlds of Welfare Capitalism: Regime Theory and Public Health Research.” *Journal of Epidemiology & Community Health* 61(12):1098–1102. doi: 10.1136/jech.2007.064295.

Bambra, Clare. 2006. “Health Status and the Worlds of Welfare.” *Social Policy and Society* 5(1):53–62. doi: 10.1017/S1474746405002721.

Bambra, Clare. 2007. “‘Sifting the Wheat from the Chaff’: A Two-Dimensional Discriminant Analysis of Welfare State Regime Theory.” *Social Policy & Administration* 41(1):1–28. doi: 10.1111/j.1467-9515.2007.00536.x.

Bambra, Clare. 2011. “Health Inequalities and Welfare State Regimes: Theoretical Insights on a Public Health ‘Puzzle.’” *Journal of Epidemiology & Community Health* 65(9):740–45. doi: 10.1136/jech.2011.136333.

Banting, KG, and S. Corbett. 2002. “Health Policy and Federalism: A Comparative Perspective on Multi-Level Governance.” Retrieved September 14, 2024.

Barnish, Max, Michelle Tørnes, and Becky Nelson-Horne. 2018. “How Much Evidence Is There That Political Factors Are Related to Population Health Outcomes? An Internationally Comparative Systematic Review.” *BMJ Open* 8(10):e020886. doi: 10.1136/bmjopen-2017-020886.

Bartram, Mary. 2020. “Government Structure, Service System Design, and Equity in Access to Psychotherapy in Australia, the United Kingdom, and Canada.” *Canadian Journal of Community Mental Health* 39(2):11–23. doi: 10.7870/cjcmh-2020-010.

Basnet, Syaron, and Michael Chaiton. 2024. “Effectiveness of the Wellness Together Canada Portal as a Digital Mental Health Intervention in Canada: Protocol for a Randomized Controlled Trial.” *JMIR Research Protocols* 13(1):e48703. doi: 10.2196/48703.

Bauder, Harald, and Rebecca Mueller. 2023. “Westphalian Vs. Indigenous Sovereignty: Challenging Colonial Territorial Governance.” *Geopolitics* 28(1):156–73. doi: 10.1080/14650045.2021.1920577.

Baum, Fran, Toni Delany-Crowe, Matthew Fisher, Colin MacDougall, Patrick Harris, Dennis McDermott, and Dora Marinova. 2018. “Qualitative Protocol for Understanding the Contribution of Australian Policy in the Urban Planning, Justice, Energy and Environment Sectors to Promoting Health and Health Equity.” *BMJ Open* 8(9):e025358. doi: 10.1136/bmjopen-2018-025358.

Baumgartner, F., and B. Jones. 1993. *Agendas and Instability in American Politics*. University of Chicago Press.

Bekken, Wenche, Espen Dahl, and Kjetil Van Der Wel. 2017. “Tackling Health Inequality at the Local Level: Some Critical Reflections on the Future of Norwegian Policies.” *Scandinavian Journal of Public Health* 45(18_suppl):56–61. doi: 10.1177/1403494817701012.

Bergqvist, Kersti, Monica Åberg Yngwe, and Olle Lundberg. 2013. “Understanding the Role of Welfare State Characteristics for Health and Inequalities – an Analytical Review.” *BMC Public Health* 13(1):1234. doi: 10.1186/1471-2458-13-1234.

Berkman, Lisa F., and I. Kawachi. 2000. *Social Epidemiology*.

Blackwell, Debra L., Michael E. Martinez, Jane F. Gentleman, Claudia Sanmartin, and Jean-Marie Berthelot. 2009. “Socioeconomic Status and Utilization of Health Care Services in Canada and the United States: Findings From a Binational Health Survey.” *Medical Care* 47(11):1136. doi: 10.1097/MLR.0b013e3181adcbe9.

Blankenau, Joe. 2001. “The Fate of National Health Insurance in Canada and the United States: A Multiple Streams Explanation.” *Policy Studies Journal* 29(1):38–55. doi: 10.1111/j.1541-0072.2001.tb02073.x.

Braun, v, and v Clarke. 2008. “Using Thematic Analysis in Psychology: Qualitative Research in Psychology: Vol 3, No 2.”

Braveman, P., and S. Gruskin. 2003. “Defining Equity in Health.” *Journal of Epidemiology & Community Health* 57(4):254–58. doi: 10.1136/jech.57.4.254.

Braveman, Paula. 2010. “Social Conditions, Health Equity, and Human Rights Social Conditions of Health: Convergences and Disjunctures: Critical Concepts.”

Brennenstuhl, Sarah, Amélie Quesnel-Vallée, and Peggy McDonough. 2012. “Welfare Regimes, Population Health and Health Inequalities: A Research Synthesis.” *J Epidemiol Community Health* 66(5):397–409. doi: 10.1136/jech-2011-200277.

Brice, Sophie, and Helen Almond. 2020. “Health Professional Digital Capabilities Frameworks: A Scoping Review.” *Journal of Multidisciplinary Healthcare* 13:1375–90. doi: 10.2147/JMDH.S269412.

Brookes, Gavin. 2021. “Empowering People to Make Healthier Choices: A Critical Discourse Analysis of the Tackling Obesity Policy.” *Qualitative Health Research* 31(12):2211–29. doi: 10.1177/10497323211027536.

Brownson, Ross C., Shiriki Kumanyika, Matthew Kreuter, and Debra Haire-Joshu. 2021. “Implementation Science Should Give Higher Priority to Health Equity | Implementation Science | Full Text.” Retrieved July 9, 2024 (https://implementationscience.biomedcentral.com/articles/10.1186/s13012-021-01097-0).

Bryant, Toba. 2002. “Role of Knowledge in Public Health and Health Promotion Policy Change*.” *Health Promotion International* 17(1):89–98. doi: 10.1093/heapro/17.1.89.

Bryant, Toba. 2009. “Social Inequalities, Public Policy, and Health.” *Humanity & Society* 33(1–2):118–44. doi: 10.1177/016059760903300108.

Bryant, Toba. 2016. “Health Policy in Canada, Second Edition - Canadian Scholars.” Retrieved June 26, 2024 (https://canadianscholars.ca/book/health-policy-in-canada-second-edition/).

Bryant, Toba, Scott Aquanno, and Dennis Raphael. 2020. “Unequal Impact of COVID-19: Emergency Neoliberalism and Welfare Policy in Canada: Unequal Impact of COVID-19.” *Critical Studies: An International and Interdisciplinary Journal* 15(1):22–39. doi: 10.51357/cs.v15i1.108.

Bryant, Toba, and Dennis Raphael. 2018. “Welfare States, Public Health and Health Inequalities.” *Oxford Bibliographies*. doi: 10.1093/obo/9780199756797-0178.

Bryant, Toba, Dennis Raphael, and Marcia Rioux. 2019. *Staying Alive: Critical Perspectives on Health, Illness, and Health Care*. 3rd edition. Canadian Scholars.

Bryant, Toba, Dennis Raphael, Ted Schrecker, and Robert Labonte. 2011. “Canada: A Land of Missed Opportunity for Addressing the Social Determinants of Health.” *Health Policy* 101(1).

Burges Watson, Duika, Alizon Draper, and Wendy Wills. 2021. “The Chimera of Choice in UK Food Policy 1976–2018.” *British Food Journal* 123(4):1596–1609. doi: 10.1108/BFJ-10-2020-0982.

Campbell, David J. T., Braden J. Manns, Robert G. Weaver, Brenda R. Hemmelgarn, Kathryn M. King-Shier, and Claudia Sanmartin. 2017. “Financial Barriers and Adverse Clinical Outcomes among Patients with Cardiovascular-Related Chronic Diseases: A Cohort Study.” *BMC Medicine* 15(1):33. doi: 10.1186/s12916-017-0788-6.

Canada, Public Health Agency of. 2023. “Canadian Network for Public Health Intelligence (Infographic).” Retrieved October 3, 2024 (https://www.canada.ca/en/public-health/services/publications/science-research-data/canadian-network-public-health-intelligence-infographic.html).

Canadian Institute for Health Information. 2024. “National Health Expenditure Trends | CIHI.” Retrieved January 11, 2025 (https://www.cihi.ca/en/national-health-expenditure-trends).

Carey, Gemma, and Brad Crammond. 2015. “Systems Change for the Social Determinants of Health.” *BMC Public Health* 15(1):662. doi: 10.1186/s12889-015-1979-8.

Carey, Gemma, Brad Crammond, and Evelyne De Leeuw. 2015. “Towards Health Equity: A Framework for the Application of Proportionate Universalism.” *International Journal for Equity in Health* 14(1):81. doi: 10.1186/s12939-015-0207-6.

Carey, Gemma, Eleanor Malbon, Brad Crammond, Melanie Pescud, and Philip Baker. 2017. “Can the Sociology of Social Problems Help Us to Understand and Manage ‘Lifestyle Drift’?” *Health Promotion International* 32(4):755–61. doi: 10.1093/heapro/dav116.

Carroll, WK. 2004. *Critical Strategies for Social Research*.

Chin, Marshall H., Paula T. King, Rhys G. Jones, Bryn Jones, Shanthi N. Ameratunga, Naoko Muramatsu, and Sarah Derrett. 2018. “Lessons for Achieving Health Equity Comparing Aotearoa/New Zealand and the United States.” *Health Policy* 122(8):837–53. doi: 10.1016/j.healthpol.2018.05.001.

Chung, Haejoo, and Carles Muntaner. 2006. “Political and Welfare State Determinants of Infant and Child Health Indicators: An Analysis of Wealthy Countries.” *Social Science & Medicine* 63(3):829–42. doi: 10.1016/j.socscimed.2006.01.030.

Coburn, David. 2004. “Beyond the Income Inequality Hypothesis: Class, Neo-Liberalism, and Health Inequalities - ScienceDirect.” Retrieved June 26, 2024 (https://www.sciencedirect.com/science/article/pii/S027795360300159X?casa_token=cpZIPAuGMdMAAAAA:SPIscm9LEpAhMhziXRWKoQv8id0aDUXAHF1yl-uLvU0hh96IFhxPB4hUS0M2bb8USlGvpcLCK1M).

Commission on Social Determinants of Health, (CSDOH). 2008. *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health - Final Report of the Commission on Social Determinants of Health*. WHO.

Costa-Font, Joan. 2017. “The National Health Service at a Critical Moment: When Brexit Means Hectic.” *Journal of Social Policy* 46(4):783–95. doi: 10.1017/S0047279417000344.

Crenshaw, K. 1990. “Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color.” *Stanford Law Review*.

Czyzewski, Karina. 2011. “Colonialism as a Broader Social Determinant of Health.” *The International Indigenous Policy Journal* 2(1). doi: 10.18584/iipj.2011.2.1.5.

Dahlgren, Goran, and Margaret Whitehead. 1991. “Policies and Strategies to Promote Social Equity in Health. Background Document to WHO - Strategy Paper for Europe.”

Damrongplasit, Kannika, Cheng Hsiao, and Xueyan Zhao. 2019. “Health Status and Labour Market Outcome: Empirical Evidence from Australia.” *Pacific Economic Review* 24(2):269–92. doi: 10.1111/1468-0106.12257.

Danielsen, Elisabet, Christer Mjåset, Tor Ingebrigtsen, Sasha Gulati, Margreth Grotle, Jan Håkon Rudolfsen, Øystein P. Nygaard, and Tore K. Solberg. 2022. “A Nationwide Study of Patients Operated for Cervical Degenerative Disorders in Public and Private Hospitals.” *Scientific Reports* 12(1):12856. doi: 10.1038/s41598-022-17194-z.

Denzin, N., and Y. Lincoln, eds. 2011. *The SAGE Handbook of Qualitative Research - Google Books*.

Di Ruggiero, Erica, Adria Rose, and Kim Gaudreau. 2009. “Canadian Institutes of Health Research Support for Population Health Intervention Research in Canada.” *Canadian Journal of Public Health* 100(1):I15–19. doi: 10.1007/BF03405504.

Diderichsen, F., T. Evans, and M. Whitehead. 2001. “The Social Basis of Disparities in Health.” Pp. 12–23 in *Challenging Inequities in Health: From Ethics to Action*.

Dobbins, Maureen, Alejandra Dubois, Donna Atkinson, Olivier Bellefleur, Margaret Haworth=Brockman, and Lydia Ma. 2021. “Commentary – Nimble, Efficient and Evolving: The Rapid Response of the National Collaborating Centres to COVID-19 in Canada.” doi: https://doi.org/10.24095/hpcdp.41.5.03.

Dye, Thomas R. 1972. *Understanding Public Policy*.

Economist Intelligence. 2022. “Global Food Security Index (GFSI).”

Edgley, Alison, Theodore Stickley, Stephen Timmons, and Andy Meal. 2014. “Full Article: Critical Realist Review: Exploring the Real, beyond the Empirical.”

Eikemo, T. A., and C. Bambra. 2008. “The Welfare State: A Glossary for Public Health.” *Journal of Epidemiology & Community Health* 62(1):3–6. doi: 10.1136/jech.2007.066787.

Eikemo, T. A., C. Bambra, K. Joyce, and Espen Dahl. 2008. "Welfare State Regimes and Income-Related Health Inequalities: A Comparison of 23 European Countries." *European Journal of Public Health* 18(6):593–99. doi: 10.1093/eurpub/ckn092.

Eikemo, Terje Andreas, Clare Bambra, Ken Judge, and Kristen Ringdal. 2008. "Welfare State Regimes and Differences in Self-Perceived Health in Europe: A Multilevel Analysis." *Social Science & Medicine* 66(11):2281–95. doi: 10.1016/j.socscimed.2008.01.022.

Elomäki, Anna. 2019. "Governing Austerity: Governance Reforms as Facilitators of Gendered Austerity in Finland." *Australian Feminist Studies* 34(100):182–97. doi: 10.1080/08164649.2019.1644607.

Esping-Andersen, Gosta. 1985. "Power and Distributional Regimes." *Politics & Society* 14(2):223–56. doi: 10.1177/003232928501400204.

Esping-Andersen, Gosta. 1990. "The Three Worlds of Welfare Capitalism - Gosta Esping-Andersen - Google Books." Retrieved June 26, 2024.

Exworthy, Mark, David Blane, and Michael Marmot. 2003. "Tackling Health Inequalities in the United Kingdom: The Progress and Pitfalls of Policy." *Health Services Research* 38(6 Pt 2):1905–22. doi: 10.1111/j.1475-6773.2003.00208.x.

Feeny, David, Mark S. Kaplan, Nathalie Huguet, and Bentson H. McFarland. 2010. "Comparing Population Health in the United States and Canada." *Population Health Metrics* 8(1):8. doi: 10.1186/1478-7954-8-8.

Ferrera, Maurizio. 1996. "The 'Southern Model' of Welfare in Social Europe." *Journal of European Social Policy* 6(1):17–37. doi: 10.1177/095892879600600102.

Fleming, Mary Louise, Melinda Service, Trish Gould, and Elizabeth Parker. 2009. "Educating the Public Health Workforce: Issues and Challenges." *Australia and New Zealand Health Policy* 6(1). doi: 10.1071/hp090608.

Flood, Colleen, William Lahey, and Bryan Thomas. 2017. "Federalism and Health Care in Canada: A Troubled Romance?" P. 0 in *The Oxford Handbook of the Canadian Constitution*, edited by P. Oliver, P. Macklem, and N. Des Rosiers. Oxford University Press.

Fosse, Karin, and Marit Helegsen. 2019. "Policies to Address the Social Determinants of Health in the Nordic Countries." Retrieved June 26, 2024 (https://www.diva-portal.org/smash/record.jsf?pid=diva2%3A1366078&dswid=2501).

Fosse, Karin, and Marit K. Helgesen. 2019. *Policies to Address the Social Determinants of Health in the Nordic Countries*.

Fox, Haylee, Stephanie M. Topp, Emily Callander, and Daniel Lindsay. 2019. "A Review of the Impact of Financing Mechanisms on Maternal Health Care in Australia." *BMC Public Health* 19(1):1540. doi: 10.1186/s12889-019-7850-6.

Francis-Oliviero, Florence, Linda Cambon, Jérôme Wittwer, Michael Marmot, and François Alla. 2020. “Theoretical and Practical Challenges of Proportionate Universalism: A Review.” *Revista Panamericana De Salud Pública* 44. doi: 10.26633/rpsp.2020.110.

Game, Chris. 2016. “Decentralisation and Devolution in the United Kingdom.” Pp. 1–34 in *Comparative Studies and Regionally-Focused Cases Examining Local Governments*. IGI Global.

Geber, Jonny, and Barra O’Donnabhain. 2020. “‘Against Shameless and Systematic Calumny’: Strategies of Domination and Resistance and Their Impact on the Bodies of the Poor in Nineteenth-Century Ireland.” *Historical Archaeology* 54(1):160–83. doi: 10.1007/s41636-019-00219-2.

Giacomini, Mita, Shawn Winsor, and Julia Abelson. 2013. “Ethics in Health Technology Assessment: Understanding Health Technologies as Policies.” *Healthcare Management Forum* 26(2):72–76. doi: 10.1016/j.hcmf.2013.04.004.

Glavin, Kari, Marjorie A. Schaffer, and Lisbeth G. Kvarme. 2019. “The Public Health Intervention Wheel in Norway.” *Public Health Nursing* 36(6):819–28. doi: 10.1111/phn.12657.

Global Network for Health in All Policies Secretariat. 2017. “Global Network for Health in All Policies.” *Global Network for Health in All Policies*. Retrieved January 18, 2025 (https://actionsdg.ctb.ku.edu/).

Gough, Brendan. 2017. “Reflexivity in Qualitative Psychological Research.” *The Journal of Positive Psychology* 12(3):311–12. doi: 10.1080/17439760.2016.1262615.

Government of Australia. 2023. “Measuring What Matters | Treasury.Gov.Au.” Retrieved January 18, 2025 (https://treasury.gov.au/policy-topics/measuring-what-matters).

Government of Canada. 1867. “The Constitution Acts, 1867/1982.”

Government of Canada, Department of Justice. 2016. “The Canadian Constitution - About Canada’s System of Justice.” Retrieved September 25, 2024 (https://www.justice.gc.ca/eng/csj-sjc/just/05.html).

Government of Canada, Public Services and Procurement Canada. 1999. “Toward a Healthy Future : Second Report on the Health of Canadians / Prepared by the Federal, Provincial and Territorial Advisory Committee on Population Health.: H39-468/1999E-PDF - Government of Canada Publications - Canada.Ca.” Retrieved September 26, 2024 (https://publications.gc.ca/site/eng/9.696295/publication.html).

Government of Scotland. 2019. *Wellbeing Report - Chapter 1 | National Performance Framework*.

Graham, Heather. 2004. “Social Determinants and Their Unequal Distribution: Clarifying Policy Understandings.” *The Milbank Quarterly* 82(1):104–24. doi: https://doi.org/10.1111/j.0887-378X.2004.00303.x.

Gray, Selena F., and David Evans. 2018. “Developing the Public Health Workforce: Training and Recognizing Specialists in Public Health from Backgrounds Other than Medicine: Experience in the UK.” *Public Health Reviews* 39(1):14. doi: 10.1186/s40985-018-0091-x.

Greer, S. L. (2004). Territorial politics and health policy: UK health policy in comparative perspective. Manchester University Press.Hackett, Christina, David Feeny, and Emile Tompa. 2016. “Canada’s Residential School System: Measuring the Intergenerational Impact of Familial Attendance on Health and Mental Health Outcomes.” *J Epidemiol Community Health* 70(11):1096–1105. doi: 10.1136/jech-2016-207380.

Hackett, Ruth A., Amy Ronaldson, Kamaldeep Bhui, Andrew Steptoe, and Sarah E. Jackson. 2020. “Racial Discrimination and Health: A Prospective Study of Ethnic Minorities in the United Kingdom.” *BMC Public Health* 20(1):1652. doi: 10.1186/s12889-020-09792-1.

Hagedorn, Jenn, Claudia Alexandra Paras, Howard Greenwich, and Amy Hagopian. 2016. “The Role of Labor Unions in Creating Working Conditions That Promote Public Health.” *American Journal of Public Health* 106(6):989–95. doi: 10.2105/AJPH.2016.303138.

Hall, Peter, and Rosemary Taylor. 1996. “Political Science and the Three New Institutionalisms.” *Political Studies* XLIV:936–57.

Halsall, Tanya, Heather Orpana, and Misha Jan. 2024. “We Cannot Keep Doing What We Have Always Done and Expect That Things Will Be Different: A Scoping Review of the Lifestyle Drift Concept | Research Square.” Pre-print retrieved June 26, 2024 (https://www.researchsquare.com/article/rs-4373279/v1).

Hamilton, N., and T. Bhatti. 1996. “Population Health Promotion: An Integrated Model of Population Health and Health Promotion.”

Hancock. 2011. “Health Promotion in Canada: 25 Years of Unfulfilled Promise | Health Promotion International | Oxford Academic.”

Hankivsky, Olena, and Ashlee Christoffersen. 2008. “Intersectionality and the Determinants of Health: A Canadian Perspective.” *Critical Public Health* 18(3):271–83. doi: https://doi.org/10.1080/09581590802294296.

Hanusaik, Nancy, Catherine M. Sabiston, Natalie Kishchuk, Katerina Maximova, and Jennifer O’Loughlin. 2015. “Association between Organizational Capacity and Involvement in Chronic Disease Prevention Programming among Canadian Public Health Organizations.” *Health Education Research* 30(2):206–22. doi: 10.1093/her/cyu062.

Harjula, Minna. 2016. “Health Citizenship and Access to Health Services: Finland 1900–2000.” *Social History of Medicine* 29(3):573–89. doi: 10.1093/shm/hkv144.

Harvey, Lee. 2022. “Critical Social Research: Re-Examining Quality.” *Quality in Higher Education* 28(2):145–52. doi: 10.1080/13538322.2022.2037762.

Haverinen, Jari, Miia Turpeinen, Petra Falkenbach, and Jarmo Reponen. 2022. “Implementation of a New Digi-HTA Process for Digital Health Technologies in Finland.” *International Journal of Technology Assessment in Health Care* 38(1): e68. doi: 10.1017/S0266462322000502.

Hawe, Penelope, and Louise Potvin. 2009. “What Is Population Health Intervention Research?” *Canadian Journal of Public Health* 100(1): I8–14. doi: 10.1007/BF03405503.

Hawkins, Benjamin, Pepita Barlow, May CI van Schalkwyk, and Chris Holden. 2023. “Brexit, Trade and the Governance of Non-Communicable Diseases: A Research Agenda.” *Globalization and Health* 19(1):61. doi: 10.1186/s12992-023-00956-3.

Healey, Gwen Katheryn. n.d. “Inuit Family Perspectives and Stories about Sexual Health and Relationships in Nunavut.” Ph.D., University of Toronto (Canada), Canada -- Ontario, CA.

Healey, Gwen Katheryn, Jennifer Noah, and Ceporah Mearns. 2016. “The Eight Ujarait (Rocks) Model: Supporting Inuit Adolescent Mental Health with an Intervention Model Based on Inuit Ways of Knowing.” *International Journal of Indigenous Health* 11(1):92–110. doi: 10.18357/ijih111201614394.

Health Behaviour in School Aged Children Survey and Dataset. 2023. “Mean Mental Well-Being (WHO-5) Score by Family Affluence, by Country and Gender.”

Heimburg, Dina Von, Isaac Prilleltensky, Ottar Ness, and Borgunn Ytterhus. 2022. “From Public Health to Public Good: Toward Universal Wellbeing.” *Scandinavian Journal of Public Health* 50(7):1062–70. doi: 10.1177/14034948221124670.

Higgins, Noelle. 2018. “Creating a Space for Indigenous Rights: The Universal Periodic Review as a Mechanism for Promoting the Rights of Indigenous Peoples.” *The International Journal of Human Rights:* 23. doi: https://doi.org/10.1080/13642987.2018.1561438.

Hobbs, Harry. 2018. “Aboriginal and Torres Strait Islander Peoples and Multinational Federalism in Australia.” *Griffith Law Review* 27(3):307–36. doi: 10.1080/10383441.2018.1557587.

Holland, Paula, Lotta Nylén, Karsten Thielen, Kjetil A. van der Wel, Wen-Hao Chen, Ben Barr, Bo Burström, Finn Diderichsen, Per Kragh Andersen, Espen Dahl, Sharanjit Uppal, Stephen Clayton, and Margaret Whitehead. 2011. “How Do Macro-Level Contexts and Policies Affect the Employment Chances of Chronically Ill and Disabled People? Part II: The Impact of Active and Passive Labor Market Policies.” *International Journal of Health Services* 41(3):415–30. doi: 10.2190/HS.41.3. b.

Hong, Jimin, and Sung Hun Seog. 2023. “Health Insurance System and Resilience to Epidemics.” *Risk Analysis* 43(1):97–114. doi: 10.1111/risa.14005.

Hughes, Gerard. 2003. “Private Pensions and Equity in Ireland and the UK.” *Pensions: An International Journal* 8(2):167–78. doi: 10.1057/palgrave.pm.5940225.

Huikko-Tarvainen, Sari, Pasi Sajasalo, and Tommi Auvinen. 2021. “Just a Leader? Leadership Work Challenges and Identity Contradiction Experienced by Finnish Physician Leaders.” *Journal of Health Organization and Management* 35(9):195–210. doi: 10.1108/JHOM-10-2020-0421.

Institut national de sante publique du Quebec. 2025. “Health in All Policies.” *National Collaborating Centre for Healthy Public Policy*. Retrieved January 18, 2025 (https://ccnpps-ncchpp.ca/health-in-all-policies/).

Jacques, Olivier, and Alain Noël. 2022. “Welfare State Decommodification and Population Health.” *PLOS ONE* 17(8): e0272698. doi: 10.1371/journal.pone.0272698.

Jain, Vageesh, Jonathan Clarke, and Thomas Beaney. 2021. “Democratic Governance and Excess Mortality during the COVID-19 Pandemic.” 2021.08.25.21262614.

Jain, Vageesh, Jonathan Clarke, and Thomas Beaney. 2022. “Association between Democratic Governance and Excess Mortality during the COVID-19 Pandemic: An Observational Study.” *J Epidemiol Community Health* 76(10):853–60. doi: 10.1136/jech-2022-218920.

James, Erin, Martín Lajous, and Michael R. Reich. 2020. “The Politics of Taxes for Health: An Analysis of the Passage of the Sugar-Sweetened Beverage Tax in Mexico.” *Health Systems & Reform* 6(1): e1669122. doi: 10.1080/23288604.2019.1669122.

Jamieson, Michelle K., Gisela H. Govaart, and Madeleine Pownall. 2023. “Reflexivity in Quantitative Research: A Rationale and Beginner’s Guide.” *Social and Personality Psychology Compass* 17(4): e12735. doi: 10.1111/spc3.12735.

Kammer, Andreas, Judith Niehues, and Andreas Peichl. 2012. “Welfare Regimes and Welfare State Outcomes in Europe.” *Journal of European Social Policy* 22(5):455–71. doi: 10.1177/0958928712456572.

Kang, Ji Young. 2020. “Institutions and the Gender Wage Gap: How Production and Welfare Regime Moderates the Effect of Family Policy.” *International Journal of Social Welfare* 30(1):46–57. doi: 10.1111/ijsw.12428.

Kautto, Mikko, Bjørn Hvinden, Johan Fritzell, Jon Kvist, and Hannu Uusitalo. 2001. “Introduction: How Distinct Are the Nordic Welfare States?” Pp. 1–17 in *Nordic Welfare States in the European Context*, edited by J. Fritzell, Bjorn Hvinden, M. Kautto, J. Kvist, and H. Uusitalo. London: Routledge.

Kawachi, I., Subramanian, and Almeida-Filho. 2002. “A Glossary for Health Inequalities | Journal of Epidemiology & Community Health.” Retrieved July 28, 2024 (https://jech.bmj.com/content/56/9/647.short).

Kemp, Lynn, Kathy Donohoe, Prue Matthews, and Wendy Aspery. 2024. “Translating ‘Proportionate Universal Healthcare’ into Meaningful System Design to Optimize Equity in Child and Family Services.” *Journal of Advanced Nursing*. doi: 10.1111/jan.16298.

Kernaghan, Kenneth. 2009. “Speaking Truth to Academics: The Wisdom of the Practitioners.” *Canadian Public Administration* 52(4):503–23. doi: 10.1111/j.1754-7121.2009.00099. x.

Kickbusch, Ilona. 2003. “The Contribution of the World Health Organization to a New Public Health and Health Promotion.” *American Journal of Public Health* 93(3):383–88. doi: 10.2105/AJPH.93.3.383.

Kim, Paul J. 2019. “Social Determinants of Health Inequities in Indigenous Canadians Through a Life Course Approach to Colonialism and the Residential School System.” *Health Equity* 3(1):378–81. doi: 10.1089/heq.2019.0041.

Kingdom of Norway. 1814. “The Constitution of the Kingdom of Norway.” Retrieved September 25, 2024 (https://lovdata.no/dokument/NLE/lov/1814-05-17).

Klavus, Jan, and Pekka Rissanen. 2018. “Evidence and Projections on the Progressivity of Health Care Financing in Finland.” *Nordic Journal of Health Economics* 6(1):49–62. doi: 10.5617/njhe.5461.

Klepp, Helleve, and Rutter. 2022. “Improving the Health of Adolescents: The Nordic Countries Can Help Fill the Evidence Gap.”

Klinberg, Sonja, Bipin Adhikari, Catherine Draper, Edna Bosire, Priscilla Tiigah, Deborah Nyirenda, and Ferdinand Mukumbang. 2021. “Engaging Communities in Non-Communicable Disease Research and Interventions in Low- and Middle-Income Countries: A Realist Review Protocol.”

Koh, Amanda, De Wet Swanepoel, Annie Ling, Beverly Lorraine Ho, Si Ying Tan, and Jeremy Lim. 2021. “Digital Health Promotion: Promise and Peril.” *Health Promotion International* 36(Supplement_1): i70–80. doi: 10.1093/heapro/daab134.

Kokko, Sami, Anne Liveng, and Steffen Torp. 2018. “20 Years of Health Promotion Research in the Nordic Countries: Health, Wellbeing and Physical Activity.” *Scandinavian Journal of Public Health* 46(20_suppl):3–6. doi: 10.1177/1403494817751041.

Kram, Kathy E., Ilene C. Wasserman, and Jeffrey Yip. 2012. “Metaphors of Identity and Professional Practice: Learning from the Scholar–Practitioner.” *The Journal of Applied Behavioral Science* 48(3):304–41. doi: 10.1177/0021886312439097.

Lalonde, Marc. 1974. “A New Perspective on the Health of Canadians.”

Lambert, Leah K., Tara C. Horrill, Scott M. Beck, Amber Bourgeois, Annette J. Browne, Shannon Cheng, A. Fuchsia Howard, Jagbir Kaur, Michael McKenzie, Kelli I. Stajduhar, and Sally Thorne. 2023. “Health and Healthcare Equity within the Canadian Cancer Care Sector: A Rapid Scoping Review.” *International Journal for Equity in Health* 22(1):20. doi: 10.1186/s12939-023-01829-2.

de Leeuw, Evelye, Carole Clavier, and Eric Breton. 2014. “Health Policy – Why Research It and How: Health Political Science.” *Health Research Policy and Systems*.

Link, Bruce G., and Jo Phelan. 1995. “Social Conditions as Fundamental Causes of Disease.” *Journal of Health and Social Behavior* 80–94. doi: 10.2307/2626958.

Loignon, Christine, Catherine Hudon, Émilie Goulet, Sophie Boyer, Marianne De Laat, Nathalie Fournier, Cristina Grabovschi, and Paula Bush. 2015. “Perceived Barriers to Healthcare for Persons Living in Poverty in Quebec, Canada: The EQUIhealThY Project.” *International Journal for Equity in Health* 14(1):4. doi: 10.1186/s12939-015-0135-5.

Lynch, Julia. 2020. *Regimes of Inequality: The Political Economy of Health and Wealth*.

Lynch, Julia, and Isabel Perera. 2017. “Framing Health Equity: US Health Disparities in Comparative Perspective.” *Journal of Health Politics, Policy and Law*.

Lyttkens, Carl Hampus, Terkel Christiansen, Unto Häkkinen, Oddvar Kaarboe, Matt Sutton, and Anna Welander. 2016. “The Core of the Nordic Health Care System Is Not Empty.” *Nordic Journal of Health Economics* 4(1):7–27. doi: 10.5617/njhe.2848.

Mackenbach, Johan P., José Rubio Valverde, Barbara Artnik, Matthias Bopp, Henrik Brønnum-Hansen, Patrick Deboosere, Ramune Kalediene, Katalin Kovács, Mall Leinsalu, Pekka Martikainen, Gwenn Menvielle, Enrique Regidor, Jitka Rychtaříková, Maica Rodriguez-Sanz, Paolo Vineis, Chris White, Bogdan Wojtyniak, Yannan Hu, and Wilma J. Nusselder. 2018. “Trends in Health Inequalities in 27 European Countries.” *Proceedings of the National Academy of Sciences* 115(25):6440–45. doi: 10.1073/pnas.1800028115.

Mackillop, Andrew. 2022. “Poverty, Health, and Imperial Wealth in Early Modern Scotland.”

Macmillan, Ross, Naila Shofia, and Wendy Sigle-Rushton. 2018. “Gender and the Politics of Death: Female Representation, Political and Developmental Context, and Population Health in a Cross-National Panel.” *Demography* 55(5). doi: 10.1007/s13524-018-0697-0.

Marmot, Michael. 2005. “Social Determinants of Health Inequalities.” *The Lancet* 365(9464):1099–1104. doi: 10.1016/S0140-6736(05)71146-6.

Marmot, Michael. 2020. “Health Equity in England: The Marmot Review 10 Years On.” *BMJ* 368:m693. doi: 10.1136/bmj.m693.

Martin, Danielle, Ashley P. Miller, Amélie Quesnel-Vallée, Nadine R. Caron, Bilkis Vissandjée, and Gregory P. Marchildon. 2018. “Canada’s Universal Health-Care System: Achieving Its Potential.” *The Lancet* 391(10131):1718–35. doi: 10.1016/S0140-6736(18)30181-8.

Martin, Debbie H. 2012. “Two-Eyed Seeing: A Framework for Understanding Indigenous and Non-Indigenous Approaches to Indigenous Health Research.” *Canadian Journal of Nursing Research Archive* 20–43.

Matthews, Richard. 2017. “The Cultural Erosion of Indigenous People in Health Care.” *CMAJ* 189(2): E78–79. doi: 10.1503/cmaj.160167.

McGibbon, Elizabeth. 2024. *The Politics of Social, Ecological, and Structural Determinants of Health in Canada*.

McGibbon, Elizabeth, and Charmaine McPherson. 2011. "Applying Intersectionality & Complexity Theory to Address the Social Determinants of Women's Health."

McGrail, Kimberlyn M., Eddy van Doorslaer, Nancy A. Ross, and Claudia Sanmartin. 2009. "Income-Related Health Inequalities in Canada and the United States: A Decomposition Analysis." *American Journal of Public Health* 99(10):1856–63. doi: 10.2105/AJPH.2007.129361.

Medvedyuk, Stella, Piara Govender, and Dennis Raphael. 2021. "The Reemergence of Engels' Concept of Social Murder in Response to Growing Social and Health Inequalities." *Social Science & Medicine* 289:114377. doi: 10.1016/j.socscimed.2021.114377.

Mehrara, Lydia, and Susan Young. 2020. "Health Equity and Universal Provision in Norway: A Case Study." *Nordic Journal of Social Research* 11(1):39–65. doi: 10.7577/njsr.2638.

Mehus, Grete, Berit Andersdatter Bongo, Janne Isaksen Engnes, and Pertice M. Moffitt. 2019. "Exploring Why and How Encounters with the Norwegian Health-Care System Can Be Considered Culturally Unsafe by North Sami-Speaking Patients and Relatives: A Qualitative Study Based on 11 Interviews." *International Journal of Circumpolar Health* 78(1):1612703. doi: 10.1080/22423982.2019.1612703.

Meier, BM, and F. Kastler. 2018. *Human Rights in Global Health: Rights-Based Governance for a Globalizing World*.

Meier, Petra S., John Holmes, Colin Angus, Abdallah K. Ally, Yang Meng, and Alan Brennan. 2016. "Estimated Effects of Different Alcohol Taxation and Price Policies on Health Inequalities: A Mathematical Modelling Study." *PLOS Medicine* 13(2): e1001963. doi: 10.1371/journal.pmed.1001963.

Melkas, Tapani. 2013. "Health in All Policies as a Priority in Finnish Health Policy: A Case Study on National Health Policy Development." *Scandinavian Journal of Public Health* 41(11_suppl):3–28. doi: 10.1177/1403494812472296.

Mills, C. Wright. 2023. "The Sociological Imagination." in *Social Work*. Routledge.

Mold, A., and V. Berridge. 2013. "The History of Health Promotion."

Montgomery, Lindsay M. 2020. "A Rejoinder to Body Bags: Indigenous Resilience and Epidemic Disease, from COVID-19 to First 'Contact.'" *American Indian Culture and Research Journal* 44(3). doi: 10.17953/aicrj.44.3.montgomery.

Mörkenstam, Ulf, Per Selle, and Sanna Valkonen. 2022. "Who Are 'We, the People'? A Comparative Analysis of the Right to Register in the Sámi Electoral Roll in Finland, Norway and Sweden." in *The Sámi World*. Routledge.

Mullard, Jordan Christina Ruth. 2021. “Race, Racism and Anthropology: Decolonising Health Inequality in a Time of Covid-19.” *Medicine Anthropology Theory* 8(1):1–19. doi: 10.17157/mat.8.1.5112.

Mundel, Erika, and Gwen E. Chapman. 2010. “A Decolonizing Approach to Health Promotion in Canada: The Case of the Urban Aboriginal Community Kitchen Garden Project.” *Health Promotion International* 25(2):166–73. doi: 10.1093/heapro/daq016.

Nampoothiri, Niranjan, and Filippo Artuso. 2021. “Civil Society’s Response to Coronavirus Disease 2019: Patterns from Two Hundred Case Studies of Emergent Agency.” *Journal of Creative Communications* 16(2). doi: 10.1177/09732586211015057.

National Collaborating Centre for Determinants of Health. 2013. *Let’s Talk Universal and Targeted Approaches to Health Equity*. Antigonish, Nova Scotia, Canada: St. Francis Xavier University.

National Collaborating Centre on Determintas of Health. 2014. *Let’s Talk: Moving Upstream | National Collaborating Centre for Determinants of Health*.

National Institute for Health and Welfare. 2012. *Kuilun Kaventajat- Kansallinen Terveyserojen Kaventamisen Tointaohjelma 2008-2011 [Narrowing the Gap. the National Action Plan to Reduce Health Inequalities 2008-2011- Final Report*. Helsinki, Finland.

Navarro, Vicente, and Leiyu Shi. 2001. “The Political Context of Social Inequalities and Health.” *International Journal of Health Services* 31(1):1–21. doi: 10.2190/1GY8-V5QN-A1TA-A9KJ.

Navarro, Vincent, Carles Muntanger, Carme Borrell, Jean Benach, Agueda Quiroga, Maica Rodriguez-Sanz, Nuria Verges, and M. Isabel Pasarin. 2006. “Politics and Health Outcomes.”

Naylor, CD, M. Basrur, Robert Bergeron, David Butler-Jones, and G. Dafoe. 2003. “Learning from SARS: Renewal of Public Health in Canada: A Report of the National Advisory Committee on SARS and Public Health.”

Ndumbe-Eyoh, Sume, Pemma Muzumdar, Claire Betker, and Diane Oickle. 2021. “‘Back to Better’: Amplifying Health Equity, and Determinants of Health Perspectives during the COVID-19 Pandemic.” *Global Health Promotion* 28(2):7–16. doi: 10.1177/17579759211000975.

Noak, H. 1990. *Conceptualizing and Measuring Health*. WHO Regional Publications.

Norum, Jan, and Carsten Nieder. 2012. “Socioeconomic Characteristics and Health Outcomes in Sami Speaking Municipalities and a Control Group in Northern Norway.” *International Journal of Circumpolar Health* 71(1):19127. doi: 10.3402/ijch. v71i0.19127.

Nutbeam, Don. 1998. “Health Promotion Glossary | Health Promotion International | Oxford Academic.” Retrieved June 26, 2024 (https://academic.oup.com/heapro/article/13/4/349/563193).

OECD. 2020a. “Infant Mortality Rates.”

OECD. 2020b. “OECD Data Explorer • Life Expectancy.”

OECD. 2023a. “Finland’s National Action Plan for the Economy of Wellbeing 2023-25 and Related Initiatives.” *OECD*. Retrieved January 18, 2025 (https://www.oecd.org/en/publications/well-being-knowledge-exchange-platform-kep_93d45d63-en/finland-s-national-action-plan-for-the-economy-of-wellbeing-2023-25-and-related-initiatives_58931a45-en.html).

OECD. 2023b. “Health Spending.”

OECD. 2023c. “Income Inequality- Gini Coefficient.” *OECD*. Retrieved September 15, 2024 (https://www.oecd.org/en/data/indicators/income-inequality.html).

OECD. 2023d. “OECD Temporary Archive- Social Expenditure Database (SOCX).” Retrieved September 14, 2024 (https://web-archive.oecd.org/temp/2024-06-24/63248-expenditure.htm).

OECD. 2023e. “Pension Spending.” *OECD*. Retrieved September 15, 2024 (https://www.oecd.org/en/data/indicators/pension-spending.html).

OECD. 2024a. “Active Labour Market Policies: Connecting People with Jobs.” Retrieved September 15, 2024 (//snapshots.compareyourcountry.org/s-56e82af6420e6?lg=en).

OECD. 2024b. “OECD Data Explorer • Avoidable Mortality.”

OECD. 2024c. “OECD Data Explorer • Collective Bargaining Coverage.” Retrieved September 14, 2024 (https://data-explorer.oecd.org/vis?df[ds]=DisseminateFinalDMZ&df[id]=DSD_TUD_CBC%40DF_CBC&df[ag]=OECD.ELS.SAE&df[vs]=1.0&dq=FIN%2BNOR%2BOECD%2BGBR%2BCAN%2BAUS..&pd=2015%2C&to[TIME_PERIOD]=false&ly[cl]=TIME_PERIOD&ly[rs]=REF_AREA&vw=tb).

Office of National Statistics. 2024. “UK Measures of National Well-Being Dashboard - Office for National Statistics.” Retrieved January 18, 2025 (https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/ukmeasuresofnationalwellbeing/dashboard).

Page, Alan. 2020. “The Scottish Constitution.” P. 0 in *The Oxford Handbook of Scottish Politics*, edited by M. Keating. Oxford University Press.

Pan American Health Organization, (PAHO). 2020. “The Essential Public Health Functions in the Americas.”

Pan-Canadian Health Inequalities Data Tool. A joint initiative of the Public Health Agency of Canada, the Pan-Canadian Public Health Network, Statistics Canada and the Canadian Institute for Health Information. 2017. “Health Inequalities Data Tool.”

Parline, IPU. 2024. “Monthly Ranking of Women in National Parliaments.” *IPU Parline: Global Data on National Parliaments*. Retrieved January 9, 2025 (https://data.ipu.org/women-ranking/).

Pauly, Bernadette (Bernie), Marjorie MacDonald, Trevor Hancock, Wanda Martin, and Kathleen Perkin. 2013. “Reducing Health Inequities: The Contribution of Core Public Health Services in BC.” *BMC Public Health* 13(1):550. doi: 10.1186/1471-2458-13-550.

Pawson, Ray, Trisha Greenhalgh, Gill Harvey, and Kieran Walshe. 2005. “Realist Review - a New Method of Systematic Review Designed for Complex Policy Interventions.” *Journal of Health Services Research & Policy* 10(1_suppl):21–34. doi: 10.1258/1355819054308530.

Peters, Guy. 2019. “Institutional Theory in Political Science, Fourth Edition: The New ... - B. Guy Peters - Google Books.” Retrieved June 27, 2024 (https://books.google.ca/books/about/Institutional_Theory_in_Political_Scienc.html?id=qY6ODwAAQBAJ&redir_esc=y).

Popay, Jennie, Margaret Whitehead, and David J. Hunter. 2010. “Injustice Is Killing People on a Large Scale—but What Is to Be Done about It?” *Journal of Public Health* 32(2):148–49. doi: 10.1093/pubmed/fdq029.

Popham, Frank, Chris Dibben, and Clare Bambra. 2013. “Are Health Inequalities Really Not the Smallest in the Nordic Welfare States? A Comparison of Mortality Inequality in 37 Countries.” *J Epidemiol Community Health* 67(5):412–18. doi: 10.1136/jech-2012-201525.

Poppleton, Aaron, Kelly Howells, Isabel Adeyemi, Carolyn Chew-Graham, Lisa Dikomitis, and Caroline Sanders. 2022. “The Perceptions of General Practice among Central and Eastern Europeans in the United Kingdom: A Systematic Scoping Review.” *Health Expectations* 25(5):2107–23. doi: 10.1111/hex.13433.

Potvin, Louise, and Catherine M. Jones. 2011. “Twenty-Five Years After the Ottawa Charter: The Critical Role of Health Promotion for Public Health.” *Canadian Journal of Public Health* 102(4):244–48. doi: 10.1007/BF03404041.

Public Health Agency of Canada, (PHAC). 2021. “A Vision to Transform Canada’s Public Health System: Chief Public Health Officer’s Report on the State of Public Health in Canada 2021.” Retrieved June 26, 2024 (https://www.canada.ca/en/public-health/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/state-public-health-canada-2021.html).

Public Health England, and Local Government Association. 2016. *Local Wellbeing, Local Growth: Implementing Health in All Policies at a Local Level: Practical Examples*.

Public Health England, and UCL Institute of Health Equity. 2014. *Local Action on Health Inequalities: Tackling Health Inequalities through Action on the Social Determinants of Health: Lessons from Experience*. London.

Public Health Scotland. 2024a. "Health in All Policies - What Is Health Impact Assessment? - Health Impact Assessment (HIA) - Health Strategy and Outcomes - Resources and Tools - Public Health Scotland." Retrieved January 18, 2025 (https://publichealthscotland.scot/resources-and-tools/health-strategy-and-outcomes/health-impact-assessment-hia/what-is-health-impact-assessment/health-in-all-policies/).

Public Health Scotland. 2024b. "Health Inequalities: How Can We Reduce Health Inequalities?" *Public Health Scotland*. Retrieved (https://publichealthscotland.scot/population-health/social-and-economic-impacts-on-health/equity-and-justice/health-inequalities/how-can-we-reduce-health-inequalities/#:~:text=A%20better%20approach%20is%20called,Cost%2C%20including%20hidden%20costs).

Puska, Pekka, and Timo Ståhl. 2010. "Health in All Policies—The Finnish Initiative: Background, Principles, and Current Issues." *Annual Review of Public Health* 31(Volume 31, 2010):315–28. doi: 10.1146/annurev.publhealth.012809.103658.

Rainford, John. 2015. "Risk Communication Preparedness: MERS CoV and The Stigma Dilemma." *Policy Options*.

Raphael, Dennis. 2008. "Grasping at Straws: A Recent History of Health Promotion in Canada." *Critical Public Health* 18(4):483–95. doi: 10.1080/09581590802443604.

Raphael, Dennis. 2011. "Poverty in Childhood and Adverse Health Outcomes in Adulthood." *Maturitas* 69(1):22–26. doi: 10.1016/j.maturitas.2011.02.011.

Raphael, Dennis. 2012. "Tackling Health Inequalities: Lessons from International Experiences. Toronto: Canadian Scholars' Press. | Request PDF." Retrieved June 26, 2024 (https://www.researchgate.net/publication/234168359_Raphael_D_2012_Tackling_health_inequalities_Lessons_from_international_experiences_Toronto_Canadian_Scholars'_Press).

Raphael, Dennis. 2013a. "The Political Economy of Health Promotion: Part 1, National Commitments to Provision of the Prerequisites of Health†." *Health Promotion International* 28(1):95–111. doi: 10.1093/heapro/dar084.

Raphael, Dennis. 2013b. "The Political Economy of Health Promotion: Part 2, National Provision of the Prerequisites of Health† | Health Promotion International | Oxford Academic." *Health Promotion International*. doi: https://doi.org/10.1093/heapro/dar058.

Raphael, Dennis. 2015a. "Political Economy of Health Promotion: Part 2, National Provision of the Prerequisites of Health† | Health Promotion International | Oxford Academic."

Retrieved June 26, 2024 (https://academic.oup.com/heapro/article/28/1/112/572553?login=false).

Raphael, Dennis. 2015b. "The Political Economy of Health: A Research Agenda for Addressing Health Inequalities in Canada." *Canadian Public Policy* 41(Supplement 2):S17–25. doi: 10.3138/cpp.2014-084.

Raphael, Dennis. 2016. *Social Determinants of Health: Canadian Perspectives*. Toronto: Canadian Scholars' Press.

Raphael, Dennis. 2018. "Understanding the Promotion of Health Equity at the Local Level Requires Far More than Quantitative Analyses of Yes-No Survey Data; Comment on 'Health Promotion at Local Level in Norway: The Use of Public Health Coordinators and Health Overviews to Promote Fair Distribution Among Social Groups.'" Retrieved June 26, 2024 (https://www.ijhpm.com/article_3518.html).

Raphael, Dennis, and Julia Brassolotto. 2015. "Understanding Action on the Social Determinants of Health: A Critical Realist Analysis of in-Depth Interviews with Staff of Nine Ontario Public Health Units." *BMC Research Notes* 8(1):105. doi: 10.1186/s13104-015-1064-5.

Reeves, Aaron. 2021. "The Health Effects of Wage Setting Institutions: How Collective Bargaining Improves Health but Not Because It Reduces Inequality." *Sociology of Health & Illness* 43(4):1012–31. doi: 10.1111/1467-9566.13272.

Regan, Sandra, Marjorie MacDonald, Diane E. Allan, Cheryl Martin, and Nancy Peroff-Johnston. 2014. "Public Health Human Resources: A Comparative Analysis of Policy Documents in Two Canadian Provinces." *Human Resources for Health* 12(1):13. doi: 10.1186/1478-4491-12-13.

Reich, Simon. 2000. "The Four Faces of Institutionalism: Public Policy and a Pluralistic Perspective." *Governance* 13(4):501–22. doi: 10.1111/0952-1895.00143.

Reinders, Kathryn. 2019. "A Rights-Based Approach to Indigenous Sovereignty, Self-Determination and Self-Government in Canada." *SURG Journal* 11. doi: 10.21083/surg.v11i0.4389.

Reynolds, C. 1995. "Public Health and the Australian Constitution." *Australian Journal of Public Health* 19(3):243–49. doi: 10.1111/j.1753-6405.1995.tb00438.x.

Rootman, Irving, Anne Pederson, Katherine Frolich, and Sohpie Dupere, eds. 2017. *Health Promotion in Canada: New Perspectives on Theory, Practice, Policy, and Research*. Fourth edition. Toronto: Canadian Scholars.

Rubin, Herbert, and Irene Rubin. 2011. *Qualitative Interviewing: The Art of Hearing Data*. Sage.

Ruger, Jennifer Prah. 2020. "Social Justice as a Foundation for Democracy and Health." *BMJ* 371:m4049. doi: 10.1136/bmj.m4049.

Sahu, Skylab. 2016. “Health Movement and Civil Society Activism: An Interface of Overlap and Exclusion.” *Studies in Indian Politics* 4(2):206–17. doi: 10.1177/2321023016665531.

Saltman, Richard B., and Juha Teperi. 2016. “Health Reform in Finland: Current Proposals and Unresolved Challenges.” *Health Economics, Policy and Law* 11(3):303–19. doi: 10.1017/S1744133116000013.

Sasakamoose, JoLee, Andrea Scerbe, Ila Wenaus, and Amanda Scandrett. 2016. “First Nation and Métis Youth Perspectives of Health: An Indigenous Qualitative Inquiry.”

Sayani, Ambreen. 2019. “Health Equity in National Cancer Control Plans: An Analysis of the Ontario Cancer Plan.” *International Journal of Health Policy and Management* 8(9):550–56. doi: 10.15171/ijhpm.2019.40.

Sayer, Andrew. 2002. “Critical Realist Methodology: A View from Sweden.” *Journal of Critical Realism* 1(1):168–70. doi: 10.1558/jocr.v1i1.168.

Scheele, Christian Elling, Ingvild Little, and Finn Diderichsen. 2018. “Governing Health Equity in Scandinavian Municipalities: The Inter-Sectorial Challenge.” *Scandinavian Journal of Public Health* 46(1):57–67. doi: 10.1177/1403494816685538.

Schrecker, Ted. 2013. “Beyond ‘Run, Knit and Relax’: Can Health Promotion in Canada Advance the Social Determinants of Health Agenda?” *Healthcare Policy* 9(SP):48–58.

Scruggs, Lyle, and James Allan. 2006. “Welfare-State Decommodification in 18 OECD Countries: A Replication and Revision.” *Journal of European Social Policy - J EUR SOC POLICY* 16:55–72. doi: 10.1177/0958928706059833.

Scruggs, Lyle, Detlef Jahn, and Kati Kuitto. 2017. “CWED2 Download Tool (Comparative Welfare Entitlements Dataset).”

Shahid, Nida, Valeria E. Rac, Joanna Bielecki, and Whitney Berta. 2021. “Understanding Factors Critical to the Implementation of Ehealth in Chronic Disease Management: A Realist Review Protocol.” *BMJ Open* 11(7):e048250. doi: 10.1136/bmjopen-2020-048250.

Sherwood, Juanita. 2013. “Colonisation – It’s Bad for Your Health: The Context of Aboriginal Health.” *Contemporary Nurse* 46(1):28–40. doi: 10.5172/conu.2013.46.1.28.

Sirag, Abdalla, Norashidah Mohamed Nor, Nik Mustapha Raja Abdullah, and Judhiana Abd Ghani. 2017. “Public Health Financing and Infant Mortality: Does Governance Quality Matter?” *Public Finance and Management* 17(4):341–68. doi: 10.1177/152397211701700403.

Skorpen, Stine, and Erik Søndenaa. 2024. “Norwegian Perspectives on Health Care for People with Intellectual and Developmental Disabilities.” *Journal of Policy and Practice in Intellectual Disabilities* 21(2):e12492. doi: 10.1111/jppi.12492.

Smith, Julia, Kent Buse, and Case Gordon. 2016. “Civil Society: The Catalyst for Ensuring Health in the Age of Sustainable Development.” *Globalization and Health* 12(1):40. doi: 10.1186/s12992-016-0178-4.

Smith, Katherine Elizabeth, and Srinivasa Vittal Katikireddi. 2013. “A Glossary of Theories for Understanding Policymaking.” *J Epidemiol Community Health* 67(2):198–202. doi: 10.1136/jech-2012-200990.

Smith, Maxwell, Alison Thompson, and Ross Upshur. 2018. “Is ‘Health Equity’ Bad for Our Health? A Qualitative Empirical Ethics Study of Public Health Policy-Makers’ Perspectives.” *Canadian Journal of Public Health* 109:633–42.

Sochas, Laura, and Aaron Reeves. 2023. “Does Collective Bargaining Reduce Health Inequalities between Labour Market Insiders and Outsiders?” *Socio-Economic Review* 21(2):827–62. doi: 10.1093/ser/mwac052.

Solar, Orielle, and A. Irwin. 2010. “Conceptual Framework for Action on the Social Determinants of Health.”

Squires, Neil, Richard Garfield, Olaa Mohamed-Ahmed, Bjorn Gunnar Iversen, Anders Tegnell, Angela Fehr, Jeffrey P. Koplan, Jean Claude Desenclos, and Anne-Catherine Viso. 2023. “Essential Public Health Functions: The Key to Resilient Health Systems.” *BMJ Global Health* 8(7):e013136. doi: 10.1136/bmjgh-2023-013136.

Storm Mienna, Christina, and Per Axelsson. 2019. “Somatic Health in the Indigenous Sami Population - a Systematic Review.” *International Journal of Circumpolar Health* 78(1):1638195. doi: 10.1080/22423982.2019.1638195.

Swank, Duane. 2005. “Globalisation, Domestic Politics, and Welfare State Retrenchment in Capitalist Democracies.” *Social Policy and Society* 4(2):183–95. doi: 10.1017/S1474746404002337.

Tenkasi, Ramkrishnan (Ram) V., and George W. Hay. 2008. *Handbook of Collaborative Management Research*. SAGE Publications, Inc.

The Commonwealth Fund. 2020. “Canada: International Health Care System Profiles.” Retrieved January 9, 2025 (https://www.commonwealthfund.org/international-health-policy-center/countries/canada).

Tong, Allison, Peter Sainsbury, and Jonathan Craig. 2007. “Consolidated Criteria for Reporting Qualitative Research (COREQ): A 32-Item Checklist for Interviews and Focus Groups.” *International Journal for Quality in Health Care* 19(6):349–57. doi: 10.1093/intqhc/mzm042.

Truth and Reconciliation Commission of Canada. 2015. *Truth and Reconciliation Commission of Canada: Calls to Action*.

UK Parliament. 2024. “Constitution.” Retrieved September 25, 2024 (https://www.parliament.uk/site-information/glossary/constitution/).

Vaismoradi, Mojtaba, Hannele Turunen, and Terese Bondas. 2013. “Content Analysis and Thematic Analysis: Implications for Conducting a Qualitative Descriptive Study.” *Nursing & Health Sciences* 15(3):398–405. doi: 10.1111/nhs.12048.

Vallgårda, Signild. 2011. “Addressing Individual Behaviours and Living Conditions: Four Nordic Public Health Policies.” *Scandinavian Journal of Public Health* 39(6_suppl):6–10. doi: 10.1177/1403494810378922.

Vastergaard, Jakob, and Robert H. Wade. 2012. “Establishing a New Global Economic Council: Governance Reform at the G20, the IMF and the World Bank.” *Global Policy* 3(3):257–69. doi: https://doi.org/10.1111/j.1758-5899.2012.00169.x.

Vivian, Alison, and Michael J. Halloran. 2022. “Dynamics of the Policy Environment and Trauma in Relations between Aboriginal and Torres Strait Islander Peoples and the Settler-Colonial State.” *Critical Social Policy* 42(4):626–47. doi: 10.1177/02610183211065701.

Weaver, Catherine, and Manuela Moschella. 2017. “Bounded Reform in Global Economic Governance at the International Monetary Fund and the World Bank.” P. 0 in *International Politics and Institutions in Time*, edited by O. Fioretos. Oxford University Press.

Wellbeing Economy Alliance. 2022. “Norway Announces New National Wellbeing Strategy : Wellbeing Economy Alliance.” Retrieved January 18, 2025 (https://weall.org/norway-announces-new-national-wellbeing-strategy).

Whitehead, Margaret. 1992. “The Concepts and Principles of Equity and Health.” *International Journal of Health Services* 22(3):429–45.

Whitehead, Margaret. 2012. “Waving or Drowning? A View of Health Equity from Europe.” *Australian and New Zealand Journal of Public Health* 36:523. doi: 10.1111/j.1753-6405.2012.00947.x.

WHO. 1978. “Declaration of Alma-Ata.”

Wilk, Piotr, Alana Maltby, and Martin Cooke. 2017. “Residential Schools and the Effects on Indigenous Health and Well-Being in Canada—a Scoping Review.” *Public Health Reviews* 38(1):8. doi: 10.1186/s40985-017-0055-6.

Wilkinson, Sue. 1988. “The Role of Reflexivity in Feminist Psychology.” *Women’s Studies International Forum* 11(5):493–502. doi: 10.1016/0277-5395(88)90024-6.

Wilson, John. 1983. *Social Theory*.

Woolhandler, Steffie, Terry Campbell, and David U. Himmelstein. 2004. “Health Care Administration in the United States and Canada: Micromanagement, Macro Costs.”

International Journal of Health Services 34(1):65–78. doi: 10.2190/MJJW-GA0V-78KT-9RGX.

World Bank. 2024. “Civil Society Participation Index | Indicator Profile | Prosperity Data360.” Retrieved September 14, 2024 (https://prosperitydata360.worldbank.org/en/indicator/VDEM+CORE+v2x_cspart).

World Health Organization. 2014. “Health in All Policies: Helsinki Statement. Framework for Country Action.”

World Health Organization, (WHO). 1946. “Constitution of the World Health Organization.” Retrieved September 5, 2024 (https://www.who.int/about/governance/constitution).

World Health Organization, (WHO). 1986. “The Ottawa Charter for Health Promotion.”

World Health Organization (WHO). 2007. “Everybody’s Business -- Strengthening Health Systems to Improve Health Outcomes.” Retrieved July 6, 2024 (https://www.who.int/publications/i/item/everybody-s-business----strengthening-health-systems-to-improve-health-outcomes).

World Health Organization, (WHO). 2016. “Strengthening Essential Public Health Functions in Support of the Achievement of Universal Health Coverage.”

World Health Organization, (WHO). 2022. “Technical Brief: Essential Public Health Functions.”

World Health Organization, WHO. 2024a. “Draft WHO Fourteenth General Programme of Work, 2025-2028.”

World Health Organization, WHO. 2024b. “Universal Health Coverage.” Retrieved September 15, 2024 (https://www.who.int/health-topics/universal-health-coverage).

Yin, Robert. 2018. “Case Study Research Defined [White Paper].” Retrieved June 26, 2024 (https://www.researchgate.net/publication/364126131_Case_Study_Research_Defined_White_Paper).

Yin, Robert. 2022. *Case Study Research and Applications*. 7t ed.

Appendix 1: COREQ Qualitative Reporting Guidelines

Table 13: COREQ 32-item Checklist, adapted from Tong (2017), with summary research notes

No	Item	Guide questions/description	
Domain 1: Research team and reflexivity			
Personal Characteristics			
1.	Interviewer/facilitator	Which author/s conducted the interview or focus group?	✓ I conducted all interviews (see Data Collection Methods)
2.	Credentials	What were the researcher's credentials? *E.g. PhD, MD*	✓ I hold advanced professional experience and am currently advancing my academic qualifications with this research as part of my academic work to complete a PhD in Health Policy and Equity Studies (see Data Collection Methods)
3.	Occupation	What was their occupation at the time of the study?	✓ At the time of the study, I was employed within the public health system in Canada, working in an area of health promotion (see Data Collection Methods)
4.	Gender	Was the researcher male or female?	✓ Female, this was covered in the positionality statements (see Researcher's Reflexive Statement)
5.	Experience and training	What experience or training did the researcher have?	✓ Extensive experience in health policy across multiple jurisdictions and contexts.
Relationship with participants			
6.	Relationship established	Was a relationship established prior to study commencement?	✓ Some professional relationships were established prior to the commencement of the study due to my role in the health policy sector (see Data Collection Methods)
7.	Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. *personal goals, reasons for doing the research*	✓ Participants were aware of my professional background, goals, and reasons for conducting this research (see Data Collection Methods)
8.	Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. *Bias, assumptions, reasons and interests in the research topic*	✓ As an insider, I possess a nuanced understanding of the field, which helps build rapport but also necessitates careful management of potential biases and assumptions. My interests in the research topic are both professional and academic (see Data Collection Methods)
Domain 2: study design			
Theoretical framework			
9.	Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. *grounded theory, discourse analysis, ethnography, phenomenology, content analysis*	✓ Methodological orientation: The study is underpinned by a critical realist and interpretivist framework (see Theoretical Frames) ✓ Explanatory case study methodology: Detailed insights into underlying mechanisms and contextual factors guiding successful health policy interventions are provided through case study research, reflecting a critical realist epistemology (Yin, 2018, 2022; Kreindler, 2017) (see Research Design)

			✓ Analytic orientation includes a thematic analysis, using apriori themes as a starting point alongside critical discourse analysis to drive deeper meaning
Participant selection			
10.	Sampling	How were participants selected? e.g. *purposive, convenience, consecutive, snowball*	✓ Participants were selected using a snowball method, leveraging the researcher's academic and professional network (see Data Collection Methods)
11.	Method of approach	How were participants approached? e.g. *face-to-face*, *telephone, mail, email*	✓ Participants were approached via email, or LinkdIn using network contacts to initiate the recruitment process (see Data Collection Methods).
12.	Sample size	How many participants were in the study?	✓ The study included 15 participants: five from Canada, four from the United Kingdom, two from Australia, and four from Nordic countries (Norway and Finland) (see Data Analysis Methods).
13.	Non-participation	How many people refused to participate or dropped out? Reasons?	✓ Minimal refusals or dropouts were recorded, and any non-participation did not significantly impact the study. Specific numbers and reasons were not detailed (see Data Collection Methods).
Setting			
14.	Setting of data collection	Where was the data collected? e.g. *home, clinic, workplace*	✓ Data was collected via Zoom, or Teams allowing participants to join from their preferred locations (see Data Collection Methods).
15.	Presence of non-participants	Was anyone else present besides the participants and researchers?	✓ No, only the participants and the researcher were present during the interviews to ensure confidentiality and minimize external influence (see Data Collection Methods).
Data collection			
17.	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	✓ Yes, an interview guide with open-ended questions was provided and pilot tested to ensure clarity and relevance (see Data Collection Methods).
18.	Repeat interviews	Were repeat interviews carried out? If yes, how many?	✓ No repeat interviews were carried out; each participant was interviewed once (see Data Collection Methods).
19.	Audio/visual recording	Did the research use audio or visual recording to collect the data?	✓ Yes, interviews were recorded using password-protected and encrypted software to ensure accuracy and confidentiality (see Data Collection Methods).
20.	Field notes	Were field notes made during and/or after the interview or focus group?	✓ Yes, handwritten notes were taken during and after the interviews to capture additional observations and reflections (see Data Collection Methods).
21.	Duration	What was the duration of the interviews or focus group?	✓ Each interview lasted approximately 60-90 minutes (see Data Collection Methods)
22.	Data saturation	Was data saturation discussed?	✓ Yes, data saturation was considered reached when no new themes emerged from the interviews (see Data Collection Methods).
23.	Transcripts returned	Were transcripts returned to participants for comment and/or correction?	✓ Transcripts were returned with direct quotes highlighted in both the results and transcripts along with high-level summaries of the discussions (see Data Collection Methods).

Domain 3: analysis and findings				
Data analysis				
24.	Number of data coders	How many data coders coded the data?	✓	One data coder
25.	Description of the coding tree	Did authors provide a description of the coding tree?	✓	Yes, original apriori themes, organic sub-themes and final themes and sub-themes were listed in a table (see Study Design and Data Collection Methods)
26.	Derivation of themes	Were themes identified in advance or derived from the data?	✓	A combination. Apriori themes were used as a starting point, from which point sub themes were elucidated organicalled, and refined through an iterative process to 4 themes and 8 sub-themes (see Approaches to Data Analysis)
27.	Software	What software, if applicable, was used to manage the data?	✓	NVIVO 14 was used
28.	Participant checking	Did participants provide feedback on the findings?	✓	Participants were given the opportunitiy to review findings and provide feedback
Reporting				
29.	Quotations presented	Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.*g. participant number*	✓	Yes, and participant numbers were provided (see Chapter 4: Results and Key Findings)
30.	Data and findings consistent	Was there consistency between the data presented and the findings?	✓	Yes, there was consistency between the data and findings (see Chapter 4: Results and Key Findings)
31.	Clarity of major themes	Were major themes clearly presented in the findings?	✓	4 themes and 8 sub-themes were clearly presented in the findings (see Chapter 4: Results and Key Findings)
32.	Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	✓	Yes (see Chapter 4: Results and Key Findings)

Appendix 2: E-mail/ LinkedIn Direct Messaging Recruitment

Good morning/afternoon,

I am reaching out today regarding a research study that I am conducting as a PhD candidate in Health Policy and Equity Studies at York University, in Toronto, Canada.

For this research, I am looking to interview at least ten people who work within the health system at the federal level in Canada (e.g., health researchers, practitioners, etc.), and ten from other neoliberal, and Nordic countries. Specifically, I am interested in the views of scholars, practitioners, and scholar-practitioners on health promotion practices within Canadian health systems, to inform a case study on how Canada's health system could implement lessons learned on effective health promotion. This work will be semi-structured against 6 themes based on adapted health system building blocks: governance and leadership; funding and financing; workforce; policy, programming, and services; knowledge, information, and evidence; and medical and digital technology.

The interviews will be up to an hour and a half long, focusing on your experiences and views about health promotion in the Canadian context. To help inform your decision, and answer any cursory questions about privacy, I have attached the Informed consent document. Happy to connect and chat about the process more at any time.

Thank you for your time and consideration,
Kelly Salmond

Appendix 3: Informed Consent Document

Informed Consent Form

Date: October 1, 2023

Study Name: Lessons for Health Promotion: A comparative case study of Canada and Nordic health promotion efforts

Researchers: Kelly Salmond, Principal Investigator, York University, 4700 Keele St, North York, Ontario; **Contact Information**: e. ksalmond@yorku.ca; **Graduate Program**: PhD candidate in Health Policy and Equity Studies, York University; **Graduate Supervisor**: Dr. Dennis Raphael

Purpose of the Research: The purpose of the research is to study health promotion efforts as an essential function of public health systems and explain how Canada can learn and apply lessons from Nordic health promotion efforts. As a part of this research, I will be conducting interviews to explore the views of health researchers and practitioners who have worked within these national health systems, to explain how, through a case study, Canada's health system could implement lessons learned on effective health promotion.

This study will unpack the complex relationships between the themes of governance and leadership; funding and financing; workforce; policy, programming, and services; knowledge, information, and evidence; and medical and digital technology**.** This study focuses on understanding expert perceptions of how these building blocks function at the macro-level, and how Canada may lean and implement from the lessons of Nordic public health systems in effective health promotion.

Research will be presented as a dissertation, including oral presentation to an academic committee, as part of the academic requirements for a doctoral degree from York University.

What You Will Be Asked to Do in the Research: I will be conducting interviews with ten people who work within the health system at the federal level in Canada (e.g., health researchers, practitioners, etc.), and ten from other neoliberal, and Nordic countries. Participants will be asked to partake in interviews for up to an hour and a half.

Risks and Discomforts: Social risks such as privacy and reputation could be considered a risk as participants will be known experts, some of whom may currently work within prominent institutions within the public health systems of both countries. To mitigate this, all identifying information will be removed prior to transcription. Original researcher notes are to be stored in a locked cabinet and destroyed in compliance with ethical standards.

Any electronic data (audio recordings) will be stored under an encrypted and password protected file until the publication of the research results, at which point it will be destroyed. Interview participants will not be told who else is included in the study to further protect privacy.

Further, given the small sample size, and that many participants may know one another, to further protect privacy/identity of participants, a list of quotations that will be included in the transcript will be provided for participants to review for any potential identifying information and inform if there are any corrections/revisions they would like to be made.

Benefits of the Research and Benefits to You: Potential benefits to the participants include a reflexive conversation in which opinions expressed may be articulated and refined. Participants may gain useful knowledge about the systems in which they work, or others, for comparison. Potential benefits to the scholarly community, or society, include the identification of lessons from international settings that could be applied to the Canadian health system to strengthen its practice of health promotion.

Voluntary Participation and Withdrawal: Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer, to stop participating, or to refuse to answer particular questions will not influence the nature of the ongoing relationship you may have with the researcher or *the* nature of your relationship with York University either now, or in the future.

There is no incentive offered for participating, but it's hoped that you will find it interesting to speak about your experiences and views.

You can withdraw from the study at any time. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible. Should you wish to withdraw after the study, you will have the option to also withdraw your data up until the analysis is complete.

Confidentiality: All 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 principal investigator will keep a link that identifies you to your coded information, but this link will be kept secure and available only to the principal investigator and/or selected members of the research team. Any information that can identify you will remain confidential.

Your data, including audio recordings and interviewer handwritten notes, will be safely stored in a locked facility, or encrypted files, and only research staff/research team members will have access to this information. Data will be stored for a period of two years, at which point it will be destroyed in alignment with required ethical standards in July 2027. Confidentiality will be provided to the fullest extent possible by law.

This study will use Zoom, or Teams, to collect data, which is an externally hosted cloud-based service. When information is transmitted over the internet privacy cannot be guaranteed. There is always a risk your responses may be intercepted by a third party (e.g., government agencies, hackers). Further, while York University researchers will not collect or use IP addresses or other information which could link your participation to your computer or electronic devices without informing you, there is a small risk with any platform such as this of data that is collected on external servers falling outside the control of the research team. If you are concerned about this, we would be happy to make alternative arrangements (where possible) for you to participate, perhaps via telephone. Please contact ksalmond@yorku.ca for further information.

Recordings (audio only) will be saved in a password protected file to research team members' local computer, not the cloud-based service.

Please note that it is the expectation that participants agree not to make any unauthorized recordings of the content of a meeting / data collection session.

Questions About the Research? If you have questions about the research in general or about your role in the study, please feel free to contact Kelly Salmond either by telephone at 416 702 9646 or by e-mail at ksalmond@yorku.ca, or research supervisor from the Graduate Program of Health Policy and Management at York University, Dr. Dennis Raphael either by telephone at 416 736 2100 Ext. 22053or by e-mail at: draphael@yorku.ca. This research has received ethics review and approval 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 Director, Research Ethics in the Office of Research Ethics, 3rd Floor, Kaneff Tower, York University (e-mail ore@yorku.ca).

Additional consent

Please provide additional consent by checking boxes for the following:

1. **Audio recording**

   ☐I consent to the audio-recording of my interview(s).

2. **Consent to use of quotes**

   ☐I consent to the use of quotations in any final reports/ publications of the research? Y / N

Legal Rights and Signatures:

I *(fill in your name here),* consent to participate in *(insert study name here*) conducted by *(insert investigator name here)*. 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

Appendix 4: Interview Guide and Questions

Recent threats to public health, including the COVID-19 pandemic, have shown that efforts to strengthen public health systems are fragmented and often focused on clinical or emergency response; reducing capacity to promote health and health equity (WHO, 2016; WHO, 2022). This has led to an increased interest and commitment to the essential functions of public health systems, which are closely tied to the Universal Health Coverage agenda (WHO, 2016; WHO, 2022).

These functions are fundamental for governments to achieve the goal of public health which is to improve, promote, protect, and restore health through collective action; health promotion is consistently recognized as an essential, or core, public health function at the global, regional, and national levels (IAPHI, 2007; WHO, 2016; WHO,2022; PAHO, 2020; Naylor, et al., 2003; PHAC, 2021). Health promotion, as defined in the Ottawa Charter (1986), involves processes that create supportive environments and healthy public policies, beyond promoting a healthy lifestyle, to enhance overall well-being (WHO 1986). In essence, health promotion seeks to create a fair and equitable distribution of health and well-being.

Health equity, the absence of unfair and preventable inequalities in health as well as the social conditions that determine them, is a fundamental aspect of health promotion, as the practice extends beyond individual behaviors and involves advocating for changes in social determinants of health (Nutbeam 1998; Raphael, 2012). These inequalities are systematically shaped by social advantage or disadvantage (Whitehead 1991; Kawachi et al., 2002; Raphael, 2012). Importantly, this term has been gaining traction among policy actors and institutions as a guiding principle (Potvin and Jones, 2011; Solar and Irwin, 2010).

Yet, scholars and practitioners from Neo-liberal countries that enjoy universal public health systems, such as the United Kingdom, Canada, and Australia, emphasize the extent to which health promotion practice has languished, unable to address the structural and policy drivers of the inequalities in health outcomes (Raphael, 2010; Bryant, Raphael, Schrecker, and Labonté, 2011; Hackock, 2011; Smith, Crawford and Signal, 2016; Rootman, Pederson, Frohlich, and Dupéré, 2017; Bambra, Munford, Brown et al., 2018; Borras, 2023).

Nordic nations, on the other hand, are often used as a critical comparison in the pursuit of health and wellbeing (Raphael and Bryant, 2020). Research consistently concludes that the universal welfare provision of Nordic countries contributes to improved population health,

including life expectancy of all social groups when compared to equivalent groups in other countries, as well as lower pre-mature mortality risks (Navarro, Muntaner, Borreell, et al., 2006; Coburn, 2004; Bambara, 2005; Chung and Muntaner, 2007; Eikemo, Bambra, Judge, et al., 2008; Bambra, 2011, Kelly-Irving, Ball, Bambra, C, et al., 2023). The affinities between principles of the social democratic welfare state and health promotion as defined by the WHO are especially evident in Finland, Norway, and Sweden (Fosse and Helgesen, 2019).

Nordic nations set the standard for assessing health promotion approaches (Marmot, 2018). In fact, a recent ranking of OECD and EU nations based on social justice—a pre-requisite for health (WHO 1986)— placed Norway, Finland, and Sweden among the top five performers, while Canada holds the twelfth spot (Hellmann et al., 2019). Their strong governance and local health promotion initiatives have made Nordic countries leaders in health promotion (Côté and Raynault, 2015; Fosse and Helgesen, 2019; Raphael and Bryant, 2020).

Importantly, welfare state institutions and policies influence social conditions that determine health, such as education, and income. So, by ensuring more equal access to improved social conditions and pre-requisites of health, universal welfare states contribute to more equitable health outcomes (Raphael and Bryant, 2020). Therefore, comparative works that focus on absolute health, with awareness of the social sphere and intersectionality, are an important entry point for learning public health systems— and contribution to the scholarship— pursuing health for all (Bambra, 2011).

In response to the critiques that universal public health systems in neo-liberal contexts have languished in their health promotion efforts where others have flourished; this research looks to explain how universal public health systems, such as those in the UK, Canada, and Australia might implement lessons from the Nordic nations to promote health—and health equity—more effectively and efficiently.

About the Interviews

Open-ended interviews will focus on themes of real and actual power and decision making within the systems and institutions of work, as well as the meaning of these power dynamics for health promotion, from the vantage point of the interview participants. Interviews are structured across 6 thematic areas to elucidate system-level lessons for health promotion efforts of national public health systems, adapted from the original WHO framework, as well as more recent domestic adaptations (WHO, 2007; PHAC, 2021).

Interview questions have been developed as a starting point for semi-structured discussion, and, as a part of responsive interviewing, are intended to be iterative throughout the data gathering process (Rubin and Rubin, 2011). Existing grey literature documents, such as reports commissioned by the health system in Canada (e.g., a Checklist on intersectoral governance produced by the Health Council of Canada, 2010), have been used to identify discussion topics within the building blocks, and guide the discussion.

Interview Questions*:

**Note: Questions and prompts to be further informed by documentary analysis as well as iterative responsive interviewing techniques (Rubin and Rubin, 2011).*

Preface: Thank you so much for your time today. As you know, we both share common ground in our wider work in the public health sectors. So, please feel free to change any name of institutions or actors that you feel uncomfortable disclosing to me. These are not relevant to the research as we are interested in your experience. I will start by asking you some questions about key concepts, the role of public health systems, and then move on to your experiences within the system.

Guiding Questions

1) Tell me a bit about yourself, including your research and work in public health. How many years' experiences have you had in the public health system?
   Prompt(s): As a researcher? As a practitioner? As both? How has this affected your perception of health policy or health equity?

2) How are the terms “health,” “health equity/inequity,” “health inequality,” conceptualized and operationalized in your context? How is “health promotion” positioned within the public health systems in your context?
   Prompt(s): Who is responsible for health promotion? Who are the main actors? At the federal/national level? Local levels? How have you interacted with the field of health promotion in your career (note dual roles of scholar-practitioner, where applicable).

3) How, in your experience, has the public health system framed policy to address health inequities?

Prompt(s): What about public policy initiatives that were not part of a public health approach, but had meaningful impacts on population health (e.g., universal childcare and guaranteed income for people living with a disability are two notable and recent examples from Canada)? How do public health systems, in your experience, promote or contribute to these policies and their framing? Were there times that you felt like there was a change in the policy landscape (e.g. COVID-19 pandemic, recent climate emergencies like heat waves or wildfires)?

4) In your experience, what is the general awareness among key policy actors (e.g. elected officials, public health system actors) of the importance of the social determinants of health for promoting population health and reducing health inequities? Why or why not?
   Prompt(s): Can you think of time when you felt a willingness to name the difficult problems and barriers that exist, and to provide the resources necessary to transcend them? Does this include recognition that it may take years, even decades, for benefits to materialize? What about during the recent COVID-19 response?

5) What is your sense of commitment by the public health system to undertake a broader approach to addressing population health and reducing health inequities?
   Prompt(s): Can you describe how this commitment has been implemented (e.g. the allocation of significant funding for research, analysis, and policy implementation)? What is your sense of the challenges to developing/realizing such commitments?

6) Can you describe a time that you were part of a policy initiative that included intersectoral participation with the public health sector/system? How was health equity positioned?
   Prompt(s): Can you describe how these activities were coordinated across ministries and departments? Do they adequately ensure that leadership, accountability, and rewards are shared among partners? How are they resources (e.g. to sustain activities beyond the tenure of the present governing authority)? Was health equity considered?

7) What has your sense of balance between central direction, and the discretion of local communities to implement goals and objectives in these policy initiatives? Prompt(s): How are accountability and evaluation frameworks incorporated? In your opinion, how could they be improved?

8) In your own experience, how are knowledge, information, and evidence used to make decisions and take policy action, and how does the institutional setting influence that relationship? Prompt(s): What kind of knowledge is favoured? Is this documented anywhere (e.g., Government Reports)? Is conclusive evidence required to make decisions? How are social sciences considered?

9) Based on your experiences, observations, and reflections, how could the public health system be more effective in its approaches to promoting health and health equity?

   Prompt(s): How important are explicit concrete objectives and visible results? What about processes, like community participation or self-determination? How is transparency in governmental efforts and activities ensured?

Administrative

10) Would you like the results of this research shared with you? If yes, in what format is the most helpful information? (e.g., two-page primer on key findings, infographic, recommendations, etc.)